Local 108
Health Expense Benefits Plan
Plan A

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Important Telephone Numbers

Listed below are some important telephone numbers you should call with any questions you may have.

For Medical claims and coverage:

Call Alicare at 212-539-5115.

For Hospital claims and coverage:

Call Horizon Blue Cross of New Jersey at 1-800-355-2583

For Dental claims and coverage:

Call DDS, Inc. at 1-800-255-5681

For Eligibility and Enrollment:

Call the Local 108 Health Benefit Plan at 973-762-7224.

For Mail Service Prescription Drug Program information:

Call 1-800-631-7780.

For Plastic Card Prescription Drug Program information:

Call 1-800-631-7780.

For finding a MultiPlan Network Provider or nominating a doctor to join the Multiplan Network (MultiPlan does not provide benefit or eligibility information):

Call 1-800-672-2140.

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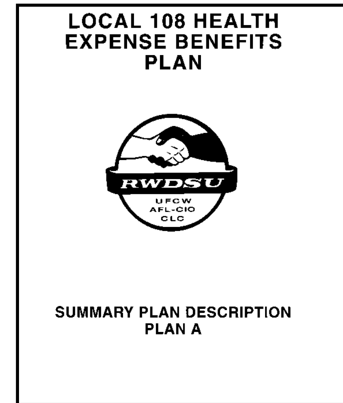

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1. Your Plan At A Glance

Health Care Coverage (For You And Your Covered Dependents)

Preferred Provider Organization (PPO) Hospital Network Coverage[1]

Maximum Payments

$35,000 maximum per inpatient hospital admission.
$70,000 maximum during any 12-month period.
$110,000 maximum per lifetime.

Hospital Inpatient Coverage[2]

Coverage for up to 100% of the Network allowance for semi-private room, board and ancillary services. Routine nursery care for newborns covered to $1,500 maximum. Infants up to age two covered for illness or injury up to a $5,000 maximum per 12 month period. Elective abortion covered up to an all inclusive maximum of $450. Mobile intensive care units covered up to a maximum of $150 per occurrence. Coverage for up to a maximum of $300 for up to 10 days for hospital room and board outside of U.S.

Hospital Outpatient Coverage

Coverage for up to 100% of the Network allowance for charges for surgery; X-ray, lab charges and pre-admission testing to a $1,200 combined maximum per 12 month period; radiation therapy, chemo-therapy and hemodialysis to an $8,000 combined maximum per 12 month period.

Coverage for up to 100% of the benefit allowance of $250 for in or out-of Network care for life or limb threatening accidental injuries (within 72 hours) and medical emergencies (within 24 hours of onset).

Alternatives to Hospital Inpatient Coverage

Covered for up to 100% of the Network allowance for a Surgicenter, Birthing Center, Home Health Care for up to $1,000 per 12 month period and a maximum of 15 visits; and, Hospice Care for up to a $3,000 lifetime maximum. No payment is available for out-of-Network Hospice Care.

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[1] If you or your eligible dependent(s) use a hospital or facility that does not participate in the Blue Cross Preferred Provider Organization (PPO) Hospital Network, then, unless otherwise stated, the benefit payment will only be 70% of the eligible amount, up to the benefit maximum. Any outstanding balance will be your responsibility.

[2] During the first 12 months of covered employment, In-Network Hospital Inpatient Coverage coinsurance is 10% of the Benefit Allowance. Thereafter, In-Network Hospital Inpatient Coverage will be paid at 100% of the Benefit Allowance.

Health Care Coverage (For You And Your Covered Dependents), Cont.

Preferred Provider Organization (PPO) Hospital Network Coverage, Cont.

Physical Rehabilitation — Covered for up to 100% of the Network allowance for inpatient physical rehabilitation for up to a $5,000 maximum per 12 month period; outpatient physical rehabilitation for up to a $1,000 maximum per 12 month period.

Mental Health/ SubstanceAbuse Care (employee only) — Covered for up to 100% of the Network allowance for inpatient facility charges for mental nervous for 5 days per 12 month period, up to 30 lifetime days. Substance abuse covered for up to a $2,500 maximum payment per 12 month period for inpatient and outpatient facility charges.

Medical Coverage

MultiPlan Network — When a MultiPlan Network Provider is selected, the amount that you are "balanced billed" is greatly reduced.

Annual Deductible — The annual deductible is $150 per person, which must be met each calendar year for all Medical Coverage expenses before you begin to receive reimbursement of recognized reasonable charges.

Surgical Benefits — Covered according to a surgical schedule for up to a maximum payment of $12,000 for all operations during any one period of continuous illness. The maximum includes charges for pre- and post-operative care by a doctor. Professional services for elective abortions are limited to a maximum payment of up to $300 (for member or spouse only).

Anesthesia — Anesthesia is covered up to 40% of the Plan payment for the surgical procedure.

Chemotherapy/Radiation/ Hemodialysis Benefits — Covered for treatment in a doctor's office for up to $200 per treatment (limited to one treatment per day) up to a maximum of $3,000 in any 12 calendar month period.

Infusion and IV Therapy — Covered for 15 days in a 12 month period to $125 per day for all charges.

C-Pap Machine — Covered up to $300 for rental or purchase every 36 months.

X-ray and Laboratory Services — Covered according to a schedule for up to a maximum of $650 per person per 12 month period. These payments are in addition to any Plan payments for outpatient X-ray and laboratory services in a hospital.

Doctors' Visits — Coverage is provided for doctors' visits in the home, office or hospital, or for doctor's charges for outpatient treatment in an emergency room or clinic. Coverage is up to $35 per visit for up to 50 visits (including 5 visits for mental health) in a calendar year, limited to one visit per doctor per day.

Optical Benefits (For You And Your Covered Dependents)

Coverage is provided for each covered person once during any consecutive 24 month period for up to $30 each for eye examinations, frame and single vision lenses and up to $50 each for frame and bifocal lenses and contact lenses, after 12 consecutive months of Plan contributions are made on your behalf.

Hearing Aid Benefits (For You And Your Covered Dependents)

Covered up to $125 for a hearing examination, $350 for a new hearing aid and $100 for necessary repairs to a hearing aid or replacement of batteries, after 12 consecutive months of Plan contributions are made on your behalf. The hearing aid and battery replacement benefit is available once in any four year period.

Dental Benefits (For You And Your Covered Dependents)

Your Dental Benefit includes:

- Preventive/Diagnostic Services covered at 100% of reasonable and customary charges,
- Therapy/Treatment Services covered at 50% of reasonable and customary charges,
- Prosthodontic Services covered at 50% of reasonable and customary charges,
- Periodontic Services covered at 50% of reasonable and customary charges,
- Inlays and Crowns covered at 50% of reasonable and customary charges,
- Oral Surgery covered at 50% of reasonable and customary charges,

Dental Benefits are available after 12 consecutive months of Plan contributions are made on your behalf. Dental Benefits are subject to a maximum of $1,000 per person per calendar year. Dental Benefits are available only if specifically provided for in the collective bargaining agreement with your employer. Collective bargaining agreements that became effective prior to July 1, 1997 all include Dental Benefits.

Prescription Drug Benefits (For You And Your Covered Dependents)

Effective 12/1/04, covered through a card program with a co-payment for generic drugs of 10% of cost or a $10 minimum and a co-payment for brand name drugs of 20% of cost or a $20 minimum per prescription or refill. Maintenance prescription drugs are covered through a mail order program with a co-payment of 10% of cost or a $10 minimum. Coverage is provided up to a $5,000 per person annual maximum payment. Prescription Drug Benefits are available after 12 consecutive months of Plan contributions are made on your behalf. Prescription Drug Benefits are available only if specifically provided for in the collective bargaining agreement with your employer. Collective bargaining agreements that became effective prior to July 1, 1997 all include Prescription Drug Benefits.

Death And Dismemberment Benefits (For Your Beneficiaries)

A death benefit of up to $8,000 is available to the beneficiaries of members depending on part-time or full-time contribution rates and years of covered employment. Effective July 1, 1998, the death benefit for members, who become eligible on or after July 1, 1998, will be determined according to a new graduated schedule. An accidental death benefit of up to $2,000 is available to the beneficiaries of members depending on part-time or full-time contribution rates. An additional benefit of up to 100% of the regular death benefit amount is provided for accidental dismemberment.

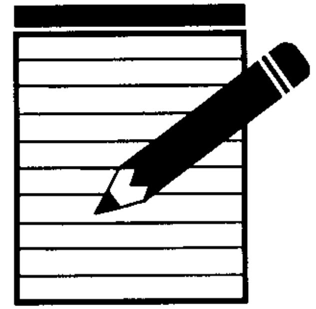
Spouse Death Benefit (For Your Spouse's Beneficiaries)

A death benefit of $250 is available to the beneficiaries of spouses of full-time contribution rate members, who are eligible for family benefits.

Retiree Death Benefit (For Your Beneficiaries)

A death benefit of $2,000 is available to the beneficiaries of full-time contribution rate retirees age 65 or older who have 15 or more years in the Plan.

2. Basic Information



What Is The Health And Welfare Plan?

The security of your family is an important concern to your employer and your Union. Without adequate protection, the cost of an illness or injury could become a serious financial burden.

Naturally, the hope is that serious illness or injury never comes your way. However, as a participant of Local 108 Health Expense Benefits Plan, you can be assured that you and your family have protection through a wide range of coverage.

The Plan described in this booklet is for participants of the Fund who are covered by collective bargaining agreements which provide for the appropriate contributions for this coverage.

How To Use This Booklet

This booklet is called a Summary Plan Description (SPD). It is designed to help you understand how your Welfare Plan works. Because certain parts of the Plan are complicated, every effort has been made to present this material in a way that is easy to understand. However, this booklet is not a replacement for the actual Plan documents. In cases where an official interpretation is needed, the Plan documents will always be used.

To assist you in understanding your coverage, there are overview charts throughout the booklet and a general overview on pages 4 through 6 of the booklet. However, it is important for you to read the entire booklet to fully understand what you are entitled to, so that you can make the best use of your Plan coverage.

If after reading this booklet you have any questions about the Plan and how its coverage works, the Fund Office will be glad to help you.

Who Pays The Cost Of The Plan?

The Plan is provided as part of the Collective Bargaining Agreement between Local 108 Retail Wholesale Department Store Union, AFL-CIO and your employer. In accordance with that agreement, the cost of the Plan is paid by your employer through monthly benefit contributions to the Fund (as well as employee contributions, where applicable) subject to the terms of the Collective Bargaining Agreement.

When you are working for an employer and your employer is making payments to the Fund on your behalf, you are considered to be working in covered employment.

Who Is Covered?

You:

When you meet the Plan's requirements for coverage (see next section), you are covered for:

- health care
- optical care
- prescription drugs
- dental care
- hearing aid benefits
- death and dismemberment benefits

Your Dependents:[1, 2]

Generally, Health Care Coverage (including optical care and prescription drugs) for your covered dependents (as defined below) begins and ends at the same time your coverage begins and ends.

Your covered dependents are:

- your legal spouse who resides with you
- your unmarried dependent children from birth to the end of the calendar month when they become age 19. This only includes a member's natural child who (1) normally resides in your household in a parent-child relationship and (2) is dependent upon you for support and maintenance
- your unmarried adoptive children to the day they become age 19 from the time the child is placed with you for adoption, if the child is under age 18 at the time of the placement and you assume a legal obligation for the child's total or partial support in anticipation of adoption, even if the

[1] Proof of dependent status (marriage certificate, birth certificate or adoption papers) is required.
[2] Dependent coverage is subject to the full time/full contribution rate as defined by the Collective Bargaining Agreement.

adoption is not yet final. If the adoption or placement for adoption occurs while you are eligible for coverage under the Plan, coverage for pre-existing conditions will not be restricted for the child (see the section titled "Exclusion For Pre-existing conditions")

- your unmarried dependent children age 19 and older who are incapable of self-sustaining employment due to mental illness, developmental disability, physical handicap or mental retardation, if the condition began prior to age 19 and the child has been continuously covered for Fund benefits prior to age 19[1]
- if both you and your spouse are each members in this Plan, you cannot claim each other as dependents and only one of you can claim children as dependents (there is no double or fill in coverage – only one of you can have family benefits and the other must have single (member only) benefits.

Changes in dependent status should be reported within 30 days of the events occurrence. You must file an Enrollment Card within 30 days after your marriage or the birth or adoption of a child.[2]

Qualified Medical Child Support Orders:

The Plan will provide health care coverage in accordance with a Qualified Medical Child Support Order, which is any judgment, decree or order issued by a court which recognizes a child or children's right to receive benefits under a group health plan in which the child's parent is an eligible participant.

The Qualified Medical Child Support Order must specify: the name and last known mailing address of the participant and the name and address of each of the eligible children, a description of the type of coverage to be provided, the period to which the order applies, and each plan to which the order applies.

The Qualified Medical Child Support Order can not require the Plan to provide any benefit or option not otherwise provided under the Plan.

When a Qualified Medical Child Support Order is received by the Plan, its receipt will be acknowledged and you will be advised of the Plan's determination of whether it is a Qualified Medical Child Support Order.

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[1] The Fund Office must be notified of any handicapped dependent children when they become age 19 and a medical form must be completed by a physician certifying that the handicap results in total disability and in complete financial dependence on the participant. Periodic updating of the medical condition will be required and the Fund may require that the dependent be examined by Fund physicians.

[2] Proof of change of family status (marriage certificate, birth certificate or adoption papers) is required.

When Coverage Begins

Enrollment:

Enrollment in the Plan is the first step you must take to be able to receive benefits.

Obtain an Enrollment Card from the Plan Office or your employer. Return the completed card promptly. If you do not, the start of your coverage may be delayed and you could lose some of your benefits.

The Enrollment Card is a permanent record of important dates for you and your eligible dependents. The beneficiary that you choose to receive your death benefit is also listed on this card.

Claims for benefits incurred before your Enrollment Card is received by the Plan Office, or for dependents not listed on your card, may be denied unless there is reasonable cause for failing to register properly or in a timely manner.

You can obtain dependent coverage outside of the open enrollment period, pursuant to marriage or a legal adoption within thirty (30) days of the event, and childbirth ninety (90) days prior to the expected birth date or within thirty (30) days of the birth date. You can change from family coverage to single only coverage in the event of the death of a spouse or child, if that spouse or child were the sole dependent.

Waiting Periods For Benefit Coverage:

Benefits coverage starts only after you have completed a period of covered employment. Covered Employment, for Plan purposes, means time for which employer contributions to the Plan are required on your behalf. These benefits apply to you and your eligible dependents (part-time employees have individual coverage only). Eligible dependents are subject to the same waiting period as eligible employees.

There are different waiting periods depending on the type of benefit.

For the following benefits eligibility begins on the first of the month for which the third consecutive monthly contribution is received:

- Hospital
- Surgical
- Anesthesia
- Laboratory and X-ray
- Accident
- Medical
- Death and Dismemberment

For the following benefits eligibility begins on the first of the month for which the thirteenth consecutive monthly contribution is received:

- Prescription Drug
- Dental
- Optical
- Hearing Aid

No benefits will be paid on any claim for services rendered before you complete the waiting period.

If you are not actively in covered employment when your benefits are first scheduled to be in force, then coverage for you and your dependents will be delayed until you return to work.

Dependents are eligible only through you, the member. Newborns ill or injured at birth are eligible immediately if properly registered with the Plan. See the Section titled "When Coverage Begins."

Exclusion For Pre-Existing Conditions

A "pre-existing condition" is any condition other than pregnancy for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the earlier of your enrollment date or the beginning of a waiting period for coverage eligibility. If you or your eligible dependents have a pre-existing condition, the Plan will not cover the condition for 12 months. This 12 month period is reduced by periods of prior coverage which were not separated by more than 63 days.

For example, if you were covered under your previous plan for nine months, your pre-existing conditions exclusion only applies for three months. If you were covered for 12 months or longer, your pre-existing condition exclusion is waived entirely. This provision applies only to medical benefits that are covered by the Fund and which were also covered by your previous plan.

When Coverage Ends

All of your benefits coverage terminates two (2) months after your covered employment ends. Generally, this is the last day of the second month after which a contribution to the Plan was made on your behalf.

Benefits coverage for your dependent(s) terminates on the earlier of (1) the date your coverage terminates or (2) the date the dependent is no longer an eligible dependent under the Plan.

All benefits coverage ends immediately if your employer ceases to be a contributing employer to the Plan.

Certificate Of Creditable Coverage

When your (and your covered dependents') coverage under the Plan ends, the Plan will issue a Certificate of Creditable Coverage to each individual or family member whose coverage ends. The Certificate provides the documentation of prior coverage and/or limitations when enrolling in a new employer-sponsored health plan.

The Plan must provide you with a Certificate:

- when you lose coverage under the Plan or COBRA continuation coverage terminates;
- if requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

- if you and/or your family had up to 18 months of creditable coverage under the Plan;
- the coverage start date (along with any eligibility waiting period);
- the coverage end date under the plan.

If, within 63 days after your coverage under the Plan ends, you and/or your eligible dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a pre-existing limitation period that may apply under the new Plan.

Change In Job Category

If you were covered by the full contribution rate for at least one (1) full Benefit Year immediately preceding a change in category, your full contribution rate benefits coverage will be extended for up to three (3) months while you remain in covered employment.

If you were eligible for single coverage only (reduced employer contribution rate) and switch to family coverage (full employer contribution rate), you must work in the full rate category for the next two (2) months to be eligible for dependent coverage starting with the third full-time month. In such case, you will also receive benefit year credit for your part-time Plan coverage.

If you become eligible for any extension of coverage due to a change in job category, you and your eligible dependents may be subject to exclusions for pre-existing conditions.

When Coverage Is Reinstated

If, within three (3) months from your last date in covered employment, you return to work in covered employment with any employer contributing to the Plan, all benefits coverage for you and your eligible dependents will be reinstated on the first day of the third month for which a Plan contribution is made on your behalf.

If, after three (3) months from your last date in covered employment, you return to work in covered employment with any employer contributing to the Plan, you will be considered a new participant and subject to all the waiting periods, exclusions for pre-existing conditions and enrollment requirements for new participants.

The Uniformed Services Employment and Reemployment Rights Act of 1994

If you stop working to enter Military Service, all benefits will terminate on the date you leave active employment. However, the Uniformed Services Employment and Reemployment Rights Act of 1994 enables you to continue your coverage for a period of time, and to be guaranteed reinstatement upon your return to work.

Continuation Coverage

Employees on uniformed service leave and their dependents who are covered by the Plan at the time leave begins may be eligible for continued health coverage while they are on leave for up to 18 months, beginning on the date on which the employee's absence for such leave commences. See "Your COBRA Rights" on page 48 for more information on the availability of continuation coverage.

Reinstatement of Health Coverage

If your health coverage under the Plan is terminated by reason of service in the uniformed services, you are entitled to reinstatement of health coverage for yourself and your dependents upon your return to employment with your Employer, without the application of any waiting periods and pre-existing conditions limitations. The Plan may apply a waiting period or pre-existing conditions period for disabilities that the Veteran's Administration ("VA") has determined to be service connected. This includes any injury or sickness found by the VA to have been incurred in, or aggravated during, the performance of service in the uniformed services.

The term “uniformed services” refers to the United States Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), the commissioned corps of the Public Health Service, and any other categories of covered services that the President of the United States may determine.

The term “service in the uniformed services” means the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Honorable Discharge

All of the rights granted by the Uniformed Services Employment and Reemployment Rights Act of 1994 are dependent on uniformed service that ends honorably. Separation from the uniformed services that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in conviction under court martial, would disqualify a service member from any of the rights under the law.

3. Health Care Coverage

Introduction

Everyone is aware that health care costs have been rising very sharply. Local 108 has introduced many new comprehensive programs to help protect you and your family against these costs. However, as consumers, we are all burdened with these costs and their impact on the nation's economy, even when we're protected by health care coverage.

One of the factors that has led to such high costs is the inefficient use of health care. You can help to control this situation by becoming a wise consumer of health care. With your help, Local 108 can continue to keep coverage levels high and your out-of-pocket expenses low.

Here are some of the ways you can help:

- Ask your doctor if surgery can be performed without a hospital inpatient admission, in the hospital outpatient department or in the doctor's office. It may be safer, quicker and more comfortable for you.
- Have diagnostic testing performed as a hospital outpatient, through a pre-admission testing program, before being admitted to a hospital.
- Be sure to leave the hospital as soon as it is medically appropriate — ask your doctor.
- Ask your doctor if a hospital stay can be shortened by using home health care.
- Consider using alternatives to hospital inpatient coverage such as a hospice program, surgicenter or birthing center where medically appropriate.

Your Comprehensive Health Coverage

Your Health Care Coverage includes the following:

- Preferred Provider Organization (PPO) Hospital Network Coverage, which is provided by the Plan and administered by Horizon Blue Cross of New Jersey (Blue Cross Networks may vary depending where you reside) and pays benefits for eligible charges for hospital and facility care, and
- Medical, which is provided by the Plan and is administered by Alicare, Inc. an affiliate of the Amalgamated Life Insurance Company in conjunction with the MultiPlan Preferred Provider Organization (PPO) Medical Network, and pays benefits for eligible charges incurred, in or out of the hospital, and, where applicable, for charges in excess of those eligible charges covered by Horizon Blue Cross of New Jersey.

In addition, the Plan provides coverage for Optical Care, Hearing Aid Benefits, Dental Care, Prescription Drugs and Death and Dismemberment Benefits.

These combined coverages provide you and your family members with a comprehensive program of health care.

Definitions

The definitions listed below refer only to material contained in the Preferred Provider Organization (PPO) Hospital Network Coverage Section.

A Benefit Year is the 12-month period from the last illness.

A Birthing Center is a facility which provides maternity services to eligible persons as a cost saving alternative to hospital inpatient care, and provides maternity services to eligible persons.

A Certified Registered Nurse Anesthetist (C.R.N.A.) is a registered nurse, certified to administer anesthesia, who is employed by and is under the supervision of a physician anesthesiologist.

Coinsurance is an amount of covered facility expenses, which you must pay on a percentage basis.

A Copayment is a specified dollar amount which you must pay either per specified covered facility expense or per specified period of time.

A Detoxification Facility is a health care facility licensed by the State of New Jersey as a detoxification facility for the treatment of alcoholism, or meeting the same standards if located in another state, which provides eligible services for the treatment of alcoholism.

An Eligible Person is the member and any eligible dependents enrolled under this program.

The Enrollment Official is the Local 108 Benefit Plan Office.

A Home Health Agency is an approved home health agency which provides skilled nursing services and other therapeutic services to eligible persons in their home.

Hospice is a hospice care program which is approved by either the Joint Commission on Accreditation of Health Care Organizations or Medicare and provides hospice services to eligible persons.

A Hospice Care Program is a health care program which provides an integrated set of services for palliative and supportive care to terminally ill patients and their families. Hospice services are coordinated through an interdisciplinary team directed by a physician.

A Hospital is an institution that receives compensation for providing the facilities for surgical and medical diagnosis and treatment of patients. A staff of physicians licensed to practice medicine and surgery supervises care that is furnished by registered graduate nurses 24 hours a day.

In-Network refers to an eligible facility which has a written agreement with a Blue Cross Plan to provide eligible services to eligible persons.

Inpatient refers to you either:

- when you receive services and supplies as a registered bed patient in an eligible facility; or
- the services or supplies provided to you when you are a registered bed patient in an eligible facility.

A Member is the employee in whose name coverage under this program is provided.

Out-of-Hospital refers to services or supplies provided to you when you are other than an inpatient or outpatient in a hospital.

Out-of-Network refers to an eligible facility which does not have a written agreement with a Blue Cross Plan to provide eligible services to eligible persons.

Outpatient refers to you either:

- when you are other than an inpatient; or
- the services or supplies provided to you when you are other than an inpatient.

A Participating Plan is any voluntary non-profit hospital or medical service corporation which has agreed to provide, in whole or in part, benefits described in this booklet.

Plan Allowance is the maximum allowance to be paid for an eligible facility other provider's expenses as determined by Horizon Blue Cross of New Jersey or a participating plan. In the case of an in-network provider, the benefit allowance is established by Local 108 Health Expense Benefits Plan.

A Psychiatric Hospital is an institution which, for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

A Rehabilitation Hospital is an institution which, for compensation from its patients, is primarily engaged in providing rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

A Residential Facility is a health care facility licensed, certified or approved by the State of New Jersey as a residential facility for the treatment of alcoholism, or meeting the same standards if located in another state, which provides eligible services for the treatment of alcoholism.

A Service Report is a claim form showing the information about the member, the eligible person receiving services and the services performed by the eligible provider.

A Surgicenter is a state-licensed, freestanding surgical center which provides ambulatory, same day surgery services to eligible persons.

You and Your mean the member and/or any eligible enrolled dependents, as the context in which the term is used suggests.

Preferred Provider Organization (PPO) Hospital Network Coverage

SUMMARY

Maximum Lifetime Payment of $110,000.

coinsurance

- In-Network – 10% during first 12 months of covered employment. There is no coinsurance after the first 12 months of covered employment.
- Out-of-Network – 30%

Coverage Includes:

- Hospital Inpatient
- Hospital Outpatient
- Hospital Inpatient Alternatives

Special limitations apply to confinements for mental health care.

Benefit Period

The Benefit Period, for purposes of the Preferred Provider Organization (PPO) Hospital Network Coverage, is twelve months from the last illness, so each benefit could have a different Benefit Period.

Coinsurance

In-Network Services

There is no coinsurance for In-Network Services after the completion of twelve (12) months of covered employment. During the first twelve (12) months of covered employment, In-Network Hospital Inpatient Coverage coinsurance is 10% of the Benefit Allowance.[1] In-Network Services will be paid at 100% of the Benefit Allowance thereafter.[1]

Out-of-Network Services

You share in paying a part of the balance of eligible expenses. This is called coinsurance. Your coinsurance is 30% of the Benefit Allowance.[1] This 30% coinsurance applies to all Out-of Network facilities, including hospital inpatient, hospital outpatient, ambulatory service centers and birthing centers.

Maximum Benefits

You and your covered dependents are entitled to a lifetime maximum benefit of $110,000 per person for In-Network and Out-of-Network Hospital expenses incurred while coverage is in effect, for all covered facility charges.

However, see the section titled “Covered Facility Expenses” for limitations on Mental Health Care expenses.

Covered Facility Expenses

Covered facility expenses are the charges determined by Horizon Blue Cross of New Jersey or your Participating Plan for the services and supplies listed on the next page when they are performed or prescribed by a physician, are medically necessary for the diagnosis or treatment of an illness or injury, and are not otherwise excluded or limited.

[1] Benefit Allowance is the Plan’s limit on the amount recognized for Preferred Provider Organization (PPO) Hospital Network Coverage charges. Any outstanding balance will be your responsibility.

This Preferred Provider Organization (PPO) Hospital Network Coverage provides you with the freedom to choose any provider. In-Network providers agree to accept Horizon Blue Cross of New Jersey or the Participating Plan's allowance, as payment in full. For Out-of-Network providers, you are responsible for 30% coinsurance and any charges above Horizon Blue Cross of New Jersey or the Participating Plan's allowance.

All benefit limitations are combined for both In-Network and Out-of-Network services, unless otherwise specified.

Hospital Inpatient Coverage[1]

- Hospital inpatient charges incurred while confined to a hospital on the date Plan coverage begins will be covered from that date forward in accordance with the terms of the Plan.
- Benefit allowance for hospital charges for semi-private room and board, including special diets, general nursing care, ancillary services and supplies is $35,000 per person per admission and $70,000, per person per 12 month period. Two or more hospital stays for the same or related causes which are not separated by 3 months return to normal activity are considered a continuous confinement for Plan purposes;
- Use of operating, recovery, treatment, delivery and emergency rooms and equipment;
- Expenses incurred in either an intensive care unit or cardiac care unit of a hospital;
- Medical and surgical dressings, supplies casts and splints;
- Anesthetics and their administration;
- Diagnostic services, including but not limited to:
  - X-ray examinations,
  - ultrasonography,
  - pathology
  - laboratory tests,
  - electrocardiograms,
  - electroencephalograms,
  - electromyograms,
  - other electronic diagnostic procedures, and
  - physiological medical testing;
- Physical rehabilitation is limited to a maximum of $5,000 per 12 month period;

[1] During the first 12 months of covered employment, In-Network Hospital Inpatient Coverage coinsurance is 10% of the Benefit Allowance. Thereafter, In-Network Hospital Inpatient Coverage will be paid at 100% of the Benefit Allowance.

- Radiation therapy, chemotherapy, dialysis treatment, physical therapy, occupational, speech and respiration/inhalation therapy;
- Mobile intensive care units/advanced life support (MICUs/ALS) service when you or your covered dependent(s) are admitted as an inpatient and the charge is part of the hospital bill. Service is limited to a maximum of $150 per occurrence;
- Blood transfusions, including the cost of blood, blood plasma and blood plasma expanders if not donated or otherwise replaced; Blood processing services rendered and charged for by a non-profit blood supplier;
- Drugs, medicines and dressings;
- Services are provided for other conditions related to pregnancy, including childbirth, miscarriage or therapeutic (medically necessary) abortions. Benefits are provided when the patient is a female member or the covered spouse of a member. The maximum facility charges are as follows:
  - $1,500 for routine nursery charges for the newborn,
  - $5,000 per benefit period for an infant up to age two for illness or injury,
  - $450 per occurrence for elective abortions for member and spouse only;[1]
- Group health plans and health insurance issuers offering group health insurance coverage 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. 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);
- Inpatient Mental health care coverage is available to you only; your dependent(s) and spouse are not covered.

  For confinements due to mental illness, benefits are limited to a combined In-Network or Out-of-Network inpatient facility maximum of 5 days at the semi-private room rate in a 12 consecutive month period, for up to 30 lifetime days;

  For confinements due to substance abuse, benefits are limited to a combined In-Network or Out-of-Network maximum payment as well as a combined inpatient and outpatient facility maximum payment of $2,500 per 12 month period;

Payment for inpatient mental illness and substance abuse will be counted toward the overall Hospital Coverage lifetime maximum for each eligible person.

- Charges for hospitalization outside of the United States are covered for up to $300 per day for up to 10 days.

Hospital Outpatient Coverage

The plan provides coverage for outpatient facilities, services and supplies when used for:

- Surgery;
- Laboratory, X-ray and pre-admission testing for up to a combined maximum of $1,200 per covered person per 12 month period. Pre-admission testing must be billed separately as an outpatient charge;
- Physical rehabilitation including cardiac rehabilitation for up to a maximum of $1,000 per covered person per 12 month period;
- Radiation therapy, chemotherapy and hemodialysis for up to a maximum of $8,000 per covered person per 12 month period;
- Treatment of an accidental injury within 72 hours or a true emergency medical condition[1], within 24 hours, will be paid at 100% of the benefit allowance for both In-Network and Out-of-Network services, subject to an all inclusive maximum of $250 per person per incident for facility charges. No benefits are available if services are not provided within the time limit stated above;
- Treatment for drug abuse and alcoholism. This coverage is available to you only; your dependent(s) and spouse are not covered.

  For confinements due to substance abuse, benefits are limited to a combined In-Network or Out-of-Network maximum payment as well as a combined inpatient and outpatient facility maximum payment of $2,500 per 12 month period

  Payment for inpatient substance abuse treatment will be counted toward the overall Hospital Coverage lifetime maximum for each eligible person.

Alternatives to Hospital Inpatient Coverage

The Plan provides coverage for the use of health care facilities, services and supplies that can be used in place of traditional hospital inpatient care including the following:

[1] For the purposes of this Plan, a true medical emergency means the sudden and unexpected onset of a serious condition or illness for which treatment cannot be delayed without the risk of loss of life or seriously or permanently impairing one's health.

- Coverage is provided for hospital home health care programs or community home health agencies, when care and treatment are prescribed by a physician, for up to a maximum of $1,000 or 15 visits per 12 month period. The following services are eligible under home health care:
  - professional visits by a registered nurse or licensed practical nurse (not full-time care),
  - physical, speech or occupational therapy,
  - medical social services under the direction of a physician,
  - medical supplies which would have been required in the hospital,
  - use of medical appliances.
- Coverage is provided for hospice services when rendered on an inpatient basis or in your home. The following services are eligible under the hospice care program:
  - home health aide services,
  - medical care rendered by a hospice care program physician,
  - therapy services (including speech, physical and occupational therapy),
  - diagnostic services,
  - medical and surgical supplies and durable medical equipment with Plan pre-authorization,
  - prescribed drugs,
  - oxygen and its administration,
  - medical social services,
  - psychological support services to the terminally ill patient,
  - family counseling related to the patient's terminal condition,
  - dietitian services,
  - inpatient room, board and general nursing services,
  - respite care;

  Your hospice benefits are limited to a $3,000 lifetime maximum for In-Network hospice care only. No payment is available for Out-of Network hospice care.
- Coverage is provided for care in a freestanding surgicenter also known as an ambulatory surgical center (ASC) or a short procedure unit (SPU) where eligible physicians' surgical services are performed;
- Coverage is provided for care in an In-Network birthing center. Services routinely performed by the center, including pre-natal care, delivery and post-natal care, will be covered when delivery occurs at the birthing center. Benefits will also be provided when, due to complications during labor, delivery occurs in a hospital because of the need for emergency and/or inpatient care. Delivery must occur within 24 hours of the eligible person's transfer from

the birthing center. If for any reason the delivery does not occur within 24 hours of transfer or the pregnancy does not go to term, all expenses incurred at the birthing center will be the respons-ibility of the patient. No payment is available for Out-of-Network birthing center care.

For additional information about your Preferred Provider Organization (PPO) Hospital Network Coverage you should consult the Plan's Certificate of Coverage, #75770, or contact your Enrollment Official, the customer service representative at Horizon Blue Cross of New Jersey or your Participating Plans. Your Enrollment Official can provide you with the names and addresses of your Participating Plans.

Medical Coverage

SUMMARY

Medical Coverage:

Significant savings when a MultiPlan Provider is used.

Deductible — $150 per covered person per calendar year.

Coverage for the following benefits:

- Surgical Benefits
- Anesthesia Benefits
- Chemotherapy/Radiation/ Hemodialysis Benefits
- Infusion & IV Therapy
- C-Pap Machine
- X-ray and Laboratory Services
- Doctors' Visits

How The MultiPlan Network Works

Network providers have agreed to accept the MultiPlan discounted fee schedules as payment, after you pay your deductible. Therefore, if you or your covered dependents use a Network provider, your cost for covered health care charges will be for the deductible and an amount not to exceed the MultiPlan providers negotiated fee. This amount includes the difference between the MultiPlan discounted fee schedule and benefit maximums specified in this Summary Plan Description.[1]

If you do not use a Network provider when one is available, the Fund's payment will be based on 90% of the MultiPlan discounted fee schedules. The charges of some health care providers may be more than this allowance. In that case, you are responsible for the additional amount over what the Fund pays.

All medical treatment you or your covered dependents receive from MultiPlan providers and out-of-Network providers is subject to the deductible.

The following example illustrates the difference in out-of-pocket expenses when a MultiPlan provider is used versus an out-of-network provider. In this example, the member has met the Plan's deductible. Note that the dollar figures noted are for illustrative purposes only.

A member experiences chest pain and is given a chest X-ray;

In-Network, the doctors charge for the X-ray service is $102. The MultiPlan allowance for the doctor's charge is $33 (amount paid to the doctor) and the balance owed by the member is $0.

Out-of-Network, the doctors charge for the X-ray service is $102. Ninety percent of the MultiPlan allowance for the doctor's charge is $29.70 (amount paid to the provider) and the balance owed by the member is $72.30 ($102 minus $29.70).

If you receive medical care in an area where there is no available network provider, benefits will be provided in accordance with a fixed schedule established by the Local 108 Health Expense Benefits Plan.

[1] For example, the Plan has a $35.00 benefit maximum for physician office visits. Note that this $35.00 payment maximum exists whether or not a MultiPlan Network physician is used.

Using The MultiPlan Network

When you call to make an appointment with your doctor or other health care provider, be sure to identify yourself as a MultiPlan Network participant.

Bring your health benefit plan identification card with you each time you visit the provider.

For your first visit, bring:

- notes about your family and personal medical history
- a list of all medications you are taking
- a list of your past hospitalizations, if any, and the dates of those visits.

Be prepared to discuss your current medical problem or condition.

When any referral is made, remind your doctor that you prefer to go to a MultiPlan Network provider. It is your responsibility to select a MultiPlan Network provider. If you receive services from a non-network provider, you may be billed for the difference between the provider's charge and the network allowance, even if you were referred to the non-network provider by a MultiPlan Network provider.

To have your physician considered for the MultiPlan Network, please request a Physician Nomination Form from MultiPlan at 800-672-2140.

How Your Medical Coverage Works

During any calendar year (January 1-December 31), before there is any reimbursement for your Medical charges, you must first incur $150 in recognized covered charges. This is called the deductible.

Once the deductible has been met, your Medical Coverage will pay 100% (90% for a non-network provider) of the recognized covered charges.

The deductible is applied separately to your health care expenses and to those of each of your covered dependents during each calendar year.

The deductible is based on the date of service or treatment. Services or treatments in 2005 count towards 2005, even if bills are received in 2006.

The following items are covered for recognized covered charges, subject to the annual deductible and the Plan's limitations as indicated:

Surgical Benefits

When surgery is performed, including maternity procedures, the legally qualified physician's or surgeon's charge will be covered up to a fixed schedule of charges for the geographic area in which the surgery is performed. The maximum payment for all Surgical Benefits is $12,000 for

all operations for the same or related causes during any one period of continuous illness.[1] The Surgical Benefit covers pre- and post-operative care.[2]

If multiple surgical procedures are performed during one operative session, the primary procedure is covered according to the surgical schedule, and the other procedures are covered at 50% of the scheduled amount subject to the $12,000 maximum payment for Surgical Benefits.

The charges of an assistant surgeon are not covered.

Computerized axial tomography (CAT Scan), PET Scan and magnetic resonance imaging (MRI) are covered according to a fixed schedule of charges subject to the $12,000 maximum payment for Surgical Benefits.

The services of a co-surgeon are covered at 50% of the scheduled amount subject to the $12,000 maximum payment for Surgical Benefits.

Physician or surgeon charges for elective abortions (for members and spouses only) are limited to a maximum payment of up to $300 subject to the $12,000 maximum payment for Surgical Benefits.

The Plan provides coverage for breast reconstruction in connection with a mastectomy. Breast reconstruction may be selected in a manner determined by you or a covered dependent in consultation with your attending physician, and the Plan will provide benefits as follows:

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

Anesthesia Benefits

The recognized reasonable charges of an anesthesiologist are covered according to the Fund's anesthesia schedule up to a maximum of 40% of the Plan's payment for the surgical procedure.

Chemotherapy/Radiation/Hemodialysis Benefits

Medical Coverage covers the recognized reasonable charges for Chemotherapy, Radiation Therapy and Hemodialysis when treatment is performed in a doctor's office.

Treatments are limited to one per day for up to a $200 maximum per treatment and up to a $3,000 maximum in any 12 calendar month period.

[1] One period of continuous illness is two or more periods of treatment for the same or related causes which are not separated by three months' return to normal activity.

[2] This coverage applies where charges are billed separately from a hospital bill. Where the charges are part of a hospital bill, they are covered as part of the Plan's Hospital Coverage.

Infusion and Intravenous (IV) Therapy

Medical Coverage covers the recognized reasonable charges for Infusion and Intravenous (IV) Therapy when treatment is performed as a hospital inpatient or outpatient, in a clinic or doctor's office, or in the patient's home.

Treatments are limited to 15 days in a 12 month period with a maximum all inclusive payment of $125 per day for all charges combined (doctors, nurses, equipment, supplies, prescription drugs, etc.).

C-Pap Machine[1]

Medical Coverage covers up to $300 every 36 months for the rental or purchase of a c-pap machine for treatment of sleep apnea.

X-ray and Laboratory Services[2]

Medical Coverage covers the recognized reasonable charges for X-ray and Laboratory Services according to a schedule for up to a maximum payment of $650 per person per calendar year.[2]

Doctors' Visits[2]

Medical Coverage covers the recognized reasonable charges of a legally licensed physician for:

- home and office visits
- inpatient treatment in the hospital
- outpatient treatment in the hospital emergency room
- physical therapy
- second opinion consultation
- any treatment for mental nervous is limited to 5 visits during a calendar year.[3]

(Coverage for mental nervous or substance abuse treatments by a physician are not available to your dependent(s) and spouse).

Coverage is provided for up to $35 per visit for up to 50 visits in a calendar year,[3] limited to one visit per doctor per day.

Physician charges for surgery are covered under the surgical schedule (see "Surgical Benefits").

[1] Effective 11/1/03.
[2] This coverage applies where charges are billed separately from a hospital bill. Where the charges are part of a hospital bill, they are covered as part of the Plan's Hospital Coverage.
[3] Prior to 1/1/04 benefit period was 12 consecutive months.

Optical Benefits

SUMMARY

Coverage is provided for:

- Eye examination
- Frame & single vision lenses
- Frame & bifocal lenses
- Contact lenses

Coverage is provided after you and your eligible dependents (part-time and reduced contribution rate members have individual coverage only) have met the requirements for coverage (see the section titled "When Coverage Begins").

Coverage is provided for:

- up to $30 for eye examinations only, and
- up to $30 for frame and single vision lenses, or
- up to $50 for frame and bifocal lenses, or
- up to $50 for contact lenses.

Optical Benefits are not subject to the annual deductible. Each covered person may use this benefit only once during any consecutive 24 month period.

Local 108 has contracted with Vision Screening to provide eligible members and dependents with these services at no out of pocket cost. Contact the Fund Office for a voucher and a list of participating Vision Screening Centers.

If you elect to obtain optical services not provided by Vision Screening, the identical benefits listed above will be provided to eligible members and dependents. However, the member is responsible for any balance due the provider.

Services for Optical Benefits must be performed by a qualified ophthalmologist, optometrist or optician.

Exclusions

The following items are not covered unless they are prescribed as medically necessary by a legally qualified physician:

- standard sunglasses
- tinting
- therapy.

Hearing Aid Benefits

SUMMARY

Coverage is provided for:

- Hearing examination
- New hearing aid
- Hearing aid repairs
- Battery replacement

Coverage is provided after you and your eligible dependents (part-time and reduced contribution rate members have individual coverage only) have met the requirements for coverage (see the section titled "When Coverage Begins").

Coverage is provided for:

- up to $125 for a hearing examination by an Otologist or an Otolaryngologist (medical doctors who are ear specialists);
- up to $350 for a new hearing aid if prescribed as necessary by an Otologist or an Otolaryngologist;
- up to $100 for necessary repairs to a hearing aid or replacement of batteries if prescribed as necessary by an Otologist or an Otolaryngologist.

Each covered person may use the hearing aid and battery replacement benefit only once in any four year period.

The Hearing Aid Benefits will not be available to you or your covered dependents if you fail to use an Otologist or an Otolaryngologist for the hearing test, to determine reimbursement for replacement, or to certify that the device or repairs are required.

Dental Benefits

SUMMARY

$1,000 maximum payment per calendar year

- Preventive/Diagnostic Services – 100%
- Therapy/Treatment Services – 50%
- Prosthodontic Services – 50%
- Periodontic Services – 50%
- Inlays and Crowns – 50%
- Oral Surgery – 50%

Coverage is provided after you and your eligible dependents (part-time and reduced contribution rate members have individual coverage only) have met the requirements for coverage (see the section titled "When Coverage Begins"). Dental Benefits are available only if specifically provided for in the collective bargaining agreement with your employer. Collective bargaining agreements that became effective prior to July 1, 1997 all include Dental Benefits.

The general rules and regulations for eligibility, benefit coverage and termination of coverage which are described in this summary plan description apply to Dental Benefits.

Your Dental Benefit is administered by DDS Inc. When any covered service is performed by a licensed dentist, an allowance for that service will be paid as stated below. The Plan uses the schedule provided by DDS, Inc. to determine "Reasonable and Customary" (R&C). Out of network dentists are paid at the same schedule as in-netowrk dentists.

If any of the percentages shown below are less than 100%, a participating dentist may bill you for the difference up to 100% of the R&C fee. A participating dentist must accept 100% of the R&C fee as payment in full. If your dentist does not participate in the DDS Inc.

Network, you must pay the difference between the DDS Inc. payment and the dentist's charge, even if it exceeds the R&C fee. If your dentist charges less than the R&C fee, DDS Inc. will pay the percent shown below of the actual charge.

There is a $1,000 per person per calendar year maximum payment for all of the dental services listed below.

Preventive/Diagnostic Services

The following preventive/diagnostic services are covered at 100% of the R&C allowance:

- Initial and periodic oral examinations once every six months;
- Bitewing X-rays once every six months and full mouth X-rays once every 36 months;
- Prophylaxis including cleaning and polishing once every six months;
- Topical application of flouride for persons under age 19, limited to once every six months.

Therapy/Treatment Services

The following therapy/treatment services are covered at 50% of the R&C allowance:

- Repair of dentures;
- Fillings consisting of silver amalgam and synthetic restorations;
- Palliative emergency dental services;
- Biopsy of oral tissue;
- Sealants;
- Pulp capping and pulpectomy;
- Simple extractions (pre-operative X-rays and a treatment plan are required for three or more extractions);
- Endodontics, root canal therapy[1];
- Space maintainers (for children under age 19)[1];
- General anesthesia (when billed for by a dentist or physician other than the operating dentist, or by a certified registered nurse anesthetist employed and supervised by a physician anesthesiologist).

Prosthodontic Services[1]

The following prosthodontic services are covered at 50% of the R&C allowance:

- Partial or complete dentures;
- Fixed bridges;
- Splinted crowns.

[1] These services (except for services requiring the removal of soft-tissue tumors) require a treatment plan and pre-operative X-rays before services are performed. Endodontics and root canal therapy also require post-operative X-rays. When a treatment plan is required, it must be approved by DDS Inc. before service is performed.

Periodontic Services

The following periodontic services are covered at 50% of the R&C allowance:

- Surgical periodontic examination;
- Gingival curettage;
- Periodontal prophylaxis;
- Management of acute infections and oral lesions[1];
- Gingivectomy and gingivoplasty[1];
- Osseous surgery, including flap entry and closure[1];
- Mucogingivoplastic surgery[1];
- Other periodontal procedures as determined by DDS Inc.[1]

Inlays and Crowns

The following services for inlays and crowns are covered at 50% of the R&C allowance:

- Inlays and crowns for restorative purposes that are not splinted or part of a bridge[1].

Oral Surgery

The following services for oral surgery are covered at 50% of the R&C allowance:

- Alveolectomy;
- Surgical extractions (A treatment plan is required for three or more extractions, unless the services are done in an emergency)[1];
- Treatment of fractures[1];
- Removal of lesions[1];
- Apicoectomy[1];
- Appliances for minor tooth movement (A treatment plan is required unless the services are done in an emergency).

Exclusions

The Plan does not provide dental coverage for:

- Replacement of dentures or bridges within five years after receiving services,
- Replacement of dentures or bridges due to loss or theft,
- Replacement of any denture or bridge that is satisfactory or can be made satisfactory,

[1] These services (except for services requiring the removal of soft-tissue tumors) require a treatment plan and pre-operative X-rays before services are performed. Management of acute infections and oral lesions require a treatment plan. When a treatment plan is required, it must be approved by DDS Inc. before service is performed.

- Any addition to an existing denture or bridge if the addition is to replace teeth that were missing when the denture or bridge was first inserted,
- Any denture or bridge or any addition to an existing denture or bridge if the addition is to replace teeth that were missing when your coverage under this program first became effective,
- Relining or rebasing initial or replacement dentures if the services are performed within six months after insertion of the denture, or more than one relining or rebasing in any 36-month period,
- Replacement of crowns or inlays within five years after receiving these services,
- Replacement of any crown and inlay that is satisfactory or could be made satisfactory,
- Single, unconnected crowns and inlays if the tooth can be restored by any other material. If DDS Inc. decides that the tooth can be restored with another material, payment will be the allowance toward the charge for a single crown or inlay,
- Services provided by an assistant surgeon,
- Services with fees payable to a hospital or other institution; all hospital services,
- Services not dentally necessary, as determined by the DDS Inc. dental staff or consultants. To be eligible for coverage, a service must be required for the prevention, diagnosis or treatment of a dental disease, injury or condition. The fact that a procedure is prescribed by your dentist does not make it dentally necessary or eligible under this program. DDS Inc. can ask for any proof it requires (such as X-rays or study models) to decide whether services are dentally necessary. If you or your dentist fail to provide this proof, DDS Inc. can adjust or deny payment for any services performed,
- Anesthesia or consultation services when given in connection with any service that is not covered,
- Services performed by a hospital resident, intern or dentist who is paid by a hospital or other source, or who is not permitted to charge for services covered under this program; or by anyone who does not qualify as a licensed dentist or physician,
- Implantology,
- Educational services, such as oral hygiene or dietary instructions,
- Services in connection with plaque control programs,
- Duplicate space maintainers,
- Services performed or items furnished strictly for cosmetic purposes,
- Any service or item which requires a treatment plan if our approval was not obtained prior to the rendering of the service or item, unless done in an emergency,
- Gold foil restorations,
- Any services by a dentist not specifically listed as covered under this program.

In addition the following restrictions apply:

- Care rendered by more than one dentist – In the event an eligible person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, DDS Inc. will be liable for no more than the amount for which we would have been liable had but one dentist rendered the service.
- Alternative course of treatment – In all cases involving services in which the dentist or the eligible person selects a course of treatment, benefits will be based on the procedure that is consistent with sound professional standards of dental practice for the dental condition concerned and which carries a lesser fee.

For additional information about your Dental Benefit you should consult the Plan's Certificate of Coverage, or contact your Enrollment Official or the customer service representative at DDS Inc. Your Enrollment Official can provide you with the names and addresses of your Participating Dentists.

Our Fund, The Trustees and Local 108 have no financial interest in or control of DDS Inc. and its dentists and, therefore, assume no liability for their services. Use of this benefit is entirely at the discretion of the patient.

How To File Claims For Dental Benefits

You will receive a Dental I.D. Card to show to the dentist when you need to use your benefits. Your I.D. Card shows the group through which you are enrolled, your type of coverage, your identification number and the effective date when you can begin to use you benefits. All of your eligible dependents share your identification number.

When you go to the dentist, show your Dental I.D. Card. If any services require a treatment plan, have the dentist complete the treatment plan portion of the claim form. The dentist must receive approval from DDS Inc. before performing any services, or no benefits will be paid.

After services are completed, the dentist sends the completed claims form to DDS Inc. Participating dentists are paid directly for covered services, unless you have already paid the dentist. If services are performed by a non-participating dentist, payment for covered services will be made directly to you. Whenever payment is made to the dentist, you will be notified of the amount of the payment.

Participating dentists should have the necessary claim forms. If your dentist does not have them, you can get them from your enrollment official or from DDS Inc.

Prescription Drug Benefits

SUMMARY

Covered through a card program with a 10% of cost or $10 minimum copayment for generic drugs and a 20% of cost or a $20 minimum copayment for brand name drugs. Maintenance Drugs covered through a mail order program with a 10% of cost or $10 minimum copayment.

Coverage is provided after you and your eligible dependents (part-time and reduced contribution rate members have individual coverage only) have met the requirements for coverage (see the section titled "When Coverage Begins"). Prescription Drug Benefits are available only if specifically provided for in the collective bargaining agreement with your employer. Collective bargaining agreements that became effective prior to July 1, 1997 all include Prescription Drug Benefits.

Your Prescription Drug Benefit is administered by Medco Health. The specific details of your coverage are described in the brochure which will be sent to you along with a prescription drug identification card which may be used at participating pharmacies, when you become eligible for the Prescription Drug Benefit.

When you need to have a prescription filled or refilled, present your prescription drug identification card to a participating pharmacy.[1] As long as you use a participating pharmacy, all you have to pay is a small copayment amount, regardless of the total cost of the prescription or refill.

The copayments are as follows:

- If a prescription or refill is dispensed using a brand name drug the copayment is 20% of the sale cost of the prescription or a minimum of $20.
- If a prescription or refill is dispensed using a generic drug the copayment is 10% of the sale cost of the prescription or a minimum of $10.
- If a mail order prescription or refill for maintenance drugs is filled the copayment is 10% of the sale cost of the prescription or a minimum of $10.

Any payment balance remaining after you pay the copayment is billed to the Plan.

Coverage is provided up to a $5,000 per person annual maximum payment.

The card plan allows you to receive up to a 21 day supply of medication and one refill. You should use your prescription card for short term, acute (for example, antibiotics), medication. If you need medication immediately, but will be taking it on an ongoing basis, ask your doctor for two prescriptions: the first one for a 21 day supply to be used at a local pharmacy, and a second prescrip-

[1] A list of participating pharmacies is available upon request from the Plan Office.

tion for up to a 90 day supply to be filled by mail order. Remember, your mail order prescription will only be dispensed at the day supply indicated on the prescription.

You will no longer be able to obtain long term medication, maintenance (i.e. more than one refill), with your prescription card. Once you have exceeded the refill limitation outlined above, you must submit a new prescription for up to a 90 day supply of medication.

Prescription Drug Benefit Exclusions

The following items are not covered:

- vitamins, unless compounded with prescribed medicines
- all drugs on the Federal "DESI" list of ineffective medicines which includes many cough syrups and creams
- experimental drugs
- injectable medications with the exception of insulin
- chemotherapy drugs
- therapeutic devices and appliances, syringes, needles, diabetic testing aides or strips
- drugs that may be dispensed without a prescription (non-Legend drugs)
- non-prescription items such as bandages, heating pads, aspirin, etc., even if prescribed by a physician
- contraceptives (oral, implant, injection, jellies, ointment, foams, etc.) diaphragms and devices
- drugs for cosmetic use
- fertility drugs
- biological sera
- blood and blood plasma.

In an emergency, when you can't use a participating pharmacy, you have to pay the full cost of the prescription and then file a claim with the Plan for reimbursement. The Plan allowance will be only the reasonable cost of the prescription minus the usual copayment amount.

Your prescription drug identification card must be returned to Local 108 immediately upon termination of employment with your present employer. Also, please notify Local 108 in writing of any change of address.

Our Fund, The Trustees and Local 108 have no financial interest in or control of Medco Health and its pharmacies and, therefore, assume no liability for their services. Use of this benefit is entirely at the discretion of the patient.

How The Plan Works With Other Coverage

Other Health Care Coverage — Coordination of Benefits

Your Plan has a Coordination of Benefits (COB) provision that determines how payments are made if you or your dependents are covered by more than one health care coverage plan. Like most health care coverage, your Plan follows the "primary" and "secondary" rules of coverage. This means that in each case, the coverage that is considered primary pays first to the full extent of its coverage. Then, the secondary coverage pays an additional amount, up to the full extent of its coverage. Coverage is up to but never more than 100% of the actual covered charges.

If the coverage does not have a coordination provision, that coverage is considered primary and always pays first. If both coverages have coordination provisions:

- the coverage that covers the patient as an employee (non-dependent) is primary and therefore pays first
- the coverage that covers the patient as a dependent is secondary and therefore pays second
- when a dependent child is covered by the coverage of more than one parent and all coverages have a coordination provision, the coverage of the parent whose birthday occurs first in the calendar year pays first and the coverage of the parent whose birthday occurs later in the year pays second. If both parents have the same birthday, the plan that has covered the parent longer pays first.

However, where the parents are divorced or separated and both coverages have coordination provisions, payment will be made as follows:

- the coverage of the parent with custody pays first
- the coverage of the step-parent with custody pays second
- the coverage of the non-custodial parent pays last.

If there is a court decree that states otherwise, that court decree will govern.

If an individual is covered as a result of having purchased continuation coverage pursuant to The Consolidated Omnibus Budget Reconciliation Act (COBRA), and is also covered under a new or current employer's group plan, the following shall be the order of benefit determination:

- the plan covering the person as an employee (or as that employee's dependent) pays first,
- the coverage purchased under the plan covering the person as a former employee (or as that employee's dependent) provided according to the provisions of COBRA pays second.

Medicare Coverage

Medicare is the federal government's health insurance program for individuals age 65 and older. Individuals under age 65 who are disabled may also be entitled to Medicare. Medicare is composed of:

- Medicare Part A (hospital insurance), which is available at no cost to you or your spouse, and
- Medicare Part B (medical insurance for doctors, nurses, laboratory, X-ray, etc.), which is available after payment of a monthly premium.

If you are working in covered employment for an employer with 20 or more employees, and you are entitled to Medicare, the Plan will provide its full health care coverage first and Medicare will pay second. If you are working in covered employment for an employer with less than 20 employees, Medicare will provide coverage first and the Plan will pay second.

Federal law requires that you have the right to elect to cancel your Plan health care coverage and have Medicare as your primary insurer. If you make this election, all your Plan health care coverage will be canceled and you will have substantially less coverage. This election is applicable only while you are age 65 or older and continue to work in covered employment. It doesn't affect your Death, Accidental Death and Dismemberment Coverages. Your covered spouse also has a separate right to elect to cancel Plan coverage provided he or she is age 65 or older and you continue to work in covered employment. Any such election must be made in writing to the Plan Office.

No-Fault Insurance (Vehicle Accidents)

The Plan does not cover charges related to injuries caused during a motor vehicle accident in a state that has a no-fault insurance law or any similar law which relates to motor vehicle insurance coverage and financial responsibility whether or not entitled as "no-fault law."

Liability Coverage (Subrogation)

When benefits are paid or payable to or for an employee or a dependent under the terms of this Plan, the Fund is subrogated to the rights of recovery of such employee or dependent against any person or entity who or which is liable for the injury or illness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid or are payable, irrespective of whether or not the settlement or judgment obtained by the employee or dependent specifically allocates a portion of the settlement or judgment to benefits paid or payable to the Fund and irrespective of whether or not the settlement or judgment is obtained before or after the Fund completes its payments. If injuries or illness are sustained by a covered dependent, the Fund shall

have the right of subrogation from any recovery obtained by or on behalf of the dependent or member with respect to those injuries.

The Fund shall have no liability to pay any benefits to or on behalf of an employee or dependent unless and until the employee and/or dependent executes a lien in favor of the Fund acknowledging the Fund's right of recovery of a portion of the settlement or judgment equal to the benefits paid and to any benefits paid thereafter by the Fund.

Such subrogation rights shall also extend to any recovery by such employee or dependent of any proceeds paid pursuant to an insurance contract. If the source of recovery is another insurance policy (including, but without limitation, an uninsured or underinsured motorist policy), irrespective of whether the employee or dependent personally purchased the policy, the Fund shall still have the right to subrogate.

Such subrogation rights shall extend only to the recovery by the Fund of the benefits it has paid or eventually does pay for such hospitalization or treatment, and the Fund shall deduct from its share of the recovery its proportionate share of fees and costs associated with such recovery.

The Fund's subrogation rights shall apply irrespective of whether or not there are claims against the participant or dependent which remain unsatisfied after the exhaustion of the Fund's liability and irrespective of whether or not the participant and/or the dependent have been made whole with respect to any claims that they may have in connection with the injury or illness which gave rise to the claim.

In the event the Fund should request information from the claimant regarding material necessary for the implementation of this subrogation provision with respect to a claim, the Fund reserves the right to withhold payment of such claim pending the submission of the requested information.

Workers' Compensation Coverage

The Plan does not cover any charges for health care for which there is entitlement to Workers' Compensation. Workers' Compensation is a state administered program which offers coverage for health care costs and loss of earnings resulting from an occupationally related disease, accident or death.

Additional information about Workers' Compensation can be obtained from the State Industrial Commission.

Government Coverage

If health care coverage is available for any condition or treatment covered by a government program (such as through a state hospital), or pursuant to any federal, state or municipal law, coverage under the Plan will not be provided.

How To File A Health Care Claim

All claims, except for those submitted electronically, must be submitted in writing to the addresses below and must include the participant name, social security number and the patient name. They must also be signed by the patient or authorized representative. Most providers will submit their standard computerized form or submit their claim electronically. If you are the one filing a claim, you must obtain an appropriate claim form. The appropriate claim form is available from the Fund office.

In order to appoint an authorized representative, the patient must complete and return an Authorization for Release of Information-Appointment of Authorized Representative form which can be obtained from the Fund office.

How To File Claims For Preferred Provider Organization (PPO) Hospital Network Benefits

No Claim Forms For Most In-Network Services

When you receive In-Network care, in most cases you do not have to file any claim forms to be reimbursed for most eligible expenses. Present your Horizon Blue Cross of New Jersey, I.D. Card for any inpatient hospital or facility admission. You pay only the applicable coinsurance or copayments. The doctors or facilities deal directly with Horizon Blue Cross of New Jersey. or the Participating Plan for payment.

Submitting Claims For Out-of-Network Services

When you receive Out-of-Network care or you are outside of the Preferred Provider Organization Service Area, you must generally pay your doctor or the facility for your treatment. You must then complete a claim form and submit it with proper documentation of your expenses to the Horizon Blue Cross of New Jersey or the Participating Plan for reimbursement.

Claim forms are available from your Enrollment Official. Send each completed claim form together with the proper documentation to the claim address shown on the claim form.

Questions regarding your Preferred Provider Organization (PPO) Hospital Network Benefits coverage or claims should be directed to Horizon Blue Cross of New Jersey at 1-800-355-2583.

How To File Claims For Medical Benefits

Each claim for benefits must be made in writing on a form provided by your business agent or the Fund Office. Completed claims forms for Medical Benefits should be sent to Alicare, Inc. P.O. Box 1447, New York, New York, 10116-1447.

Questions regarding your Medical Benefit coverage or claims should be directed to Alicare's Member Services Department at 212-539-5115.

File your claim promptly (a late filing may cause loss of benefits). Claims filed later than 90 days after treatment began may be denied, unless there is a satisfactory explanation for the delay, but in no event will the Plan consider a claim filed more than one year after the date treatment began.

The Fund office or its administrator makes all claim decisions. Payment will be made to the facility or health care provider unless receipts are submitted showing that the bill has already been paid, in which case, payment will be made directly to the patient or legal guardian. Adverse claims decisions may be appealed (see "Your Right to Appeal").

What Is A Claim?

A claim is a request for benefits submitted in accordance with Fund rules.

Claim Type Definitions

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims:

Urgent Care Claim - An urgent care claim is any claim for medical care or treatment with respect to which, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or, in the opinion of the treating physician with knowledge of the medical condition, would subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Pre-Service Care Claim - A pre-service care claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as pre-certification) of the benefit in advance of obtaining medical care.

Post-Service Care Claim - A post-service care claim is a claim for a benefit under the Plan that is not a pre-service claim. It involves the submission of bills by the patient or their authorized representative for care or services already rendered. An itemized bill forwarded by the provider who has a right to balance bill (for charges other than co-insurance and deductibles) is considered to be a claim for benefits.

Concurrent Care Claim - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Under the Plan, a claim for benefits means a request for a Plan benefit or benefits made by you or your authorized representative in accordance with the following claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Your interactions with participating providers, panel providers, pharmacists or any other health care provider under the Plan will not be treated as a claim for benefits. In addition, a request for a prior approval of a benefit that does not require prior approval by the Plan or an inquiry about Plan eligibility is not a claim for benefits. You must file a claim for benefits in accordance with the claims procedures listed below in order to appeal a claim under the Plan.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Plan Administrator in writing of that person's designation. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim. If an authorized representative is designated, any subsequent communication will be made consistent with that authorization. If an authorized representative is designated, all subsequent notices will be provided to you through your authorized representative.

You may file any claim for benefits, including ones for concurrent care, pre- service care, or post-service care, yourself or through your authorized representative. Any of these types of claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile.

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone, or by U.S. Mail, by hand delivery or by facsimile. If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the Plan may require in support of your claim.

The Plan Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing.

Determination of Benefits

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Plan Administrator in its sole discretion determines you are entitled to receive.

Timeframes for Notification of Initial Benefit Determination

Urgent Care Claim - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but in no event more than seventy-two (72) hours after the Plan has received the claim. If the claim does not include sufficient information for the Plan Administrator to make an intelligent decision or you have failed to follow the Plan's claim procedures, you or your representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. You will also receive a copy of the proper procedures to be followed. You will have at least forty-eight (48) hours to respond to this request. The Plan Administrator must inform you of its decision as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (i) receiving the additional information or (ii) the end of the period you had to provide the specified information.

Concurrent Care Claim - you or your authorized representative will be notified of the Plan's decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If the claim to extend the course of treatment or the number of treatments involves urgent care, the Fund will notify you, whether adverse or not, within twenty-four (24) hours after receiving the claim provided that the claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or the number of treatments. You will be given time to provide any additional information required to reach a decision.

Pre-Service Care Claim - you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as possible, but not more than fifteen (15) days from

the date the Plan receives the claim. This 15-day period may be extended by the Fund for an additional fifteen (15) days if the extension is required due to matters beyond the Fund's control. If such an extension is necessary, you will receive written notice of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision prior to the expiration of the 15-day period. If the extension is necessary due to your failure to submit the information necessary to decide the claim or your failure to follow the Fund's claim procedures, you will receive a notice that specifically describes the required information or the proper procedures to be followed. You will receive notification of your failure to follow the Fund's claim procedures not later than five (5) days after your claim is filed. You will have at least forty- five (45) days to provide to the Fund any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Post-Service Care Claim - you or your authorized representative will be notified of the Plan's decision on the claim, only if it is denied in whole or in part. This notification will be issued no later than thirty (30) days after the Fund receives the claim. The Fund may extend this 30-day period one time for up to fifteen (15) days if the extension is required due to matters beyond the Fund's control and if the Fund notifies you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least forty-five (45) days to provide to the Fund any additional information requested of you. In the event that a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Manner and Content of Notification of Initial Benefit Determination

If your claim for benefits has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reason(s) for such denial with references to the specific plan provisions on which the denial is based;

- a description of any additional material or information necessary for you to perfect the claim (including an explanation as to why such information is necessary);
- a description of the review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- that if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, you will receive either a copy of the specific rule, guideline, protocol, or other similar criterion, you will receive or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge, upon request; and
- that if the benefit determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning a claim involving urgent care, you will also receive a description of the expedited review process applicable to such claim. In addition, if your claim involves urgent care, the information described in the first three items above may be provided orally, provided that a written or electronic notification is furnished to you not later than three (3) days after the oral notification.

Continuation Of Coverage Through COBRA

Background Information

In 1886, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the plan would otherwise end.

If you or your eligible dependents are covered under the medical Plan, you and/or your dependents can continue coverage for a time if coverage ends for one of several reasons.

COBRA Continuation Coverage is administered by Local 108 Health Expense Benefits Plan at the following address:

Local 108 Health Expense Benefits Plan
1576 Maplewood Avenue
Springfield, NJ 07040

Entitlement to COBRA Continuation Coverage When (called the Qualifying Event) and For How Long

A Qualified Beneficiary is entitled to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date.

"Qualified Beneficiary"

Under the law, a Qualified Beneficiary is any employee or retiree or the spouse or dependent child of an employee or retiree who was covered by the Plan when a 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 employee or retiree during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an employee or retiree during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.

"Qualifying Event"

Qualifying Events are those shown in the chart below. 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 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 does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare), then COBRA is not yet available.

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 occurs, measured from the time the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this booklet on extending COBRA in cases of disability). That period may also be cut short for the reasons set forth in the section on Termination of COBRA that appears later in this section.

Qualifying Events and Maximum Periods of Continuation of Coverage

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation of coverage. For example, both you and your spouse may elect continuation of coverage, or only one of you. A parent or legal guardian may elect continuation coverage for a minor child.

Qualifying Event	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross miconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same 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
Employee becomes covered under Medicare	N/A	36 months	36 months
Dependent Child ceases to have Dependent status	N/A	N/A	36 months

Notice You Must Give to the Plan

As a covered employee or qualified beneficiary, you are responsible for providing the Local 108 Health Expense Benefits Plan with timely notice of certain qualifying events. You must provide the fund with notice of the following qualifying events:

1) The divorce or legal separation of a covered employee from his or her spouse.

2) A beneficiary ceasing to be covered under the plan as a dependent child of a participant.

3) The occurrence of a second qualifying event after a qualified bene ficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include an employee's death, coverage under Medicare, divorce or legal separation or child losing dependent status.

In addition to these qualifying events, there are two other situations where a covered employee or qualified beneficiary is responsible for providing the Local 108 Health Expense Benefits Plan with notice within the timeframe noted in this section:

4) When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure the Local 108 Health Expense Benefits Plan is notified of any of these five occurrences listed above. Failure to provide this notice in the form and within the timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How a Notice Should be Provided

Notice of any of the five situations listed above must be provided in writing. You may send a letter to the Local 108 Health Expense Benefits Plan containing the following information: your name, which of the five events listed above of which you are providing notice, the date of the event, the date on which the participant and/or beneficiary will loose coverage.

When a Notice Should be Sent

If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must

sent the notice no later than 60 days after the later of (1) the date upon which coverage would be lost under the plan as a result of the qualifying event, (2) the date of the qualifying event or (3) the date on which the qualified beneficiary is informed through the furnishing of a summary plan description or initial COBRA notice of the responsible to provide the notice and the procedures for providing the notice to the Local 108 Health Expense Benefits Plan.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that you are no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you are no longer disabled.

Who can Provide a Notice

Notice may be provided by the covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, her spouse and her child are all covered by the plan, and the child ceases to become a dependent under the plan, a single notice sent by the spouse would satisfy this requirement.

In the event of the employees death, his/her family should notify the Local 108 Health Expense Benefits Plan promptly and in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in the transmittal of information to the Local 108 Health Expense Benefits Plan.

Notice When You Become Entitled to COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, become covered under Medicare, or when the Local 108 Health Expense Benefits Plan is notified that a dependent child lost dependent status, you divorced or were legally separated, the COBRA Administrator of the Local 108 Health Expense Benefits Plan will give you, your spouse and/or your covered dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to enable you and/or them to apply for COBRA Continuation Coverage.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS AFTER RECEIVING NOTICE, YOU AN/OR THEY WILL HAVE NO HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

Where you or your dependents have provided notice to the Local 108 Health Expense Benefits Plan of a divorce or legal separation, a beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event but are not entitled to COBRA, the Local 108 Health Expense Benefits Plan will send you a written notice stating the reason why you are not eligible for COBRA.

Coverage That Will Be Provided if You Elect Continuation Coverage

If you and/or your Dependent(s) choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical and/or dental plan that is provided for similarly situated employees or family
members.

The same rules about Dependent status and qualifying changes in family status that apply to active employees will apply to you and/or your Dependent(s).

Adding a New Dependent

If, during the period of COBRA continuation coverage, you marry, have a newborn child, or have a child placed with you for adoption, that spouse of dependent child may be enrolled for coverage for the balance of the period of COBRA continuation coverage on the same terms available to active employees. You will need to enroll that spouse or child for coverage within 30 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Loss of Other Group Health Plan coverage

If, while you are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll your spouse or dependent within 30 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.

When the Maximum Period of Continuation Coverage May Change

Second Qualifying Event

If your continuation coverage (according to the table) is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36-month period of continuation coverage, the 18-month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the first qualifying event.

For example, if you terminated employment and elected COBRA continuation coverage for 18 months for yourself and your covered spouse and/or dependent child(ren), and you died during the 18-month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

Entitlement to Social Security Disability Income Benefits

If you, your spouse or any of your covered dependent children are entitled to COBRA continuation 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 benefits, and for any other covered family members, for up to 11 additional months if:

- the disability occurred on or before the start of COBRA continuation coverage, or during a COBRA continuation coverage;
- the disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and
- you or the disabled person notifies the Plan of such a determination within that 18-month period.

This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled individual becomes covered under Medicare.

These extended periods of COBRA Continuation Coverage are not available to anyone who became your spouse after the termination of employment or reduction in hours. 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 covered employee) during the 18 month period of COBRA Continuation Coverage.

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the above section). As a result, if an employee experiences a reduction in hours followed by 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 initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

What You Must Pay for COBRA Continuation Coverage

You, your covered spouse and/or your covered dependent child(ren) will have to pay 102% of the full cost of the coverage during the COBRA continuation period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA Continuation Coverage.

The amount you, your covered spouse and/or your covered dependent child(ren) must pay for your COBRA Continuation Coverage will be payable monthly. There will be an initial grace period of 45 days to pay the first amounts due starting with the date continuation coverage was elected. There will then be a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA Continuation Coverage will terminate.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect or you, your spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation coverage will be confirmed, but with notice to the health care provider that the cost of the

COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be terminated if:

- the employer no longer provides any medical or dental coverage to any of its
  similarly situated employees;
- you do not pay the applicable premium for your COBRA Continuation Coverage on time;
- the covered person enrolls in Medicare; or
- the covered person is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any Pre-Existing Condition of the covered person.

If any covered person enrolls in Medicare, the COBRA Continuation Coverage of that person ends, but the COBRA Continuation Coverage of any covered spouse or dependent child of that covered person will not be affected.

If continuation coverage is terminated before the end of the maximum coverage period, the Local 108 Health Expense Benefits Plan will send you a written notice as soon as practicable following the determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Other Information About COBRA Continuation Coverage

If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

Keep the Local 108 Health Expense Benefits Plan Informed of Address Changes

In order to protect your family's rights, you should keep Alicare and/or the Local 108 Health Expense Benefits Plan informed of any changes in the addresses of family members. You should also keep a copy for your records, of any notices you send to the Local 108 Health Expense Benefits Plan.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

Both when coverage under this Plan initially ends and when your COBRA coverage ends, the Local 108 Health Expense Benefits Plan will provide you and/or your covered dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If, within 52 days after your coverage under this Plan ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered dependents, a health insurance policy, you may need this certificate to reduce any exclusion for pre-existing conditions that may apply to you and/or your spouse and dependent children in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated.

In addition, a certificate will be provided to you and/or any covered dependent upon receipt of a request for such a certificate if that request is received by the Local 108 Health Expense Benefits Plan within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the Local 108 Health Expense Benefits Plan, 1576 Maplewood Avenue, Springfield, NJ 07040.

What The Plan Does Not Cover

The Plan does not cover:

- any claim made by you or your dependent(s) when you or your dependent(s):
  - were not eligible for benefits claimed
  - failed to submit required evidence to substantiate the claim
  - failed to apply or make timely application for benefits
  - made material misstatements in connection with eligibility or the claim (the Plan shall have the right to recover from you any payments made in reliance on such misstatement
  - omitted facts or material statements as to other insurance available to you or your dependents
- any charges for telephone consultations, missed appointments or fees added for filling out claim forms
- any charges which are deemed not medically necessary to the diagnosis or treatment of an illness or injury, or are educational in nature or primarily for the purpose of medical research, or are deemed to be experimental or investigational or not medically appropriate as determined by Alicare's Medical Director, using generally accepted standards of medical practice, or in accordance with government guidelines which include, but are not limited to:
  1) Whether the Food and Drug Administration approved the drugs for the specified usage,
  2) Whether there is sufficient information to allow the Fund to decide if the procedure is safe and efficacious,
  3) Whether available evidence demonstrates a net beneficial effect,
  4) Whether the procedure is as safe and efficacious as existing alternatives,
  5) Whether the procedure satisfied criteria (3) and (4) outside of the research setting
- any charges for services, supplies and treatment unless performed or prescribed as necessary by a legally licensed physician, which, for the purpose of the Plan, means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.). Services of a licensed Midwife, in a hospital or birthing center under the supervision of a physician are eligible. A legally qualified Doctor of Podiatry will be considered a Physician, for the purposes of the Plan, in the performance of surgical services on the foot or feet, provided surgery is performed at or below the ankle, and the cutting is through the true skin. Services of an Optometrist or Optician are eligible only in respect to the Optical Benefits of the Plan
- clinic facility charges not covered
- any charges for the services of a Chiropractor

- any charges which are in excess of either the Fund's or MultiPlan's reasonable and customary fee or maximum recognized charge for the services rendered
- any charges which are in excess of the Horizon Blue Cross/Blue Shield of New Jersey's reasonable and customary fee or maximum recognized charge for the services rendered
- any charges for non-contributory group health coverage that is available through other employment. If you or your spouse decline participation in that plan or insurance, this Plan may offset its benefit by the amount that would have been paid by the other plan or insurance as if you had properly enrolled
- any charges for a terminally ill (or injured) patient (a person who has a life expectancy of six months or less) services, supplies and equipment for or relating to resuscitation or life support solely to prolong life
- any hospital or hospital alternative confinement which is primarily for custodial purposes, long-term care, care in a nursing home or home for the aged, or care during the non-acute stages of an illness
- any charges for any part of a stay that is primarily for milieu therapy even though other treatment also is provided. This means that services are not covered during any part of a stay in a health care facility if the stay is chiefly to change or control your environment and the treatment you receive does not require inpatient care
- any charges for services for which no payment was required
- any charges for services of a hospital resident, intern or other health care provider who is paid by a hospital or other source, who is not permitted to charge for services covered under this Plan. Services performed by such health care providers are excluded whether or not the health care provider is in training
- any charges for services for mandatory consultations required by hospital regulations, routine pre-operative consultations and stand-by services
- any charges for services performed during a hospital stay or any period of a hospital stay which is primarily for diagnostic studies or examinations during an admission which is primarily for diagnostic studies or examinations
- any charges for services or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group
- any charges incurred after the date your benefits coverage terminates
- any charges incurred during an eligible person's temporary absence from the eligible provider's grounds before discharge
- any charges for durable medical equipment except as described in the section titled "Medical Coverage"
- any charges for disposable medical supplies

- any charges for medical appliances except for breast prostheses in accordance with the women's cancer rights act and C-Pap machines
- any charges for services rendered by the claimant's immediate family
- any charges for the services of an assistant surgeon or standby
- any charges for treatment of temporomandibular joint dysfunction/pain syndrome
- any charges for personal convenience items such as television, radio or telephone, or for personal hygiene items
- any charges for genetic testing or counseling
- any charges for services for conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or for inpatient confinement for environmental change
- any charges for treatment of infertility, including charges for artificial insemination, in-vitro fertilization and gametet intrafallopian transfer or similar or related procedures or elective sterilization or reversal of elective sterilization
- any charges for the treatment of sexual dysfunction not related to organic disease
- any charges for sex change surgery
- any charges for treatment by acupuncture
- any charges for prosthetic devices or shoes and the fitting thereof, except a basic cardiac pacemaker or an artificial lens implant due to illness or injury to the eye are covered
- any charges for treatment of any kind of obesity, weight reduction or dietary control, including stomach stapling (gastroplasty) unless the condition is considered life threatening
- any charges for eye glasses or contact lenses except as specifically provided for as part of the Plan's Optical Benefit
- any charges for hearing aids and the examinations for prescribing and fitting them except as specifically provided for as part of the Plan's Hearing Aid Benefit
- any charges for dental work or treatment (except as a result of accidental injury while covered by this Plan) except as specifically provided for as part of the Plan's Dental Benefit
- any charges for drugs or vitamins that can be purchased without a prescription or for prescription drugs or vitamins other than those administered during a hospital stay except as specifically provided for as part of the Plan's Prescription Drug Benefit
- any charges resulting from an act of war, whether declared or undeclared or caused during service in the armed forces of any country
- any charges for an illness or injury arising out of or in the course of an employee's employment, benefits will be denied if you or your dependent fails to prosecute a Workers' Compensation claim
- any charges for penalties assessed by a primary medical plan, Medicare or a Health Maintenance Organization (HMO) due to failure to obtain from the primary plan precertification, second surgical opinion or for any other reason

- any charges for cosmetic surgery to improve the appearance of the individual, unless due to accidental injury while covered by the Plan or for psychological reasons. Cosmetic surgery includes, but is not limited to: breast enlargement or reduction, liposuction, rhinoplasty, ear pinning, facial lifts, radial keratotomy, and stomach stapling (gastroplasty)
- any charges for palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet
- any charges for outpatient, out-of-hospital speech, occupational and respiratory therapy
- any charges for services provided by a skilled nursing facility
- any charges for home care services for care of mental, psychoneurotic and personality disorders or tuberculosis
- any charges for services provided by an Out-of-Network birthing center
- any charges for the treatment of mental illness in an outpatient facility
- any charges for housekeeping services under home health care visits
- any charges for infusion and intravenous (IV) therapy under the home health care program
- any charges for X-ray examinations made without film (except for covered hospital inpatient benefits)
- any charges for well-baby care or immunization
- any charges for travel
- any charges for routine adult physical examinations
- any charges for school or camp examinations
- any charges for treatment by a private duty nurse which is not certified by a doctor as medically necessary and for charges which exceed $75 per 8 hour shift and/or charges in excess of 5 shifts
- any charges resulting from or occurring during the commission of a crime or illegal act by the covered person including the use of illegal drugs
- any charges for membership in, fees or dues incurred with regard to recreational facilities, fitness centers, diet, stress management centers or nutritional centers, even though prescribed or recommended by a physician
- any charges for which mandatory automobile no-fault benefits(or any similar benefits which relate to motor vehicle insurance coverage and financial responsibility whether or not entitled as "no-fault" benefits) are payable
- any charges incurred in a country or principality outside the United States, where health care is available without charge
- any hospital inpatient day where there is a non-emergency hospital inpatient admission on a weekend (Friday, Saturday, Sunday), unless surgery or other vital services are performed within 24 hours of that day
- any charges for vision correction for myopia by surgery
- any charges for treatment or services unless specifically stated as covered in this Summary Plan Description booklet.

4. Death And Dismemberment Benefits

Death Benefit

Summary

Death Benefit:

- $2,000-$8,000 depending on eligibility

Accidental Death Benefit:

- $1,000-$2,000 depending on eligibility

Spouse Death Benefit:

- $250

Dismemberment Benefit:

- Up to 100% of the regular death benefit amount

Retiree Death Benefit:

- $2,000

The death benefit covers your life but not the lives of your dependents. After you have been in continuous Plan coverage for two months, the amount of your death benefit is based on your rate of contribution and years of covered employment. The regular death benefit payable to your designated beneficiary is as follows:

	Full-Time Full Contribution Rate Members[1]	Part-Time and Reduced Contribution Rate Members
1st year of covered employment	$4,000	$2,000
2nd year of covered employment and thereafter	$8,000	$4,000

Effective July 1, 1998, the Death Benefit for members, who become eligible on or after July 1, 1998, will be determined according to the following graduated schedule:

	Full-Time Full Contribution Rate Members	Part-Time and Reduced Contribution Rate Members
1st year of covered employment	No Benefit	No Benefit
2nd year of covered employment	$4,000	$2,000
3rd year of covered employment	$6,000	$3,000
4th year of covered employment	$8,000	$4,000

[1] This coverage is subject to the full time/full contribution rate as defined by the Collective Bargaining Agreement.

Spouse Death Benefit

A death benefit of $250 is available to the beneficiaries of spouses of full-time contribution rate members, who are eligible for family benefits.

Accidental Death Benefit

In addition to your regular death benefit, $2,000 ($1,000 for part-time and reduced contribution rate members) is payable to your designated beneficiary in the event of accidental death.

For example, the amount paid to your beneficiary in the event of your accidental death is the $8,000 regular death benefit plus the $2,000 accidental death benefit for a total of $10,000 ($4,000 plus $1,000 for a total of $5,000 for part-time and reduced contribution rate member).

Dismemberment Benefit

If an accidental injury occurs while Plan coverage is in effect, an allowance based on your regular death benefit amount in effect at the time of loss will be paid as follows:

One hundred percent (100%) of the regular death benefit amount for loss of:

- a hand
- a foot
- an eye.

Twenty five percent (25%) of the regular death benefit amount for loss of:

- thumb and index finger of the same hand.

Only one amount from the schedule above will be paid for all losses due to the same accident.

The loss of hand or hands, or foot or feet, means severance at or above the wrist joint or ankle joint, respectively. The loss of thumb and index finger means severance of two or more entire phalanges of both thumb and the index finger. The loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof.

How To Name Your Beneficiary

You may designate or change your beneficiary at anytime by filing official notice with the Plan Office.

In the event you fail to specify a beneficiary or if your designated beneficiary predeceases you and you have not yet designated another beneficiary, then the death benefit on your behalf will be payable in the following order of priorities:

- Legal spouse
- Child (or children, in equal shares)
- Parent (or parents, in equal shares).

If none of the above applies for the benefit, it is forfeited and remains part of the Plan.

The designated beneficiary may assign any portion of the death benefit otherwise payable to him or her to be paid directly to a provider for funeral or burial expenses.

Retiree Death Benefit

A retiree death benefit of $2,000 is payable to the beneficiary of a retiree. This benefit applies to retiree age 65 and older who had at least 15 years in the Plan and who remain(ed) in active covered employment until at least age 62 (there is no death benefit coverage during ages 62, 63 and 64).

5. How Your Rights Are Protected

As a participant in the Local 108 Health Expense Benefits 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

- 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 Pension and Welfare Benefit Administration.
- 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 administrator may make reasonable charge for the copies.
- 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.

Continue Group Health Plan Coverage:

- 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.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage

under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries:

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. No one, including your employer, your union, 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:

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.

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. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. 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.

Assistance With Your Questions:

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 Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Your Right To Appeal

If your entire claim, or part of your claim is denied, you have the right to appeal. The following appeals procedures apply only to claims for benefits provided under this Plan to Participants.

Appeal of Adverse Benefit Determination

If you disagree with the determination, you may request an appeal of such denial by written request filed with the Fund at least one hundred and eighty (180) days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

Review Process

In connection with your right to appeal the initial determination regarding your claim, you:

- will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- will be provided, at your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination;
- will be provided with the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

- are entitled to have your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial; and
- are entitled to a review that is conducted by a different individual, who is neither the individual who made the adverse benefit determination, nor the subordinate of such individual.

In the case of a claim involving urgent care, you are entitled to an expedited review process pursuant to which all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and you by telephone, facsimile, or other available expeditious methods.

Time Frames for Review and Appeal

The Fund must issue a review decision on your appeal according to the following timetable:

Urgent Care Claims - not later than seventy-two (72) hours after receiving your request for a review.

Concurrent Care Claims - an appeal of a concurrent care claim will be treated as either an urgent care claim, pre-service care claim, or a post-service care claim, depending on the facts.

Pre-Service Care Claims - not later than thirty (30) days after receiving your request for a review.

Post-Service Care Claims - The Appeals Committee meets four times each year. If your appeal is received more than thirty days prior to the next Appeals Committee Meeting, it will be considered at that meeting. If your appeal is received within thirty days of the next Appeals Committee Meeting, your appeal will be considered at the meeting that follows. You will receive a written decision of the outcome of your appeal within 30 days of the decision. If you lose your appeal, you have the right to file suit in State or Federal Court under section 502(a).

Manner and Content of Benefit Determination on Review

If your appeal under this Fund has been denied, in whole or in part, you will be provided with adequate notice in writing setting forth:

- the specific reasons for the decision;
- references to the specific plan provisions on which it was based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- a statement describing your right to bring a civil action under section 5O2(a) of ERISA;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge, upon request;
- if the benefit determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

The decision of the Trustees of the Fund (or its designated committee) on review shall be final and binding on all parties.

Amendment / Termination Of The Plan

The Trustees of the Fund expect to continue this Plan indefinitely. They have the right, however, to amend or terminate the Plan at any time. The Plan may also be terminated if the obligation of all employers to contribute to the Fund ceases.

Any amendment to the Plan may be made by an action consented to or taken by a majority of the Trustees.