SUMMARY PLAN DESCRIPTION FOR

UNITED BENEFIT FUND

Plan of Benefits as of January 1, 2014

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Dear Participant:

We are pleased to be able to provide health care benefits for the eligible participants and dependents of the UNITED BENEFIT FUND. This booklet, known as the Summary Plan Description ("SPD") describes in detail the benefits available to you and your eligible dependents as of January 1, 2014. This booklet is also the Plan of Benefits for the United Benefit Fund. It sets forth the rules of eligibility governing your entitlement to benefits and provides the required procedures that must be followed when filing your claims or appealing a denial of benefits. This booklet also explains your right to continue coverage if your employment terminates or you are no longer eligible to be covered under the Plan. If you have trouble understanding any part of this booklet, contact the Fund Office in writing at 150-28 Union Turnpike, Suite 250 Flushing, New York 11367. You may also call the Fund Office at (718) 416-4020.

Please read this booklet carefully and share its provisions with your family so that you will all understand what benefits are available, the rules of eligibility, how to submit claims, and how claims are paid. This SPD replaces any prior SPDs you may have received. There have been some significant changes to the SPD since the last printing of this booklet. Also, please remember to put this booklet in a safe place in order to assure its availability for future reference.

The UNITED BENEFIT FUND is funded by monthly Employer contributions negotiated on your behalf by the Union and paid by your Employer pursuant to a written contractual agreement. A Board of Trustees is responsible for the operation of the Fund and for the Plan of benefits. The Board is comprised of an equal number of Employer and Union Trustees, each of whom serves the Fund as a fiduciary without pay.

Our schedule of benefits has been established by the Trustees of the Plan, with the Fund's Plan Administrator and professional consultants assisting the Trustees to make the best use of the Fund's available assets. The coverage schedules are structured to meet the most common needs of all participants and to take into account the most current and prevalent conditions. The benefits will cover a significant part of your medical expenses; however, they may not cover your entire medical bills. Before having any medical treatment performed, you should first discuss the charges with your doctor so that you will know exactly what portion of the bill you will be responsible for after the Fund and/or other insurance reimbursements. We encourage you to contact the Fund Office prior to agreeing to out-of- pocket charges.

We appreciate your understanding of our efforts to provide health care benefits to you and your covered family members and to preserve the Plan for the collective good of all the Participants and eligible dependents.

Sincerely yours,

BOARD OF TRUSTEES

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*MRI's must be performed by an in-network PPO on an out-patient basis unless it is medically necessary to perform the procedure in a hospital or the procedure is deemed medically necessary and performed while the patient is otherwise hospitalized.

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*You must notify the Plan prior to an elective admission.
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SECTION 1
DEFINITIONS

The following definitions are used throughout this booklet. The definitions will help you understand your benefits. In all cases, the Board of Trustees has sole discretion to interpret the meaning of any of the provisions in the Plan. Wherever the following terms are used, they are capitalized and have the following meanings:

Allowable Charge for services or supplies is:

1. For PPO Providers, the charge the Provider has agreed to accept as payment in full under a contractual agreement the Provider has with the PPO-Provider network; or

2. For Non-PPO Providers, the Medicare Rate developed by the Centers for Medicare and Medicaid Services used to reimburse physicians and other Providers on a fee-by-fee basis. However, the Allowable Charge for the UBF Building Maintenance 2 Plan for covered services rendered by Non-PPO Providers is the Customary, Usual and Reasonable ("CU&R") rate, which is the lesser of the Allowable Charge as determined by the Plan or the CU&R rates determined by comparing the provider fee most often charged for a particular service nationally, adjusted for the locality where the service was performed. The Participant is responsible for the difference between what is charged by the Non-PPO Provider and what the Plan considers CU&R.

Clinical Eligibility for Coverage requires medical services to be required for the diagnosis or treatment of an Injury or sickness. Services must be known to be safe, effective and appropriate by most qualified practitioners who are licensed to treat that injury or sickness. Services must be performed safely at the appropriate level of care, and in the least costly setting required by the injury or sickness. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the qualified practitioner.

Any service or supply that does **not** meet the Plan's guidelines for clinical eligibility for coverage is excluded from coverage.

Co-Payment is that portion of eligible medical and prescription drug expenses for which you are financially responsible.

Covered Person includes any Participant and his or her eligible Dependents when properly enrolled in the Plan as a new hire, enrolled during the open enrollment period or allowed to enroll because of a qualifying event such a birth, marriage or adoption, as defined in Section 2.

Deductible is the amount of eligible medical or prescription drug expenses that you are responsible for paying out-of-pocket, each calendar year before the Plan pays for any allowable expenses. Currently there are no Plan Deductibles.

Dependent under this Plan is:

Your legal Spouse when residing in the United States, excluding a legally separated spouse, who is listed on your enrollment card, or

Your unmarried or married biological children, legally adopted children, and stepchildren up to age 26. Coverage will be terminated at the end of the month in which the child turns 26 years old.

Grandchildren are not eligible for coverage.

Emergency Care is medical or dental care and treatment provided for:

- A medical condition that comes on suddenly and is manifested by symptoms of such severity, including severe pain, that a prudent person with average knowledge of medicine could reasonably expect that the absence of immediate medical attention could result in:
  - Placing the health of the afflicted person in serious jeopardy; or
  - Causing serious dysfunction of any bodily organ or part; or
  - Causing serious disfigurement of the afflicted person.
- Treatment and services due to a non-work related accident and rendered within 48 hours of such accident;
- Treatment and services due to a sudden onset of serious illness and rendered within 24 hours of such illness; and
- Emergency situations such as uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, serious burns or cuts, and broken bones.

Employee means an individual covered by a collective bargaining agreement between an Employer and a participating Union, who is actively working in a full-time position covered under the terms of collective bargaining agreement, or an individual whose Employer has entered into a written participation agreement directly with the Fund which obligates the Employer to make contributions to the Fund for the purpose of providing the Employer's employees with benefits under the Plan.

Employer means an Employer that is party to a collective bargaining agreement with a participating Union or has executed a written agreement with the Fund, obligating the Employer to make payments to the Fund on the behalf of its Employees working in employment covered under the collective bargaining agreement or participation agreement in order to provide those Employees with Plan benefits. The Fund and the Union are Employers only to the extent that they make contributions to the Fund for coverage of their Employees.

Employment means a position with an Employer for which contributions are required to be made to the Fund.

Essential Health Benefits are the medical services described by Section 1302(b) of the Patient Protection and Affordable Care Act, which are health benefits that include the medical services

and items covered within the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Please note that some but not all Essential Health Benefits are covered under the Plan. Any benefit provided under the Plan which is considered an Essential Health Benefit will not be not be subject to annual or lifetime Plan limitations if the services are rendered by a PPO Provider. Please note that grandfathered group health plans are not required to provide coverage for Essential Health Benefits. This Plan is a grandfathered group health plan and not all Essential Health Benefits are covered under this Plan.

Experimental or Unproven Services

1. Experimental, investigational or unproven services, which means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

    a. Items within the research, investigational or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

    b. Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

    c. Items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established; or

    d. Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits

provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Fund or Welfare Fund means the UNITED BENEFIT FUND.

Health Care Provider means an individual trained to provide the services rendered to the patient and licensed under laws of the jurisdiction where the services are rendered who acts within the scope of his or her license. Pursuant to the Public Health Services Act, Section 2706(a), to the extent an item or service is a covered benefit under the Plan or coverage, and consistent with reasonable medical management techniques specified under the Plan with respect to the frequency, method, treatment or setting for an item or service, a Plan or issuer shall not discriminate based on a provider's licensure or certification, to the extent the provider is acting within the scope of the provider's license or certification under state law.

Hospital means an accredited general or specialty hospital that has full diagnostic surgical and therapeutic facilities under the supervision of a staff of Physicians, and which regularly provides 24-hour nursing services by registered, graduate nurses or licensed practical nurses. Care in institutions or parts of institutions principally used as clinics or maintained for care of the aged or chronically ill, rest or nursing homes, or other extended care facilities (such as acute and sub-acute rehabilitation) are not considered Hospitals within the meaning of the Plan.

Illness is any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Expenses incurred because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any other Illness.

Incurred is any charge submitted to the fund for medical services actually received. The benefits paid may not be the actual amount charged by the Provider.

Injury is any damage to a body part resulting from trauma from an external source.

Medicare is the Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as amended.

Medicare Rates are the comprehensive listing of fee maximums and schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies developed by the Centers for Medicare and Medicaid Services used to reimburse a physician and/or other providers on a fee-for-service basis.

In the case of a Non-PPO Provider covered expenses are payable at 100% of the Medicare Rate. UBF Plans that are "Building Maintenance 2" Plans, reimburse covered expenses for services rendered by a Non-PPO Provider at the Customary, Usual and Reasonable ("CU&R") rate, which is the lesser of the Allowable Charge as determined by the Plan or the CU&R rates

determined by comparing the provider fee most often charged for a particular service nationally, adjusted for the locality where the service was performed. The Participant is responsible for the difference between what is charged by the Non-PPO Provider and what the Plan considers CU&R.

1. If more than one surgical procedure is performed through the same incision during the same operative session, the Allowable Charge is limited to 100% of the Medicare Rate (or where applicable the CU&R rate) for the primary surgical procedure. The secondary and any additional procedures are payable at 50% of the Medicare Rate (or where applicable the CU&R rate).

2. The Medicare Rate payable for an assistant surgeon or physician's assistant is based on the Medicare Rates (or where applicable the CU&R rate) for the primary surgeon as follows: 16% of the Medicare Rate (or where applicable the CU&R rate) for an assistant surgeon; and 14% of the Medicare Rate (or where applicable the CU&R rate) for a physician's assistant.

Morbid Obesity is having a Body Mass Index (BMI) equal to or greater than 40. BMI is your weight in kilograms divided by the square of your height in meters. The Plan provides coverage for certain non-experimental and scientifically proven surgical and non-surgical treatment of morbid obesity by qualified practitioners. Pre-authorization is required prior to obtaining treatment or benefits will not be payable under the Plan. The Plan reserves the right to determine whether You are eligible for coverage. Benefits do **not** include nutritional supplements, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs.

Net Payout/Payment is the final amount payable for medical services rendered (which is the adjudicated price after network re-pricing, co-pays, deductibles, out-of-network penalties, if any, and any applicable audit reductions). The Fund will never pay out more than the Net Payout maximum.

Participant is an Employee who meets the eligibility requirements of Section 2 of this Plan. A former Employee who continues to be eligible for coverage under COBRA Coverage is also a Participant until that coverage ends.

Physician is a person licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs under laws of the jurisdiction where the services are rendered and who acts within the scope of his or her license.

Plan Document means the benefits and provisions described in this booklet.

Plan Policies are the coverage rules as explained in this SPD and the procedures under which the Fund operates that apply to all Participants and any eligible Dependents.

Preventive Care Services are the recommended preventive services identified by the federal Patient Protection and Affordable Care Act (PPACA).

These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and Health Resources and Services Administration (HRSA) Guidelines, including the American Academy of Pediatrics Bright Futures periodicity guidelines.

Only Preventive Care Services rendered by a PPO Provider are covered under the Plan.

Qualified Medical Child Support Order (QMCSO) is a court or state administrative agency order that complies with requirements of federal law as described in Section 2.

Surgery is any operative or diagnostic procedure performed in the treatment of an Injury or illness by instrument or cutting procedure through an incision or any natural body opening.

Total Disability or Totally Disabled means a disability that result from a bodily Injury or disease that wholly prevents the person from engaging in any gainful work.

Work Related means an Injury or Illness arising out of or in the course of one's employment, whether or not the person properly asserts his or her rights and whether or not any recovery is received. If, except for your failure to follow the appropriate procedural requirements for filing a claim or to otherwise similarly act, your claim could have been compassable by, for example, the relevant Workers' Compensation law; it will be treated as Work Related by the Fund and excluded from coverage under the Plan.

You or Your refers to the Participant, unless the context clearly indicates otherwise. This booklet describes the Plan as it applies to most Covered Persons. It is subject to administrative modifications, rules, regulations and procedures of the Plan in effect at time of service. In dealing with situations not specifically covered by the general terms of the Plan, the rules and regulations are interpreted by the Trustees in a manner consistent with the intent and limits of the Plan description as described in Sections 15 and 16 of this Booklet.

SECTION 2
ELIGIBILITY

You become eligible to participate in the Plan as of the date indicated by the collective bargaining agreement or other written agreement under which you are covered and which obligates your Employer to make contributions to the United Benefit Fund on your behalf. If the collective bargaining agreement or other written agreement is silent with regard to your effective date for participation in the Plan you become eligible when you work in full-time Employment as an Employee with an Employer.

INITIAL ENROLLMENT

Once you become eligible you must enroll in the Plan to receive benefits. You must enroll in the Plan within thirty (30) days of when you first become eligible. You must obtain an Enrollment Card from the Fund Office and return the completed card immediately. If you do not, the commencement of your coverage may be delayed and you may lose some benefits but you will never wait an excessive period of time as prohibited by the Affordable Care Act.

The Enrollment Card is a permanent record of important dates for you and your eligible Dependents. For family benefits, you must list your eligible Dependents with their dates of birth and submit legal marriage, birth, or adoption certificates.

The Funds will deny claims for benefits incurred before your Enrollment Card is received by the Fund Office, or for a Dependent not listed on the card.

It is your obligation to keep the Fund Office informed and to file for a new Enrollment Card within sixty (60) days of any changes in your:

- Address
- Dependent Status (Birth/Adoption of a Child)
- Marital Status

REQUESTS FOR INFORMATION

You are required to submit all documentation necessary to substantiate the eligibility of your covered Dependents whenever requested by the Fund. If you refuse or fail to furnish such documentation the Fund may deny eligibility or withdraw your Dependents from enrollment.

LATE ENROLLMENT

If you and/or your eligible Dependents did not enroll during your original 30-day eligibility period or any special enrollment periods described in this Section and later decided to apply for coverage, you may enroll by making written application to the Plan Administrator. In these circumstances, you and/or your eligible Dependents will be considered late enrollees. Coverage will become effective at 12:01 A.M. on the first day of the month following enrollment.

Special Enrollment Periods

This Plan provides special enrollment periods that allow you to enroll in the Plan without any extended restrictions even if you declined enrollment during an initial or subsequent eligibility period.

If you declined enrollment for yourself or your Dependents (including your spouse) because you had other health coverage, you may enroll for coverage for yourself and/or your Dependents if the other health coverage is lost. You must make written application for special enrollment within sixty (60) days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on November 14.

If You are an eligible Employee or Dependent and you lose your Medicaid or state Children's Health Insurance Program coverage, also called CHIP, you have sixty (60) days to elect coverage under the Plan.

You or your eligible dependents may enroll during this special enrollment period if the person who wishes to enroll, called the "enrollee," meets all of the following conditions:

- The enrollee is eligible for coverage under the terms of this Plan;
- The enrollee is not currently enrolled under the Plan;
- When enrollment was previously offered, the enrollee declined because of coverage under another group health plan or health insurance coverage. You or the enrollee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
- The other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The enrollee is not eligible for this special enrollment right if:

- The other coverage was COBRA continuation coverage and the enrollee did not exhaust the maximum time available for that COBRA coverage; or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the enrollee will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

Special Enrollment for New Dependents

If you acquire a new Dependent as a result of marriage, birth, adoption, or the placement of a child with you for adoption, you may be able to enroll yourself and your Dependents during a special enrollment period. You must make written application for special enrollment no later than sixty (60) days after you acquire the new Dependent, excluding the day of the acquisition. For example, if you are married on September 15, you must notify the Plan Administrator and apply for coverage by close of business on November 14.

You may enroll yourself and/or your eligible Dependents during this special enrollment period if:

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new Dependent through marriage, birth, adoption or the placement of a child with you for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your Dependent(s) will be effective at 12:01 a.m.:

- For a marriage, on the first day of the calendar month following the date of marriage provided that the Fund Office receives the required employer contribution for the coverage.
- For a birth, the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Qualified Medical Child Support Orders (QMCSOs)

The Fund will provide coverage to your child if required to do so under the terms of a qualified medical child support order (referred to as a "QMCSO"). The Fund will provide coverage to a child under a QMCSO even if you do not have legal custody of the child, the child is not dependent on you for support, the child does not reside with you, and regardless of any waiting period that otherwise may exist for Dependent coverage. If the Fund receives a QMCSO and if you do not enroll the affected child, the Fund will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Fund's procedures for determining whether an order is a QMCSO can be obtained from the Fund Office.

OPEN ENROLLMENT

Open Enrollment gives you the opportunity to make changes to your benefit elections for the coming year. Open Enrollment is usually held every year for an entire month, from January 1 through January 31. Some Employers may have open enrollment during a different time of year and/or a different length, depending on their contract with the Union and agreements with UBF. Please make sure to check with your employer to verify when your open enrollment period begins and ends, and for the proper procedures in making changes to your coverage during your open enrollment period.

WAITING PERIOD

On the first day of the month in which the initial (first) Employer contribution to the Fund is received on your behalf, you will become eligible (if applicable) for the following benefits:

- Medical Benefits
- Major Medical Benefits
- Surgical Benefits
- Optical Benefits
- Dental Benefits
- Hospital Benefits
- Prescriptions Benefits

If you are not actively employed by an Employer in Employment when your benefits are first scheduled to be in force, then coverage for you will be delayed until you return to active, full-time employment. However, the waiting period may be no longer than that allowed by Section 2708 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act which currently is 90 days.

However, if you are not actively at work due to Illness or Injury, you will be treated as being actively at work for purposes of eligibility under the Fund, provided that you actually began work covered by the Fund.

This Plan does not discriminate among Participants on any impermissible basis and does not require late enrollees to pass a physical exam.

SECTION 3
TERMINATION OF BENEFITS

All benefit coverage for both you and your Dependents terminates as of the last day of the month your Employer makes contributions on your behalf. Other reasons for termination are described in Section 14 of this Summary Plan Description.

The Plan will be permitted to retroactively rescind an individual's coverage only for fraud or intentional misrepresentation of material facts or, in the case of COBRA, for non-payment of premiums.

Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you are inducted into the Military Service of the Armed Forces of the United States of America, or if you enlist in the Military Service, including part-time National Guard Service, or if, because of membership in a reserve component of the Armed Forces, you are called into active federal service, your health coverage will be continued by the Fund during your first thirty-one (31) days of military service in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994. After thirty-one (31) days, your eligibility for health care coverage under this Plan will be suspended during the period of your military service. You should receive military health care coverage at no cost. You may choose to continue coverage under this Plan, at your own expense up to a maximum of 24 months. You and your Dependents covered under the Plan may also be eligible to continue coverage under the COBRA provisions by making the required self-payments. The Fund does not voluntarily maintain your coverage; you and your eligible Dependents will be given the opportunity to elect continuing coverage at your own expense.

If you are in the reserves and return from active duty you will be entitled to resume eligibility under this Plan if you return to active covered employment within ninety (90) days from the date of discharge, you originally left the employer for military service from other than a temporary position, and was released from active duty under "honorable conditions." The veterans' rights law requires this ninety (90) day grace period as a type of protection for participants, for the duration of the reserve call-up or any other type of military service up to five (5) years. The Fund is not obligated to offer this ninety (90) day period to participants serving in the military for five (5) or more years.

Essentially, the Fund will suspend your eligibility in the Plan until you are discharged. Your eligibility will be based on your hours worked in covered employment prior to entering the military. If you do not return to active covered employment within ninety (90) days (or any time otherwise specified), you will be considered a new employee, subject to the initial eligibility provisions.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the USERRA continuation of coverage should be referred to the Fund Office

May I continue to participate while I am absent under USERRA?

You may elect to continue coverage under the Plan for yourself and your Dependents, when:

- You and your Dependents were Covered Persons in the Plan immediately prior to your leave of absence for uniformed service; and

- The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

- You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your participating Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

- The cumulative length of this absence and all previous absences with your participating Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

- You comply with the notice requirements set forth above under the question "When will coverage continued through USERRA terminate?"

The law requires your participating Employer to allow you to elect coverage which is identical to similarly situated Employees who are not on USERRA leave. This means that if the coverage for similarly situated Employees and Dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

- For leaves of 30 days or less, the same as the contribution required from similarly situated Employees;

- For leaves of 31 days or more, up to 102% of the contribution required from similarly situated Employees and your participating Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earliest of the following events:

The date you fail to apply for or fail to return to work for your participating Employer following completion of your leave. You must notify your participating Employer of your intent to return to Employment within:

- For leaves of 30 days or less, or if you are absent from Employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the participating Employer:
    - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
    - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.
- For leaves of 30 to 180 days, by submitting an application for reemployment with your participating Employer:
    - Not later than 14 days after completing uniformed service; or
    - If submitting such application within that period is impossible or unreasonable through no fault of your own, then the next first full calendar day when submission of such application becomes possible.
- For leaves of more than 180 days, by submitting an application for reemployment with your participating Employer not later than 90 days after completing uniformed service.
- If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your participating Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your participating Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.
- The date you fail to pay any required contribution.

- 24 months from the date your leave began.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your Dependents' coverage be reinstated immediately upon your return to Employment, so long as you comply with the requirements set forth above under the question "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your participating Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your Dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your participating Employer.

Family and/or Medical Leave

The Family and Medical Leave Act ("FMLA") is a federal law that applies, generally, to Employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA leave at the same cost as if the FMLA leave not been taken.

If the FMLA applies to your Employer, the law requires that your Employer give you up to 12 weeks of job-protected, unpaid leave during any 12-month period for one or more of the reasons described below, so long as you have worked 1,250 hours during the preceding 12 months.

The FMLA also requires your Employer maintain your coverage under the Plan during your period of leave under the FMLA just as if you were in active Employment. Your coverage under the FMLA will cease once the Fund is notified or otherwise determines that you have terminated Employment, exhausted your 12 week FMLA leave entitlement, informed the Fund of your intent not to return from leave, or your Employer ceases to make contributions to the Fund on your behalf during the period of FMLA leave.

Once the Fund is notified or otherwise determines that you are not returning to Employment following a period of FMLA leave, you may elect continued coverage under the COBRA continuation of coverage rules. The Qualifying Event entitling you to COBRA coverage is the last day of your FMLA leave.

If you fail to return to Employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition that affects you or a Family Member and that would normally qualify you for leave under the FMLA. If you fail to return from FMLA leave for impermissible reasons, the Fund may offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of the benefits paid on your behalf during the period of FMLA leave.

If provisions under the Plan change while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

FMLA leave may be paid (using accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the Plan contribution, if any, during the FMLA leave. Payment must be made within thirty (30) days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

Questions regarding your entitlement to FMLA leave should be referred to your Employer. Questions about the FMLA continuation coverage should be referred to the Fund Office.

Am I an eligible employee?

You are an eligible employee if all of the following conditions are met:

- You have been employed with the participating Employer for at least 12 months;
- You have been employed with the participating Employer for at least 1,250 hours during the 12 consecutive months prior to the request for FMLA leave; and
- You are employed at a worksite that employs at least 50 Employees within a 75-mile radius.

What circumstances qualify for FMLA leave?

Coverage under FMLA leave is limited to a total of 12 work-weeks during any 12-month period for the following reasons:

- The birth of, and to care for, your newborn son or daughter;
- The placement of a child with you for adoption or foster care;
- Your taking leave to care for your spouse, son or daughter, or parent who has a serious health condition; or

- Your decision to take leave due to a serious health condition which makes you unable to perform the functions of your position.

- A qualifying exigency arising out of the fact that a spouse, son or daughter, parent, or next of kin of the Employee is a regular or reserve component in the Armed Forces.

Military Caregiver Leave

Coverage for military caregiver leave under FMLA is limited to a total of 26 workweeks during any 12-month period for the following situations:

- To care for a service member following a serious illness or injury to that service member, when the Employee is that service member's spouse, son or daughter, parent, or next of kin.

- To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's spouse, son or daughter, parent, or next of kin.

What are the notice requirements for FMLA leave?

You must provide at least 30 days' notice to your participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your participating Employer has the right to require medical certification to support your request for leave due to a serious health condition for yourself or your eligible family members.

How long may I take FMLA leave?

During any one 12-month period, the maximum amount of FMLA leave may not exceed 12 work-weeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a serious illness or injury that was incurred in the line of active duty may take up to 26 weeks of FMLA leave in a single 12-month period to care for that service member. Your participating Employer may use any of four methods for determining this 12-month period.

If you and your spouse are both employed by the participating Employer, FMLA leave may be limited to a combined period of 12 work-weeks, for both spouses, when FMLA leave is due to:

- The birth or placement for adoption or foster care of a child; or

- The need to care for a parent who has a serious health condition.

Will FMLA leave terminate before the maximum leave period?

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

- When you inform your participating Employer of your intent not to return from leave;
- When your Employment relationship would have terminated but for the leave (such as during a reduction in force);
- When you fail to return from the leave; or
- If any required Plan contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under FMLA leave ends, you will be eligible for COBRA continuation of coverage at that time.

Recovery of Plan contributions

Your participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA leave if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a serious health condition that entitles you to FMLA leave (in which case your participating Employer may require medical certification) or other circumstances beyond your control.

Will my coverage be reinstated when I return to work?

The law requires that coverage be reinstated upon your return to work following an FMLA leave whether or not you maintained coverage under the Plan during the FMLA leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA leave had not been taken. The waiting period will be credited as if you had been continually covered under the Plan.

Definitions

For the purpose of this FMLA provision only, the following terms are defined as stated.

Next of kin is the nearest blood relative to the service member.

Parent is your biological parent or someone who has acted as your parent in place of your biological parent when you were a son or daughter.

Qualifying exigency includes the following situations:

- Short-notice deployment.
    - To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
    - Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
- Military events and related activities.
    - To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
    - To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
- Childcare and school activities.
    - To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;
    - To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care

arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;

- To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and

- To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;

- Financial and legal arrangements.

  - To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

  - To act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;

- Counseling. To attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis,

who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

- Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible Employees may take up to five days of leave for each instance of rest and recuperation;

- Post-deployment activities.

    - To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and

    - To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and

- Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

Serious health condition is an illness, injury, impairment, or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential medical facility; or

- Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

Serious illness or injury is defined as an illness or injury incurred in the line of duty that may render the service member medically unfit to perform his or her military duties.

Son or Daughter is your biological, child, adopted child, stepchild, foster child, a child placed in your legal custody, or a child for which you are acting as the parent in place of the child's natural blood related parent.

Spouse is your husband or wife.

NOTE: For complete information regarding your rights under FMLA, contact your participating Employer.

Reinstatement of Coverage After FMLA or USERRA Leaves of Absence

If your coverage ends while you are on an approved leave of absence under the FMLA or USERRA, your coverage will be reinstated on the day you return to Employment, if you return immediately after your leave of absence ends, subject to all accumulated overall and annual maximum benefits that were incurred prior to the leave of absence.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage will be sent to you (or to any of your Dependents) by first class mail within a reasonable time after your or their coverage under this Plan ends. If you (or any of your Dependents) elect COBRA Coverage, another certificate will be sent to you (or them if COBRA Coverage is provided only to them) by first class mail shortly after the COBRA Coverage ends for any reason.

Extensions

If you are laid-off, granted a leave of absence or disabled, coverage for you and your Dependents who were eligible at the time of termination may continue, provided monthly contributions are continued by your Employer. After this extension period is up, you and your Dependents are still entitled to full COBRA rights. The full description of your COBRA benefits are described in Section 14 of this Summary Plan Description.

To be eligible for extended benefits, you must apply to the Fund Office at the time your full-time Employment ceases.

All benefit coverage ends immediately if the Plan is terminated or if your Employer ceases to be a contributing Employer to the Fund.

SECTION 4
MEDICAL BENEFITS

If a benefit is covered under this Plan and you are eligible for this benefit, the Fund will pay no more than the Allowable Charge. The Allowable Charge for a service or supply is:

1. For PPO Providers, the charge the Provider has agreed to accept as payment in full under a contractual agreement the Provider has with the PPO network; or

2. For Non-PPO Providers, the Medicare Rate developed by the Centers for Medicare and Medicaid Services used to reimburse physicians and other Providers on a fee-by-fee basis.

Some non-PPO Providers may request more than the Allowable Charge which is permissible under our Plan. In that case, you are responsible for the additional amount over what the Plan pays. Whenever possible, discuss the situation with the doctor or surgeon in advance so that you will have an idea what you might have to pay.

NOTIFICATION PROVISION

Notification is necessary for the Fund to evaluate the proposed treatments or services for clinical eligibility for coverage before they are rendered. Hospital services, medical services, second surgical opinions, and pre-determination of benefits, as explained below, all require notification.

In general, your Provider needs to initiate the approval process by calling the Fund Office before services are rendered. You will receive notification by telephone or in writing no more than three (3) business days after the Fund Office receives all necessary medical information.

To notify the Fund of an admission to a Hospital, the Provider must contact the Fund Office as follows:

- At least ten (10) days prior to the date of admission for elective procedures; and

- Within two (2) business days after an emergency admission;

Other procedures that require notification before benefits will be paid are:

- Chemotherapy treatment, which is restricted to non-hospital, outpatient facilities only, unless the participant is clinically eligible for coverage in a hospital. All drugs must be supplied by the Plan's contracted provider;

- MRI's, which must be performed by an in-network PPO on an out-patient basis unless it is medically necessary to perform the procedure in a hospital or the procedure is deemed medically necessary and performed while the patient is otherwise hospitalized;

- CAT scans; and

- Outpatient surgery.

The following information must always be provided to the Fund to satisfy the notification requirement. The Fund may also require additional information.

- Participant and patient's information: Name, Relationship to the Participant, Date of Birth and Address.

- Provider's information: Provider ID number, Tax ID number, Diagnosis code and Procedure code.

Failure to provide notification of all services that require notification will cause the Fund to deny your request for benefits.

SPECIAL PROCEDURAL REQUIREMENTS

- Sleep Apnea Studies. Sleep apnea studies are covered when medically necessary and only if the patient receives home testing first, prior to participating in a sleep apnea study.

Failure to follow these procedural requirements may result in a denial of benefits.

In-Network Benefits

Medical benefits are provided in two ways under the Plan:

The Fund has makes medical, hospital, optical, prescription and dental benefits available to you and your Dependents through several preferred provider organizations ("PPO"). Each Section of this SPD will describe the PPO arrangement and the rules that you must follow to receive benefits under the Plan. If you choose to use a PPO provider, you are generally required to make a Co-Payment to the Physician or Hospital and the Deductible (if any) will be waived, up to the maximum benefit limits (if applicable) and any exclusions.

If you use a provider that is not part of the PPO, benefits will be payable for Non-PPO provider services (except for Preventive Care services) **ONLY** if the services rendered are covered under the Plan.

Remember, except for Preventive Care services, the Plan covers the same services whether you use a PPO provider or not, so services that are not covered by the Plan will not be covered just because you used a PPO provider. However, using a PPO provider for covered services is less costly for you and saves the Fund money and savings may be used to improve benefits for you.

Newborn and Mothers' Health Protection Act

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's or newborn's attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or surgical care of an illness.

Women's Health and Cancer Rights Act

The federal Women's Health and Cancer Rights Act contains coverage requirements for breast cancer patients who elect reconstruction in connection with a mastectomy. The law requires group health plans that provide mastectomy coverage to also cover breast reconstruction surgery and prostheses following mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a medically necessary mastectomy will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications from all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

This coverage will be subject to the same annual deductible and coinsurance provisions that currently apply to mastectomy coverage, and will be provided in consultation with you and your attending physician.

The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") and ERISA prohibit group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information. Accordingly, the Fund does not discriminate on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- An individual's genetic tests;
- The genetic tests of family members of an individual; and
- An individual's family members' manifested diseases or disorders.

A genetic test is an analysis of human chromosomes, DNA, RNA or proteins that detects genotypes, mutations, or chromosomal changes.

For example, a genetic test includes a test to determine whether someone has the BRCA1 or BRAC2 variant indicating a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer and a test for a genetic variant for Huntington's disease.

The Fund will not require that a participant undergo a genetic test.

GINA also prohibits the Fund from requesting or requiring disclosure of genetic information of an individual or a family member of the individual, except as specifically allowed by GINA. To comply with this law, the Fund asks that you do not provide any genetic information when responding to any Fund request for medical information.

SECTION 5
OPTICAL BENEFITS FROM UNITED HEALTH CARE VISION

SPECIAL NOTE: NOT ALL PLANS CONTAIN A VISION BENEFIT PLEASE CHECK THE SCHEDULE OF BENEFITS YOU RECEIVED WITH THE PLAN

Your vision is important to your health. Whether your vision is 20/20 or less than perfect, everyone should receive regular vision care. The Vision Benefit is being offered as a part of our commitment to your well-being. The Vision Benefit provides affordable, quality vision care, nationwide. Through our national provider network, you will receive a comprehensive vision examination, as well as eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses. Carefully review the summary of your vision benefit. If you have any questions or concerns about your vision options, please call UnitedHealthcare Vision's Customer Service Center at (1-800) 638-3120 or TDD (1-800) 524-3157 for the hearing impaired. You may call Monday – Friday, 8:00 a.m. to 11:00 p.m., EST and Saturday 9:00 a.m. to 6:30 p.m. EST.

Schedule of Benefits

- Exam once every 12 months
- Lenses once every 12 months
- Frames once every 24 months
- Contacts* once every 12 months

*Contacts benefits are available in lieu of lenses & frames. You are eligible for a $105 contact lens allowance which may be applied to the fitting/evaluation fee and the purchase for contact lenses.

For example, if the fitting/evaluation fee for eyeglasses is $30, you will have $75 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.

Benefits are available every 12 months (depending on the benefit frequency), based on last date of service.

UnitedHealthcare Vision now offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses.

Exam co-pay is $10

Materials co-pay is $0

With the UnitedHealthcare Vision Benefit, you are able to visit any provider you choose, but you maximize your savings when you visit a PPO Provider.

How to locate a PPO Provider:

On your computer or smartphone go to www.myuhcvision.com and click on "Provider Locator" on the top left portion of the screen. Click on whether you are a Current Member or a Future Member. Then enter your search options, and select a provider near you.

The online Provider Locator offers door-to-door directions to your selected network provider's office. Other services, such as claim status tracking, order tracking, and answers to frequently asked questions, are also available online.

You may also find a network provider through UnitedHealthcare's Interactive Voice Response (IVR) system at (1-800) 839-3242. Simply follow the voice prompts. Once you've chosen a network provider, call them to schedule your appointment. Let your provider know you have UnitedHealthcare Vision coverage, and give your primary insured's unique identification number and the patient's name and date of birth.

Network PPO Benefits

Examinations once every 12 months with a $10 co-pay. With this benefit you receive a comprehensive eye examination from a state-licensed optometrist or ophthalmologist, covered-in-full, after the exam co pay.

This benefit provides:

- A pair of lenses once every 12 months
- Lens Options
- Frames (once every 12 months)
- Contact Lenses in Lieu of Eyeglasses (once every 12 months)

Out-of-Network Benefit

If you choose a Non-PPO Provider, you will be reimbursed up to:

$40 for exam and for lenses up to:

- $40 for single vision;
- $60 for bifocal;
- $80 for trifocal; and
- $80 for lenticular.

You will also be reimbursed up to $45 for frames and $105 for elective contact lenses or $210 for medically necessary contact lenses* (less any network fitting/evaluation fee) in lieu of eyeglasses (lenses & frame).

*Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions:

- Following cataract surgery without intraocular lens implant;
- To correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; or
- With certain conditions of keratoconus.

If your provider considers your contacts medically necessary, you should ask your provider to contact UnitedHealthcare Vision concerning the reimbursement that UnitedHealthcare Vision would make before you purchase such contacts.

If you visit an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

UnitedHealthcare Vision
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
FAX: (248) 733-6060

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

Laser Vision Correction

You may receive access to discounted laser vision correction procedures from numerous provider locations throughout the United States. To find a participating laser vision correction surgeon in your area, visit our Web site at www.uhclasik.com or call (1-888) 563-4497.

SECTION 6
PRESCRIPTION BENEFITS

Services and Supplies Provided to Covered Persons By 4D Pharmacy

Prescription drug benefits are provided to participants through 4D Pharmacy. To use this benefit, simply present your UNITED BENEFIT FUND/Medical Card at any 4D Participating Pharmacy. Participating pharmacies will display a green and white 4D Pharmacy decal in the store window or near the pharmacy areas. If you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please feel free to call the 4D Pharmacy toll free Customer Service Department at (877) 647-4026. Your pharmacist will dispense your medication, submit the claim through the 4D system, and notify you of the amount that you are required to pay. There is no guarantee that the Fund will cover the whole amount of the pharmacy charge and you are responsible for the balance, if any. Whenever possible, you should discuss prescription drug charges with your doctor or pharmacists in advance so that you are aware of any portion that will be your responsibility to pay.

Schedule of Benefits and Prescription Co-payments

Covered Persons must pay for a part of their prescription drug benefits. For each prescription at a participating pharmacy or by mail order, you must pay the Co-Payment listed below. The Co-Payment is different for generic or brand name prescription drugs.

The Plan allows for the dispensing of up to a 30-day supply as prescribed by the Physician.

The mail order program was designed to allow Covered Persons to receive large quantities of maintenance medication (e.g., heart medication, blood pressure medication, diabetic medication, etc.). Covered Persons may obtain up to a 90-day supply of their prescription.

Call the Fund Office to determine your maximum benefit for covered prescription drug expenses for each year

COVERED ITEMS

- Federal legend (prescription) drugs
- State restricted (prescription) drugs
- Anabolic steroids
- Bee sting kits
- Cholesterol lowering drugs
- Compounded prescriptions
- Cough and cold preparations
- Dexedrine/Ritalin under age
- Diabetic drugs (oral)
- Diabetic lancets
- Diabetic test strips
- Immune altering drugs

- Insulin on prescription
- Non-steroidal anti-inflammatory drugs
- Pre-natal vitamins
- Retin-A under age 25
- Syringes and needles

EXCLUSIONS

In addition to the Exclusions applicable to all benefits under the Plan (see Section 10), Prescription Benefits do not cover:

- Drugs or medications available over-the-counter for which state or federal laws do not require a prescription.
- Any drugs that are labeled as experimental or investigational.
- United States Food and Drug Administration (FDA) approved prescriptions drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia, such as The United States Pharmacopoeia (USP) Drug Information, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, the Physician Drug Reference (PDR)) or in current medical literature. Medical literature means scientific studies published in peer-reviewed national professional medical journals.
- Drugs newly approved by the FDA, prior to their review by the Fund's Pharmacy and Therapeutics Committee.
- Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications.
- Allergy serums
- Anorexiants
- Diagnostic drugs
- Federal legend oral contraceptives (except if clinical eligibility for coverage)
- Federal legend smoking cessation products
- Federal legend vitamins (adult)
- Fertility drugs (injectables)
- Fertility drugs (oral)
- Genetically engineered drugs
- Imitrex (refill vials)
- Imitrex auto injector
- Injectables
- Injectable contraceptives
- Lupron
- Male sexual dysfunction drugs
- Rhogam
- Rogaine and similar drugs
- Serums
- Yohimbine and similar drugs

- Prescriptions covered without charge under federal, state or local programs, including Worker's Compensation
- Any charge for the administration of a drug or insulin
- Unauthorized refills
- Immunization agents, biological serums, blood or plasma
- Medication for a Covered Person confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity
- Any charge where the Allowable Charge is less than the Covered Person's co-payment
- Any charge above the advertised, or posted price, whichever is less than the Allowable Charge.
- Any mental health drug which is prescribed for to treat any mental or psychological health condition.

SECTION 7
COORDINATION OF BENEFITS

Members of a family may be covered under more than one health program or insurance contract. This Coordination of Benefits provision covers all benefits to ensure that the Fund does not make duplicate payments, which can increase the cost of your health coverage.

This Coordination of Benefits applies to similar medical benefits payable under other health programs or insurance contracts, including: (a) any group insurance coverage, (b) an Employer-sponsored Blue Cross Blue Shield, or other pre-payment coverage, (c) any coverage under labor-management trusteed Plans or Employee benefits organization Plans, including this Plan, (d) any coverage under government programs, (e) any coverage required or provided by statute (except Medicaid), (f) any mandatory "no-fault" coverage, and (g) student coverage obtained or offered by an educational institution.

One of the two or more Plans is considered the "Primary Plan" and the others are the "Secondary Plan(s)." The Primary Plan pays benefits first, without consideration of the other Plans. The Secondary Plans will then make up the difference up to 100% of the Allowable Charges for each procedure. This Plan will never pay more than it would have paid without this provision. You must provide the Fund Office with any information necessary for administering this provision.

To determine which coverage is primary and which is secondary, the following rules apply:

- The plan without a coordination of benefits provision similar to this one will be the primary plan.

- The plan in which the patient is the participant (rather than a Dependent) will be the primary plan. If your Dependent child is covered under both your spouses' and your health plans, the primary coverage will be determined by the following factors:

    - The plan of the parent whose birthday falls first during the year (regardless of year of birth) will pay first.

    - If you and your spouse share the same birthday, the plan covering the parent longer will be primary.

    - If the other plan does not have a birthday provision and uses gender to determine primary responsibility, the father's plan will be primary.

If you and your spouse are divorced or separated, and there is no court decree giving financial responsibility for your child's health care expenses to one parent, your Dependent child will receive primary coverage under the custodial parent's health coverage program. The plan of the parent that was given financial responsibility for the child's health care by decree of the court is the Primary Plan.

If you and/or your spouse remarries, the following order is used to determine primary responsibility for your Dependent child's health coverage program:

- The parent with legal custody
- The spouse of the parent with legal custody
- The parent without legal custody
- The spouse of the parent without legal custody

A patient's health coverage as an actively-employed participant or as a Dependent of an actively employed participant is Primary over other health care programs that they may have, either as a laid-off Employee, a retired Employee, or a Dependent of a laid-off Employee or a retired Employee. If the other health care coverage is primary, then this rule will not apply.

If none of the previous rules apply, the Plan that has covered the patient the longest will be the Primary Plan.

If both a husband and wife are participants of this Plan, the benefit is calculated first as if this Plan was the Primary Plan and then as if this Plan was secondary. This will allow the same coverage as if the husband and wife were covered as Employees in two different plans.

If this Plan is the Secondary Plan and the Primary Plan is a health maintenance organization or preferred provider organization, then this Plan assumes that the Primary Plan pays the full value of the services and this Plan is the Secondary Plan only for any Deductible or Co-Payment under the Primary Plan. If you have coverage through your work under an HMO and this Plan is the Secondary Plan for you as a Dependent, you must follow the rules of the HMO in order to have remaining balances considered for payment by the Plan as the Secondary Plan. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to this Plan for payment, it will be denied. For purposes of coordinating benefits, an HMO is treated the same as any other plan. If you fail to follow the rules of any Primary Plan, this Plan will not pay benefits as either primary or secondary.

The Fund also has the right to collect any excess payment directly from the parties involved, from the other plan, or by an offset against any future benefit payment from the Fund on the Participant or Dependent's behalf, if he or she failed to notify the Fund Office of the availability of other health coverage. This right of offset does not keep the Fund from recovering erroneous payments in any other manner.

To ensure that the Plan coordinates benefits with any other health plan coverage you have, you must keep the Plan informed of any and all coverage you have for you and your Dependents.

If the Fund has made payment of any amount that is in excess of that permitted by these Coordinating of Benefits rules, the Fund Administrator's Office has the right to recover such

amount from any party who has received such overpayment by requesting a refund from such party, crediting other claims against the amount owed to the Fund, or taking legal action.

COORDINATION WITH MEDICARE:

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Medicare includes hospital insurance benefits (Part A) as well as supplementary medical insurance (Part B). In general, if you or a Dependent are enrolled in the Fund and enrolled in Medicare, the Fund will provide all benefits due under the Participant's Plan. Medicare may then pay any remaining charges, if such charges are covered under Medicare. In technical terms, the Fund is "primary" (pays first) for your covered medical and hospital expenses, while Medicare is "secondary" (pays second).

Rule for Small Employers of Participants Age 65 and Over and Their Dependents: If you work for an Employer with fewer than 20 Employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year and the Fund has obtained an exception for your Employer, then Medicare will be primary for you and your Dependents. The Fund will notify you if Medicare is primary because your Employer has obtained this exception.

Disabled Employees or Disabled Dependents Under 65: This Plan is primary for Employees or their Dependents who are under age 65 and Employees or their Dependents who have a Social Security Disability Award and are entitled to Medicare benefits due to Total Disability (other than End Stage Renal Disease).

End Stage Renal Disease: If, while you are in Employment, you or any of your Dependents become entitled to Medicare because of End Stage Renal Disease (ESRD), this Plan pays primary and Medicare pays secondary for 30 months starting with the earlier of (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays primary and this Plan pays secondary.

Medicaid: If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services): If you are covered by both this Plan and CHAMPUS, this Plan pays as primary and CHAMPUS pays secondary.

Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

SECTION 8
SUBROGATION

Were you or your Dependent injured in an accident for which someone else is liable? If so, that person or his/her insurance may be responsible for paying your or your Dependent's related medical and disability expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for these injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund will advance you or your Dependent benefit payments related to such an accident based on the Fund's rights of reimbursement and subrogation.

In order for you to be entitled to this benefit, you and/or the Dependent are required to notify the Fund within ten (10) days of any accident or Injury for which someone else may be liable. This deadline is important, and your failure to comply with it will result in a denial of any claim for benefits for an injury that someone else may be liable.

Further, the Fund must be notified within ten (10) days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

If you or your Dependent receive any benefit payments from the Fund for an Injury or Illness and you or your Dependent recover any amount from any third party or parties in connection with such Injury or Illness, you or your Dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your Dependent's behalf in connection with such Injury or Illness. This is referred to as the Fund's right of reimbursement.

In addition, if you or your Dependent receive any benefit payments from the Fund for any Injury or Illness, the Fund is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such Injury or Illness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your Dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such Injury or Illness in your or your Dependent's name and also has a right to intervene in any such action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy. This is referred to as the Fund's right of subrogation.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury or Illness, and regardless of whether you or your Dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order.

The Fund's rights of reimbursement and subrogation provides the Fund with first priority to any and all recovery in connection with the Injury and Illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your Dependent in obtaining recovery.

Consistent with the Fund's rights set forth in this section, if you or your Dependent submit claims for or receive any benefit payments from the Fund for an Injury or Illness that may give rise to any claim against any third-party, you and/or your Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. Your failure to execute this agreement will result in a denial of this benefit. This Agreement must also be executed by you or your Dependent's attorney, if applicable. Payments are not payable unless you sign a Subrogation Agreement, you or your Dependent's claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund. This means that, if you file a claim and your Subrogation Agreement is not received promptly, the claim will be untimely and will not be paid if the sixty day period for filing claims passes (see Section 11) before your Subrogation Agreement is received.

Under this provision, you and/or your Dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of you or your Dependent's receipt of any recovery. You or your Dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your Dependent chooses not to pursue the liability of a third party, you or your Dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately.

If you or your Dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

SECTION 9
WORKER'S COMPENSATION CASES

No benefits will be paid by this Fund for an accident or Illness in any way connected with Employment. If you have a Work-Related accident or Illness, notify your Employer immediately and file a Worker's Compensation claim with your Employer.

Certain Illnesses like hernias, varicose veins, allergy to chemicals or materials may occur due to the nature of the work in the industry. Since Worker's Compensation offers certain protections if you have such an Illness, discuss your job activities with the doctor to determine if it could be Work-Related.

Failure to file a Worker's Compensation claim could mean the loss of benefits which might otherwise protect you against medical costs or loss of earnings resulting from a Work-Related accident or Illness.

SECTION 10
EXCLUSIONS

DENIAL OR LOSS OF BENEFITS

In addition to the exclusions and limitations set forth in the various benefit sections of this booklet, the following circumstances may cause loss of benefits and/or charges and expenses which are not payable from the Fund.

Benefits are denied when it is determined that, at the time the claim was incurred, **you** or **your** Dependent, as the case may be:

- 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 intentional material misstatements in connection with eligibility or any payments made in reliance on such misstatement.
- Omitted facts or material statements as to other insurance available to **you** and **your** Dependents.

Each benefit section of this SPD may contain limitations and exclusions that apply to that particular benefit. The following exclusions and limitations apply to all benefits under the Plan except as otherwise specifically indicated in this Plan. Benefits under the Plan do not include:

- Any service or supply that is not medically necessary.
- Genetic testing or counseling, unless used to treat the sickness or injury of a Covered Person or used in the treatment of a high risk pregnancy.
- Any illegal surgeries or medical treatments.Except for Preventive Care Services, any service, treatment or hospital stay unrelated to an Illness or Injury;.
- Hospitalization furnished under federal, state and other laws for which a government program is primary.
- Care in a veteran's facility or a Hospital operated by federal or state government, to the extent permitted by law.
- Hospitalization for which no charge is made.
- Confinement primarily for custodial or for rest cures.
- Admissions due to illegal Surgery or for dentistry (except as the result of an accident).
- Services of private or special nurses or services generally provided on an out-patient basis.
- Medical Services in the event that the Plans benefit limit is reached.
- Medical Services in connection with an Injury or Illness arising out of a procedure, surgery or treatment performed by a Doctor/Facility/Provider that causes harm to a participant.
- Medical Services in connection with an injury or Illness arising out of or in the course of Employment for which benefits are payable under Worker's

Compensation Laws (benefits may be denied if you or your Dependent fail to prosecute a Worker's Compensation claim).

- Medical services which are not approved for the diagnosis and treatment of a condition.
- Any medical services, supplies and/or treatments unless performed or prescribed as necessary by a legally licensed Physician.
- Medical Services which Medicare benefits are payable (or would be payable if the patient had enrolled in Medicare when first eligible). See Section 7.
- Medical Services when No-Fault Insurance is required. There is no coverage under the Plan if No-Fault insurance coverage is required by New York or other state laws. No-Fault insurance is always primary.
- Any Medical or Surgical procedures performed for cosmetic purposes (except as a result of accident).
- Medical Services in connection with dental work or treatment (except as a result of accident or injury) other than the dental benefits in effect.
- Charges for services that the Covered Person is not legally required to pay.
- Medical Services for any Experimental procedures, services, or drugs. For example, Hospital stays for any procedure that is no longer generally regarded as effective or it is Experimental in the sense that its effectiveness is not generally recognized.
- Charges for any services rendered by the Covered Person's Family Member.
- Charges for injuries arising out of or in the course of any Employment for wage or profit.
- Charges in connection with an Illness or Injury that was self-inflicted or resulted from the person participating in an illegal act, such as crime, riot or insurrection or care or treatment while in prison.
- Charges in connection with an Illness or Injury that is incurred or is a result of insurrection military services.
- Charges for ay medical procedure, surgery, or treatment which was required as a result of the medical provider's malpractice, negligence, or malfeasance.
- Charges for prescription drugs or vitamins other than those administered during a Hospital stay (except where otherwise provided).
- Charges for recreational or leisure travel, even if recommended by a doctor.
- Expenses for the treatment of infertility and its complications, including drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, adoption, and reversal of sterilization procedures except as required by the Affordable Care Act.
- Transportation charges to and from health care providers except as specified in this Plan booklet.
- Services related to gender change.
- Care for surrogate mothers.
- Coverage for any weight loss or control, such as gym memberships, diet pills and dietary supplements.

- Coverage for gastric bypass or any other surgical procedure unless approved by a Physician.
- Coverage for hair loss.
- Coverage for marriage or family counseling.
- Except as otherwise specifically covered, expenses related to the prevention of pregnancy, including, but not limited to, condoms and diaphragms, and expenses furnished in connection with the pregnancy of a Dependent child, including termination of pregnancy.
- Membership fees, dues or any other charges in connection with recreational facilities, fitness centers, diet, stress management centers or nutritional centers, even if prescribed or recommended by a Physician.
- Charges for the preparation of medical reports or claim forms, mailing or handling expenses, charges for broken appointments, photocopying fees and any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, or any representative of the Plan for any purpose whatsoever.
- Charges for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of an Injury or Illness.
- Charges for physical examinations and testing required for Employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
- Charges for prayer, religious healing, spiritual healing, naturopathic, naprapathic, homeopathic services or supplies, hypnosis, hypnotherapy or biofeedback.
- Charges for massage therapy, Rolfing and related services.
- Expenses for nicotine gum or patches, or other products, services or programs intended to assist an individual to stop smoking.
- Coverage for mental health and psychological services and/or the treatment of mental health or psychological conditions.

Any participant who improperly collects benefits from the Fund, based on misstatement or misrepresentation, will be legally liable for the return to the Fund of any improper Fund payments. In addition the Participant will be subject to suspension of all benefits.

The Mental Health Parity Act

This Plan does not cover Mental health and substance abuse disorder benefits.

SECTION 11
HOW TO CLAIM YOUR BENEFITS

Filing Medical Claims

All claims must be filed at the Fund Office on the appropriate form. A Participant may obtain the necessary forms for filing a claim by telephone or writing to the Fund Office at 150-28 Union Turnpike, Suite 250, Flushing, New York 11379. The telephone number is (718) 416-4020. All necessary information must accompany your claim in order for the Fund to process the claim effectively including all medical notes which were generated as a result of the medical treatment and/or care.

There is a sixty (60) day time limit from the date services were received for filing medical claims. Any claim received after this time limit will be denied.

IMPORTANT NOTE: You and your Dependents should be aware that you or your medical provider's failure to file a claim for benefits within the sixty (60) day deadline will mean that if your claim is late it cannot be paid by the Fund. Consequently, the medical provider may seek to collect any money it is owed directly from you. It is therefore very important that you make sure that you or your provider submit your medical claims on time.

Additionally, if the Fund denies or partially denies any claim for benefits that you do make, you or your provider must appeal the denial within the one hundred and eighty (180) days as explained in Section 12 if you wish to contest the Fund's decision. A failure to request this review binds you and your provider to accept the amount, if any, that the Fund has already paid regarding the claim. The Fund cannot pay any claims after the time to appeal a denial has elapsed and the medical provider may then seek to collect any money it is owed directly from you.

You must file a completed claim form each time a bill is submitted. If you wish us to pay the provider of services directly, you must provide us with your original signature (not a photocopy) authorizing us to do so. Please be sure to indicate on the claim form if there is an Injury involved, a lawsuit or third party recovery, or any change in your marital status, you or your spouse's employment status or eligibility for other medical coverage.

You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Omni Administrators, Inc.
1430 Broadway, Suite 1303
New York, New York 10018

(718) 416-4020

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including PPO network repricing information);
- The name of the Plan;
- The name of the Participant; and
- The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures for All Claims

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to the third party administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the summary plan description has been delegated to the third party administrator.

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Covered Person has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person fails to furnish such proof as is requested, no benefits are payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

Pre-service Claims A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Covered Person needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay and then later file the claim as a Post-Service claim.

Further, if the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

The Plan Administrator determines that the course of treatment should be reduced or terminated;

or

The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Since the Plan does not require that the Covered Person obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Covered Person should simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a post-service claim.

Post-Service Claims.

A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the claims administrator within sixty (60) days from the date charges for the service were incurred. In no event will the time limit be extended beyond sixty (60) days from the date the charges were incurred except in the case of legal incapacity of the Covered Person. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Late Claims will be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the third party administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within 45 days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of the Fund's Claim Decisions

The Plan Administrator will notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- **Pre-service Non-urgent Care Claims:**
    - If the Covered Person has provided all of the information needed to process the claim, the Fund shall notify the Participant of the Fund's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    - If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period),

or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

- **Concurrent Claims:**

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the Fund shall make the notification before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

  - Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- **Post-service Claims.**

  - If the Covered Person has provided all of the information needed to process the claim, the Fund shall notify the Participant within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

- **Extensions – Pre-service Non-urgent Care Claims**. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Extensions – Post-service Claims**. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an

extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator may provide notifications of adverse benefit determinations either by letter or electronically. Every notice of an adverse benefit determination shall include:

- Information sufficient to identify the claim involved, including the date of the service, the name of the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the

scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

SECTION 12
CLAIM APPEAL PROCEDURE

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- Covered Persons with 180 days following receipt of a notification of an initial adverse benefit determination to appeal the determination;

- Covered Persons with the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

- That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline,

protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

Requirements for Appeal

The Covered Person must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

Omni Administrators, Inc.
1430 Broadway, Suite 1303
New York, New York 10018
(212) 278-0754

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Employee/Covered Person;
- The Employee/Covered Person's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information the Administrator will be able to decide the appeal.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

- **Pre-service Non-urgent Care Claims:** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- **Concurrent Claims:** The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

- **Post-service Claims:** Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

If, upon appeal, the Plan Administrator denies a Participant's appeal, either in whole or in part, the Plan Administrator shall provide the Participant with notification, in writing or electronically, setting forth:

The specific reason or reasons for the denial;

Reference to the specific portion(s) of the summary plan description on which the denial is based;

The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;

If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;

A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Access to, and copies of, documents, records, and other information described in this Section, as appropriate.

External Review

When a Covered Person has exhausted the internal appeals process outlined above, the Covered Person has a right to have that decision reviewed by independent health care professionals who has no association with the Plan, the Plan Sponsor, or the Fund. If the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request for external review within **4 months** after receipt of a denial of benefits to American Health Holding, Inc. (888) 974-5702.

For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your Plan Administrator with any questions on your rights to external review.

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a physician of its own choosing examine any Covered Person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the Participant or Covered Person whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such Covered Person.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers

Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. provider;
- The Covered Person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;

- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;

- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

- Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other persons or entities accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict adherence with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then

that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Legal Action for Benefits

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. **Note that: all claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within ninety (90) days after the Plan's claim review procedures have been exhausted.**

SECTION 13
GRIEVANCE PROCEDURE

In addition to the procedure for appeals for denial of benefits set forth above, we have instituted the following grievance procedure for other concerns that do not involve a claim for benefits under the Plan:

CONCERNS - Level I

If you are dissatisfied with a person, a service, the quality of care, or the contractual benefits, you may express this concern to the Fund Office. The Fund Office will make an attempt to solve problems expressed orally to your satisfaction during the initial telephone call or interview. Concerns will be acknowledged in writing no later than in 15 working days. Concerns of an expedited nature will be resolved within 72 hours. All other concerns will be resolved within 15 working days.

If you are not satisfied with the Fund's response, you should put the concern in writing. This will elevate the concern to the complaint level, level II.

COMPLAINTS - Level II

If you have a complaint concerning a person, a service, the quality of care, or the contractual benefits, you may register the complaint in writing with the Fund Office. For the purposes of this section, a complaint means a written dissatisfaction regarding the resolution of a concern from you registering a request for review of a prior decision regarding a concern.

Within 15 working days of the receipt of the written complaint, you will be notified of the time frame when the complaint will be resolved and whether any additional information is necessary in order to make the decision. Complaints of an expedited nature will be resolved within 72 hours. All other complaints will be resolved within 30 working days.

If you still are not satisfied with the decision regarding the complaint, you may file a written appeal for review by the Board of Trustees within 60 working days of the receipt of the complaint determination. This will elevate your complaint to the Grievance level III.

GRIEVANCE - Level III

For purposes of this section, grievance means a notice sent by you to register a request for a formal review of a complaint decision. Issues categorized as grievances are those that have proceeded through the Concern and Complaint levels and you are dissatisfied with the outcome of the issue reviewed at both levels.

Within 15 working days of receipt of a written appeal, you will receive written acknowledgment of the appeal**.** This acknowledgment will state whether additional information is necessary to review the issue. You will be notified of the scheduled review.

The Board of Trustees will render a decision within 3 working days for expedited Grievances and within 30 working days for all other Grievances. You will be notified in writing of the Board of Trustees decision, which shall be the final administrative review of the matter.

For levels I, II, and III, review will be contingent on the receipt of all necessary information.
In addition, a concern, complaint or grievance is considered to be of an expedited nature if delay would significantly increase risk to your health.

SECTION 14
CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, generally requires that health plans offer Employees and their Dependents the opportunity to temporarily continue their health care coverage at group policy rates when coverage under the Plan would otherwise end. This extended coverage is called "COBRA Coverage." COBRA Coverage under the Plan includes all benefits that the person was entitled to before the Qualifying Event, except Short Term Disability Benefits and Ancillary Benefits.

If you, your spouse and/or your Dependent child(ren) are covered under the Plan, you and/or your spouse or children can continue coverage for a time if coverage ends for one of several reasons (called "Qualifying Events"), even if you or they are already covered by another group health Plan or Medicare.

Qualifying events are certain events that would cause you or your Dependent to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and how long the Plan must offer them COBRA coverage.

Qualifying Events for Employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct;
- Reduction in the number of hours of Employment resulting in a loss of eligibility for health benefits.

Qualifying Events for Spouses:

- Voluntary or involuntary termination of the Employee's Employment for any reason other than gross misconduct;
- Reduction in the hours worked by the Employee resulting in a loss of eligibility for health benefits;
- Employee becomes entitled to Medicare;
- Divorce or legal separation from the Employee;
- Death of the Employee.

Qualifying Events for Dependent Children:

- Loss of Dependent child status under the Plan rules;
- Voluntary or involuntary termination of the Employee's Employment for any reason other than gross misconduct;
- Reduction in the hours worked by the Employee resulting in a loss of eligibility for health benefits;
- Employee becomes entitled to Medicare;
- Death of the Employee.

If you and/or your Dependents do not elect COBRA Coverage, you and/or your Dependent's group health coverage will end if one of these Qualifying Events occurs.

Reporting Requirements

Your Employer must notify the Fund Office if the Employee's employment is terminated, his or her hours are reduced resulting in a loss of eligibility for health benefits, he or she becomes entitled to Medicare or he or she dies. This notification must be in writing and must be provided within thirty days of the Qualifying Event. Failure to provide such timely notification may subject the Employer to federal excise taxes.

The Participant or the affected Dependent must notify the Fund Office within sixty (60) days of divorce, legal separation or loss of eligibility by a Dependent child. Both the Participant and the affected Dependent are jointly responsible for this notice. If you or your Dependent fails to give written notice to the Fund Office within the required sixty days, the affected person will lose the right to COBRA Coverage.

Financial Responsibility for Failure to Give Notice

If a Covered Person fails to give written notice within sixty days of the date of the Qualifying Event, or an Employer within thirty days of the Qualifying Event, and as a result, the Plan pays a claim for a Covered Person whose coverage terminated due to a Qualifying Event and who does not elect COBRA Coverage under this provision, then the Covered Person or the Employer, as appropriate, must reimburse the Plan for any claims that should not have been paid. If a Covered Person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the Covered Person was his or her Dependent**.**

Notice and Election Form

COBRA Coverage requires timely election of the coverage. The Fund Office will, within fourteen (14) days of receiving notice of the Qualifying Event, send to the affected Covered Person a COBRA Notice and Election Form. This form will describe the cost of coverage and the conditions under which the COBRA Coverage will terminate. **In order to obtain COBRA Coverage, the Election Form must be completed and returned to the Fund Office within sixty (60) days after receipt.**

Details of Continuation Coverage

If you choose COBRA Coverage, the coverage provided is identical to the coverage provided under the Plan to Covered Persons. If the coverage provided under the Plan is modified after you elect COBRA Coverage, your Cobra Coverage also will also be modified.

Children born to or placed with you for adoption during the COBRA period may also receive coverage for the duration of your COBRA Coverage period as long as the child is added to the Plan.

You do not have to show that you are in good health to elect COBRA Coverage. However, under COBRA, you will have to pay the cost of the premiums for your Continuation Coverage.

Payment Provisions

COBRA Coverage requires timely monthly payments. The payment due date is the first day of each month in which the COBRA Coverage continues. For example, payments for the month of November must be paid on or before November 1st.

The monthly cost of COBRA Coverage is based on 102% of the full monthly cost of the coverage under the Plan. If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits (described below), the cost of COBRA Coverage is based on 150% of the full monthly cost of COBRA coverage during the 11-month extension of COBRA Coverage. The Fund Office will tell you the cost of COBRA Coverage at the time you receive your notice of entitlement to COBRA Coverage.

There is an initial grace period of 45 days to pay the first amount due starting with the date COBRA Coverage was elected. The payment due for the initial period of COBRA Coverage must include payment for the period of time dating back to the date that your employer sponsored coverage terminated. There is then a grace period of 30 days after the due date for each of the subsequent monthly amounts due. If payment of the amounts due is not received by the end of the applicable grace period COBRA Coverage will terminate.

Once a timely election of COBRA Coverage has been made, it is the responsibility of the Covered Person seeking COBRA Coverage to make all required timely payment. The Fund will not send a notice that a payment is due or that it is late, or that COBRA Coverage is about to be or has been terminated due to the untimely payment of a required payment**.**

Maximum Periods of COBRA Coverage for Each Qualifying Event

Qualified Beneficiary	Qualifying Event	Period of Coverage
Employee, Spouse, Dependent child	Termination Reduction in hours	18 months (This 18-month period may be extended for all qualified beneficiaries if certain conditions are met in cases where a qualified beneficiary is determined to be disabled for purposes of COBRA.)
Spouse, Dependent child	Entitled to Medicare Divorce or legal separation Death of covered employee	36 months
Dependent child	Loss of Dependent child status	36 months

If your Dependent's coverage is continued for 18 months as a result of a Qualifying Event listed above and during the COBRA period a second Qualifying Event occurs that entitles the Dependent to continue coverage, your Dependent may elect to continue coverage up to a

combined maximum of 36 months. For example, if you retire and you and your Dependents elect COBRA Coverage from May 1, 2014 and you then become entitled to Medicare on November 1, 2014, your Dependents can elect to continue coverage for the balance of 36 months, measured from May 1, 2014.

If your coverage is continued under the Plan after you stop working because of one of the Qualifying Events listed in this Section, your COBRA Coverage period will be measured from the date that your coverage ends.

Entitlement to Social Security Disability Income Benefits

Extended COBRA Benefits

29-Month Period (Disability Extension): If a qualified beneficiary of COBRA benefits is determined under Title II or XVI of the Social Security Act to have been disabled within the first sixty (60) days of the commencement of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional eleven (11) months. In addition, a qualified beneficiary who has been determined under Title II or Title XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage, and who has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage, is considered to be disabled within the first 60 days of COBRA continuation coverage.

The qualified beneficiary may lose all rights to the additional eleven (11) months of coverage if notice of the determination is not provided to the Plan Administrator within 60 days of the date of the determination and before the expiration of the eighteen (18) month period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the Plan Administrator of the determination.

18 to 36-Month Period (Special Rule): If an Employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a termination of Employment or a reduction of Employment hours, the period of coverage for the Employee's spouse and Dependent children ends with the later of the thirty six (36)-month period that begins on the date the Employee became entitled to Medicare, or the eighteen (18) or twenty nine (29) month period that begins on the date of the Employee's termination of Employment or reduction of Employment hours. However, the Employee's Medicare entitlement is not a qualifying event because it does not result in loss of coverage for the Employee's Dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.

18 to 36-Month Period (Second Qualifying Event): Your spouse and Dependent children who experience a second qualifying event may be entitled to a total of thirty six (36) months of COBRA Coverage. The second qualifying event may include your death, the divorce or legal separation from the Employee, your entitlement to Medicare benefits (under Part A, Part B or both), or a Dependent child ceasing to be eligible for coverage as a Dependent under this Plan. The following conditions must be met in order for a second event to extend a period of coverage:

1. The initial qualifying event is the Employee's termination or reduction of hours of Employment, which calls for an eighteen (18)-month period of continuation coverage;

2. The second event that gives rise to a thirty six (36)-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the twenty nine (29)-month period of coverage if a disability extension applies);

3. The second event would have caused a qualified beneficiary to lose coverage under the Plan in the absence of the initial qualifying event;

4. The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and

5. The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the Plan Administrator of a divorce or a child ceasing to be a Dependent under the Plan within sixty (60) days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from eighteen (18) months (or twenty nine (29) months) to thirty six (36) months.

Termination of COBRA Coverage

If you and/or your Dependent elect COBRA Coverage, the Cobra Coverage will cease on the first of the following dates:

1. The date the Plan terminates or the Plan no longer provides coverage to similarly situated Participants or Dependents.

2. The date a required payment is due and unpaid after the applicable grace period.

3. The date you and/or your Dependent(s) first become covered under another group health Plan as long as it is after the Qualifying Event. This may not apply if you and/or your Dependent have a pre-existing condition, which is not covered under the new Plan. Contact the Fund for additional information when you and/or your Dependent(s) become covered under another group Plan.

4. The date you or your Dependent(s) first become eligible for Medicare, as long as it is after the Qualifying Event.

5. The date the applicable period of COBRA Coverage ends; or

6. The first month that begins more than (30) thirty days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for eleven (11) months, so long as the period of Continuation Coverage does not exceed twenty nine (29) months.

7. Your Employer ceases to maintain any group health Plan for its Employees through the Fund.

SECTION 15
ADMINISTRATION OF THE PLAN

The Plan shall be administered by the Plan Administrator, which shall have the discretionary authority to control and manage the operation of the Plan as named fiduciary. The Administrator shall have such power, in its sole discretion, to administer the Plan in all of its details, including, but not limited to, the following powers:

1. Interpretation of the Plan, including determinations as to eligibility and entitlement for Plan benefits, such interpretation shall be final and conclusive on all individuals claiming rights under the Plan;

2. Adoption of such procedures and regulations as in its opinion are necessary for the proper and efficient administration of the Plan and are consistent with the terms and purposes of the Plan;

3. Enforcement of the Plan according to its terms, rules and regulations;

4. The responsibility to administer and manage the Plan;

5. The responsibility to prepare, report, file and disclose any forms, documents and other information required by law or otherwise to be reported or filed with any governmental agency, or to be prepared and disclosed to all Covered Persons or other persons entitled to benefits under the Plan;

6. Maintenance of records necessary for administration of the Plan;

7. The discretionary authority to require any Covered Person to furnish any documentation that it may deem necessary to substantiate the eligibility of a Covered Person's claimed Dependent for the purpose of the proper administration of the Plan and as a condition to receiving any benefit under the Plan, wherein refusal or failure to submit such documentation may result in the withdrawal of enrollment of such dependent; and

8. The responsibility to review claims or claim denials and to determine benefit eligibility under the Plan.

Notwithstanding the foregoing, the Plan Administrator may delegate to, Third-Party Administrators, organizations or persons (who also may be Employees) specific fiduciary responsibilities in administering the Plan. Any such delegation must be in writing and, to the extent applicable, in accordance with ERISA or other applicable law.

The determination of the Plan Administrator as to any question involving the general administration and interpretation of the Plan shall be final, conclusive and binding upon all persons claiming any interest in or under the Plan except as otherwise provided by law. Any discretionary actions to be taken under the Plan by the Plan Administrator shall not be subject to

de novo review if challenged in court, by arbitration or in any other forum, and shall be upheld unless found to be an abuse of discretion.

SECTION 16
AUTHORITY OF THE PLAN ADMINISTRATOR

The power and authority to administer the Plan is vested exclusively with the Board of Trustees pursuant to the Agreement and Declaration of Trust. The Board of Trustees has empowered the Plan Administrator with the authority and discretion to:

1. Determine whether you are eligible for any benefits under the Plan;

2. Determine whether your Dependents are eligible for any benefits under the Plan;

3. Request the submission of documents necessary to substantiate the eligibility of your claimed Dependents where your refusal or failure to furnish such documentation may result in the denial of eligibility and the withdrawal of enrollment of your dependents;

4. Determine the amount of benefits, if any, you are entitled to from the Plan;

5. Determine or find facts that are relevant to any claim for benefits from the Plan;

6. Interpret all of the provisions of the Summary Plan Description;

7. Interpret the provisions of any collective bargaining agreement or written participation agreement involving or impacting the Plan;

8. Interpret the provisions of the Trust Agreement governing the operation of the Plan;

9. Interpret, construe and apply all of the terms used and make factual determinations regarding the construction, interpretation and application of the Plan, the Summary Plan Description, and all of the other governing agreements, documents, and instruments; and

10. Amend, modify, or discontinue all or part of the Plan whenever, in its judgment, conditions so warrant, subject to applicable legal restrictions.

All such determinations and interpretations made by the Board of Trustees, or their designee are made in good faith and are final and binding upon any individual claiming benefits under the Plan and upon all Employees, all Employer, the Union, any party who has executed any agreement with the Trustees or the union and all other persons who may be involved or affected by the Plan.

All such determinations shall also be given deference in all courts of law, to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless the court finds that the Trustees or their designee, abused their discretion in making such determination or rendering such interpretation.

SECTION 17
MISCELLANEOUS

State of Jurisdiction

Except to the extent superseded by the laws of the United States, the Plan and all rights and duties thereunder shall be governed, construed, and administered in accordance with the laws of the State of New York.

Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or enforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

Plan Not An Employment Contract

The Plan is not an employment contract. Nothing in the Plan shall be construed to limit in any way the right of an Employer to terminate an Employee's employment at any time for any reason whatsoever, with or without cause.

Non-Transferability of Interest and Facility of Payment

Except as otherwise expressly permitted by the Plan, the interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and, except as may be required by the tax withholding provisions of the internal revenue Code or any other applicable law, may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered. The right of a Participant to receive a benefit payable under the Plan shall not be considered to be an asset of such Participant or his beneficiary (if applicable) in the event of his divorce, insolvency, or bankruptcy. When any person entitled to benefits under the Plan is under legal disability, or in the Plan Administrator's opinion is in any way incapacitated so as to be unable to manage his affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for his benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator may determine.

Mistake of Fact

Any mistake of fact or misstatement of fact shall be corrected, and proper adjustment made by reason thereof, to the extent practicable, provided that such mistake or misstatement is brought to the attention of the Administrator or its delegate within a reasonable time, not to exceed six months. The Fund shall not be liable in any manner for any determination of fact made in good faith.

Withholding for Taxes

Notwithstanding any other provision of the Plan, the Plan Administrator or other organization, or institution providing benefits under the Plan, may withhold from any payment to be made under the Plan such amount or amounts as may be required for purposes of complying with tax withholding provisions of the Internal Revenue Code or any other applicable law.

Titles and Headings

The captions preceding the provisions of the Plan are used solely as a matter of convenience and In no way define, modify or limit the scope or intent of any provision of the Plan.

Notices

Notices and documents relating to the Plan may be delivered, or mailed via registered mail, postage prepaid, to the Plan Administrator. Any notice required under the Plan may be waived by the person entitled to such notices.

Evidence

Evidence required of anyone under the Plan may be fulfilled by means of certificate, affidavit, or other documentation, or such other information as the Plan Administrator shall require under rules uniformly applicable.

No legal action, grievance, or arbitration proceeding against the Plan, the Trustees, the Fund, the Plan Administrator, or any other person for the recovery of any claim may be commenced until the Plan's claims procedures as set forth herein have been exhausted.

Non-assignment

No assignment of any rights or benefits under the Plan may be made.

Government-Provided Benefits

The Plan does not provided benefits in lieu of, and does not affect any requirement for coverage by, any benefits provided under any federal, state or local government including without any limitation, any workers' compensation insurance or benefits.

Privacy, Confidentiality, Release of Records and Information

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without written consent, except as follows:

- Information will be disclosed to those who require such information to administer the Plan or process claims.

- Information with respect to duplicate coverage will be disclosed to the Plan or insurer that provides duplicate coverage.

- Information needed to determine if health care services or supplies are medically necessary or if the charges for them are usual and customary will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee to make those determinations.

- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.

No Liability For Practice Of Medicine

The Plan, the Trustees, the Fund, any related Union or any of their designees are not engaged in the practice of medicine nor do any of them have any control over any diagnosis treatment care or lack thereof, or any health care services provided or delivered to any Participant by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to any Participant by any health care provided by reason of negligence, by failure to provide care or treatment, or otherwise. All medical decisions are between the patient and the physician and do not involve the Plan, the Trustees, the Fund or any related Union.

Right of Recovery

Whenever payments for a claim have been made in excess of the maximum limit for that claim under the Plan, the Plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment and/or the Participant.

Taxes

The Plan, at all times shall comply with the requirements of the Internal Revenue Code so as to enable the Employer to treat contributions to the Fund as a deduction for income tax purposes. The Fund shall also comply with all laws and regulations governing Taft-Hartley, multiemployer welfare funds, including but not limited to the Employee Retirement Income Security Act of 1974 ("ERISA") (Pub.L. 93-406 codified as 29 USCS § 1002).

Grandfathered Status

The United Benefit Fund believes that the following Plans are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). The Affordable Care Act allows grandfathered health plan to preserve some health coverage options and restrictions that were already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to provide preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of annual or lifetime limits on Essential Health Benefits, if provided.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the UBF fund office at (718) 416-4020. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or find additional information at www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SECTION 18
HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

- Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

- Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule.

- Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule.

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- Make available PHI to the Participant in accordance with the privacy standards.

- Make a Participant's PHI available for the Participant to amend to the extent required by the privacy rules.

- Make available the information required to provide an accounting of disclosures.

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the privacy standards.

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required by the privacy rules.

The Fund Administrator is the contact person for all PHI information requests.

In the event any of the individuals in the Fund Administrator's office do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

Disclosure of Certain Enrollment Information to the Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to comply with the above privacy rule provisions.

Pursuant to the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has dis-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

HIPAA has a number of special rules, and the information presented covers only basic points.
If you want to know more about how HIPAA applies to group health plans, the Department of Labor offers a booklet **"Questions and Answers: Recent Changes in Health Care Law."**

You may request this booklet free of charge by calling (**1-800) 998-7542.**

This booklet is also available on the Internet at http://www.dol.gov/dol/pwba

More information about HIPAA is also available at the Health Care Financing Administration (HCFA) Internet site at **http://www.hcfa.gov** or www.dol.gov/ebsa/heatlthreformwww.dol.gov/ebsa/heatlthreformwww.dol.gov/ebsa/heatlthreform.

SECTION 19
IMPORTANT INFORMATION ABOUT THE PLAN

Fund Administration: The Fund is administered by a joint Board of Trustees consisting of a Union representative and an Employer representative.

The Employer Trustee is Thomas D'Ambrosio. The Union Trustee is Andrew Talamo. All can be reached at the Fund Office, 150-28 Union Turnpike, Suite 250, Flushing, New York 11367.

Financial Information: Benefits are provided from the Fund's assets that are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust for the purpose of providing benefits to Participants and Dependents and defraying reasonable administrative expenses. The Fund Office will provide you with information as to whether an Employer is contributing to this Plan on behalf of its Employees working under the collective bargaining agreement upon written request.

Plan Benefits: All of the types of benefits provided by the Plan are set forth in this Plan Booklet, including those benefits administered by Omni Administrators, General Vision Services, and National Prescription Administrators. The complete terms of these self-insured benefits are set forth in this Plan. Except for those benefits that may become payable for Hospital, surgical, or other medical expenses, no rights or benefits may be assigned.

Name of Plan: The UNITED BENEFIT FUND

Employer Identification Number (EIN): 56-242-3802 **Plan Number**: 501

Type of Plan: An employee welfare benefits plan, including medical benefits, dental benefits, and vision benefits.

Type of Administration: Omni Administrators administers all self-insured benefits. There is no administration by the Fund for dental services by D.D. Services, because the Participant pays all costs directly. Vision Screening, and National Prescription Services process their own claims.

Plan Administrator: The name and address of the Plan Administrator is:

Omni Administrators Inc.
1430 Broadway, Suite 1303
New York, NY 10018
Phone (718) 416-4020

Agent for Service of Legal Process: For disputes arising under the Plan, service of legal process may be made on:

Board of Trustees
UNITED BENEFIT FUND
150-28 Union Turnpike, Suite 250
Flushing, New York 11367

Service may also be made upon an individual Trustee.

CLAIMS ADMINISTRATOR

Omni Administrators, Inc.
1430 Broadway, Suite 1303
New York, New York 10018
(718) 416-4020

Contributions to the Plan: All contributions to the Plan are made by Employers pursuant to the terms of collective bargaining agreements between the Union and various Employers or under written agreements with the Fund. These agreements set forth the conditions under which Employers are required to contribute to the Plan and the rate(s) of contribution. A copy of any agreement and a list of contributing Employers may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Participants at the Fund Office.

Plan Year: The Plan's fiscal records are kept on a twelve-month period beginning each January 1 and ending on the following December 31.

Plan Amendments or Termination: The Board of Trustees intends to continue the benefits described in this Booklet. However, the Trustees reserve the right to amend or terminate this Plan, or any part of it at any time. Benefits provided by the Plan and Plan eligibility rules:

1. Are not guaranteed and may be changed or discontinued by the Board of Trustees;

2. Are subject to the rules adopted by the Board of Trustees;

3. Are subject to the Trust Agreement that establishes and governs the Fund operations; and

4. Are subject to the provisions of any group insurance policies or other contracts purchased by the Trustees.

Notice - No Fund Liability: Use of the services of any Hospital, clinic, doctor, or other provider rendering health care, whether designated by the Fund or otherwise, is the voluntary act of the Participant or Dependent. This is not meant to be a recommendation or instruction to use

the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not Employees of the Plan. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

SECTION 20
ERISA RIGHTS

As a Participant in the Plan described herein you are entitled to rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrators office and at all other specified locations, such as work-sites and union halls, all other 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.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing 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 a reasonable charge for the copies.

3. Receive a summary of the Plans' annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the summary annual report.

4. 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.

You should be provided a certificate of coverage, free of charge, from your group health plan or health insurance issuer on request or 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.

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of Employee benefit Funds. The people who operate your Fund, called Fiduciaries of the Fund, have a duty to do so prudently and in the interest of you and other Participants and Dependents. 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Fund review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Fund 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 Fund Administrator to provide the materials and pay up to $120.00 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 Federal Court.

If it should happen that Fund Fiduciaries misuse the Fund'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 the court costs and legal fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, 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.

DISCLOSURE REQUIREMENTS

Under current Department of Labor interim disclosure rules, Summary Plan Descriptions ("SPD"), Summaries of Material Modifications ("SMM") and pursuant to the Patient Protection and Affordable Care Act ("ACA") Summaries of Benefits and Coverage ("SBC"), which are the documents Funds are required to provide to employees, must:

- Effective September 1, 2012, Plan Sponsors must provide notice of any material modification in any of the terms of the Plan or coverage (as defined under §102 of ERISA) that is not reflected in the most recent SBC no later than 60 days prior to the date on which such modification will become effective pursuant to the Public Health Services Act ("PHSA") section 2715 (d)(4), as added by ACA.

- Notify participants and beneficiaries of "material reductions in covered services or benefits" (for example, reductions in benefits or increases in deductibles and co-payments) generally within 60 days of adoption of the change. This compares to previous requirements under which Plan changes can be disclosed as late as 210 days after the end of the Plan year in which a change was adopted.

- Disclose to participants and beneficiaries information about the role of issuers (e.g., insurance companies and HMOs) with respect to their group health plan. In particular, the name and address of the issuer, whether and to what extent benefits under the Plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

- Tell Participants and beneficiaries which Department of Labor office they can contact for assistance or information on their rights under ERISA and HIPAA. You can reach The Department of Labor at 1-212-264-8185.