MAN-U SERVICE CONTRACT
HEALTH AND WELFARE TRUST FUND

Plan Document and Summary Plan Description
for Monthly Contribution Rate Participants
(as Amended and Restated effective January 1, 2014)

FUND OFFICE
AND
CLAIMS ADMINISTRATOR
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June 2014

Dear Participant:

We are pleased to present this updated booklet describing the benefits provided by Man-U Service Contract Health and Welfare Trust Fund ("Fund" or "Plan") for you and your eligible Dependents. This restatement of the Plan/SPD is effective as of January 1, 2014.

This booklet is designed specifically to set forth and explain the benefits afforded to Participants of employers who contribute to the Fund on a monthly (rather than hourly) basis. This booklet will help you understand the medical, dental, vision, and prescription drug benefits, and other benefits provided by the Fund, and how to use them wisely. You should review it and show it to your covered family members. The booklet describes:

- the benefits provided;
- the procedures to follow in submitting claims; and
- your responsibilities under the Fund.

As the Plan is amended from time to time, the Trustees will send you notices explaining the changes. You should keep these notices with this booklet as updates. The Trustees reserve the right to amend the Plan from time to time, including the right to modify the benefits provided. The Trustees also retain the right to terminate the Fund at any time.

Be sure to keep this booklet and any notices of Plan changes in a safe and convenient place to refer to when needed. Should you have any questions about benefits, eligibility, or claims, please do not hesitate to contact the Fund Office where the staff will be happy to assist you.

We are proud to bring you these benefits.

Sincerely,

THE BOARD OF TRUSTEES

Notice Regarding Status of Plan as a Grandfathered Health Plan

The Man-U Service Contract Trust Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Man-U Service Contract Trust Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of 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 lifetime limits on benefits.

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 Fund Administrator at the telephone numbers listed below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions, please contact the Fund Office at (410) 872-9500 or toll free at (888) 490-8800. Membership Services Representatives are available to assist you Monday through Friday from 8:30 AM until 5 PM.

I. DEFINITIONS

The following are definitions of specific terms used in this document. These definitions do not, and should not, be interpreted to extend coverage under the Plan.

A. **Allowable Charge** means the usual charge made by a Physician or other health care provider for a like service in the absence of the insurance, but not more than the prevailing charges, as determined for benefits of a comparable nature, made by Physicians or providers of similar training and experience, within the areas in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided or such greater areas as necessary to obtain a representative cross section for a like service.

B. **Board of Trustees or Trustees** means the Board of Trustees of the Man-U Service Contract Trust Fund.

C. **Calendar Year** means the 12-month period beginning January 1 and ending December 31.

D. **Claims Administrator or Administrator or Fund Administrator** means the person or organization designated by the Trustees to be responsible for claims payment, certain medical review services, claims inquiry services and health advisory services.

E. **Collective Bargaining Agreement** means a written agreement (as extended, reviewed, amended, or replaced) entered into by an Employer and a union that requires the Employer to make contributions to the Fund.

F. **Coinsurance** means that portion of Covered Expenses for which the Participant has financial responsibility.

G. **Co-Payment or Co-Pay** means the set dollar amount the Participant pays when Covered Expenses are incurred.

H. **Covered Employment** means work by an Employee in a job category for which the Employer is required to make contributions to the Fund on his or her behalf.

I. **Covered Expense** means an expense, to the extent it is an Allowable Charge, that is allowable under the Plan for (1) a service or supply that is Medically Necessary for the diagnosis, treatment, mitigation, or cure of an illness or injury to a structure or function of the mind or body, or (2) wellness and preventive services.

   The Plan will not always pay benefits equal to or based on a Physician's actual charges, even after you have paid the applicable Deductibles and Coinsurance. This is because the Plan covers only the Allowable Charge for services and supplies. The Plan will not reimburse you for any expenses that are not Covered Expenses. That means you are responsible for paying the full cost of all expenses that are not covered by the Plan. Any amount in excess of Allowable Charge does not count toward the Plan's out-of-pocket maximum for each benefit.

J. **Deductible** means the amount of Covered Expenses you are responsible for paying before the Plan begins to pay certain benefits.

K. **Dependent** has the meaning set forth in Article II, Subsection C.

L. **Durable Medical Equipment** means equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the

absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

M. **Employee** means a person employed by an Employer contributing to the Plan who is eligible to enroll for coverage under the Plan.

N. **Employer** means either any entity having a Collective Bargaining Agreement with the Laborers' International Union of North America, or other written agreement (including but not limited to a participation agreement) with the Trustees, and who is obligated to contribute to the Fund.

O. **Fund** means the Man-U Service Contract Health and Welfare Trust Fund.

P. **Hospital** means an institution that:

- Is licensed to provide and is engaged primarily in providing diagnostic and therapeutic services for the diagnosis and medical and surgical treatment of injured and sick persons.
- Operates 24 hours a day every day under the continuous supervision of a staff of doctors (M.D., D.O.).
- Provides, or has written agreement with another Hospital in the area for the provisions of any generally accepted diagnostic or therapeutic services that may be required during a confinement.
- Is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The term "Hospital" includes other institutions, such as those that specialize in physical rehabilitation, or in the diagnosis and treatment of mental disorders or substance abuse, and recognized as Hospitals under this Plan, such as: Public Health Service Hospital; college infirmaries; licensed tuberculosis sanitariums; Christian Science Sanitariums operated, or listed and certified, by the First Church of Christ Scientist, Boston, MA.; Hospitals in a foreign country; and, for outpatient services, independent Ambulatory Surgical Facilities approved by the Joint Commission on Accreditation of Healthcare Organizations.

Q. **Medically Necessary** means care, treatment and supplies that are:

- Provided by a licensed Physician, surgeon, or other licensed health care provider;
- Provided in a Hospital or other facility approved by the Board of Trustees;
- Consistent with standards of good medical practice as generally recognized and accepted by the medical community where the services are provided, and appropriate to the diagnosis or treatment of an illness or injury; and
- Not merely for the personal comfort or convenience of the patient, the family or the provider;
- Is not part of or associated with scholastic education or the vocational training of the patient.

Confinement in a Hospital is considered Medically Necessary only if the patient's condition is such that the care cannot safely be provided on an outpatient basis.

The Board of Trustees has the discretion to make the final determination as to whether care, treatment and supplies are Medically Necessary.

R. **Medically Necessary Orthodontic Services** means procedures that help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip, maxillary/mandibular micrognathia (underdeveloped upper or lower jaw), extreme mandibular prognathism, severe asymmetry (craniofacial anomalies), ankylosis of the temporomandibular joint, and other significant skeletal dysplasias. Orthodontic services are not covered if the individual does not meet the criteria described above.

S. **Participant** means the Employee or Dependent who has enrolled for coverage under the Plan.

T. **Plan** means the Man-U Service Contract Health and Welfare Trust Fund, as amended from time to time.

U. **Physician** means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.); or for certain specified services covered under the Plan, a licensed dentist (D.D.S. or D.M.D.), a licensed podiatrist or chiropodist (D.P.M. or D.S.C.), practicing within the scope of their licenses. A Physician is also a licensed doctor of psychiatry (M.D.), a psychologist (including a clinical psychologist who is a person licensed as a psychologist or, in a jurisdiction not requiring licensing, one who is certified as a clinical psychologist by the State Psychological Association).

For purposes of the Physician Office Visit benefit only (and without regard to whether such services are otherwise covered elsewhere under the Plan), the following practitioners shall also be considered a Physician, if such practitioners meet the appropriate and applicable educational and licensing requirements: Chiropractor; Licensed Clinical Social Workers (L.C.S.W.); Nurse; Physician Assistant; and Midwife. Practitioners not specifically mentioned in the Plan are not considered Physicians for purposes of this Plan.

Although the Plan's definition of Physician includes licensed dentists, office visits for routine dental care are not covered as a Physician Office Visit, but instead may be covered under the Dental Benefits portion of the Plan. Dental services required as a result of accidental injury will be covered under the Medical Benefits portion of the Plan.

V. **Spouse** means the Employee’s legally married spouse as determined by applicable state law and federal tax law, who is not legally separated from the Employee.

II. ELIGIBILITY

This Plan has been established for employees who are represented by local unions affiliated with the Laborers' International Union of North America.

A. INITIAL ELIGIBILITY RULES

The terms of your Collective Bargaining Agreement set forth for whom the Employer must contribute and how much. Contributions received by the Fund on your behalf by the 20th day of the month will provide eligibility for the following month. For example, contributions made by your Employer by December 20th for January provide eligibility for benefits for January. If that is the last month of contributions, your eligibility will terminate at the end of January. The amount of monthly contributions received by the Plan will determine whether coverage is for the Employee only, or whether Plan coverage will extend to some or all Dependents.

A full-time Employee may opt out of coverage under certain conditions. Such Employee must timely complete the applicable Form provided by the Fund Office, and provide substantiation to the Fund of alternative comparable medical coverage. Any Employee who opts out of coverage shall have the right to acquire (or reacquire) coverage under the Fund during the annual Open Enrollment Period (see also Section II(D) regarding changes in Dependent coverage).

B. ENROLLMENT

You must enroll for coverage by submitting a completed enrollment form, which may be obtained from the Fund Office. If you want Dependent coverage, you should enroll your eligible Dependent at the same time (see Part II to determine whether your Dependents are eligible for coverage). It is important that you include the names, dates of birth, and social security numbers on all your eligible Dependents. You must submit a copy of your marriage certificate to enroll your Spouse, a birth certificate, and other legal documents, when applicable, to enroll Dependent child(ren).

The enrollment form is very important. It is used to determine who your eligible Dependents are, and especially your beneficiary to receive the proceeds of your life insurance in the event of your death.

C. COVERING YOUR DEPENDENTS

You may elect to cover your Dependents under the Fund based on the terms of your Collective Bargaining Agreement or participation agreement. When you lose eligibility, your Dependents (if they had been eligible for coverage under the Plan during your eligibility) will lose their coverage also. Your eligible Dependents are:

- Your Spouse;
- Your children, including a stepchild, legally adopted child or a child who is placed with you for adoption, who is under age 26. A child must not be a "qualifying child" of any other person, except for the child's other parent in cases of divorce/separation (see the special rule below). The term "qualifying child" is defined in IRC § 152(c).

  There is a special rule in cases of divorce/separation. If you do not provide over half of the child's support, he or she will be an eligible Dependent provided that:
- You and the child's other parent are:
  - Divorced or legally separated under a decree of divorce or separate maintenance;

- Separated under a written separation agreement; or
- Live apart at all times during the last six months of the Calendar Year;

- You and the child's other parent provide over half of the child's support;
- The child is in the custody of one or both of his or her parents for more than half of the year; and
- The child meets all other required eligibility criteria.

In the event you and your spouse divorce, a previously recognized stepchild of a Participant will no longer be considered a stepchild, and coverage will terminate, unless otherwise required by a QMCSO.

The Fund reserves the right to request documentation of dependent eligibility at any time. Such documentation includes, but is not limited to, marriage certificates, birth certificates, divorce decrees, or tax forms. You may also be required to certify that your dependent(s) meet the Fund's definition of Dependent. The Fund has the right to rely upon this certification unless it has reason to believe that the certification is incorrect. You are also required to notify the Fund if you have any reason to believe that any of your dependents is not entitled to receive health coverage on a tax-free basis.

D. CHANGES IN COVERAGE

1. Newly Acquired Dependents

If you are enrolled for individual coverage and if you acquire a Spouse by marriage, or if you acquire any Dependent children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or Dependent child(ren) within 60 days after the date of marriage, birth, adoption or placement for adoption.

- Your Spouse's coverage will become effective as of the date of marriage.
- Your Dependent child's coverage will become effective as of the date of birth, adoption, or placement for adoption.

2. Late Enrollment for Newly Acquired Dependents

If you do not enroll your Spouse or Dependent child(ren), coverage will begin effective the March 1st following the date of the event, *if coverage is elected during the next Open Enrollment Period*.

If your Dependent child becomes eligible for coverage as an Employee, your child will cease to be a Dependent child, and may enroll for coverage as an Employee, in which case coverage as a Dependent child will terminate as of the date coverage as an Employee begins.

E. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

If a court or state administrative agency has issued an order with respect to health care coverage for your Dependent children, the Administrator or its designee shall determine if the court or state administrative order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law. The Plan will notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent child(ren). However, no coverage will be provided for any Dependent child pursuant to a QMCSO unless all of the Plan's requirements for coverage of that Dependent child have been satisfied. If you have questions

about QMCSOs or you would like a copy of the Plan's QMCSO procedures free of charge, please contact the Fund Office.

F. Family and/or Medical Leave

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to family and medical leave reasons. **In order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification and payment to the Fund. Please contact your Employer to determine whether you are eligible.** The general rules are set forth below:

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period for any of the following reasons:

- the birth, adoption or placement of a child with you for adoption;
- to provide care for your Spouse, child or parent who is seriously ill; or
- your own serious Illness.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

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

- worked for an Employer for at least 12 months;
- worked at least 1,250 hours in Covered Employment over the previous 12 months;
- worked at a location where at least 50 employees are employed by the Employer within 75 miles.

The Fund will maintain your eligibility status until the end of the leave, provided the Employer properly grants the leave under FMLA and makes the required notification and payment to the Fund. Please contact your Employer to determine whether you are eligible for FMLA leave.

G. Leave for Military Service

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to service in the uniformed services of the United States. **Please note that in order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification and payment to the Fund. Please contact your Employer to determine whether you are eligible.** The general rules are set forth below:

If you are on active military duty for a period of 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are on active military duty for more than 31 days, USERRA permits you to continue medical, dental, vision, and prescription drug coverage for you and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. See page 8 for a full explanation of the COBRA coverage provisions. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE, the military health system. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from service in the Uniformed Services, your full eligibility will be reinstated on the day you return to Covered Employment, provided that you return to employment:

- Within 90 days from the date of discharge if the period of service was more than 180 days; or
- Within 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

  If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

  If you have any questions about taking a leave of absence, please speak directly with the Employer. If you have any questions about how a leave of absence affects your coverage, please contact the Fund Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

H. Certification of Coverage

If you or your Dependents lose coverage under this Plan for any reason, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Plan to provide you with a certificate showing your period of coverage. You may also request a certificate of coverage from the Administrator at any time within the first 24 months after your coverage ends.

You will be required to furnish this certificate if you seek coverage under another group health plan with a pre-existing condition limitation. If the new plan imposes a waiting period for a pre-existing condition, the waiting period may be reduced by your period of coverage under this Plan if you meet certain other requirements. The new plan will notify you of all the requirements you must meet.

III. COBRA CONTINUATION COVERAGE

A. WHEN YOU MAY BE ENTITLED TO COBRA CONTINUATION COVERAGE

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), you and your eligible Dependents may continue medical coverage temporarily at your own expense, where coverage otherwise would end due to a “Qualifying Event.” Under the law, only “Qualified Beneficiaries” are entitled to elect COBRA continuation coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include an Employee, and his or her spouse and Dependent child(ren) who were covered by the Plan when a Qualifying Event occurs.

If you choose COBRA continuation coverage, you and your Dependents may continue the same medical, dental, vision and prescription drug coverage that you had prior to the Qualifying Event. COBRA does not cover the weekly accident and sickness, accidental death and dismemberment, or life insurance benefits.

B. WHAT IS A QUALIFYING EVENT?

To be eligible to elect COBRA continuation coverage, you or your Dependent must lose coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase Continuation Coverage	For How Long?
Voluntary or involuntary termination of your employment, (other than by reason of gross misconduct) or loss of eligibility due to a reduction of your work hours	Employee and Dependents	18 months
You or your Dependent becomes disabled (as determined by the Social Security Act) at some time before the 60th day of COBRA Continuation Coverage and the disability lasts until the end of the 18-month COBRA continuation coverage period	Employee and Dependents	29 months
You die	Dependents	36 months
You become legally separated or divorced from your Spouse	Dependents	36 months
Your child is no longer considered a Dependent under this Plan’s definition (e.g., he or she reaches the maximum age limit or marries)	Dependent Child	36 months

C. WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Fund Administrator has been notified or is able to determine from its own records that a Qualifying

Event has occurred. The Fund Administrator will determine if you lose coverage as a result of termination of employment, reduction in your work hours, or your death. ***However, you or your family should also notify the Fund Administrator promptly if such a Qualifying Event occurs in order to avoid confusion over the status of your Plan coverage in the event there is a delay or oversight in the Fund Administrator being advised that a Qualifying Event has occured.***

D. You Must Give Notice of Some Qualifying Events

For all other Qualifying Events (your divorce or legal separation from your Spouse, or your Dependent child losing Dependent status under the Plan), you (or your Dependent) must notify the Fund Administrator no later than sixty (60) days after the Qualifying Event occurs. The notice of occurrence of any of these events must be provided to the Fund Administrator in writing.

In addition to the qualifying events listed above, there are two other situations where you are responsible for notifying the Fund Administrator:

- When a Qualified Beneficiary is determined by the Social Security Administration ("SSA") to be disabled during a COBRA continuation coverage period or when the SSA determines that a Qualified Beneficiary is no longer disabled. See the section below entitled, "COBRA for Disabled Participants."
- When a Qualified Beneficiary becomes entitled to (i.e., enrolls in) Medicare during a COBRA continuation coverage period. You must notify the Fund Administrator within 30 days. The Fund reserves the right to retroactively cancel COBRA continuation coverage and will require reimbursement of all benefits paid after the date of commencement of Medicare entitlement.

If you have any questions about how to provide a written notice of a Qualifying Event or other events, please contact the Fund Administrator. **Failure to provide notice within the form and timeframe described above may prevent you and/or your Dependents from obtaining or extending the COBRA continuation coverage.**

E. How is COBRA Continuation Coverage Provided?

Once the Fund Administrator determines or receives notice that a Qualifying Event has occurred, the Fund Administrator will then provide you and/or your Dependents with notice of the date on which your coverage under the Plan will end, and the information and election form that you will need in order to elect COBRA continuation coverage. Under the law, you and/or your Dependents will then have only **60 days** from the later of the date you ordinarily would have lost coverage because of one of the Qualifying Events described above, or the date you and/or your Dependents received the notice, to apply for COBRA continuation coverage.

IF YOU AND/OR ANY OF YOUR DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN **SIXTY (60) DAYS** AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN **60 DAYS** AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL LOSE THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA continuation coverage, the members of the

family must have been covered by the Plan on the date of the Qualifying Event or became an eligible Dependent by marriage, birth, adoption or placement for adoption during the period of COBRA continuation coverage. An Employee may elect COBRA continuation coverage on behalf of his or her spouse and a parent may elect or reject COBRA continuation coverage on behalf of a Dependent child living with him or her.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in coverage, and election of COBRA continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

F. PAYMENT FOR COBRA

You are responsible for the entire cost of COBRA continuation coverage and can pay for the coverage on a monthly basis. When you and/or your Dependents become entitled to this coverage, the Fund Administrator will notify you of the COBRA premium amounts that you must pay. Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA for Disabled Participants.")

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Fund Administrator not later than **45 days** after the date you elect the COBRA continuation coverage. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within this timeframe, you will lose all COBRA continuation coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. You will not be billed for subsequent months. *No further notice will be sent to you or your Qualified Beneficiaries regarding payments for COBRA continuation coverage.*

G. GRACE PERIOD FOR PAYMENTS

Although payments are due on the first day of the month, you will be given a grace period of **30 days** after the first day of the coverage period to make each payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make your payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

H. MAXIMUM COVERAGE PERIOD

The maximum time period for COBRA continuation coverage depends upon the Qualifying Event that causes the termination of coverage. Please refer to the "What is a Qualifying Event?" section above to determine how long your coverage will last. In no event will a COBRA continuation coverage period be longer than a total of 36 months.

I. COBRA FOR DISABLED PARTICIPANTS

If during an 18-month COBRA continuation coverage period the Social Security Administration determines that you (or a member of your family who is eligible for COBRA continuation coverage) were disabled at some time before the 60th day of COBRA continuation coverage, the disabled person, and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA continuation coverage for a total maximum of 29 months. **You must notify the Fund Administrator of the determination of your disability within 60 days of the date of that determination and before the end of the 18-month period of COBRA continuation coverage**. The notice of disability must be in writing. If the 18-month period of COBRA continuation coverage is extended because of an SSA-determined disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the Plan's cost for the additional 11 months of coverage.

This extended period of COBRA continuation coverage will end on the earlier of:

- The last day of the month, 30 days after the SSA has determined that you and/or your Dependent(s) are no longer disabled;
- The end of the 29 months COBRA continuation coverage; or
- The date the disabled person becomes entitled to Medicare.

You must notify the Fund Administrator within **30 days** of a final SSA determination that you are no longer disabled.

J. MULTIPLE QUALIFYING EVENTS WHILE COVERED UNDER COBRA

If, during an 18-month period of COBRA coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a covered Dependent child ceases to be an eligible Dependent under the Plan, the maximum COBRA continuation period for the affected spouse and child is extended to 36 months from the date of your termination of employment or reduction in hours.

> ***Example:*** Assume you lose your job (the first COBRA-Qualifying Event), and you enroll yourself and your Dependents for COBRA continuation coverage. Three months after your COBRA continuation coverage begins, your child attains age 19 and ceases to qualify as an eligible Dependent. Your child then can continue COBRA continuation coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

In no case are you (the Employee) entitled to COBRA continuation coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA continuation coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA continuation coverage

may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event. You must notify the Fund Administrator of a second Qualifying Event in writing.

K. Termination/Reduction in Hours That Follows Medicare Entitlement

If you become entitled to Medicare and are still actively employed, and you later have a termination of employment or reduction in hours, your Dependents who are Qualified Beneficiaries would be entitled to COBRA continuation coverage for a period of: (a) 18 months (29 months if the 11-month Social Security Disability extension applies) from your termination of employment or reduction in hours; or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

L. Special Enrollment Rights

If while you are enrolled for COBRA continuation coverage you marry, have a newborn child, adopt a child or have a child placed with you for adoption, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within **30 days** after the marriage, birth, adoption or placement for adoption. Notice is to be provided to the Fund Administrator in writing.

Any Qualified Beneficiary can add a new spouse or child to his or her COBRA continuation coverage. However, the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to extend a COBRA continuation coverage period in certain circumstances, are children born to, adopted, or placed for adoption with the Employee. A person who becomes your spouse during a period of COBRA continuation coverage would not have the rights of a Qualified Beneficiary.

If while you are enrolled for COBRA continuation coverage, your Dependent(s) lose coverage under another group health plan, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within **30 days** after the termination of the other coverage. Notice is to be provided to the Fund Administrator in writing.

In order to be eligible for this special enrollment right, the Dependent must have been eligible for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to loss of eligibility under another plan, including, but not limited to, termination of employment, termination of employer contributions or exhaustion of COBRA continuation coverage under another plan. Loss of eligibility does not include a loss of coverage due to failure of the individual or Participant to pay premiums on a timely basis or termination of employment for cause.

Adding a Dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.

M. Notice of Unavailability of COBRA Continuation Coverage

In the event the Fund Administrator is notified of a Qualifying Event, but the Fund Administrator determines that an individual is not entitled to the requested COBRA continuation coverage, the individual will be sent an explanation indicating why the COBRA continuation coverage is not available. This notice of the unavailability of the COBRA continuation coverage will be sent according to the same timeframe as a COBRA election notice.

N. Early Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the last day of the maximum period of

coverage unless it is cut short for any of the following reasons:

- All required payments are not made on time;
- The person receiving the coverage becomes covered by another group health plan that does not contain any legally applicable exclusion or limitation with respect to preexisting conditions that the covered person may have;
- The person receiving the coverage becomes entitled to Medicare;
- If under the COBRA disability extension, you or your Dependent(s) are no longer disabled;
- The Plan is terminated, or otherwise does not provide group health coverage; or
- The Employer that employed you prior to the Qualifying Event has stopped contributing to this Fund, but is making group health plan coverage available through another health plan. You should contact your former employer to determine whether it will assume your COBRA continuation coverage.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving continuation coverage (such as fraud). Once your COBRA coverage terminates, it cannot be reinstated. You and your eligible Dependents can only become covered under the Plan again if you return to Covered Employment and meet the eligibility requirements.

The Fund reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the date a Qualified Beneficiary (i) commences Medicare entitlement; (ii) is determined by the SSA to no longer be disabled; or (iii) becomes covered under another group health plan that does not contain any pre-existing condition exclusions or limitations, if notice of these events is not provided to the Fund Office.

O. NOTICE OF EARLY TERMINATION OF COBRA

The Fund Administrator will notify a Qualified Beneficiary if COBRA continuation coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA continuation coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period and the date COBRA continuation coverage terminated. The notice will be provided as soon as practicable after the Fund Administrator determines that COBRA continuation coverage will terminate early.

P. CONFIRMATION OF COBRA TO PROVIDERS

Under certain circumstances, federal rules require the Fund to inform your health care providers as to whether you have elected and/or paid for COBRA continuation coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA continuation coverage, or you have elected COBRA continuation coverage but have not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that COBRA continuation coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

Q. If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Fund Administrator identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

R. Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members by submitting your changes in writing to the Fund Administrator. You should also keep a copy of any notices you send to the Fund Administrator for your records.

S. Plan Contact Information

Man-U Service Contract Health and Welfare Trust Fund
ATTN: Fund Administrator
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(800) 638-8824

IV. SCHEDULE OF BENEFITS

The Plan's benefits are summarized below. For a more detailed description of the medical benefits, please refer to Article V, Medical Expense Coverage, beginning on page 23. Please also see the Exclusions sections of this document for important information on exclusions and limitations to these Plan benefits.

A. MEDICAL BENEFITS

Note: Medical Benefits are only available when services are received from an In-Network provider (except in the case of Emergency Care). No benefits will otherwise be paid for services from an Out-of-Network provider.

Annual Deductible	None
Annual Co-Payment Maximum	
Individual	$2,000
Family	$4,000
Service	**In-Network Benefit**
Inpatient Hospital Services	$150 daily Co-Payment (maximum of 5 Co-Payments per admission)
Emergency Room	$100 Co-Payment
Doctor's Office Visits	
Primary Care Services	$15 Co-Payment
Specialist Services	$30 Co-Payment
Outpatient Laboratory / Pathology	100%
Outpatient X-Ray / Radiology	
Routine / Diagnostic	$30 Co-Payment
MRI/MRA, CT/CTA Scan, PET Scan	$60 Co-Payment
Outpatient Surgery	$75 Co-Payment
Maternity	
First Obstetrical Visit	$15 Co-Payment
Hospital	$150 daily Co-Payment (maximum of 5 Co-Payments per admission)
Mammogram	100%
Routine Gynecological Exam/PAP (limited to one per Calendar Year)	$15 Co-Payment
Routine Eye Exams (limited to once per calendar year)	$30 Co-Payment

Pediatric Immunizations	100%
Ambulance	100%
Therapy Services	
Physical and Occupational (limited to 30 visits per Calendar Year)	$30 Co-Payment
Cardiac Rehabilitation (limited to 36 visits per Calendar Year)	$30 Co-Payment
Pulmonary Rehabilitation (limited to 36 visits per Calendar Year)	$30 Co-Payment
Speech (limited to 20 visits per Calendar Year)	$30 Co-Payment
Orthoptic/Pleoptic (limited to 8 session per lifetime)	$30 Co-Payment
Spinal Manipulations (limited to 20 visits per Calendar Year)	$30 Co-Payment
Chemotherapy / Radiation / Dialysis	100%
Outpatient Private Duty Nursing (limited to 360 hours per Calendar Year)	85%
Skilled Nursing Facility (120 days per Calendar Year)	$75 daily Co-Payment (maximum of 5 Co-Payments per admission)
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	50%
Mental Health Care	
Outpatient	$30 Co-Payment
Inpatient	$150 daily Co-Payment(maximum of 5 Co-Payments per admission)
Substance Abuse Treatment	
Outpatient / Partial Facility Visits	$30 Co-Payment
Rehabilitation	$150 daily Co-Payment (maximum of 5 Co-Payments per admission)
Detoxification	$150 daily Co-Payment (maximum of 5 Co-Payments per admission)
Nutrition Counseling for Weight Management (limited to 6 visits per Calendar Year)	100%

B. DENTAL BENEFITS

Note: There is no Dental Preferred Provider Organization Applicable for Caring Heart Employees.

Description	Benefit Amount
Benefits are limited to an overall maximum of $3,000 per family per calendar year. Pediatric oral care for individuals under 19 is not subject to this calendar year maximum.	
Preventive Care -- 100% of Covered Expenses up to $105.00 per Calendar Year for prophylaxis, diagnostic visit and emergency treatment of pain. Pediatric oral care for individuals under 19 is not subject to this calendar year maximum.	
Basic Services -- Plan will pay by the following schedule for fillings, extractions, x-rays, oral surgery, anesthesia, periodontics, restorative dentistry, and space maintainers:	
X-RAY & PATHOLOGY	
Single Film	$9.75
Each Additional Films (up to 12)	2.50
Superior or inferior maxillary, extra-oral, one film	24.25
Superior or inferior maxillary, extra-oral, two films	36.50
Bitewing films, including exam (not more than once every six months)	
2 films	12.25*
4 films	17.25*
* Pediatric vision care for individuals under 19 is not subject to these dollar limits. Rather, benefits are provided up to the Allowable Charges.	
Panoramic survey, maxillary and mandibular, single film (considered an entire dental series)	41.25
Biopsy and examination of oral tissue	19.50
Microscopic Examination	36.50
ORAL SURGERY, EXTRACTIONS	
Uncomplicated (single)	$35.00
Each additional tooth	14.75
Surgical removal or erupted tooth	36.50
Post-operative visit (sutures and complications) after multiple extractions and impaction	7.25
ORAL SURGERY, IMPACTED TEETH	
Removal of tooth (soft tissue)	$41.25
Removal of tooth (partially bony)	60.50
Removal of tooth (completely bony)	96.50
ORAL SURGERY, ALVEOLAR OF GINGIVAL RECONSTRUCTIONS	
Alveolectomy (edentulous) per quadrant	$60.50
Alveolectomy (in addition to removal of teeth) per quadrant	24.25
Alveoplasty with ridge extension, per arch	101.50
Removal of palatal torus	84.75
Removal of mandibular tori, per quadrant	84.75
Excision of hyperplastic tissue, per arch	77.25
Excision of pericoronal gingiva	24.25

Description	Benefit Amount
ORAL SURGERY, CYSTS AND NEOPLASMS	
Incision and drainage of abscess	$24.25
Radical resection of mandible with bone graft	724.50
Removal of cyst or tumor up to ½”	24.25
ORAL SURGERY, OTHER PROCEDURES	
Sialolithotomy: removal of salivary calculus	$79.75
Closure of salivary duct	145.00
Dilation of salivary duct	41.25
Transplantation of tooth or tooth bud	169.00
Removal of foreign body from bone (independent procedure)	36.50
Maxillary sinusotomy for removal of tooth fragment or foreign body	157.25
Closure of oral fistula of maxillary sinus	96.50
Sequestrectomy for osteomyelitis or bone abscess, superficial	48.25
Condylectomy of temporomandibular joint	724.50
Menisectomy of temporomandibular joint	603.75
Removal of foreign body from soft tissue	24.25
Frenectomy	60.50
Suture of soft tissue injury	24.25
Crown exposure for orthodontia	36.50
Injection of sclerosing agent into temporomandibular joint	72.50
Treatment of trigeminal neuralgia by injection into 2nd and 3rd divisions	82.25
ANESTHESIA	
General, only when provided in conjunction with a surgical procedure	$36.50
PERIODONTICS	
Emergency treatment (periodontal abscess, acute periodontitis, etc.)	$24.25
Subgingival curettage, root planting, per quadrant (not prophylaxis)	29.00
Correction of occlusion, related to periodontal problems, per quadrant	29.00
Gingivectomy (including post-surgical visits), per quadrant	120.75
Gingivectomy osseous or muco-gingival surgery (including post-surgical visits), per quadrant	145.00
Gingivectomy, treatment per tooth (fewer than six teeth)	24.25
ENDODONTICS (Limit shown is for one tooth unless otherwise indicated)	
Pulp capping	$14.75
Therapeutic pulpotomy (in addition to restoration)	14.75
Vital pulpotomy	29.00
Remineralization (calcium, hydroxide, temporary restoration) as a separate procedure only	24.25
Root Canals, including necessary x-rays and cultures, but excluding final restoration	
Single rooted canal therapy	$108.75
Bi-rooted canal therapy	145.00
Tri-rooted canal therapy	181.25

Description	Benefit Amount
Apicoectomy (including filling of root canal)	120.75
Apicoectomy (separate procedure)	84.75
RESTORATIVE DENTISTRY, INCLUDING INLAYS, CROWNS (other than stainless steel) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)	
Amalgam Restorations – Primary Teeth Cavities – per surface	$28.00
Amalgam Restorations – Permanent Teeth Cavities – per surface	35.00
Synthetic Restorations	
Silicate cement filling	21.75
Plastic filling	26.50
Composite filling	26.50
Pins	
Pins (Retention) when part of restoration used instead of gold or crown restoration	7.25
Crowns	
Stainless steel (when tooth cannot be restored with a filling material)	41.25
Full and Partial Denture Repairs – Acrylic	
Broken denture, no teeth involved	29.00
Replacing missing or broken teeth, each tooth	7.25
SPACE MAINTAINERS (Includes all adjustments within six months after installation.)	
Fixed space maintainer (band type)	$84.75
Removable acrylic with round wire, rest only	96.50
Stainless steel clasps and/or activating wires, in addition to basic allowances, per wire or clasp	12.25
Study models	12.25
Removable inhibiting appliance to correct thumbsucking	96.50
Fixed or cemented inhibiting appliance to correct thumbsucking	96.50
Major Services – Plan will pay for crowns, bridges and dentures by the following schedule:	
RESTORATIVE (Gold restorations and crowns are covered only when teeth cannot be restored with filling material.)	
Inlays	
One surface	$73.50
Two surfaces	84.00
Three or more surfaces	105.00
Onlay, in addition to inlay allowance	21.00
Crowns	
Acrylic	126.00
Acrylic with metal	157.50
Porcelain	157.50
Porcelain with metal	210.00
Gold (full cast)	136.50
Gold (3/4 cast)	126.00
Gold dowel pin	21.00
PROSTHODONTICS	
Bridge Adjustments (See Inlays and Crowns)	
Pontics	

Description	Benefit Amount
Cast gold (sanitary)	$84.00
Steele's facing	94.50
Tru-Pontic type	115.50
Porcelain fused to gold	168.00
Plastic processed to gold	94.50
Removable Bridge (unilateral)	
Once piece casting, gold or chrome cobalt alloy clasp attachment (all types), per unit	42.00
Recementation	
Inlay	$10.50
Crown	10.50
Bridge	21.00
Repairs: crowns and bridges	Scheduled Limit will be based upon extent and type of damage and nature of materials involved
Dentures and Partials (Fees for dentures, partial dentures and relining include adjustments within six months after installation.) (Specialized techniques and characterizations are not eligible.)	
Complete maxillary denture	325.50
Complete mandibular denture	325.50
Partial acrylic upper and lower with gold or chrome cobalt alloy clasps, base	157.50
Teeth and clasps, extra per unit	10.50
Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base	315.00
Teeth and clasps, extra per unit	10.50
Simple stress breakers, extra	29.50
Stayplate, base	63.00
Teeth and clasps, extra per unit	6.25
Office recline, cold cure, acrylic	31.50
Denture reline	73.50
Special tissue conditioning, per denture	31.50
Denture duplication (jump case), per denture	115.50
Adjustment to denture more than six months after installation	8.40
Partial denture repairs (metal)	*See* "Repairs" above.
Adding teeth to partial denture to replace extracted natural teeth	
First tooth	52.50
First tooth with clasp	63.00
Each additional tooth and clasp	10.50
Orthodontics–Plan pays 50% of Covered Expense, up to a lifetime maximum of $2,000 per Participant. Medically Necessary Orthodontic Services for individuals under 19 are not subject to this lifetime maximum.	

C. PRESCRIPTION DRUG BENEFITS

Description	Benefit (Employees and Dependents)
Prescription Drugs (including diabetic supplies) – Participating Retail Pharmacy	$10 Co-Payment for generic prescription drugs and prescription drugs that have no generic equivalent;

	$10 Co-Payment and price differential for non-generic drugs. Prescription drugs must be obtained through a CVS/Caremark participating pharmacy. Limited to up to a 30-day supply.
Prescription Drugs (including diabetic supplies) – CVS retail or Mail Order Pharmacy	$20 Co-Payment for generic prescription drugs and prescription drugs that have no generic equivalent; $20 Co-Payment and price differential for non-generic drugs. Prescription drugs must be obtained through the CVS retail or CVS/Caremark mail order pharmacy. Limited to up to a 90-day supply.

D. VISION BENEFITS

Description	Benefit (Employees and Dependents)	
Eye Examinations	Up to $50.00*	
	Prior to January 1, 2015	***Effective January 1, 2015***
Frames	Up to $35.00*	Up to $45.00*
Lenses, pair:	Prior to January 1, 2015	***Effective January 1, 2015***
Single Vision Prescription	Up to $37.00*	Up to $47.00*
Bifocal Prescription	Up to $40.00*	Up to $50.00*
Trifocal Prescription	Up to $45.00*	Up to $55.00*
Lenticular Prescription	Up to $90.00*	Up to $100.00*
Contact Lenses	Up to $160.00*	Up to $170.00*
*Pediatric vision care for individuals under 19 is not subject to these dollar limits. Rather, benefits are provided up to the Allowable Charges.		

E. WEEKLY ACCIDENT AND SICKNESS BENEFITS

Description	Benefit (Employees Only)
Weekly Accident and Sickness Benefit	60% of weekly gross earnings, up to a maximum of $200 per week, payable for a maximum of 15 weeks

F. LIFE INSURANCE, DEATH BENEFITS AND AD&D BENEFITS

Description	Benefit
Life Insurance (Employees)	$15,000
Death Benefit (Dependents)	Spouse: $2,000 Child: • 14 days to less than 6 mos.: $100 • 6 mos. to less than 2 yrs.: $200

	• 2 yrs. to less than 3 yrs.: $400 • 3 yrs. to less than 4 yrs.: $600 • 4 yrs. to less than 5 yrs.: $800 • 5 yrs. and older: $1,000
Accidental Death & Dismemberment (Employees Only)	• Loss of life; loss of both hands, both feet or sight of both eyes; loss of one hand and one foot; loss of speech and hearing in both ears; loss of one hand or one foot and sight of one eye; quadriplegia: $25,000 • Loss of one hand or one foot or sight of one eye; paraplegia; hemiplegia: $12,500 • Loss of speech; loss of hearing in both ears; loss of thumb and index finger of same hand: $6,250

V. *MEDICAL EXPENSE COVERAGE*

A. GENERAL INFORMATION

The Schedule of Benefits that begins on page 15 in this booklet shows the amount of any required Deductibles, Co-Payments and the percentage of Covered Expenses that will be paid by the Plan after you meet any applicable Co-Payments or Co-Insurance amounts, up to the applicable maximum Plan benefit amount.

Your medical benefits are provided generally on an In-Network basis; Out-of-Network medical coverage is limited, as later described.

B. PREFERRED PROVIDER ORGANIZATIONS (PPO)

The Plan offers health care coverage through the CareFirst BlueCross BlueShield (CareFirst) Preferred Provider Organization (PPO). A PPO is a network of selected Physicians, Hospitals and other health care providers who have agreed to supply medical services or supplies to you and your Dependents for a reduced charge. CareFirst is the BlueCross BlueShield Plan that covers the Greater Washington, DC area, including Maryland and Northern Virginia. If you live outside of the CareFirst area, you will receive the same benefits from providers who participate with your local BCBS plan (i.e., Anthem BCBS in the VA Tidewater area and/or Independence BCBS in PA).

The PPO can be used for all covered medical services and conditions, including routine services, emergency medical conditions and the treatment of substance abuse.

Medical benefits are only available when services are received from an In-Network provider (except in the case of Emergency Care). Other than Emergency Care, no benefits are paid for services by an Out-of-Network provider.

When you become eligible for benefits under the Plan, you will receive a combined medical and prescription ID card. Present this ID card when you see a provider who participates with the PPO. Your ID card will identify you as a member so that providers will know how to submit claims on your behalf.

To find a CareFirst provider, visit the CareFirst website at www.carefirst.com. If you are in Maryland, DC or Northern Virginia, you may also contact CareFirst at (800) 235-5160. Participants outside the CareFirst BCBS service area (considered "FlexLink") should call (888) 444-8115 for assistance is locating a doctor or to verify if your provider is in your local BlueCross BlueShield network. You may also access this information on-line by going to www.carefirst.com.click on "Members and Visitors", then "Find a Doctor". You can then search by provider type (medical or facilities) depending on your needs. Under the heading at the bottom of the page, which says "Other Networks" click on "PPO-National/International BlueCross BlueShield Directory" link.

C. COVERED EXPENSES

The Plan will not always pay benefits equal to or based on the health care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductibles and Coinsurance. This is because the Plan covers only the Allowable Charge for services or supplies. The Plan will not reimburse you for any expenses that are not Covered Expenses. That means you are responsible for paying the full cost of all expenses that are not covered by the

Plan. Any amount in excess of the Allowable Charge does not count toward the Plan's out-of-pocket maximum for each benefit.

D. Annual Deductibles

There is no annual Deductible.

E. Out-of-Pocket Expenses

These are the expenses for medical services and supplies that you are responsible for paying yourself. Under the Plan, each year, you will be responsible for paying out of your own pocket:

- Any applicable Deductibles;
- Any applicable Coinsurance;
- All expenses for medical services or supplies not covered by the Plan;
- All charges in excess of the Allowable Charge;
- All charges in excess of any other limitation of the Plan;
- Applicable penalties if you fail to comply with the Utilization Management Program (see page 29).

F. Coinsurance and Copayments

If a Deductible applies to a particular benefit, you must pay the Deductible before the Plan begins to pay for that benefit. This means that once you have met your annual Deductible for that particular benefit, the Plan pays a percentage of the Covered Expenses, and you are responsible for paying the rest. The part you pay is called the "Coinsurance." Please remember that charges in excess of the Allowable Charge are not considered Covered Expenses under the Plan. *See* the Schedule of Benefits to determine the percentage paid by the Plan.

Some services are paid subject to Coinsurance, where the Plan pays a percentage of the Covered Expenses, and you are responsible for paying any remaining Covered Expenses. However, many Covered Expenses are paid subject to a Co-Payment. This means that you must pay the applicable Co-Payment, and the Plan pays the remainder of the Covered Expenses. There is a limit to the amount of Co-Payments you are required to pay during a Calendar Year, as shown in the Schedule of Benefits.

IMPORTANT

If you fail to follow certain of the Plan's Utilization Management Programs, you may be subject to a $500 penalty. That means that medical expenses covered by the Plan may be reduced by $500 in addition to any Deductibles or Coinsurance that may apply. These features are described in Article VI of this booklet.

G. Description of Medical Benefits

Please note that virtually all of the categories of health benefits are subject to Co-Pays, which are set forth in the Schedule of Benefits beginning on page 15.

1. Hospital Room and Board Benefits

Inpatient Hospital services are subject to a daily Co-Payment, as shown in the Schedule of Benefits.

Hospitalization must be pre-certified by American Health Holdings. For additional

information on the pre-certification requirements, please refer to the Utilization Management Program Article beginning on page 29. Hospital Room and Board benefits will only be provided if you and/or your Dependents are actually confined to a Hospital for which room and board expenses have been incurred.

2. Other Hospital Expenses

If you or your Dependents are confined in a Hospital or use the Hospital on an outpatient basis, for a non-occupational bodily injury or illness, you will be covered for the following expenses, in the amount shown in the Schedule of Benefits, provided the use of the items is Medically Necessary:

- Operating room and recovery room fees;
- Medical and surgical supplies (catheter, underpads, tubing, etc.);
- IV therapy and IV solutions;
- Medicines;
- Anesthesiology supplies;
- In-patient oxygen.

3. Surgical Expenses

Under most circumstances, the Plan will pay for Medically Necessary surgery performed on Participants, subject to a Co-Payment. The Plan pays for surgical operations when you undergo surgery due to a non-occupational accident or disease for which you are not entitled to benefits under any workers' compensation law. Benefits are payable whether the operation is performed at a Hospital, Physician's office or other appropriate facility, and the services are provided by a Physician.

Multiple Surgeries. In the event you have two or more surgical procedures performed at the same time, the Plan will treat them as a single procedure if the same incision or operative area is used. In this instance, the Plan will reimburse up to the amount shown in the Schedule of Benefits for the first procedure and then up to 50% of the amount shown in the Schedule of Benefits for all secondary procedures. If, however, multiple procedures are performed on different operative areas and/or different causes are involved, the Plan will treat the multiple procedures as separate surgeries and will pay up to the amount shown in the Schedule for each procedure.

4. Laboratory and Radiology Expenses

The Plan provides benefits for laboratory and radiology expenses, as shown in the Schedule of Benefits for x-ray and laboratory expenses, including chemotherapy expenses.

5. Emergency Room Expenses

After you pay the Emergency Room Co-Payment, Hospital charges incurred by you where emergency treatment is provided within 72 hours of a medical emergency is covered by the Plan, provided the charges are Allowable Charges. The Emergency Room Co-Payment is waived if you are admitted to the Hospital from the Emergency Room.

6. Ambulance Expenses

Benefits are available for Ambulance Expenses incurred by you where emergency treatment is provided within 72 hours of a medical emergency, provided the charges are Allowable Charges.

Benefits are provided for ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical emergency, acute illness or inter-health care facility transfer

7. Physician Office Visits

The Plan provides benefits for office visits you make to a Physician, as shown in the Schedule of Benefits.

8. Organ Transplants

The Plan provides benefits for services directly related to non-experimental transplants of human organs or tissue including bone marrow, stem cells, cornea, heart, intestine, islet tissue, kidney, liver, lung(s), pancreas, or skin, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.

9. Durable Medical Equipment

Coverage is provided for Durable Medical Equipment under the Plan, as shown in the Schedule of Benefits, for:

- Rental of Durable Medical Equipment (but only up to the allowed purchase price);
- Purchase of standard models at the option of the Plan; and
- Repair, adjustment or servicing or Medically Necessary replacement of the Durable Medical Equipment due to a change in the Participant's physical condition or if the equipment cannot be satisfactorily repaired.

Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician.

10. External Prosthetic Equipment

Coverage is provided for external prosthetic equipment under the Plan, as shown in the Schedule of Benefits, for:

- rental of external prosthetic equipment (but only up to the allowed purchase price);
- purchase of standard models of external prosthetic equipment at the option of the Plan;
- repair, adjustment or servicing of the external prosthetic equipment or replacement of the equipment due to a change in the Participant's physical condition or if the equipment cannot be satisfactorily repaired.

External prosthetic equipment is a type of corrective appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, corrective lenses needed after cataract surgery, casts, splints, trusses, braces, and crutches. Such equipment is covered only when ordered by a Physician.

11. Wellness and Preventive Services

Coverage for wellness and preventive services is provided for both children and adults, as shown in the Schedule of Benefits.

a. **Wellness and Preventive Services for Children**. Covered Expenses include:

- Routine childhood immunizations (e.g., DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus).

b. **Wellness and Preventive Services for Adults.** Covered Expenses include:

- For women: gynecology exams, pap tests, and screening mammograms;

12. Physical Therapy

The Plan provides benefits for office visits you make for physical therapy, as shown in the Schedule of Benefits.

13. Home Dialysis Services

Benefits are provided for the Allowable Charges for kidney dialysis performed in a Participant's home, as shown in the Schedule of Benefits, provided the Participant has been diagnosed with end-stage renal disease (ESRD).

H. ALCOHOL AND SUBSTANCE ABUSE BENEFITS

Inpatient and outpatient care for the treatment of alcohol and substance abuse will be provided in amounts, at levels and with limitations as set forth in the Schedule of Benefits. Hospital care includes covered room and board, and other Hospital services. **You must obtain pre-certification by American Health Holdings prior to being admitted to a Hospital for alcohol and substance abuse treatment**.

In order for you to receive inpatient Alcohol and Substance Abuse benefits, confinement in a Hospital must result from the diagnosis and recommendation of a Physician who certifies that a treatment plan has been established under a Physician's direction for your rehabilitation. The treatment plan must be submitted to **American Health Holdings** before or with any claim for benefits.

Benefits are provided for treatment in a residential treatment center, intensive outpatient treatment and partial hospitalization.

I. ADDITIONAL COVERED MEDICAL SERVICES

The following categories of health benefits are covered and are paid as shown in the Schedule of Benefits.

- Routine eye exams;
- Therapy services, including cardiac and pulmonary rehabilitation, speech and orthoptic/pleoptic therapy;
- Spinal manipulations;
- Outpatient private duty nursing
- Skilled nursing facility services;
- Hospice and home health care;

- Mental health care, including treatment in a residential treatment center, intensive outpatient treatment and partial hospitalization; and
- Nutrition counseling for weight management.

J. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain prior authorization from the Plan for prescribing a length of stay not in excess of those periods. However, discharge of the mother and newborn may take place earlier, provided the attending Physician has consulted with the mother.

K. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending Physician and the patient, for:

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

This coverage is subject to the Plan's annual Deductible and Co-Payment provisions.

If you have any questions about whether the Plan covers mastectomies or reconstructive surgery, please contact the Fund Office at 1-800-638-8824.

L. DENTAL

Dental services required as a result of accidental injury will be covered under the Medical Benefits portion of the Plan. Routine dental care is covered only under the Dental Benefits portion of the Plan (described beginning on page 31).

VI. *UTILIZATION MANAGEMENT PROGRAM*

A. THE UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program is designed to help control increasing health care costs by avoiding unnecessary services or treatments that are more costly than other available effective treatments.

If you do not follow these procedures, you will have to pay more out of your own pocket, in addition to any Deductibles or Coinsurance.

> **Prior to any scheduled Hospital admission**, you or your doctor **must** call American Health Holdings for pre-admission certification. American Health Holdings will review the proposed treatment plan with your Physician to assure your care is appropriate. **Check your health plan member I.D. card for the telephone number you are required to call for pre-certification.**

In the event of an emergency (a life-threatening situation), go straight to the hospital. You or a family member must notify American Health Holdings within 48 hours of the emergency care.

The Plan's Utilization Management (UM) Program consists of:

- Pre-certification review of proposed health care services before the services is provided. Some Physicians may obtain pre-certification for you. However, you are responsible for ensuring that Hospital services have been pre-certified. Therefore, you should confirm pre-certification with your Physician prior to Hospital admission.
- Case Management, whereby the patient, the patient's family, Physician and/or other Health Care Providers work with the UM Company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for patients who require complex, high-technology Medical services. Case management may include prior approval for treatment, discharge planning and psychiatric procedure review, among other things.
- Maternity, if you are expecting a baby, you should call about 30 days before your delivery date and then call again within 48 hours once you are admitted for delivery.

The UM Program is currently administered by American Health Holdings. The health care professionals in the UM Company focus on:

- necessity and appropriateness of Hospital stays, and
- necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

The UM Company determines whether or not a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms of this Plan.

IMPORTANT

Your Physician's recommendation for surgery, Hospitalization, confinement in a specialized health care facility, or other medical services or supplies does **not** mean that the recommended services or supplies will be considered Medically Necessary for determining coverage for medical benefits under the Plan.

The UM Company does not diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification does not guarantee a benefit payment. Payment of benefits is subject to the terms and conditions of the Plan as described in this Plan document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician believe to be the most appropriate, even if the UM Company does not certify the proposed medical treatment, Hospitalization or confinement in a specialized health care facility as Medically Necessary. The benefits payable by the Plan may, however, be affected by the determination of the UM Company.

Note: The Administrator, the Plan and the UM Company are not engaged in the practice of medicine, and none is responsible for the quality of health care services actually provided, whether or not certified by the UM Company as Medically Necessary.

B. WHAT HAPPENS IF YOU DO NOT FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES

If you do not follow the required Utilization Management procedures outlined above, your claim for benefits will be referred to the UM Company for a retrospective review to determine if the services are Medically Necessary.

- If the UM Company determines that the services are not Medically Necessary, no Plan benefits will be payable for those services.
- If the UM Company determines that the services are Medically Necessary, Plan benefits will be payable for those services. However, you will have to pay up to an additional $500 toward the cost of services, in addition to any Deductible or Coinsurance that may apply. The additional $500 does not count towards your Deductible or Out-of-Pocket Maximum.

VII. DENTAL COVERAGE

A. DENTAL BENEFITS

The Plan provides preventive, basic, major and orthodontic dental coverage benefits for you and your Dependents. The Plan will pay for preventive, basic, and major dental expenses as shown in the Dental Schedule of Benefits, up to the benefit amount shown for each item, up to the Calendar Year maximum per family. For orthodontic services, the Plan will pay, as shown in the Dental Schedule of Benefits, up to the lifetime maximum per eligible Participant.

If you incur charges above the benefit amounts listed in the Dental Schedule of Benefits, you are responsible for payment of those expenses, as well as any dental expenses that exceed the annual or lifetime maximum amounts covered by the Plan.

If you have selected family coverage under the Plan, the maximum benefit per Calendar Year is the maximum amount provided to your whole family, regardless of the number of Dependents you may have on the Plan.

B. LIMITATIONS AND EXCLUSIONS

If for any charge a benefit amount would be provided both under this coverage and any other coverage of the Plan, the charge will be eligible under this dental coverage only to the extent necessary to provide a benefit equal to the excess, if any, of (a) the benefit that would be payable for such charge under this coverage in the absence of this limitation over (b) and aggregate benefit payable for that charge under all coverages of the Plan. The following is a list of some dental services, supplies, and expenses that **are not covered** by the Plan:

- Those that are not Medically Necessary or not customarily performed for dental care;
- Those that are not furnished by a licensed dentist, unless the service is performed by a licensed dental hygienist under the supervision of dentist or is an x-ray ordered by a dentist;
- A service furnished to a person for cosmetic purposes or dental care for congenital or developmental malformation. Facings on crown or pontics, posterior to the second bicuspid shall always be considered cosmetic.

VIII. VISION COVERAGE

A. GENERAL INFORMATION

The Plan provides vision care benefits for you and your Dependents. These benefits include eye examinations, eyeglass lenses and frames, and contact lenses. You can obtain vision care from any licensed optometrist or ophthalmologist; however, the Plan will pay only up to the amount shown in the Vision Schedule of Benefits. If you incur expenses that exceed the benefit limitations and maximums, you will be responsible for payment of those expenses.

B. COVERED SERVICES

The Plan's vision coverage provides payment for:

- One annual eye examination, including refraction, per Calendar Year period;
- Two lenses per two (2) Calendar Year period;
- One set of frames per two (2) Calendar Year period;
- Contact lenses to the extent they are provided: (a) after cataract surgery; or (b) in the case where the only means available for the restoration of the visual activity of the Participant's better eye to 20/70 or better is by the use of contact lenses.

C. EXCLUSIONS

Following is a list of vision services, supplies and expenses that are **not covered** by the Plan.

- Sunglasses, whether prescription type or otherwise;
- Replacement of lost, stolen or broken lenses or frames furnished under the Plan;
- Eye examinations required (1) by an Employer as a condition of employment, which the Employer is required to provide by virtue of a labor agreement, or (2) by a government body;
- Lasik surgery;
- Charges in connection with special procedures such as orthoptics and vision training, or in connection with medical or surgical treatment of the eye;
- Any vision care to the extent that benefits are payable for the service or supply under any other insurance of the Plan.

IX. PRESCRIPTION DRUG COVERAGE

A. GENERAL INFORMATION

The Plan provides prescription drug coverage for *generic drugs only* for you and your Dependents subject to the applicable Co-Payment listed in the Prescription Drug Schedule of Benefits. Whenever possible the pharmacy will dispense generic drugs. **The Plan will only pay for the cost of brand name drugs should a generic equivalent not be available**. If you or your Physician insist on a brand name drug when there is a generic equivalent, you will be responsible for payment of the difference between the cost of the generic drug and the brand name.

When a prescription drug is needed, you or your eligible Dependent should present your drug card and the prescription to the pharmacy. Upon receiving the prescription you should sign a claim form (which is provided by the pharmacy) indicating receipt of the prescription. If for any reason you are required to pay for the full cost of the prescription at the pharmacy (for example, if you do not have your prescription card with you), you can contact the Fund Office and request a reimbursement form.

B. LIMITATIONS

Following is a list of limitations on the quantity of drugs prescribed:

- The amount of drug (including insulin) which may be dispensed per prescription is up to and including a 30-day supply for Prescription Drugs purchased at a retail pharmacy, or a 90-day supply for Prescription Drugs purchased at the mail order pharmacy or at a CVS retail pharmacy;
- Prescriptions for erectile dysfunction drugs (e.g., Viagra, Cialis, etc.) will be limited to five (5) pills per month.

C. EXCLUSIONS

Following is a list of some prescription drug services, supplies and expenses that are **not covered:**

- Therapeutic devices or appliances (i.e., hypodermic needles, supporting garments and other non-medical substances, except that diabetic supplies are covered);
- Medication to be taken or administered while in a Hospital;
- Medication for which the cost is recoverable under workers' compensation or occupational disease law, or any state or government agency;
- Medication furnished by any other drug or medical plan for which no charge is made to the recipient;
- Any medication excluded from the CVS/Caremark formulary, except by Prior Authorization (see Section F. below);
- Any drug labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs even though a charge is made to the patient;
- Allergy serums;

- Cosmetic products (e.g., Botox Cosmetic, depigmenting agents, hair growth stimulants, hair removal agents, etc.);
- Nutritional supplements;
- Prescription devices other than respiratory devices;
- Vaccines / toxoids;
- Injectable erectile dysfunction drugs;
- Smoking cessation drugs (e.g., smoking cessation gum, smoking cessation inhaler, smoking cessation patch, smoking cessation spray, etc.)
- Respiratory therapy supplies (e.g., Aerochambers / Inspirease / Spacers, peak flow meters, etc.); and

D. MANDATORY GENERIC DISPENSING

<u>Dipsense As Written</u>

The Plan provides for certain prescription benefits for participants and dependents through its pharmacy benefit manager, Caremark. Many brand name prescription drugs have a generic equivalent that has the same chemical components as the brand name drug and are just as effective. Generic drugs, however, are often a less expensive alternative to brand name drug. If a participant or dependent presents a prescription from the participant's or dependent's physician that has a generic equivalent, the participating pharmacy will substitute the generic equivalent for the brand name drug, unless the physician specifically requires that the brand name be dispensed instead of the generic drug. If the brand name drug is dispensed, the Plan will only pay for the generic price, and you are responsible for the remainder. Substitution of the generic drug will provide both the Plan and the participant a savings on the cost of the medication.

<u>Generic Step Therapy (Effective January 1, 2015)</u>

This program helps you and your doctor choose a lower-cost, generic medicine as the FIRST STEP in treating your health condition. Just because a medicine costs more doesn't mean it works better. Some health conditions have many treatment options that vary in cost. Generic Step Therapy helps make sure the medicines that are effective and priced right are used first.

With Generic Step Therapy, if you choose to stay on your current, higher-cost brand-name medicine, you may have to pay the full price if you have not tried a generic option to treat your health condition. For some health conditions, you may have to try two generic options. The Fund will only cover the brand-name medication if the generic options are not effective.

You can learn more about Generic Step Therapy by watching a short video: **www2.caremark.com/sitetour/steptherapy/**. You can also visit Caremark.com and click "Find Savings and Opportunities" OR call the toll-free number on the back of your prescription ID card.

<u>Generic Incentive</u>

If you are taking a brand name medication and there is a generic equivalent available, the pharmacist will ask if you would like to switch to the generic equivalent. If you agree to switch to the generic equivalent, the first generic fill will be at no cost to you. Refills will be charged at the generic prescription drug copay, $10.

E. MAINTENANCE DRUGS

Maintenance drugs must be purchased at a CVS Pharmacy or through the mail order program. "Maintenance drugs" are drugs, which are prescribed for a long period of time and are necessary to sustain good health. Examples are drugs used to treat high blood pressure, diabetes, and arthritis. You will only be allowed to fill a prescription for a maintenance medication for less than a 90-day supply two times. After which, you will be required to get a 90-day supply at either CVS or through the Mail Order Program.

F. PRIOR AUTHORIZATION PROGRAM

CVS/Caremark has excluded certain prescription drugs from coverage. Generally, these are brand-name drugs for which less expensive alternatives are available. You can obtain a list of the excluded drugs from the Fund Office. The list of excluded drugs is subject to change. Subject to Section C above, coverage will only be provided by this Fund for these otherwise excluded drugs if a prior authorization is obtained from CVS/Caremark by the prescribing physician who indicates that the particular drug is clinically necessary for the patient.

Compound Drugs (effective January 1, 2015):

Prior authorization is required for all prescriptions for compound drugs that cost $300 or more. Compounds can contain substances that have not been rigorously tested for safety or effectiveness, nor are all compounds approved by the FDA for use by the prescribed route of administration. Excluding certain ingredients and determining coverage through a prior authorization process helps to ensure that coverage is available for compound ingredients that are safe and likely to be effective for their intended use. Coverage for certain compounding chemicals (bulk compounding powders and bases) will be excluded from the prescription benefit. Compound drugs are limited to one fill per month unless medically necessary.

Your doctor may request additional information or choose to initiate the prior authorization process for you by calling (800) 294-5979.

G. SPECIALTY DRUGS (EFFECTIVE JANUARY 1, 2015)

At times, certain medical conditions call for the use of specialty drugs, which are extremely costly to the Plan. A Specialty Drug is a drug that is biologically derived and that is on the list of specialty drugs maintained by your prescription benefits manager, CVS/Caremark. To manage participants' use of Specialty Drugs, the Plan participates in Caremark's "Specialty Guideline Management Program with the Preferred Plan Design." Under this program, all Specialty Drugs must be filled through Caremark's dedicated pharmacies. A list of Caremark's specialty pharmacies can be found at www.caremark.com. The Preferred Plan Design requires you to use lower cost specialty drugs before trying more costly drugs (similar to the Generic Step Therapy program explained above).

X. *WEEKLY ACCIDENT & SICKNESS BENEFITS, LIFE INSURANCE AND AD&D INSURANCE*

A. WEEKLY ACCIDENT & SICKNESS BENEFITS

A Weekly Accident and Sickness Benefit is payable to eligible Employees should you become disabled or prevented from working as a result of a non-occupational accident or disease for which benefits are not payable under workers' compensation law. You do not have to be confined to your home to collect this benefit, but you must have been seen by and be under the care of a Physician during the period of your disability.

The weekly benefit to which you are entitled will commence on the ***first*** (1st) day of disability resulting from an accident and on the ***eighth*** (8th) day of disability resulting from sickness. These benefits will be payable for a maximum period of fifteen (15) weeks during any consecutive fifty-two week period. Please see the Schedule of Benefits to determine the amount of coverage you are eligible to receive. Payments will be made for as many separate and distinct periods of disability as may occur, subject to the maximum fifty-two week limitation described above. Successive periods of disability separated by less than two (2) weeks of active full-time work will be considered one period of disability unless the subsequent period of disability is due to an injury or sickness entirely unrelated to the cause of the previous disability. Participants are eligible for this Weekly Accident and Sickness Benefit only if it is referenced in an applicable collective bargaining agreement or participation agreement, and only if the Employer contribution rate is sufficient to cover the cost of this benefit as determined by the Board of Trustees.

Copies of pay stubs from your Employer, covering the most recent eight-week period of employment preceding the disability, must accompany all claims for this benefit. Weekly Accident and Sickness Benefit claims will not be processed without current pay stubs.

B. LIFE INSURANCE AND DEATH BENEFITS

Should you or your Dependents die while eligible for benefits under the Plan, the named beneficiary will receive a lump sum death benefit in accordance with the amount shown on the Schedule of Benefits. If there is no named beneficiary on file at the Fund Office, payment will be made in the following order: (i) to your surviving Spouse, if any; (ii) to your surviving children equally if there is no surviving Spouse; or (iii) to your estate if there is no surviving Spouse or child. Payment to a minor child may be made to the legal guardian of that child.

Life insurance benefits for Employees are insured; Dependent death benefits are self-funded by the Fund.

C. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

The Plan provides for AD&D insurance to eligible Employees only. AD&D provides benefits for the accidental loss of life, limbs, sight, speech and hearing, including losses resulting from occupational accidents. The maximum amount of insurance that the Plan provides is shown in the Schedule of Benefits beginning on page 15.

The full principal sum to which you are entitled to will be paid for the accidental:

- Loss of life (in addition to the Life Insurance described in Section B above)
- Loss of both hands, both feet or sight of both eyes

- Loss of one hand and one foot
- Loss of one hand or one foot and sight of one eye
- Loss of speech and hearing in both ears
- Quadriplegia

One-half of the principal sum will be paid for the accidental:

- Loss of one hand or one foot or sight of one eye
- Paraplegia
- Hemiplegia

One-fourth of the principal sum will be paid for the accidental loss of:

- A thumb and index finger of same hand
- Speech
- Hearing in both ears.

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Quadriplegia means total paralysis of all four limbs. Paraplegia means total paralysis of both lower limbs. Hemiplegia means paralysis of one arm and one leg on the same side of the body. Paralysis must be the result of a spinal cord injury that is due to an accident. AD&D benefits are not provided for any paralysis caused by a stroke or for loss of use of the hand or foot or thumb and index finger.

If more than one such loss results from any one accident, the Plan will pay only the largest benefit listed in the Schedule of Benefits.

D. AD&D EXCLUSIONS

The Plan will not provide AD&D benefits when the loss is caused by:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury that occurs when you commit or attempt to commit a felony.
- Voluntary use of any drug, narcotic or hallucinogenic agent –
    - unless prescribed by a doctor.
    - that is illegal.

- not taken as directed by a doctor or the manufacturer.

- Intoxication, meaning your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

XI. General Coverage Exclusions

Unless the Plan specifically provides otherwise, no benefits are payable under this Plan for any expense, charge or fee incurred in connection with any of the following:

- Services or supplies covered by workers' compensation or a similar law;
- Services or supplies for which you would not be charged if you did not have any Medical coverage and for which you are not legally required to pay;
- Services or supplies not recommended by your Physician;
- Services not Medically Necessary;
- Treatment of infertility;
- Expenses above Allowable Charges;
- Charges caused by warfare, injury or sickness while a member of the Armed Forces;
- Charges for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the Armed Forces of a government;
- Charges for services or supplies which are paid for or otherwise provided for under any law of government;
- Charges for services and supplies which are not necessary for the treatment of the injury or disease, or are not recommended and approved by a legally qualified surgeon or Physician (except as specifically provided for herein);
- Charges made by a nursing home or any institution (or part of one) used mainly as a facility for convalescence, nursing, or rest for the aged;
- Custodial care not intended to treat a specific injury or illness, or any education or training;
- Charges by a health care provider or Physician who is a member of your immediate family or who lives with you;
- Genetic testing and counseling, except in connection with testing fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan;
- Charges in connection with the care, treatment or surgeries which are performed for cosmetic purposes unless such expenses are incurred as a result of an accident, except to the extent otherwise required by the Women's Health and Cancer Rights Act of 1998 or the Health Insurance Portability and Accountability Act of 1996;
- Disturbances of the temporomandibular joint (TMJ);
- Expenses for the purpose of purchasing or fitting hearing aids;
- Items for personal comfort or convenience;
- Charges for any injury resulting from, or in the course of, any employment for wage or profit;
- Experimental or investigational medical treatment;

- Charges by an intern of a Hospital;
- Charges for medical services due to attempted suicide or self-inflicted injuries, unless caused by a related physical or mental condition;
- Any charges that are not listed as Covered Expenses in this Summary Plan Description, unless approved for payment by the Board of Trustees or the Plan Administrator prior to the services actually being rendered.

XII. *CLAIMS AND APPEALS PROCEDURES*

A. WHAT IS A CLAIM

A "claim" is a request from you or your authorized representative for payment of your Plan benefits made in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a claim.

The presentation of a prescription order at a pharmacy does not constitute a claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. Similarly, interactions between Participants and Physicians and Hospitals within the BlueCross Blue Shield PPO network do not constitute claims in cases where the providers exercise no discretion on behalf of the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under the "Determination of a Benefit Claim" section, below.

B. HOW BENEFITS ARE PAID

In general, the Fund Office will consider your claim for medical, dental, vision, life insurance, accidental death & dismemberment insurance and weekly accident & sickness benefits for payment upon the receipt of a completed claim form. However, Pre-Service, Concurrent Claims to extend approved Urgent Care treatment and Urgent Care Claims may be made over the telephone by calling American Health Holdings at (800) 641-5566. There are no claims to file when you obtain your prescription drugs through a pharmacy that participates in the Caremark network.

A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. If medical services are provided through a BlueCross Blue Shield PPO, the health care provider may submit a proof of claim directly to the Plan or may complete the necessary claim form and return it to you for submission to the Plan. However, you will be responsible for the payment to the health care provider of any applicable Coinsurance or Co-Payments.

C. HOW TO FILE A CLAIM

You can obtain claim forms from the Fund Office. The claim form must be completed in full for each family member, including all information and statements from Physicians, Hospitals, or other providers of service, and forwarded to the Fund Office at the following address:

Man-U Service Contract Health and Welfare Trust Fund

c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (410) 872-9500

D. TIME LIMIT FOR FILING A CLAIM

All claims must be submitted to the Fund Office within twelve (12) months of the date of

services, or your claim will be denied. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time.

E. Right to an Authorized Representative

If you wish, you can appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denied claim. You also can simply choose to represent yourself. In order to use an authorized representative (this person may be an attorney, but need not be), however, you must notify the Fund Office in advance in writing of the name, address, and phone number of the authorized representative. A health care professional with knowledge of the your medical condition (e.g., a treating Physician) may act as your authorized representative in connection with an Urgent Care Claim, without you having to notify the Fund Office of the designation of authorized representative.

F. Determination of a Benefit Claim

The determinations of benefit claims will vary depending on the type of claim. The period of time for the Plan to make a benefit determination begins at the time the claim is filed in accordance with the Plan's procedures, without regard to whether all the necessary information accompanies the filing. Please read each section carefully to determine which procedure is applicable to your request for benefits.

1. Medical, Dental, Vision or Prescription Claims

The Plan differentiates between four types of claims, divided according to their urgency. In general, dental, vision or prescription claims will be treated as Post-Service Claims. Pre-Service Claim

Pre-Service Claim

A Pre-Service Claim is a claim for a benefit for which the Plan requires prior approval of the benefit (in whole or in part) before medical care is obtained. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Pre-Service Claims. Under this Plan, prior approval of services is required for those medical services listed in Article VI of this booklet. Pre-Service Claims must be submitted by calling American Health Holdings at (800) 641-5566.

Important: If you fail to precertify these services, the applicable penalties will be applied (see Article VI).

For properly submitted Pre-Service Claims, you will be notified in writing of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of American Health Holdings. If an extension is necessary, you will be notified, before the end of the *initial 15-day period*, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is needed because American Health Holdings needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended from the date of the

extension notice until either *45* days or the *date you respond to the request* (whichever is earlier). American Health Holdings then has *15* days to make a decision on the Pre-Service Claim and notify you of the determination.

If you improperly file a Pre-Service Claim, American Health Holdings will notify you as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

Urgent Care

An Urgent Care Claim is any Pre-Service Claim for medical care or treatment that must be processed quickly to prevent serious jeopardy to your life or health, or your ability to regain maximum function. Additionally, Urgent Care Claims include those Pre-Service Claims that, in the opinion of your Physician, would subject you to severe pain that cannot be managed without the care or treatment requested under the claim.

Whether your claim is an Urgent Care Claim is determined by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

Urgent Care Claims, which may include pre-certifications of Hospital admissions, must be submitted in the same manner as Pre-Service Claims by calling American Health Holdings at (800) 641-5566.

For properly filed Urgent Care Claims, you will be notified of a decision in writing or by telephone as soon as possible, taking into account the medical exigencies, but not later than *72 hours* after receipt of the Claim. If you are notified by telephone, the determination will also be confirmed in writing not later than 3 days after the telephone notification.

If an Urgent Care Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, you will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours from receipt of the notification to supply the requested information. If the information is not provided within that time, your claim will be denied.

During the period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 48 hours or the date you respond to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for you to provide this information, whichever is earlier.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing an Urgent Care Claim. You will only receive notice of an improperly filed Urgent Care Claim if your claim includes (i) your name, (ii) your specific medical

condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless refiled properly, it will not constitute a Claim.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves a termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request to *extend* approved Urgent Care treatment must be submitted in the same manner as Urgent Care Claims by calling American Health Holdings at (800) 641-5566. You will be notified of a decision within *24 hours* of receipt of the claim, provided the claim is received at least *24 hours* prior to the expiration of the approved treatment. If the claim is not made at least *24 hours* prior to the expiration of the approved treatment, the request must be treated as an Urgent Care Claim and decided according to the Urgent Care Claim timeframes. A request to extend approved treatment that does not involve Urgent Care Claim will be decided according to the Pre-Service or Post-Service Claim timeframes, whichever applies.

Post-Service Claim

A Post-Service Claim is a claim that is not a Pre-Service, Urgent Care or Concurrent Claim (for example, a claim submitted for payment after health services and treatment has been obtained).

A Post-Service Claim must be submitted in writing to the Fund Office within twelve (12) months of the date of services, or your claim will be denied. A claim form may be obtained by contacting the Fund Office. If medical benefits are provided through a PPO, the PPO health care provider may submit the Post-Service Claim directly to the Fund Office.

Ordinarily, the Fund Office will notify you of decisions on Post-Service Claims within 30 days from the receipt of the claim. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the *45-day* period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the *date you respond to the request*, whichever is

earlier. The Plan then has *15 days* to make a decision on the claim and notify you of the determination.

2. *Weekly Accident & Sickness Claim and Dependent Life Insurance Claim*

Weekly accident & sickness benefit claims and dependent life insurance claims (see next section for employee life insurance claims) must be submitted in writing to the Fund Office. If your claim for either of these benefits has been denied, in whole or in part, you will be notified in writing within 45 days after your claim whole or in part, you will be notified in writing within 45 days after your claim has been received by the Fund Office. If the Plan needs more time to review your claim for reasons beyond its control, it may take an additional 30 days. Should additional time be required, you will be sent a notice of this extension before the initial 45-day period expires specifically explaining the circumstances requiring the extension, the date by which a final decision is expected to be rendered, the standards on which entitlement to a benefit is based the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues.

A second 30-day extension of time is also available to the Plan should the Plan determine that such an extension is necessary because a decision cannot be rendered within the extension period due to reasons beyond the Plans control. If a second extension is necessary, the notice of the second extension will be sent to you before the first 30-day extension period expires, and will include the same notification requirements listed in the paragraph above. In no event will the Plans extensions exceed 105 days from the date your original claim is made.

If an extension is required because the Plan needs additional information from you, the extension notice will specify the information needed. You will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period in which you are allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request, whichever is earlier. The Plan then has 15 days to make a decision on the claim and notify you of the determination.

3. *Employee Life Insurance or Accidental Death & Dismemberment Claim*

The life insurance and accidental death & dismemberment insurance for covered employees are fully insured by a life insurance carrier, which is currently ReliaStar Life. All claims and appeals decisions are made by the life insurance carrier as follows. The life insurance carrier will consider your appeal upon written application by you or your duly authorized representative. You may, in the course of this appeal, review relevant documents and submit to the life insurance carrier written comments, documents, records and other information relating to the claim. Review of the claim denial and the final decisions are the responsibility of the life insurance carrier. Your request for an appeal must be mailed and delivered within 60 days of the date of the claim denial. The life insurance carrier will respond to your request within 60 days of the date of your appeal.

G. NOTICE OF A CLAIM DECISION

If your claim is denied, in whole or in part, you will be provided with written notice of a denial of a claim. However, for Urgent Care Claims and Concurrent Claims to extend approved Urgent Care treatment, you may be notified of a denial of a claim by telephone, provided that a written

notice is provided to you not later than 3 days after the telephone notification. This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims.
- With respect to claims other than for life insurance or accidental death & dismemberment claim:
    - If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive a statement that the rule is available upon request at no charge.
    - If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that the explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

Note: For Urgent Care Claims and Pre-Service Claims, you will receive a notice of the determination even when the claim is approved.

H. REQUEST FOR A REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you or your authorized representative may ask for the claim to be reviewed.

- You have 180 days from the day you received notice of the initial decision to appeal medical, dental, vision, prescription or weekly accident & sickness claims. However, for a Concurrent Claim that involves a termination or reduction or previously approved care, the appeal must be completed before the care is terminated or reduced.
- You have 60 days from the day you received notice of the initial decision to appeal life insurance and accidental death & dismemberment claims.

Except as noted below, your request for review must be made in writing to the Board of Trustees and delivered or mailed to the Fund Office.

- Appeals involving Pre-Service and Concurrent Claims must be made in writing and delivered or mailed to American Health Holdings at 100 West Old Wilson Bridge Road, Worthington, OH 43085, (800) 641-5566.
- Appeals involving Urgent Care Claims and any Concurrent Claims requesting extension of approved Urgent Care treatment may be made in writing and delivered or mailed to

American Health Holdings at the address provided above, or via telephone, facsimile or other available similarly expeditious method.

- Appeals involving Pre-Service Concurrent Claims that do not involve an Urgent Care Claim must be made in writing to American Health Holdings. Appeals involving Post-Service Concurrent Claims that do not involve an Urgent Care Claim must be made in writing to the Board of Trustees.

I. REVIEW PROCESS

You have the right, upon request and free of charge, to receive reasonable access to and copies of all documents "relevant" to your claim. A document, record or other information is relevant if:

- it was relied upon in making the decision;
- it was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- it demonstrates compliance with the administrative processes for ensuring consistent decision making; or
- with respect to claims other than for life insurance or accidental death & dismemberment claim, it constitutes a statement of Plan policy regarding the denied treatment or service.

The review will take into account all comments, documents, records and other information you submit relating to the claim (regardless of whether this information was submitted or considered in the initial benefit determination).

With respect to claims other than life insurance or accidental death & dismemberment claims:

- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.
- A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

J. TIMING OF NOTIFICATION OF DECISION ON APPEAL

- Pre-Service Claims: American Health Holdings will send you a notice of decision on review within 30 days of receipt of the appeal.
- Urgent Care Claims: American Health Holdings will send you a notice of a decision on review within 72 hours of receipt of the appeal.
- Concurrent Claims: You will be sent a notice of a decision on review for a Concurrent Claim that involves a termination or reduction of previously approved care before the care is terminated or reduced. Notice of a decision on review for a Concurrent Claim that involves

an extension of care will be sent based on the timeframes for Urgent Care, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

- Life Insurance and Accidental Death and Dismemberment Claims: Decisions on review involving Life Insurance and Accidental Death and Dismemberment Claims will be made no later than 60 days following receipt of the claimant's request for review. If the reviewer requires an extension of time due to special circumstances, and notifies the claimant in writing, prior to the extension, of the special circumstances and the date by which a determination will be made, the reviewer will have up to 60 days from the end of the initial 60-day period in which to make a determination on review.
- All Other Claims: Ordinarily, decisions on appeals involving all other claims, including Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

K. NOTICE OF A DECISION ON REVIEW OF APPEAL

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

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- With respect to claims other than life insurance or accidental death & dismemberment claim:
  - A statement that if an internal rule, guideline or protocol was relied upon by the Plan, it is available upon request at no charge.
  - If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, is available upon request at no charge.

L. DECISION OF TRUSTEES

The denial of an application or claim to which the right of review has been waived or the decision of the Board of Trustees, or its designees with respect to a petition for review, shall be final and binding upon all parties, including the applicant, claimant or petitioner and any person claiming under the application, claimant or petitioner, subject only to judicial review. The provisions of this section shall apply to and include any and every claim to benefits from the

Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan within the meaning of those terms as defined in ERISA.

M. Limitation on When a Lawsuit may be Started

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

XIII. DUPLICATE COVERAGE

A. COORDINATION OF BENEFITS

Many families are covered by more than one medical plan. You must inform the Administrator of **all** your available coverage when you submit a claim. Failure to provide this information will delay benefit payments.

Coordination of benefits (or COB) operates so that one health plan (called the primary plan) will pay benefits first. The other health plan (called the secondary plan) then pays benefits. **In no event may the primary and secondary plans combined pay benefits over 100% of the total expenses incurred.** Sometimes, the combined benefits will be less than the total expenses incurred.

If you are eligible to receive benefits from another health plan, benefits will not be paid for any health care services and/or supplies that are not paid by the other health plan due to your failure to comply with the terms or conditions for receipt of benefits under the other health plan. This includes, but is not limited to, failure to comply with the other health plan's utilization, pre-authorization, or case management rules.

B. COORDINATION OF BENEFITS RULES

The COB rules determine the order of payment by two or more plans. If the first rule does not establish a sequence or payment of benefits, the next rule is applied, and so on, until the payment order is established. If you are eligible for Medicare, you also should read the Medicare section below. The rules are:

Rule 1: A health plan that does not have COB provisions is the primary plan and this Plan will be the secondary plan.

Rule 2: The plan that covers a person as an employee or participant (other than as a dependent) is the primary plan; and the plan that covers the same person as a Dependent will be the secondary plan.

Rule 3: For a Dependent child, the plan that covers the parent whose ***birthday*** falls earlier in the Calendar Year is the primary plan; and the plan that covers the parent whose birthday falls later in the Calendar Year will be the secondary plan. The year of birth is ignored in making this determination.

Rule 4: For a Dependent child, if a court order ***assigns*** responsibility to one parent for the child's health care, the plan of that parent is the primary plan.

Rule 5: For a Dependent child, if the parents **are** unmarried, separated (whether or not they ever were married), or divorced, with no court assignment of responsibility for the child's health care, then:

- The plan of the custodial parent is the primary plan, and
- The plan of the non-custodial parent will be the secondary plan.

Rule 6: The plan that has provided coverage for the longer period of time is the primary plan; and the plan that has provided coverage for the shorter period of time will be the secondary plan.

C. When Both You and Your Spouse Work for the Employer

If you and your Spouse both work for participating Employers and are eligible for coverage under the Plan, you can be covered as an Employee or as a Dependent. However, you cannot be covered as both an Employee and a Dependent.

D. How Much This Plan Pays as a Secondary Plan

When this Plan is the secondary plan, it will pay an amount equal to the same benefits it would have paid as a primary plan (after any Deductible or Coinsurance you pay), minus any payment amounts actually made by the primary plan. In no event will this Plan pay more than it would as a primary plan.

E. Medicare and other Government Programs

When you reach age 65, you are generally eligible for Hospital insurance benefits (Part A) and supplemental medical insurance (Part B) under Medicare. If you continue to work and remain covered by the Plan, the Plan continues to be your primary plan (and your Dependents' primary plan if you have family coverage). Medicare provides secondary coverage. You continue to submit your claims to the Plan and receive the same benefits as other Employees. Medicare then considers claims for any remaining expenses.

You are responsible for enrolling in the Medicare program. You should call or visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn about Medicare or visit their website at www.medicare.gov.

F. Medicaid

If you are covered by both this Plan and Medicaid, this Plan is the primary plan and Medicaid is the secondary plan.

G. Motor Vehicle no-fault Coverage Required by Law

If you are covered for medical and/or dental benefits by both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

H. Workers' Compensation

This Plan does **not** provide benefits if the medical expenses are covered by workers' compensation or occupational disease law.

I. Third-Party Liability (Subrogation)

1. "Subrogation" means the right of the Plan to be substituted in your place with respect to any lawful claim, demand, or right of action against a third party who caused your injury or illness resulting in payment of benefits. The Plan has the right to be reimbursed for benefits paid or payable for you or your covered Dependent for an injury, illness, expense or loss caused by a third party. When a Plan Participant or Dependent makes a damage claim against a third party or his or her uninsured or underinsured automobile insurance policy, the Plan, at its unilateral discretion, shall assert a lien on the proceeds of that

claim in order to reimburse itself to the full amount of benefits it has been called upon to pay. The Plan’s lien will apply to any and all recoveries or to any right of recovery (whether by lawsuit, settlement, or otherwise) for such claim. This provision does not allow the Plan's share of the recovery to be reduced because you or your Dependent do not receive the full amount of damages claimed or for your attorney's fees and costs, unless the Board of Trustees agrees, in writing to the reduction. By accepting the benefits from the Plan, the Participant and/or Dependent agree to the following:

- The Plan will automatically have an equitable lien, to the extent of the benefits, upon any recovery, whether by settlement, judgment, or otherwise, by the Participant and/or Dependent. The Plan's lien extends to any recovery from the third party, and third party's insurer, and the third party's guarantor, and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of recovery are traceable to particular funds or assets.
- The Plan holds a constructive trust for that portion of the recovery up to the extent of the benefits paid. The Participant or Dependent, and those acting on their behalf shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.
- Should the Participant, Dependent, or those acting on their behalf, fail to maintain this segregated account, or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.
- The Plan's share of recovery should also not be reduced because of the way in which the award was characterized by the court or the parties to a settlement (regardless of whether it was characterized as medical expenses, pain and suffering, etc.).

2. The Trustees shall have the right to refuse to pay benefits of any kind whatsoever to any Participant or Dependent who does not execute a Reimbursement and Subrogation Agreement, or who does not execute such documents as are necessary to enable the Trustees to exercise their subrogation right to amounts paid to such Participant or Dependent as a result of an injury or illness caused by a third party. As a condition to the receipt of benefits from the Plain, each Participant shall agree that in the event that the Plan has made, does make, or is obligated to make payments to the Participant or on the Participant's behalf, arising out of any illness or injury, then, as a condition for receiving benefits from the Plan, the Participant shall execute an agreement providing that the Participant will:

- Notify the Plan in writing that a claim relating to such illness or injury has been filed by the Participant against a third party seeking available funds.
- Notify the Plan in writing of the name and address of the Participant's attorney, provide said attorney with a copy of the agreement and require said attorney to comply with its terms. The agreement shall serve as authorization to the Participant's attorney to comply with its terms and to release all requested information about the claims to the Plan.

- Keep the Plan informed in writing of the progress and/or settlement of his/her third party claim.
- Include in all claims a claim for benefits paid by the Plan to and/or claimed from the Plan by the Participant.
- Reimburse the Plan in full for any benefits paid by the Plan to or on behalf of the Participant, plus interest accruing from the date of payment of such benefits.
- Require and authorize his/her attorney, if any, to withhold from available funds any monies due the Plan pursuant to the agreement and to forward them to the Plan as required by the agreement. In case of any dispute over what monies are due the Plan, available funds are to be escrowed pending resolution of such dispute.

In the event that the Participant fails or refuses to comply with the provisions of the Plan and the agreement, then the Plan, in addition to any other rights to which the Plan or the Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Participant or to third parties on behalf of the Participant from the Plan any amount necessary until the Plan is fully reimbursed.

The Participant shall authorize the Plan to record and/or use the agreement in any proceedings involving the Participant, including using the agreement in any third party claims that the Participant may have.

The Participant shall authorize any person or entity paying available funds to or on behalf of the Participant to pay over to the Plan such monies as the Plan is entitled to receive under the terms of the Plan and the agreement, and the agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Plan, available funds shall be escrowed pending resolution of such dispute.

Any Participant making a claim on behalf of any minor child under the Plan and who shall make the agreement on behalf of said minor child shall warrant that he/she is authorized to make the agreement on behalf of said minor child.

It is agreed that any payment received by the Participant from any health insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan (and excluding motor vehicle insurance), for which the Participant has paid in the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from requirements of this provision.

XIV. YOUR ERISA RIGHTS

As a Participant in the Man-U Service Contract Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

- **Receive** information about your Plan and benefits
- **Examine**, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- **Obtain**, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- **Receive** a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- **Continue health care coverage** for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- **Reduction or elimination of exclusionary periods** of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you

request a copy of Plan documents or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

As a participant in the Man-U Service Contract Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for a benefit that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XV. *OTHER INFORMATION*

The following information, together with the information contained in other portions of this booklet, forms the Summary Plan Description under the EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA"):

A. TYPE OF PLAN

This Plan is an employee welfare benefit plan that provides death benefits, accidental death and dismemberment benefits, pharmaceutical care, dental care, vision care, hospitalization, surgical, and medical benefits to eligible Employees and their qualified Dependents.

B. NAME OF THE PLAN

Man-U Service Contract Health and Welfare Trust Fund

C. PLAN IDENTIFICATION NUMBERS

a. Employer Identification Number: 54-1008444
b. I.R.S. Plan Number: 501

D. PLAN SPONSOR

The Man-U Service Contract Health and Welfare Trust Fund is the Plan Sponsor. All communications to the Plan Sponsor should be sent to:

Man-U Service Contract Health and Welfare Trust Fund
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(800) 638-8824

E. PLAN ADMINISTRATOR

The Man-U Service Contract Health and Welfare Trust Fund is the Plan Administrator.
All communications to the Plan Administrator should be sent to:

Board of Trustees
Man-U Service Contract Health and Welfare Trust Fund
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(800) 638-8824

The Trustees are:

Employer Trustees	Union Trustees
Sam Jefferson (Fund Chairman) Impact Imaging Ent., Inc. 8240 Cumberland Road New Kent, VA 23124	Anthony Seiwell (Fund Co-Chairman) Laborers' District Council of Eastern Pennsylvania 540 Grange Road P. O. Box 1038 Trexlertown, PA 18087
William Grace Grace Industries 310 Fairway Lane Yorktown, VA 23693	Orlando Bonilla Baltimore/Washington Laborers One Freedom Square 11951 Freedom Drive, 13th Floor Reston, VA 20190
Janice Grace Grace Industries 310 Fairway Lane Yorktown, VA 23693	Larry Doggette PSE Local 572 5627 Allentown Road, Suite 206 Camp Springs, MD 20746
Richard Yost 1746 Creek View Drive Fogelsville, PA 18051	Thomas P. Borum Laborers' International Union of North America Local 1310 317 North Washington Street Wilkes Barre, PA 18701

A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants upon written request to the Administrator, and is available for examination by Participants. In addition, Participants may receive from the Administrator, upon written request, information as to whether a particular Employer or employee organization is a contributing Employer, and if the Employer or employee organization is a contributing Employer, the contributing Employer's address.

F. Claims Administrator

The Board of Trustees has contracted with Carday Associates, Inc. to administer the claims for the Plan's benefits and can be reached at the following address:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(410) 872-9500
(800) 638-8824

G. Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made upon the Chairman of the Fund at the Fund Office, as well as on any individual Trustee at the addresses shown above.

H. TYPE OF ADMINISTRATION OF THE PLAN

The Plan is administered by the Board of Trustees through a third party administrator, Carday Associates, Inc. Hospital, surgical, medical, dental, weekly accident and sickness benefits, and vision benefits are provided on a self-insured basis. Life Insurance and Accidental Death and Dismemberment Insurance benefits are provided through contracts with ING. Prescription drug benefits are provided through a contract with CVS/Caremark.

I. SOURCE OF CONTRIBUTION AND FUNDING MEDIUM

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 Fund for the purpose of providing benefits to Participants and defraying reasonable administrative expenses. All benefits except Group Life and Accidental Death and Dismemberment insurance are provided on a self-funded basis. The Fund's assets and reserves are invested and are held in custody by investment managers designated by the Board of Trustees.

The benefits are paid according to Plan provisions out of a Trust Fund that is used solely for that purpose. If you have any questions or problems about benefit payments, you have the right to get answers from the Trustees who administer the Plan.

J. COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to a Collective Bargaining Agreement(s). Plan Participants may obtain copies of any such Agreements upon written request to the Fund Office, where it also is available for examination by Plan Participants.

K. FISCAL YEAR OF THE PLAN

The fiscal year of the Plan begins on January 1 and ends on December 31.

L. PLAN AMENDMENTS OR TERMINATION

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time. In the event this Plan is terminated, the Board of Trustees shall use any remaining funds to satisfy existing and arising claims for benefits under the terms of this Plan and to pay reasonable administrative expenses until such funds are exhausted. After termination of this Plan, any remaining funds shall be distributed in accordance with the terms of the Agreement and Declaration of Trust.

M. DISCLAIMER

The Board of Trustees, any Employer, Union or other individual or entity guarantees none of the benefits provided in this Plan. The benefits may be provided only from assets of the Fund available for such purpose. This Plan may be terminated at any time, for any reason, at the discretion of the Trustees.

N. RIGHT TO OFFSET

In the event any payment is made by the Plan to an individual who is not entitled to payment, the Plan shall have the right to reduce future payments payable to such individual by the amount of any erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.

O. DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Administrator and other individuals with delegated responsibility for the administration of the Plan, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

P. NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund, the Board of Trustees and their designee are not engaged in the practice of medicine, and have no control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Physicians or other health care providers. You should select a provider or course of treatment based on all appropriate facts, only one of which should be coverage by the Plan. Neither the Plan, Administrator, nor any of their designees, will have any liability whatsoever for any loss of injury caused to you by any Physician or health care provider by reason of negligence, by failure of provide care or treatment, or otherwise.

Q. PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Fund protect the confidentiality of your private health information. The Fund maintains a Notice of Privacy Practices that provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Administrative Office. This summary is not intended and cannot be construed as the Fund's Notice of Privacy Practices. In the event of any inconsistency between this summary and the Notice of Privacy Practices, the terms of the Notice control.

The Fund and the Board of Trustees will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, the Fund will not, without your written authorization, 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.

The Fund also hires professionals and other companies to assist it in providing health care benefits. The Fund has required these entities called, "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Fund's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to

request confidential communications. You also have the right to file a complaint with the Fund or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

If you have questions about the privacy of your health information, or if you wish to file a privacy violation complaint, please contact the Fund's Privacy Official at the Fund Office address located in the front of this booklet.

R. Named Fiduciary Under ERISA

The named fiduciary under the Plan is the Board of Trustees.

S. No Assignment of Benefits

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or providers of medical care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider can be considered to be a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so. Notwithstanding the foregoing, the Board of Trustees shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order.

T. Governing Law

This Plan is created and accepted in the State of Maryland, and all questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Maryland except as to matters preempted by federal law.

U. Savings Clause

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect other provisions of this Plan or the application of any provisions to any other person or instance unless such illegality shall make impossible the functioning of this Plan.

V. Titles

The title of any Article, Section or provision of this Plan is for convenience and reference only and is not to be considered in interpreting the terms and conditions of this Plan.

W. Construction of Words

Any words used in this Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would so apply. Any words used in this Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would so apply, and vice-versa.

XVI. QUICK REFERENCE CHART

For information on:	You should contact:
Claims, eligibility, COBRA, medical benefits, dental benefits, vision benefits, death benefits, weekly accident and sickness benefits, life insurance, accidental death, and dismemberment benefits, and claims and appeals information	Man-U Service Contract Health and Welfare Trust Fund c/o Carday Associates, Inc. 7130 Columbia Gateway Drive, Suite A Columbia, MD 21046 (410) 872-9500 (800) 638-8824
PPO Provider	CareFirst BlueCross BlueShield 10455 Mill Run Circle Owings Mills, MD 21117 (800) 235-5160 Participants outside the CareFirst BCBS service area (considered "FlexLink") should call (888) 444-8115
Utilization Management Program	American Health Holdings 100 Old West Wilson Bridge Road Worthington, OH 43085 (800) 641-5566
Prescription Drug Program	Caremark Rx, Inc. P.O. Box 686005 San Antonio, TX 78268-6008 www.caremark.com (866) 282-8503
Life and AD&D Insurance	ING Life Claims P.O. Box 1548 Minneapolis, MN 55440 (800) 537-5024 – select option 2