PRESSMEN WELFARE FUND

SUMMARY PLAN DESCRIPTION

Revised Effective October 1, 2012

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October 1, 2012

To All Eligible Participants:

We are pleased to present you with this updated summary of your Plan of Benefits. Since the purpose of the Pressmen Welfare Fund is to benefit you and your family, we urge you to read this booklet carefully.

This Summary Plan Description ("SPD") furnishes a summary of the benefits to which you and your family are entitled, the rules governing these benefits and the procedures that should be followed when filing a claim for benefits or an appeal. Because this booklet is only an SPD, it does not necessarily set forth all of the details of the Plan or the underlying Plan documents. **In case of doubt or discrepancy between this SPD and the Plan documents, the official Plan documents will always govern**.

Interpretations regarding eligibility for benefits, claims, status of employees, status of contributing employers, or any other matter relating to the Pressmen Welfare Fund should only be obtained through the Board of Trustees or the Fund Administrator. **The Trustees are not obligated, bound by, or responsible for, opinions, information or representations about the Plan from any other source.**

Changing economic conditions require a constant assessment of the Plan of Benefits offered so that the Fund may maintain its financial stability. Within this framework, the Trustees will continue to make those changes that benefit the participants. However, the Trustees reserve the right to change, modify or eliminate any of the benefits offered by the Fund at any time.

Sincerely,

BOARD OF TRUSTEES

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HIGHLIGHTS

The Pressmen Welfare Fund offers:

- **Comprehensive Medical Benefits** covering doctor visits, laboratory testing, surgery, and hospital stays, as well as selected preventive care coverage. This includes mental health and chemical dependency services offered through various plan options provided by Kaiser Permanente.

- **Prescription Drug Benefits** to help you handle the high cost of prescription medicines.

- **Dental Benefits** designed to assist you with certain expenses necessary for care and treatment of your teeth and gums.

- **Vision Benefits** to pay for eye exams, eyeglasses, and contact lenses.

- **Life Insurance Benefits** to assist you in the financial protection of your family.

- **Accidental Death and Dismemberment Benefits** to provide death benefits to your Beneficiary(ies), or benefits to you if you suffer certain severe injuries in a covered accident.

- **Short Term Disability Benefits** to provide you with short-term financial protection in the event you become disabled.

This is just a brief overview. You will find in this Summary Plan Description a more detailed explanation of each benefit, including the name and address of each of the providers and a description of the applicable copayments and deductibles. You will also find in this Plan booklet a detailed explanation of the procedures you must follow for filing a claim and for appealing any denial of benefits. Remember, this booklet provides only a summary of those benefits. Consult the Plan documents for additional details.

ELIGIBILITY AND COVERAGE

WHO IS ELIGIBLE?

Active Employees

This Plan covers all employees who work in Covered Employment. Covered Employment is work for which an Employer is required under a collective bargaining agreement with Pressmen Local 72 to make contributions to the Pressmen Welfare Fund (called a Contributing Employer). The Plan also covers employees who are eligible to participate in the Plan pursuant to a participation agreement with a Contributing Employer approved by the Trustees of the Fund.

Employees are also required to make contributions to the Pressmen Welfare Fund through payroll deductions. The amount of the employee contribution depends on which Kaiser plan the employee chooses.

If you are an Active Employee who is eligible for Medicare, the Plan will coordinate your benefits under this Plan with Medicare Part A benefits. If you fail to enroll for Medicare Part A benefits, the Plan will nonetheless coordinate benefits as if you had enrolled in Medicare Part A. The Plan will be primary to Medicare Part A benefits. You are not required to enroll in Medicare Parts B or D coverage. If you *do* enroll in Medicare Parts D and/or B, however, the Plan will coordinate benefits with Medicare Parts B or D.

Retirees

Employees who retire from Covered Employment may continue coverage under this Plan until they become eligible to receive Medicare coverage. Retirees, however, may continue coverage under the Plan only for medical, prescription and limited vision benefits offered through the Kaiser plans. No other benefits are available to Retirees or their Eligible Dependents. A Retiree electing coverage under this Plan must pay the premium determined by the Trustees by the first day of each month for which coverage is sought.

A Retiree who wishes to continue his coverage under this Plan must elect such coverage immediately upon retirement. Employees who retire and do not immediately elect to continue coverage under this Plan will not be permitted to elect retiree coverage under this Plan at a later time. A Retiree may also elect coverage for his Eligible Dependents, but must do so at the same time he elects coverage for himself.

A Retiree is eligible to participate in the Plan until he becomes eligible to receive Medicare coverage. **At that time, the Retiree's coverage under the Plan will terminate *even if* the Retiree had failed to enroll for Medicare coverage when he was first eligible to do so.**

This rule applies equally to a Disability Retiree who becomes eligible for Medicare because he has obtained a disability rating from the Social Security Administration. In those circumstances,

a Disability Retiree will be ineligible to participate in the Plan after the last day of the month following the expiration of the initial waiting period for Medicare coverage.

All Retirees, including Disability Retirees, should apply for Medicare coverage as soon as they are eligible to do so.

After the Retiree's participation terminates because he has become eligible for Medicare, or because he dies, his Spouse and any Eligible Dependent(s) may continue to obtain Retiree benefits under the Plan until the Spouse becomes eligible for Medicare. When the Spouse becomes eligible for Medicare, the Spouse's and Eligible Dependent(s)' coverage under the Plan will terminate. If the Spouse dies, any Eligible Dependent(s) then covered under the Plan will be eligible only for COBRA Continuation Coverage. This same rule applies if the Retiree's participation terminates because he dies.

Eligible Dependents

This Plan also covers Eligible Dependents of Active Employees and Retirees. Eligible Dependents include your Spouse. Coverage for your Spouse continues until the end of the month of your date of divorce or legal separation.

Eligible Dependents also include children, up to the age of 26, under the specific conditions explained herein. Children are defined as your natural children, adopted children, and step-children. An adopted child is covered as of the day the child is placed with you for adoption, even if the adoption is not yet final. The term "placement," as used in this definition, means your assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The Plan also covers your grandchild if you have been awarded court-ordered custody of the child. Coverage for your Eligible Dependent child will end on the last day of the month in which the child turns age 26.

Eligible Dependents children are covered regardless of their financial dependency on you or any other person, their residency with you or any other person, their student or marital status, and whether they are enrolled in the plan of another parent, or any combination of these factors. An unmarried child older than age 26 may also be an Eligible Dependent if he or she is physically or mentally incapable of self-support and relies on you for more than half his/her economic support. Such incapacity must have arisen, however, prior to the child's reaching age 26.

In order to receive group coverage for your Eligible Dependents you must submit with your application to the Fund Administrator proof of your marriage to your Spouse (if applying for coverage for your Spouse) and copies of birth certificates or legal guardianship for your children (if applying for coverage for your Eligible Dependent children). You will be required to submit a Dependent Eligibility Form in order to receive coverage for your Dependents.

The Fund will comply with any special enrollment rules required by the Health Insurance Portability and Accountability Act.

Change in Family Status

You have an obligation to advise the Fund Office in writing of any change in family status (e.g., divorce, addition to or deletion from the family), within 30 days of such change, and provide any documentation deemed necessary by the Fund Office relating to such change.

This information is necessary to avoid any delays in the processing of your claims. Advising the Fund Office of any change in family status is also important to avoid any mispayment of claims for individuals who are no longer entitled to coverage under the Pressmen Welfare Plan. If the Trustees pay a claim for benefits by or on behalf of you or your family member who is no longer eligible for benefits under the Plan because you have failed to advise the Fund Office in writing of a change in family status as required above, the Trustees will hold you financially responsible. If any benefits are paid to or on behalf of your ineligible family members, you and any Eligible Dependents may be denied all further benefits until restitution of the money improperly obtained (whether by offset or otherwise) is made to the Fund.

PERIODIC MEMBER CERTIFICATIONS

Periodically, you will be required to complete a form providing the Fund Office with required information about you and your dependents. This form will be used to determine your continued eligibility for benefits and that of your dependents. If you fail to submit a completed form as required, your coverage in this Plan may be terminated.

WHEN DOES COVERAGE BEGIN?

The benefits for you and your Eligible Dependents described in this SPD will become effective on the first day of the month for which contributions are required to be made to the Fund on your behalf during which you have worked in Covered Employment for a Contributing Employer. For coverage to become effective, you must also submit a Kaiser-approved enrollment application.

This Plan's Open Enrollment Period is September 1 to September 30 each year. During this Open Enrollment Period, all eligible persons may change their enrollment and switch between the various Kaiser plans offered by the Pressmen Welfare Fund.

MAINTAINING COVERAGE DURING ABSENCES

Short-Term Absences from Covered Employment

Employer contributions to the Fund are due for you if you are absent from Covered Employment due to a disability for up to six months. Employer contributions are due for you if you experience a second period of absence, provided that you have returned to full-time employment from a prior absence of up to six months for a period of at least 30 days.

Coverage During Leave Under the Family and Medical Leave Act

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

1. the birth of a child of the Employee, or placement of a child with the Employee for adoption or foster care;

2. to provide care for a spouse, child, or parent who is seriously ill;

3. the Employee's own serious illness; or

4. a "qualifying exigency" that arises in connection with the covered active duty of a child, spouse, or parent of the Employee in the Armed Forces (including the National Guard or Reserves).

Additionally, an eligible Employee who is a qualifying family member or next of kin of a covered military service member of the Armed Forces (including the National Guard or Reserves) is able to take up to 26 workweeks of leave in a single 12 month period to care for the covered service member if s/he is on the temporary disability retired list or undergoing medical treatment, recuperation or therapy as a result of a serious injury or illness sustained in or aggravated by service in the line of covered active duty. Covered service members include veterans who were members of the Armed Forces (including the National Guard or Reserves) at any time during the 5 years preceding the date on which the medical treatment, recuperation or therapy began.

During his or her leave, the Covered Employee may continue all of his medical coverage and other benefits offered through the Fund. The Covered Employee is generally eligible for leave under the FMLA if the Employee:

1. has worked for a Contributing Employer for at least 12 months;

2. has worked at least 1,250 hours over the previous 12 months; and

3. has worked at a location where at least 50 employees are employed by the Contributing Employer within 75 miles.

The Fund will maintain the Employee's eligibility status until the end of the leave, provided the Contributing Employer properly grants the leave under the FMLA and the Contributing Employer makes the required notification and payment to the Fund. If you need to take leave for an FMLA-qualifying event you should immediately notify your Employer. You should also contact the Fund Office so that the Fund is aware of your Employer's responsibility to report the period of your absence.

WHEN DOES COVERAGE TERMINATE?

For Covered Employees

The following circumstances may result in termination of your coverage:

- ► Failure of a Contributing Employer to make timely contributions on your behalf to the Fund (*see* section entitled "What Happens if Timely Contributions Are Not Sent on My Behalf to the Fund?" (page 7);

- ► If you are not actively working but your Employer is still required to make contributions on your behalf to the Plan, your failure to remit your share of the monthly premium payment in a timely manner;

- ► Failure of a Retiree (or his Spouse, where applicable) to make timely premium payments to the Fund, as required by the Trustees;

- ► Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave employment with a Contributing Employer to serve in the armed forces of the United States, and you meet the other requirements of USERRA, you are entitled to continuation health coverage as discussed below after the COBRA Continuation Coverage section of this plan document (page 9).;

- ► Cessation of work in Covered Employment; or

- ► The termination of the Plan. If the Plan is terminated, coverage for all Employees and their Dependents will cease on the date of the termination. In all other events, your coverage will cease as of the last day of the month for which contributions were required to be paid on your behalf.

For Dependents

The following circumstances will result in the loss of your Dependents' coverage under the Plan:

- ► The termination of the Plan;

- ► The loss of the Covered Employee's coverage in any of the circumstances described above;

- ► The failure to make any self-payment that is required under the terms of the Plan; or

- ► When your Dependent fails to meet the requirements for being considered a "Dependent" under the Plan as explained above.

Your Dependents' coverage will terminate as of the last day of the month in which the Covered Employee's coverage is lost, any required self-payment is not made, or when the Dependent fails to meet the requirements for being considered a "Dependent" under the "Eligible Dependents" Section above. If the Plan is terminated, coverage for all employees and their dependents will cease on the date of the termination.

WHAT HAPPENS IF TIMELY CONTRIBUTIONS ARE NOT SENT ON MY BEHALF TO THE FUND?

Employer Delinquencies

As explained in the section of the SPD entitled "When Does Coverage Terminate?" your coverage (and that of your eligible Dependents) under the Pressmen Welfare Fund will terminate if your Employer fails to make timely contributions on your behalf to the Plan. The Fund considers an Employer to be untimely if the required contributions are not received by the Fund Office by the 10th day of the month following the month in which contributions are owed. The Fund Office will send you and your Employer a notice on or about the 15th of the month advising you that timely contributions were not sent in on your behalf. The notice will also advise that, as a result of your Employer's delinquency, your coverage will be terminated as of the 1st day of the following month unless contributions are in the Fund Office's possession by the 25th of the month. If your Employer does not remit contributions as required by the 25th of the month, the Fund Office will notify you accordingly. Thus, for example, if your Employer does not remit contributions on your behalf for the month of January by the required deadline of February 10, the Fund Office will send you a Notice on or about February 15 advising of this delinquency and further advising that your Employer has until February 25 to remit the contributions in full. If your Employer does not remit those contributions in full by February 25, your coverage WILL TERMINATE prospectively on March 1, and the Fund Office will notify you accordingly.

To prevent your coverage from terminating because of your Employer's delinquency, you may elect to self-pay contributions to the Fund in an amount that is equal to 102% of the total contribution due the Fund (employer plus employee share) on your behalf. When you are notified of the delinquency, you will be advised what rate you are required to self-pay to continue your coverage. Your contribution must be in the Fund Office by no later than the 1st day of the month to prevent termination of your coverage. Thus, in the above example, if your Employer failed to remit required contributions by February 25, you would have until March 1 to remit your own self-pay contributions to prevent your coverage from terminating.

Whether or not you elect to self-pay for coverage, the Fund will continue to pursue collection of your Employer's delinquent contributions as well as liquidated damages and interest. All amounts collected will be applied to the earliest delinquency, which includes contributions, liquidated damages and/or interest. Thus, your Employer will be considered delinquent until all amounts due the Fund are paid in full.

If the Fund succeeds in collecting the delinquent amounts due, your coverage under the Fund will be reinstated as of the first day of the month following receipt of all delinquent amounts due. You will not be entitled, however, to retroactive reinstatement of your coverage under the Plan.

You may, however, be entitled to reimbursement of either your self-payments or other medical expenses as follows. If you elected to self-pay to maintain your coverage, you will be entitled to a proportionate reimbursement of the monthly self-payments you made (less 2%), depending on how much in delinquent contributions the Fund collected from your Employer. If, on the other hand, you did not elect to self-pay to maintain your coverage, you may seek reimbursement directly from the Fund for any medical expenses you incurred for you or your eligible Dependent(s) while you were without coverage. Such expenses will be reimbursed only if they 1) are for charges that would be deductible health care expenses within the meaning of the Internal Revenue Code; 2) were paid by you and not otherwise paid or reimbursed by other insurance; and 3) are documented to the Trustees' satisfaction. Under no circumstances shall the amount of reimbursement to which you are entitled exceed the amount of delinquent contributions collected by the Fund that should have been remitted by your Employer on your behalf. Moreover, if you incur no reimbursable expenses during the period you are not covered because of your Employer's delinquency, you will be entitled to no reimbursement.

If you purchase catastrophic coverage insurance when your eligibility terminates because your Employer has not paid the required contributions on your behalf and because you have declined to self-pay to maintain your coverage, the Plan will pay you a one-time reimbursement of up to $100 for the premium cost of such policy. Please contact the Fund Office to find out whether your policy qualifies for and how to obtain such reimbursement.

You may also be entitled to limited continuation coverage for benefits directly from Kaiser Permanente. Refer to your Summary Plan Description or your Kaiser Permanente Evidence of Coverage documents.

Employee Delinquencies

Your coverage (and that of your eligible Dependents) will also terminate if you fail to remit your share of the monthly contribution to the Fund in a timely manner when you are not actively working (and thus are not having your employee share deducted from your paycheck) but your Employer is still required to make contributions to the Plan on your behalf. Your share of the required contributions must be received by the Fund Office by the 10th day of the month following the month in which contributions are owed. The Fund Office will send you a notice on or about the 15th of the month advising you that your share of the required contributions was not received timely and that, consequently, your coverage will be terminated as of the 1st day of the following month. You will have until the 25th of the month to cure the delinquency. Thus, for example, if you do not remit your share of the required contributions for the month of January by the required deadline of February 10, the Fund Office will send you a Notice on or about February15 advising of this delinquency and further advising that you have until February 25 to remit your share of the contributions in full. If you do not remit your share in full by February 25, your coverage (and that of your eligible Dependent(s)) WILL TERMINATE prospectively on March 1 and will continue for the duration of your delinquency. Your coverage under the Fund will be reinstated as of the first day of the month following receipt of all delinquent amounts due. You will not be entitled, however, to retroactive reinstatement of your coverage under the Plan, and you are not entitled to any reimbursements of any medical or other

expenses you may have incurred during the time your coverage was terminated because you failed to pay your share of your contributions.

You may also be entitled to limited continuation coverage for benefits directly from Kaiser Permanente. Refer to your Summary Plan Description or your Kaiser Permanente Evidence of Coverage documents.

HOW TO CONTINUE YOUR COVERAGE (COBRA)

General Information

So that you and your Eligible Dependents have access to health care coverage in certain situations where coverage otherwise would terminate, the Plan will provide individuals who are already covered under the Plan the opportunity to extend their health coverage temporarily. The law requiring this coverage is the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Health care coverage provided under COBRA is called "COBRA Continuation Coverage." It will be offered to you and your Eligible Dependents, called Qualified Beneficiaries, at group rates when coverage under the Plan would otherwise end because of a life event known as a "qualifying event." You do not have to show that you are insurable for COBRA Continuation Coverage.

COBRA Continuation Coverage became effective under the Plan on January 1, 1989. The occurrence of any qualifying event on or after this date triggers your COBRA Continuation Coverage rights.

As a Covered Employee, you may continue the health care coverage that you have when your coverage otherwise would be lost because of a reduction in your hours of work, or the termination of your employment (for reasons other than gross misconduct on your part). If your spouse and/or dependent child(ren) are covered under the Plan, they may continue their coverage also.

You also have the right to elect COBRA Continuation Coverage for your spouse and dependent child(ren) when they otherwise would lose health care coverage as a result of any of the following qualifying events:

- your death;
- your divorce or legal separation;
- your becoming entitled to Medicare; or
- for a dependent child, ceasing to qualify as an "Eligible Dependent" under the terms of the Plan.

If you do not elect COBRA Continuation Coverage for your Spouse and Eligible Dependents, they have an independent right to do so for themselves.

Notice of Qualifying Event and Election of Continuation Coverage

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the Covered Employer, the Covered Employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the Contributing Employee or other beneficiary must notify the Plan Administrator of the qualifying event within 30 days of its occurrence.

For the other qualifying events (divorce or legal separation of the Covered Employee and Spouse or a child's ceasing to be eligible for coverage as an Eligible Dependent) you must notify the Fund Office within 60 days of: (1) the event giving rise to the loss of coverage, or (2) the date the beneficiary would lose coverage under the Plan as a result of that event, if later. In addition to including the names, addresses, telephone and Social Security Numbers of all persons whose coverage will be affected by such event, the notice must also include an explanation of the nature of the qualifying event, the date on which it occurred and any supporting documents, if any. Some examples of acceptable supporting documents are divorce decrees, separation agreements, and death certificates.

When the Fund Office is notified that one of these events has occurred, you will be notified within 14 days of the right to elect COBRA Continuation Coverage. You have 60 days from the later of the date of the event that triggers your right to COBRA Continuation Coverage or the date of the COBRA notice to inform the Fund Office that you want COBRA Continuation Coverage.

If you do not elect COBRA Continuation Coverage, your health care benefits under the Plan will terminate.

Since additional information about your rights under COBRA will be sent to you, it is important that you keep the Fund Office informed of any changes in your address and those of any dependents not living with you. So, if your Spouse or any Eligible Dependents have an address different from yours, or if your family status has changed, please notify the Fund Office.

Duration of Continuation Coverage

If health care coverage is lost because of your termination of employment or reduction in hours of work, the required COBRA Continuation Coverage period is 18 months from the date of the qualifying event. An 11-month extension of coverage may be available if you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled. The disability must have started before the 60th day of COBRA continuation coverage and must last until the end of the initial 18 month period. You must send the Fund Office a copy of the SSA's determination within 60 days of that determination and before the end of the first 18 months of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the

qualified beneficiary is determined by SSA to be no longer disabled, you must send the Fund Office a copy of the SSA's determination within 30 days of that determination.

An 18-month extension of coverage will be available to Spouses and Eligible Dependents who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the following:

- ► the death of a Covered Employee;
- ► divorce or separation from the Covered Employee;
- ► the Covered Employee's becoming entitled to Medicare benefits; or
- ► a dependent child's ceasing to be eligible for coverage as an Eligible Dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

You must notify the Fund Office within 60 days after a second qualifying event occurs if you want to extend your coverage.

Termination of Continuation Coverage

Once you have elected to maintain your coverage through COBRA, benefits will continue until the earliest of the following events:

- ► you discontinue making the required monthly premium payments;
- ► you become eligible for other coverage under another group health plan as an Employee or Dependent. However, if the other group health plan excludes pre-existing conditions or limits coverage and the other plan's limit or restriction applies to you, your Continuation Coverage may not be terminated for this reason;
- ► you become entitled to Medicare (this includes disability retirees);
- ► the time limit under which you are eligible for COBRA Continuation Coverage expires; or,
- ► the Plan ceases to provide coverage to anyone.

Level of Benefits

Unless otherwise stated, each Qualified Beneficiary shall be entitled to continue the same benefits he or she was provided under the Plan prior to the qualifying event. If the Qualified Beneficiary was required to be covered for both Core (Health and Prescription Drugs) and Non-Core benefits (dental and vision) under this Plan prior to the qualifying event, he or she may not be required to select between Core Benefits and Non-Core benefits after the Qualifying Event.

MARYLAND CONTINUATION OF COVERAGE

Maryland residents are entitled to an additional benefit under state law, when coverage terminates in certain circumstances, including:

- ► death of the subscriber;
- ► divorce of the subscriber and his or her spouse; and
- ► voluntary or involuntary termination of a subscriber's employment for reasons other than for cause.

Refer to your Kaiser Permanente Evidence of Coverage for details and limitations on this benefit.

CERTIFICATES OF CREDITABLE COVERAGE

If you or your eligible dependents lose health coverage under the Plan, the Fund will issue a Certificate of Creditable Coverage showing how long you were covered under the Plan. Also, you or your eligible dependents may request the Fund to provide you with a Certificate at any time while you are covered under the Plan and within 24 months of losing coverage.

You will receive the Certificate automatically if you or your eligible dependents lose coverage under the Plan or become entitled to COBRA Continuation Coverage. You will also receive a Certificate of Creditable Coverage when your COBRA Continuation Coverage ceases.

The Certificate provides evidence of any prior health coverage under the Plan. You may need to furnish this Certificate if you or your dependents become eligible under a group health plan or insurance policy that excludes certain medical conditions that existed prior to enrollment in a new plan. This Certificate may need to be provided if medical advice, diagnosis, care or treatment was recommended or received for the condition within the 6 month period prior to enrollment in the new plan.

MILITARY SERVICE

Under USERRA, if you leave covered employment to serve in the armed forces of the United States and you meet the other requirements of that Act, you are entitled to elect continuation

coverage for yourself and your dependents. USERRA continuation coverage is governed by the same procedures as are set forth above for COBRA except for the following:

Duration of Coverage

USERRA continuation coverage will be provided for the lesser of (1) 24 months from the date on which your qualified leave for uniformed service begins; or (2) the period beginning on the date your leave for uniformed service begins and ending on the date you fail to apply for reemployment within the time frames provided in USERRA.

Cost of Coverage

If you are absent from work to perform military service for a period of 30 or fewer days, the Plan will provide continuation coverage to you. The amount of employer contributions owed for the first 30 days of qualified military service will be considered an administrative expense of the Welfare Fund, and no individual Employer will be liable to make such contributions. You will be required to pay the applicable Employee share of the monthly premium payment for this 30 day period, however. If your leave is for 31 or more days, the Plan may charge you up to 102% of the full cost of coverage.

Notice and Election of Coverage

You are required by USERRA to give advance notice to your employer that you are leaving for a period of military service, unless giving such notice is impossible or unreasonable or barred by the military. Upon giving such notice to your employer, you should also notify the Fund in writing that you are leaving to perform military service and that you elect to continue your medical coverage. Within 60 days after receipt of that notice, the Fund Office will provide you with specific information regarding the cost of USERRA continuation coverage.

If you do not give advance notice of your leave for military service to your employer, your coverage will be terminated as of the date you leave employment for military service. If your failure to give advance notice of your military service is excused, because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Fund Office will reinstate your health coverage retroactive to the date of departure from employment if you contact the Fund Office to request continuation coverage within 30 days of your departure and return the USERRA Continuation Coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

If you give advance notice of your leave for military service to your employer but fail to notify the Fund Office that you desire to elect continuation coverage, your coverage will be terminated as of the date you leave employment for military service. The Fund Office will reinstate your health coverage retroactive to the date of departure from employment, however, if you contact the Fund Office to request continuation coverage within 30 days of your departure and return the USERRA Continuation Coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

HOSPITAL STAY AFTER CHILDBIRTH

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

MEDICAL BENEFITS

WHAT ARE YOUR OPTIONS?

The Pressmen Welfare Plan offers medical benefits through several expanded health care networks offered through Kaiser Permanente. The Kaiser Plans listed below will include medical, prescription and vision benefits. Schedules A and B, which are attached to this SPD, reflect the Summary of Benefits for each Kaiser Plan. This Summary of Benefits describes briefly each Kaiser Plan available under the Pressmen Welfare Plan. You will also receive separate plan documents from Kaiser describing in more detail the coverage you have chosen and the exclusions from and limitations of coverage for each Kaiser plan.

The Kaiser Permanente HMO Signature Plan

The Kaiser Permanente HMO Signature Plan offers members a wide choice of personal physicians and specialists from Kaiser's Mid-Atlantic Permanente Medical Group and from Baltimore's Affiliated Primary Care Physician Network ("APCPN"). Signature members must choose a primary physician and receive care at any one of the 30 Kaiser medical centers. The primary care physician will coordinate all of the member's health needs, from routine visits to specialist referrals. Members have the flexibility of choosing a different primary care physician for each family member. The Signature Plan offers complete comprehensive medical care. Under the Signature Plan, you will have access to 29 Kaiser medical facilities (30 facilities with the opening of the Baltimore Medical center, expected spring 2013) providing primary care, specialty care, urgent/after hours care and pharmacy services.

The Kaiser Permanente Select Plan

The Kaiser Permanente Select Plan consists of the Kaiser centers available under the Kaiser HMO Signature Plan described above. The Plan also includes access to a comprehensive network of physicians and other providers throughout the Washington and Baltimore areas, including the Johns Hopkins Healthcare System.

The Kaiser Permanente Flexible Choice Plan

The Kaiser Permanente Flexible Choice Plan is a multi-tiered option in which you have access to three options. Option 1 is the Kaiser HMO Signature Plan, which is described above. Option 2 is the "PPO Plan," which provides access, through two networks, to physicians and providers throughout the mid-Atlantic region and nationwide. Option 3 is the "Indemnity," which provides access to any licensed provider in the United States. This option also provides you and your family with total freedom of choice outside the boundaries of any network.

Open Enrollment Period

Please be advised that there will be an Open Season for changing among the various Kaiser options during the period from September 1 through September 30 of each year. Please contact the Fund Office at (410) 872-9500 for the Forms needed to make a change or to obtain a listing of health care providers now offered through network. You can also learn more at Kaiser's web site: www.kaiserpermanente.org.

SUMMARY OF MEDICAL BENEFITS

A Summary of Medical Benefits provided under the Kaiser Permanente HMO Signature Plan, the Kaiser Permanente Select Plan, and the Kaiser Permanente Flexible Choice Plan are set forth in Schedules A and B, which are attached at the end of this SPD. These Summaries not only summarize the categories of covered benefits, they also provide information on applicable copayments, coinsurance and other limitations. **DO NOT RELY ON THESE SUMMARIES ALONE**. Please read the Evidence of Coverage ("EOC"), the Group Policy, or the Certificate of Insurance and Schedule of Coverage, whichever applies to your coverage, to learn what benefits are payable for each specific kind of expense and what the definitions, exclusions, and limitations are. **IF THERE IS ANY CONFLICT BETWEEN THE ATTACHED SCHEDULES AND THE BENEFITS SET FORTH IN THE EOC OR THE GROUP POLICY, THE EOC AND THE GROUP POLICY WILL CONTROL.**

OBTAINING BENEFITS

Simply present your membership card at the time of service and make the required co-payment to the provider. Flexible Choice Multi-Plan PPO providers will submit the claim to Kaiser Permanente on behalf of the member. If you utilize a non-Kaiser provider, and you need to submit an out-of-network claim to Kaiser, you will need to submit a completed Health Insurance Claim Form (HICF) and proof of payment for services rendered to:

Kaiser Permanente Insurance Company
P.O. Box 261130
Plano, Texas 75026

See the Plan's Claims and Appeals Procedures (page 29) for what to do if your claim for benefits is denied in whole or in part.

MEDICAL CARE CONVERSION PRIVILEGE

You may be eligible for conversion coverage if your coverage terminates for any reason other than failure of the insured person to pay a required premium or contribution.

You will not be eligible for conversion coverage if:

- ► You are enrolled in another HMO;
- ► You are covered under a group policy providing benefits substantially similar to the maximum which you could elect under the converted policy;
- ► You have other health benefits available at least equal to the level of benefits that would permit Kaiser to refuse to renew a converted policy under Maryland insurance law;
- ► You are eligible for Medicare; or
- ► Your coverage was terminated for nonpayment of premium.

You must apply for conversion coverage within the later of 31 days from the date your coverage terminates or the date Kaiser notifies you of your conversion rights. During this period, your eligibility for conversion coverage will not be subject to evidence of insurability. Your conversion coverage begins when your coverage under the group policy ends. You will have to pay a premium, and the benefits and co-payments under the non-group coverage may differ from those under the Kaiser plans.

If Kaiser fails to notify you of your conversion option within 30 days of your termination date, then you will have 90 days from such termination date to apply for your conversion coverage.

PRESCRIPTION DRUG BENEFITS

COVERAGE

Active and Retired Employees and their Eligible Dependents covered under the Pressmen Welfare Fund are eligible for prescription drug benefits provided through the three Kaiser Plans: Kaiser Permanente HMO Signature Plan, Kaiser Permanente Select Plan, and Kaiser Permanente Flexible Choice Plan. Both retail and mail order prescription drug benefits are available through the Kaiser Plans. Kaiser Permanente covers drugs, supplies and supplements when prescribed in accordance with its drug formulary guidelines.

A Summary of Prescription Drug Benefits provided under the Kaiser Permanente HMO Signature Plan, the Kaiser Permanente Select Plan, and the Kaiser Permanente Flexible Choice Plan are set forth in Schedules A and B, which are attached at the end of this SPD. These Schedules not only summarize the categories of covered benefits, they also provide information on applicable copayments, coinsurance and other limitations. **DO NOT RELY ON THESE**

SUMMARIES. Please read the Evidence of Coverage ("EOC"), the Group Policy, and/or the Certificate of Insurance and Schedule of Coverage, whichever applies to your coverage, to learn what benefits are payable for each specific kind of expense and what the definitions, exclusions, and limitations are. **IF THERE IS ANY CONFLICT BETWEEN THE ATTACHED SCHEDULES AND THE BENEFITS SET FORTH IN THE EOC OR THE GROUP POLICY, THE EOC AND THE GROUP POLICY WILL CONTROL.**

If you would like information about whether a particular drug, supply or supplement is covered, please access www.kaiserpermanente.org, or call the Member Services Call Center at (301) 468-6000, TDD (301) 879-6380, or 1-800-777-7902.

VISION CARE BENEFITS

COVERAGE

The Pressmen Welfare Fund offers Vision Care Benefits to all Active Employees, Retirees, and their Eligible Dependents through their choice of one of the three Kaiser Plans.

A Summary of Vision Care Benefits provided under the Kaiser Permanente HMO Signature Plan, the Kaiser Permanente Select Plan and the Kaiser Permanente Flexible Choice Plan are set forth in Schedules A and B, which are attached at the end of this SPD. **DO NOT RELY ON THESE CHARTS ALONE**. Please read the Evidence of Coverage ("EOC"), the Group Policy, or the Certificate of Insurance and Schedule of Coverage, whichever applies to your coverage, to learn what benefits are payable for each specific kind of expense and what the definitions, exclusions, and limitations are. **IF THERE IS ANY CONFLICT BETWEEN THE ATTACHED SCHEDULES AND THE BENEFITS SET FORTH IN THE EOC OR THE GROUP POLICY, THE EOC AND THE GROUP POLICY WILL CONTROL.**

DENTAL BENEFITS

ELECTION OF DENTAL BENEFIT OPTION

Employees and their Eligible Dependents (age four (4) and above) covered under the Pressmen Welfare Plan are eligible for dental benefits. Dental benefits are not available to Eligible Dependents under the age of four (4), Retirees, or Retirees' Eligible Dependents.

The Fund provides both HMO and indemnity coverage for dental benefits. **You must elect either HMO or indemnity coverage when you begin participation in the Plan.** The Schedule of Benefits and terms of coverage are different for the HMO and the indemnity option. The description of HMO dental benefits is attached to this SPD as Schedule C; the description of the indemnity benefits is attached as Schedule D. Please review these Schedules and the following description of each type of coverage carefully before making your decision about which dental benefits to choose.

The Plan offers an annual open season period during the month of December in which you may change your dental coverage. If you wish to change your dental coverage from the HMO option

to the indemnity option, or vice-versa, you must send the Fund Office a written request, which must be received by the Fund Office no later than December 31 of each year. Your new coverage will then begin effective January 1 of the following year.

HMO DENTAL BENEFITS (GDS)

The HMO dental benefit is provided through a contract with Group Dental Services of Maryland ("GDS"). You will receive a copy of the GDS Certificate of Coverage which provides a detailed explanation of your benefits under this feature of the Plan, as well as important detailed information on your claims and appeals rights. Once you enroll in GDS, you and your family will be GDS members for the next 12 months. Next year, you may re-enroll for another 12 months.

How to Use GDS

To use GDS, you must call GDS at 301-770-1480 or 800-242-0450 between the hours of 10:00 a.m. to noon and 1.00 p.m. to 4:00 p.m., Monday through Friday, to obtain assistance in choosing a participating dentist convenient to where you live or work. You will need to tell GDS that you are a participant in the Pressmen Welfare Plan and you will need to give GDS your Social Security Number. If you have any questions concerning your eligibility, please call the Fund Office at 410-872-9500. To answer any concerns or questions regarding participating dentists in your area, about GDS, or about the dental plan, please call GDS and speak to a GDS Member Service Representative.

Broken Appointment Fee

As you can appreciate, many participants will need dental services. As available dental time is limited, broken appointments may keep some participants from obtaining treatment. Therefore, any broken appointment will be charged to you at a rate of $10.00 per half-hour unless the GDS provider is notified a day before the appointment time. Unless the broken appointment fee is paid, no further dental work will be done. You should plan to be at the dentist's office at least ten minutes in advance. If you arrive ten minutes late for an appointment, it will be considered a broken appointment and a broken appointment charge will apply.

Your Financial Responsibility

Most services require no out-of-pocket expense. Co-payments, if any, are due at the beginning of treatment. The Schedule of Benefits, with applicable co-payments, is attached to this Summary Plan Description as Schedule D.

Non-Participating Dentists

All services shall be provided through GDS network dentists. A list of participating providers will be provided to you by GDS in a separate document without charge. Services rendered by a non-network dentist are not covered, with one exception. If GDS is unable to retain a dentist in the portion of the metropolitan area in which you live, services rendered to you and/or your

eligible dependents by a non-network dentist will be covered up to the amount GDS would have paid an in-plan dentist.

Specialist's Services

When requiring the service of an oral surgeon, endodontist, periodontist or orthodontist, your primary care dentist must contact GDS for a referral.

Benefits

The HMO dental benefits available to Active Employees and their Eligible Dependents are set forth in Schedule C, which is attached to this Summary Plan Description. Certain services are provided at No Charge when they are provided by a Participating Dentist. Other services require you to pay a copayment. Those services and the amounts of the copayments are set forth in the Schedule. If there is any conflict between the Schedule and the benefits set forth in the Certificate of Coverage provided to you by GDS (as periodically updated), the Certificate of Coverage will control.

If your claim for services has been denied, in whole or in part, you may appeal the denial by following the claims appeals procedures set forth in the GDS Certificate of Coverage and in the Plan's Claims and Appeals Procedures (*see* page 29).

DENTAL INDEMNITY PLAN

General

The Plan also provides an indemnity plan for dental benefits for Active Employees and their Eligible Dependents. The benefits are described in Schedule E, attached to this Summary Plan Description. The indemnity plan is self-funded by the Pressmen Welfare Fund. The Trustees have selected Carday Associates ("Carday" or "Claims Administrator") to be the claims administrator for this benefit. As the claims administrator, Carday processes all claims for benefits and also provides utilization review and pre-authorization services for the Plan. The dental benefits available to you are set forth in Schedule E to this Summary Plan Description.

Obtaining Dental Services and Reimbursement

Under the indemnity plan, you may select a Dentist of your choosing. After services have been rendered, you must submit your invoice directly to Carday. Carday will review the services provided and, subject to the terms of the Plan of Benefits, including all coverage provisions, copayments and deductibles, provide you with direct reimbursement. You must send your invoice to:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

You may also call Carday toll-free at 888-490-8800 if you have any questions.

All claims should be reported promptly. If, through no fault of your own, you are unable to file a claim in a timely manner, the claim will be accepted if filed as soon as possible but not later than 12 months after the date the expense was originally incurred, unless in the case of legal incapacity. Otherwise, late claims will not be covered. Benefits will be paid when the necessary written proof to support the claim is received. You must indicate whether benefits are to be assigned to any other provider of service.

Dental Benefits

The Fund's indemnity dental benefit covers procedures that fall within three separate categories: Preventive Benefits, Basic Benefits and Major Benefits. The specific benefits available to you in each of these categories is set forth in Schedule E, which is attached to this Summary Plan Description. Covered services will be deemed incurred on the date the services are performed except as follows:

- ► Root Canal Therapy: Expenses will be considered incurred on the date the pulp chamber is opened or canals are explored.
- ► Fixed Bridges, Crowns, Inlays or Onlays: Expenses will be considered incurred on the date the teeth are first prepared.
- ► Dentures: Expenses will be considered incurred on the date the final impressions are taken.
- ► Benefits for Temporary Work: Benefits for temporary dental services (including temporary prosthetics) will be considered a part of the final service. Temporary prosthetics means any prosthetic inserted and utilized by a Covered Person for fewer than twelve (12) months. Any prosthetic inserted and utilized by a Covered Person for at least twelve (12) months will be considered permanent in nature.
- ► Orthodontia Services: Orthodontia benefits are payable for Active Employees and Eligible Dependents. Benefits are calculated upon receipt of a treatment plan. The Plan will allow 1/3 of the benefit payable at the time the bands are placed. Benefits will be calculated on a monthly basis for the remainder of treatment up to the lifetime maximum of $1,000.

Maximums

The maximum amount paid by the Fund for all dental expenses incurred by any Covered Person in a Calendar Year, excluding Orthodontia, is $1,000.

The Maximum Lifetime Benefit for any Covered Person for Orthodontic expenses is $1,000.

Deductibles

The Calendar Year Deductible is $0 for Preventive Benefits.

The Calendar Year Deductible per individual is $50 for Basic and Major Benefits combined.

The Calendar Year Deductible per family is $100 for Basic and Major Benefits combined.

Predetermination of Dental Benefits

Whenever the estimated cost of a recommended Dental Treatment Plan exceeds $200, the Dental Treatment Plan must be submitted to Carday for review before treatment begins. Carday will notify you and the Dentist of the benefits payable based upon the Dental Treatment Plan. In determining the amount of benefits payable, consideration will be given to Alternate Dental Treatment that will, as determined by Carday, accomplish a professionally satisfactory result. If you and the Dentist agree to a more costly method of treatment than that determined by Carday, the excess amount will not be paid by the Fund. If a Dental Treatment Plan is not submitted to Carday, the Fund will not pay benefits until a Dental Treatment Plan is received and approved by Carday.

Usual, Reasonable and Customary Charges

Dental expenses are reimbursed according to guidelines Carday considers to be Usual, Reasonable and Customary. Guidelines Carday uses to determine Usual, Reasonable and Customary are:

- The usual fees the hospital, doctor or other medical provider most frequently charges the majority of patients for a similar medical service procedure.

- Fees which fall into the customary range of fees charged in the provider's geographic area by most hospitals. doctors, or other medical providers with similar training and experience for the performance of a similar medical service or procedure.

- Unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular medical service or procedure.

Benefits After Termination of Insurance

Expenses incurred after termination of dental coverage for dentures, Fixed Bridgework, or Crowns will be considered to be expenses incurred when ordered, but only if the item is installed or delivered no later than 30 days after termination of coverage. "Ordered" means, as to a denture, impressions have been taken from which it will be prepared. As to Fixed Bridgework or Crowns, teeth which will service as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions have been taken from which it will be prepared.

Claim Determination Period

The Claim Determination Period is a Calendar Year. However, if a person is not eligible for benefits under this Plan during all of a Calendar Year, the Claim Determination Period for the person for that Year will be the part of the Year during which he or she was eligible for benefits.

LIFE INSURANCE BENEFIT

Life insurance provides you and your family with financial protection in the event of your death. Life Insurance benefits are available only to Active Employees. These benefits are not available to Eligible Dependents or Retirees.

The Policyholder of this life insurance is the Board of Trustees of the Pressmen Welfare Fund. The Policy is underwritten by Mutual of Omaha Insurance Company ("Mutual of Omaha"). The Group Number is # GUG-AKES. Your benefits are governed by the terms of the Policy, not this summary. You may obtain, upon request and free of charge, a copy of the Certificate of Insurance and the Policy from the Fund Administrator.

Life Insurance Benefit

If you die while you are covered by this Group Policy, Mutual of Omaha will pay a Life Insurance Benefit of $37,500.00. Mutual of Omaha will pay this amount when it receives proof of your death.

Living Benefit

If you have been insured under this Plan for at least sixty (60) days, and you are certified as terminally ill, you may receive a Living Benefit instead of a death benefit payment to your beneficiary(ies). In order for this Living Benefit to be paid, you must make a written request and Mutual of Omaha must receive from your designated beneficiary(ies) a signed acknowledgement and agreement to payment of this benefit. In addition, Mutual of Omaha may confirm the terminal diagnosis with a second medical exam performed at Mutual of Omaha's expense.

The Living Benefit will be in an amount equal to 75% of the total benefit applicable to you on the date of certification of the terminal illness. This benefit may be paid in a single lump sum or in installment payments mutually agreed upon by Mutual of Omaha and you. The Living Benefit is payable to you one time only. Your Life Insurance Benefits will be reduced by any benefit paid under the Living Benefit.

Beneficiary

The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with the Plan Administrator and will be effective on the date you sign it. Any payment made by Mutual of Omaha before receiving the designation shall fully discharge the Fund to the extent of that payment. If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each

beneficiary. Otherwise, they will share the benefit equally. The beneficiary's consent is not needed if you wish to change the designation. The beneficiary's consent is also not needed to make any changes in the Policy. If the beneficiary dies at the same time as you, or within 15 days after your death but before Mutual of Omaha receives written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise. If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

(1) your legal spouse;
(2) your surviving children (including legally adopted children), in equal shares;
(3) your surviving parents, in equal shares;
(4) your surviving siblings, in equal shares; or if none of the above,
(5) your estate.

Mutual of Omaha will not be liable for any payment it has made in good faith.

Facility of Payment

If, in Mutual of Omaha's opinion, a beneficiary cannot give a valid release (and no guardian has been appointed), Mutual of Omaha may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000. If you have not named a beneficiary or the named beneficiary is not surviving at your death, Mutual of Omaha may pay up to $2,500.00 of the benefit to the person(s) who, in Mutual of Omaha's opinion, has incurred expenses in connection with your last illness, death or burial. The balance of the benefit, if any, will be held by Mutual of Omaha until an individual or representative is validly named or is appointed to receive the proceeds, and can give a valid release to Mutual of Omaha. The benefit will be held with interest at a rate set by Mutual of Omaha.

Settlement Options

You may elect a different way in which payment of the insurance benefit payment may be made. You must provide a written request to Mutual of Omaha for its approval. If the option covers less than the full amount due, you must advise Mutual of Omaha of what part is to be under an option. Amounts under $2,000.00 or option payments of less than $20.00 each are not eligible. If no instructions for a settlement option are in effect at your death, the beneficiary may make the election, with Mutual of Omaha's consent. The Settlement Options are described in the Policy.

Notice of Claim

To obtain benefits under this Policy, the claimant must file a written claim with Mutual of Omaha within 31 days after the loss occurs, or as soon as reasonably possible. The notice should be sent to Mutual of Omaha at its Administrative Office or to its authorized agent. The notice should include your name and the Policy number.

Claim Forms

Upon receipt of a written notice of claim, Mutual of Omaha will send the claimant a form within 15 days. If the claimant does not receive a claim form from Mutual of Omaha, he may still satisfy the requirements of written proof of loss by sending Mutual of Omaha written proof of the loss describing the occurrence, extent and nature of the loss. The claimant must submit this proof of loss to Mutual of Omaha within 90 days, or as soon as reasonably possible. In any event, proof must be given within one year, unless the claimant is legally incapable of doing so.

Payment of Claims

Payment will be made by Mutual of Omaha as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, will be paid to the beneficiary. Mutual of Omaha shall serve as the claims review fiduciary with respect to the insurance policy and the Plan.

Physical Examinations and Autopsies

Mutual of Omaha has the right, at its own expense, to have you examined as reasonably necessary when a claim is pending. Mutual of Omaha may also direct that an autopsy be performed unless prohibited by law.

Conversion Privilege

If your coverage ends for any reason except non-payment of premiums, you may contact Mutual of Omaha regarding the issuance of a policy of individual life insurance.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT

The Fund's Life Insurance Benefits Policy described above (Group Number # GUG-AKES) also provides an Accidental Death & Dismemberment ("AD&D") Insurance Benefit. AD&D benefits are available only to Active Employees. They are not available to any Eligible Dependents or to Retirees.

The following is a summary of your benefits under this Policy. Your benefits are governed by the terms of the Policy, not this summary. You may obtain, upon request and free of charge, a copy of the Policy from the Fund Administrator.

Amount of Benefits Payable

If you suffer any of the losses listed below, as a result of an injury, Mutual of Omaha will pay the benefit shown below. The loss must be caused solely by an accident that occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident.

Loss of	*Benefit Payable*
Life	$37,500
Both Hands	$37,500
Both Feet	$37,500
The Sight of Both Eyes	$37,500
Speech and Hearing	$37,500
One Hand and One Foot	$37,500
One Hand and Sight of One Eye	$37,500
One Foot and Sight of One Eye	$37,500
One Hand	$18,750
One Foot	$18,750
Speech or Hearing	$18,750
The Sight of One Eye	$18,750
Thumb and Index Finger of Same Hand	$9,375

Exceptions

A benefit will not be payable for a loss that results from an intentionally self-inflicted injury; any act of war, declared or undeclared; or sickness or disease which contributes to the loss (except for infection which results from an accidental cut or wound).

Other Requirements

The provisions of the Life Insurance Benefit describing Beneficiary, Facility of Payment, Settlement Options, Notice of Claim, Claim Forms, Payment of Claims, Physical Examinations and Autopsies, and Conversion Privilege, described above, also apply to the AD&D Benefit.

SHORT-TERM DISABILITY INSURANCE BENEFIT

The group short-term disability insurance described in this Summary Plan Description provides you with short-term financial protection in the event that you become disabled. Short-term disability benefits are available only to Active Employees. They are not available to any Eligible Dependent or to Retirees.

The policyholder of this short-term disability insurance is the Board of Trustees of the Pressman Welfare Fund. The Policy is underwritten by Mutual of Omaha Insurance Company ("Mutual of Omaha"). The Group Number # GUG-AKES. The following is a summary of your benefits under this Policy. Your benefits are governed by the terms of the Policy, not this summary. You may obtain, upon request and free of charge, a copy of the Policy from the Fund Administrator.

Benefits Payable

Weekly Benefits, for one period of disability, will be paid at 66.7% of the employee's Basic Weekly Earnings, as defined below. The weekly amount of the Disability Benefit shall not exceed $250.00. The Maximum Benefit Period shall not exceed 26 weeks. Benefits, for one period of disability due to Injury, will be paid from the first day of Disability. For disability due to Sickness, benefits begin from the eighth consecutive day of Disability or from the first day

you are hospital confined or have surgery on an outpatient basis, if earlier. In order for benefits to be payable from the first day of outpatient surgery, you must be Disabled for eight consecutive days. The weekly benefits available under the Plan terminate upon an Employee's retirement.

Definitions

Injury
"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The injury must cause disability, which begins while you are insured under the Policy.

Sickness
"Sickness" means illness or disease causing disability that begins while you are insured under the Policy. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications arising from any of these.

Disabled or Disability
"Disabled" or "Disability" means you are unable to do the material duties of your job, and are not doing any work for payment, and are under the regular care of a physician.

Basic Weekly Earnings
"Basic Weekly Earnings" means your earnings for the normal work week established by the Board of Trustees of the Pressmen Welfare Fund for your job classification, exclusive of bonus and overtime pay. Changes in amounts of insurance due to a change in your classification shall be effective on the first of the month following the date of the classification change. However, if you are not actively at work on the date the amounts of insurance would otherwise increase, the effective date of any increase will be deferred until the day you return to work.

Period of Disability

Each period of disability starts from the first day benefits are due. It will end when you are no longer disabled or all benefits due have been paid. Two or more disabilities will be deemed the same period of disability if they are from the same or related causes and are not separated by thirty (30) days of active work, or are from a different cause and are not separated by one full day of active work.

Exclusions

A benefit will not be payable for a loss that results from an intentionally self-inflicted injury; an act of war, declared or undeclared; your commission of a felony; sickness which is covered by a Workers' Compensation Act, or other workers' disability law; or injury which occurs out of or in the course of work for wage or profit.

Not in Lieu of Workers' Compensation

This policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Claim Forms and Written Proof of Loss

Upon receipt of notice of a claim, Mutual of Omaha will send you a form to file the proof of loss. If Mutual of Omaha does not send the form within 15 days after it receives notice, then the proof of loss requirements will be met by giving Mutual of Omaha a written statement of the nature and extent of the loss within 90 days after the loss began. If it is not reasonably possible to provide proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within one year unless you are legally incapable of doing so.

Payment of Claims

Upon receipt of written proof of loss, Mutual of Omaha will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as Mutual of Omaha becomes liable. Mutual of Omaha will pay benefits to you, if living, or else to your estate. If you have died and Mutual of Omaha has not paid all benefits due, it may pay up to $1,000 to any relative by blood or marriage, or the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefits. Mutual of Omaha will not be liable for any payment it has made in good faith.

Other Requirements

The provisions of the Life Insurance Benefit describing Notice of Claim and Physical Examinations and Autopsies also apply to the Benefit provided in this section of the Summary Plan Description.

CONTINGENT SHORT-TERM DISABILITY INSURANCE BENEFIT

The Contingent Short-Term Disability Benefit provides you with short-term financial protection in the event that you become disabled due to sickness or injury, and you have been: (1) denied benefits under a Workers Compensation Act or other workers' disability law; and (2) denied Short-Term Disability Insurance benefits by Mutual of Omaha on the ground that (a) your sickness is covered by a Workers Compensation Act or other workers' disability law, or (b) your injury occurred out of or in the course of work for wage or profit.

To be eligible for Contingent Short-Term Disability Benefits, you must establish to the satisfaction of the Fund that you are in the process of exhausting or have exhausted all appeals for benefits under a Workers Compensation Act or other workers' disability law and for Short-Term Disability Insurance Benefits provided by Mutual of Omaha. If you fail to exhaust all appeals, you will not be entitled to Benefits under this Section of the Summary Plan Description. Moreover, all Contingent Short-Term Disability Benefits paid pursuant to this Section of the Summary Plan Description are subject to reimbursement should you succeed in your workers compensation and/or Mutual of Omaha appeal.

Contingent Short-Term Disability Benefits are available only to Active Employees. They are not available to any Eligible Dependent or to Retirees. Your benefits are governed by the terms of this Summary Plan Description.

Benefits Payable

Weekly Benefits, for one period of Disability, will be paid at 66.7% of the Employee's Basic Weekly Earnings, as defined below. The weekly amount of the Disability Benefit shall not exceed $250.00. The Maximum Benefit Period shall not exceed 26 weeks. Benefits, for one period of disability due to Injury, will be paid from the first day of Disability. For Disability due to Sickness, benefits begin from the eighth consecutive day of Disability or from the first day you are hospital confined or have surgery on an outpatient basis, if earlier. In order for benefits to be payable from the first day of outpatient surgery, you must be Disabled for eight consecutive days. The weekly benefits available under the Plan terminate upon an Employee's retirement.

Definitions

<u>Injury</u>
"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The injury must cause Disability, which begins while you are an Active Employee.

<u>Sickness</u>
"Sickness" means illness or disease causing Disability that begins while you are an Active Employee. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

<u>Disabled or Disability</u>
"Disabled" or "Disability" means you are unable to do the material duties of your job, and are not doing any work for payment, and are under the regular care of a physician.

<u>Basic Weekly Earnings</u>
"Basic Weekly Earnings" means your earnings for the normal work week established by the Board of Trustees of the Pressmen Welfare Fund for your job classification, exclusive of bonus and overtime pay. Changes in amounts of insurance due to a change in your classification shall be effective on the first of the month following the date of the classification change. However, if you are not actively at work on the date the amounts of insurance would otherwise increase, the effective date of any increase will be deferred until the day you return to work.

Period of Disability

Each Period of Disability starts from the first day benefits are due. It will end when you are no longer disabled or all benefits due have been paid. Two or more Disabilities will be deemed the same period of Disability if they are from the same or related causes and are not separated by thirty (30) days of active work, or are from a different cause and are not separated by one full day of active work.

Exclusions

A benefit will not be payable for a loss that results from an intentionally self-inflicted injury; an act of war, declared or undeclared; or your commission of a felony. A benefit will not be payable if you have received either of the following benefits for the Sickness or Injury for which you are submitting a claim: (1) benefits payable under a Workers Compensation Act or other workers' disability law; or (2) Short Term Disability Insurance benefits payable by Mutual of Omaha.

Reimbursement

If you receive benefits under a Workers Compensation Act or other workers' disability law and/or under the Mutual of Omaha Short-Term Disability Insurance Benefit policy as the result of your appeal, you are required to notify the Fund Office immediately. Your entitlement to benefits under this Section shall then cease and you will be required to reimburse the Fund for any benefits you receive from workers compensation and/or Mutual of Omaha but only up to the amount of Contingent Short-Term Disability Benefits you have received under this Section of the Plan.

Claim Forms and Written Proof of Loss

You must submit to the Fund Office proof of the nature and extent of the loss within 90 days after the loss began. If it is not reasonably possible to provide proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within one year unless you are legally incapable of doing so.

Payment of Claims

Upon receipt of written proof of loss, the Fund will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as the Fund becomes liable. The Fund will pay benefits to you.

Physical Examinations

The Fund has the right, at its own expense, to have you examined as reasonably necessary to ascertain your eligibility for this Benefit.

CLAIMS AND APPEALS

The procedures for filing a claim for benefits under this Plan differ depending on the type of benefit sought. The procedures for each type of benefit will be processed in accordance with the procedures established by each provider. Should you have any questions about the claims filing procedures, please contact the Fund Administrator.

GRIEVANCE AND APPEALS PROCEDURE FOR MEDICAL, PRESCRIPTION, AND VISION CLAIMS

Kaiser Permanente ("Kaiser") will handle all appeals for all medical, prescription and vision claims. **There will be no second level of appeal to the Trustees**. Kaiser Permanente will decide your appeal in accordance with the procedures set forth in the Kaiser Permanente Evidence of Coverage documents, the text of which is reproduced here.

Definitions

As used in this section, the terms below have the following meanings:

Adverse Decision

A utilization review decision made by Kaiser that: (a) a proposed or delivered Service is or was not medically necessary, appropriate or efficient; and (b) may result in non-coverage of the Health Care Service. An Adverse Decision does not include a decision about your status as a Member under Kaiser.

Appeal

A protest filed in writing by a Member or his or her Authorized representative with Kaiser under its internal appeal process regarding a Coverage Decision concerning a Member. An Appeal does not include a verbal request for reconsideration of a benefit and/or eligibility determination.

Appeal Decision

A final determination by Kaiser that arises from an Appeal filed with Kaiser under its Appeal process regarding a Coverage Decision concerning a Member.

Authorized Representative

An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals or Grievances to Kaiser. A Health Care Provider (as defined below) may act on behalf of a Member with the Member's express consent, or without such consent in an Emergency Case.

Commissioner

The Maryland Insurance Commissioner.

Complaint

A protest filed with the Commissioner of Insurance involving a Coverage Decision or Adverse Decision as described in this section.

Coverage Decision

An initial determination by Kaiser or a representative of Kaiser that results in non-coverage of a Health Care Service. Coverage Decision includes: a determination by Kaiser that an individual is not eligible for coverage under Kaiser's health benefit plan; any determination by Kaiser that results in the rescission of an individual's coverage under a health benefit plan; or nonpayment of all or any part of a claim. A Coverage Decision does not include an Adverse Decision.

Emergency Case

A case in which an Adverse Decision was rendered pertaining to Health Care Services which have yet to be delivered and such Health Care Services are necessary to treat a condition or illness that, without medical attention would: (a) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or (b) cause the Member to be in danger to self or others.

Grievance

A protest filed by a Member or his or her Authorized Representative with Kaiser through Kaiser's internal grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

Grievance Decision

A final determination by Kaiser that arises from a Grievance filed with Kaiser under Kaiser's internal grievance process regarding an Adverse Decision concerning a Member.

Health Education and Advocacy Unit

The Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

Health Care Provider

An individual who is licensed or otherwise authorized in Maryland or another State to provide health care services in the ordinary course of business or practice of a profession and is the treating provider of the Member; or a hospital.

Health Care Service

A health or medical care procedure or service rendered by a Health Care Provider that:

(a) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

(b) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or

(c) provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of human beings.

Urgent Medical Condition

As used in this section, a condition that satisfies either of the following:

(a) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of Kaiser, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

- Placing the Member's life or health in serious jeopardy;
- The inability of the Member to regain maximum function;
- Serious impairment to bodily function;

- Serious dysfunction of any bodily organ or part; or
- The Member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage decision.

Health Care Service Review Program

Pre-Service Reviews

If you do not have an Urgent Medical Condition and you have not received the Health Care Service you are requesting, then within two working days of receiving all necessary information, but no later than 15 calendar days after your request for pre-service review is received, Kaiser will make its determination. Kaiser may extend this time period for an additional 15 calendar days if Kaiser does not have the necessary information to make its decision. Kaiser will notify you or your Authorized Representative of the need for an extension within three calendar days of the initial request and explain in detail what information is required. Necessary information includes, but is not limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required.

Kaiser must receive the information requested by the notice within 45 calendar days from the receipt of the notice identifying the additional necessary information, or Kaiser will make our decision based upon the information Kaiser has available to it at that time. If the authorization procedures are not followed, Kaiser will notify you and/or your Authorized Representative of the failure to follow the procedures within five calendar days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If an admission, procedure or service is preauthorized, Kaiser will: (a) Notify the provider by telephone within one working day of pre-authorization; and (b) Confirm the pre-authorization with you and the provider in writing within five working days of our decision. If pre-authorization is denied, or an alternate treatment or service is recommended, Kaiser will: (a) Notify the provider by telephone within one working day of making the denial or alternate treatment or service recommendation; and (b) Confirm the denial decision with you and your Authorized Representative in writing within five working days of making our decision. You or your Authorized Representative may then file an Appeal or Grievance as appropriate, as described below.

Expedited Pre-Service Reviews

If you have an Urgent Medical Condition and you have not received the Health Care Service for which you are requesting review, then within 24 hours of your request, Kaiser will notify you if

it needs additional information to make a decision, or if you or your Authorized Representative failed to follow proper procedures which would result in a denial decision. If additional information is requested, you will have only 48 hours in which to submit the requested information. Kaiser will make a decision for this type of claim within 48 hours following the earlier of (1) receipt of the information from you; or (2) the end of the period for submitting the requested information. A decision regarding pre-service review if you have an urgent Medical Condition will be communicated to you by telephone within 24 hours. Such decisions will be confirmed in writing within three calendar days of Kaiser's decision.

Concurrent Reviews

When you make a request for additional treatment, when Kaiser had previously approved a course of treatment that is about to end, Kaiser will make concurrent review determinations within one working day of receiving the request or within one working day of obtaining all the necessary information so long as the request for authorization of additional services is made prior to the end of prior authorized services.

In the event that Kaiser's review results in the end or limitation of Health Care Services, Kaiser will make a review determination with sufficient advance notice so that you can file a timely Grievance or Appeal of Kaiser's decision. If you have an Urgent Medical Condition, then a request for concurrent review will be handled like any other pre-service request for review when an Urgent Medical Condition is involved, except that Kaiser's decision will be made within one working day. If Kaiser authorizes an extended stay or additional Health Care Services under the concurrent review, Kaiser will: (a) Notify the provider by telephone within one working day of the authorization; and (b) Confirm the authorization in writing with you or your Authorized Representative within five working days after the telephone notification. The written notification will include the number of extended days or next review date, or the new total number of Health Care Services approved.

If the request for extended stay or additional Health Care Services is denied, Kaiser will: (a) Notify the provider and/or you or your Authorized Representative of the denial by telephone within one working day of making the denial decision; and (b) Confirm the denial in writing with you or your Authorized Representative and/or the provider within five working days after the telephone notification.

Coverage will continue for Health Care Services until you or your Authorized Representative and the provider rendering the Health Care Service have been notified of the denial decision in writing. You or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below. If you filed a request for additional services at least 24 hours before the end of an approved course of treatment, you may continue to receive those services during the time your Appeal or Grievance is under consideration. If your Appeal or Grievance is then denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, Kaiser will decide your request for review within a reasonable period of time appropriate to the circumstances but, in no event, later than 30 calendar days from the date on which the Appeal or Grievance was received.

Filing for Payment/Reimbursement of a Post Service Claim

When you receive an itemized bill from a hospital, physician, or ancillary provider not contracting with Kaiser, please forward that bill directly to Kaiser for processing. Simply indicate the medical record number of the patient on the bill and submit it directly to Kaiser. A request for payment or reimbursement of the cost of covered services received from physicians, hospitals or other health care providers not contracting with Kaiser must be submitted to Kaiser within 6 months, or as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. You must notify Kaiser within the later of 48 hours of any hospital admission or on the first working day following the admission unless it was not reasonably possible to notify Kaiser within that time. Reimbursement for covered Services will be made to the applicable provider of the Services, or if the claim has been paid, to you or in the case of a child, to the parent who incurred the expenses resulting from the claim or the Department of Health and Mental Hygiene.

Post Service Claim Reviews

Kaiser will make its determination on post service review within 30 days of receiving a claim. This time period may be extended one time by Kaiser, for up to 15 calendar days, if Kaiser determines that an extension is necessary because (1) the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary, or (2) the claim is not clean and, therefore, Kaiser needs more information to process such claim. Kaiser will notify you of the extension within the initial 30 day period. Kaiser's notice will explain the circumstances requiring the extension and the date upon which Kaiser expects to render a decision. If such an extension is necessary because Kaiser needs information from you, then Kaiser's notice of extension will specifically describe the required information which you need to submit.

You must respond to requests for additional information within 45 calendar days or Kaiser will make its decision based upon the information it has available to it at that time. Kaiser will send a notice to you or your Authorized Representative explaining that: (a) The claim was paid; or (b) The claim is being denied in whole or in part; or (c) Additional information is needed to determine if all or part of the claim will be reimbursed and what specific information must be submitted; or (d) The claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean. If Kaiser denies payment of the claim, in whole or in part, you or your Authorized Representative may then file an Appeal or Grievance, as appropriate, as described below.

Internal Grievance and Appeal Processes

A Member may file a Grievance or an Appeal on their own behalf or through an Authorized Representative.

The Health Education and Advocacy Unit of the Office of the Attorney General

The Health Education and Advocacy Unit can help you or your Authorized Representative prepare a Grievance or an Appeal to file with Kaiser as follows:

(a) The Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a Grievance or Appeal under the internal grievance and appeals processes. However, the Health Education and Advocacy Unit is not available to represent or accompany you and/or your Authorized Representative during the proceeding of the internal grievance and appeals process;

(b) The Health Education and Advocacy Unit can assist you and/or your Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with Kaiser, but at any time during the mediation, you and/or your Authorized Representative may file a Grievance or Appeal; and

(c) You and/or your Authorized Representative may file a Complaint with the Commissioner without first filing a Grievance or Appeal as explained below under Maryland Insurance Commissioner.

(d) The Health Education and Advocacy Unit may be contacted at:

Office of the Attorney General
Consumer Protection Division
Health Education and Advocacy Unit
200 St. Paul Place
Baltimore MD, 21202
410-528-1840
1-877-261-8807 (toll free out-of-area)
410-576-6571 (facsimile)
www.oag.state.md.us (Web site)
heau@oag.state.md.us (E-mail address)

Maryland Insurance Commissioner

You, your Authorized Representative, or a Health Care Provider must file a Grievance or Appeal with Kaiser and exhaust Kaiser's internal grievance or internal appeals process as described in this section prior to filing a Complaint with the Insurance Commissioner except when:

(a) The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;

(b) You, your Authorized Representative, or a Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust Kaiser's internal process for resolving Grievances (protests regarding Adverse Decisions), such as when a delay in receiving the Health Care Service could result in loss of life, serious impairment to bodily organ or part, or your remaining seriously mentally ill with symptoms that cause you to be in danger to self or others;

(c) Kaiser failed to make a Grievance Decision for a pre-service Grievance within 30 working days after the filing date, or the earlier of 45 working days or 60 calendar days after the filing date for a post-service Grievance;

(d) Kaiser or its representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within 24 hours after you or your Authorized Representative filed the Grievance;

(e) Kaiser has waived the requirement that its internal grievance process must be exhausted before filing a Complaint with the Commissioner;

(f) Kaiser has failed to comply with any of the requirements of the internal grievance process; or

(g) The member, member's Authorized Representative or the health care provider provides sufficient information and documentation in the complaint that demonstrates a compelling reason to do so.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation -- Life and Health/Appeals and Grievances
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260

Internal Grievance Process

This process applies to a utilization review determination made by Kaiser that a proposed or delivered Health Care Service was not medically necessary, appropriate, or efficient thereby resulting in non-coverage of the Health Care Service.

Initiating a Grievance

You or your Authorized Representative may initiate a Grievance by submitting a written request, including all supporting documentation that relates to the Grievance to:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
Fax: 301-816-6192

The Grievance must be filed in writing within 180 calendar days from the date of receipt of the Adverse Decision notice. If the Grievance is filed after the 180 calendar days, Kaiser will send a letter denying any further review due to lack of timely filing.

If within five working days after you or your Authorized Representative file a Grievance Kaiser needs additional information to complete its internal Grievance process, Kaiser shall notify you or your Authorized Representative that it cannot proceed with review of the Grievance unless it receives the additional information. If assistance is needed and requested, Kaiser will assist you or your Authorized Representative in gathering the necessary additional information without further delay.

Grievance Acknowledgment

Kaiser will acknowledge receipt of a Grievance within five working days of the filing date of the written Grievance notice. The filing date is the earliest of five calendar days after the date of mailing (postmark) or the date of receipt.

Pre-service Grievance

If the Grievance is for a Health Care Service that the Member is requesting (that is, the Health Care Service has not been rendered), an acknowledgment letter will be sent requesting any additional information that may be necessary within five working days after the filing date. Kaiser will also inform you and your Authorized Representative that a decision will be made regarding the Grievance in writing, and such written notice will be sent within 30 working days of the filing date of the Grievance.

Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgment letter will be sent requesting additional information that may be necessary within five working days after the filing date. Kaiser will also inform you and your Authorized Representative that a decision will be made in writing and such written notice will be made within the earliest of 45 working days or 60 calendar days of the filing date of the Grievance.

For both pre-service and post-service Grievances, if there will be a delay in our concluding the Grievance in the designated period, Kaiser will send you and your Authorized Representative a letter requesting an extension. Such extension period shall not exceed more than 30 working days. If you or your Authorized Representative does not agree to the extension, then the Grievance will be completed in the original designated period. Any agreement to extend the period for a Grievance decision will be documented in writing. If the pre-service or post-service Grievance is approved, a letter will be sent to you and your Authorized Representative stating the approval. If the Grievance was filed by your Authorized Representative, then a letter stating the Grievance Decision will also be sent to you.

If the pre-service or post-service Grievance results in a denial, Kaiser will notify you and your Authorized Representative of the decision within 30 working days or no later than the last day of the extension period for a pre-service Grievance or the earlier of 45 working days or 60 calendar days from the date of filing or no later than the last day of the extension period for a post-service Grievance. Kaiser will communicate our decision to you or your Authorized Representative

verbally and will send a written notice of such verbal communication within five working days of the verbal communication to you and your Authorized Representative.

If Kaiser fails to make a Grievance Decision within the stated timeframes herein, or an extension of such timeframe, you or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from Kaiser. Note: In cases which a complaint against Kaiser's grievance decision is filed with the Commissioner, you or your Authorized Representative must authorize the release of medical records that may be required to assist the Commissioner with reaching a decision in the Complaint.

Expedited Grievances for Emergency Cases

You or your Authorized Representative may seek an expedited review in the event of an Emergency Case as that term is defined in this section. An expedited review of an Emergency Case may be initiated by calling Member Services at (301) 468-6000 during business hours (M-F, 7:30 a.m.-5:30 p.m.), or by calling an advice nurse after hours at (703) 359-7878. Once expedited review is initiated, clinical review will determine if you have a medical condition which meets the definition of an Emergency Case. A request for expedited review must contain the telephone number where Kaiser may reach you or your Authorized Representative in an effort to communicate regarding its review. In the event that additional information is necessary for Kaiser to make a determination regarding the expedited review, Kaiser will notify you or your Authorized Representative by telephone to inform him/her that review of the expedited review may not proceed unless certain additional information is received. Upon request, Kaiser will assist you or your Authorized Representative in gathering such information so that a determination may be made within the prescribed timeframes.

If the clinical review determines that you do not have the requisite medical condition, the request will be managed as a non-expedited Grievance pursuant to the procedure outlined above. If Kaiser determines that an urgent medical condition does not exist, Kaiser will verbally notify you or your Authorized Representative within 24 hours, and inform you or the Authorized Representative of the right to file a Complaint with the Commissioner. If Kaiser determines that an Emergency Case does exist, then the expedited review request will be reviewed by a physician who is board certified or eligible in the same specialty as the treatment under review and who is not the individual (or the individual's subordinate) who made the initial decision. If additional information is needed to proceed with the review, Kaiser will contact you or your Authorized Representative by telephone or facsimile.

Within 24 hours of the filing date of the expedited review request, Kaiser will verbally notify you or your Authorized Person of its decision. Kaiser will send written notification to you or your Authorized Representative within one calendar day after the decision is verbally communicated. If approval is recommended, then Kaiser will assist you in arranging the authorized treatment or benefit. If the expedited review results in a denial, Kaiser will notify you and your Authorized Representative within one calendar day after the decision is verbally communicated.

If Kaiser fails to make a decision within the stated timeframes for an expedited review, you or your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from Kaiser.

Notice of Adverse Grievance Decision

If Kaiser's review of a Grievance, including an expedited Grievance, results in denial, Kaiser will send you and your Authorized Representative written notice of its Grievance Decision within the time frame stated above. This notification shall include:

(a) the specific factual basis for the decision in clear understandable language;

(b) references to any specific criteria or standards on which the decision was based, including but not limited to interpretive guidelines used by Kaiser;

(c) a statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;

(d) the name, business address, and business telephone number of the medical director who made the Grievance Decision;

(e) a description of your or your Authorized Representative's right to file a complaint with the Commissioner within 4 months after receipt of the Grievance Decision;

(f) the Commissioner's address, telephone number and facsimile number;

(g) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Kaiser with the Commissioner;

(h) the Health Education and Advocacy Unit's address, telephone number, facsimile number, and electronic mail address; and

(i) Kaiser must provide notice of an adverse decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If Kaiser sends you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

Internal Appeal Process

This process applies to Kaiser's Coverage Decisions. You must exhaust Kaiser's internal Appeal process prior to filing a Complaint with the Commissioner, except if the Coverage Decision involves an Urgent Medical Condition for which care has not been rendered.

Initiating an Appeal

These internal appeal procedures are designed by Kaiser to assure that concerns are fairly and properly heard and resolved. These procedures apply to a request for reconsideration of a Coverage Decision rendered by Kaiser regarding any aspect of Kaiser's health care service. The Member or the Member's Authorized Representative must file an internal appeal within 180 calendar days from the date of receipt of the Coverage Decision. The Appeal should be sent to Kaiser at the following address:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
Fax: 301-816-6192

In addition, the Member or the Member's Authorized Representative may request an internal appeal by contacting the Member Services Department. The Member or the Member's Authorized Representative, as applicable, may review Kaiser's appeal file and provide evidence and testimony to support the appeal request. Member Service Representatives are available by telephone each day during business hours to describe how internal appeals are processed and resolved and to assist with filing an internal appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 AM to 5:30 PM at 301-468-6000, if calling within the local area, or 301-816-6344 TTY (Telephonic Device for the Deaf).

Along with your appeal you may also send additional information including comments, documents or additional medical records which you believe supports your claim. If Kaiser had asked for additional information before and you did not provide it, you may still submit the additional information with your appeal. In addition, you may also provide testimony in writing or by telephone. Written testimony may be sent along with your appeal to the address listed above. To arrange to give testimony by telephone, you may contact the Member Services Appeal Unit. Kaiser will add all additional information to your claim file and will revise all new information without regard to whether this information was submitted and/or considered in its initial decision.

In addition, prior to rendering its final decision, Kaiser will provide the Member or Member's Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) Kaiser in connection with the Member or Member's Authorized Representative appeal. If during Kaiser's review of the Member or Member's Authorized Representative appeal, it determines that an adverse coverage decision can be made based on a new or additional rationale, Kaiser will provide the Member or Member's

Authorized Representative with this new information prior to issuing its final coverage decision and explain how you can respond to the information if you choose to do so. The additional information will be provided to the Member or Member's Authorized Representative as soon as possible and sufficiently before the deadline to give the Member or Member's Authorized Representative a reasonable opportunity to respond to the new information.

Kaiser will respond in writing to an Appeal within 30 calendar days for a pre-service claim, or 60 calendar days for a post-service claim after our receipt of the Appeal. If our review results in a denial, Kaiser will notify you and your Authorized Representative in writing within three calendar days after the Appeal Decision has been verbally communicated. This notification will include:

(a) the specific factual basis for the decision in clear understandable language;

(b) reference to the specific plan provision on which determination was based. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim;

(c) a description of you or your Authorized Representative's right to file a Complaint with the Commissioner within 4 months after receipt of our Appeals Decision;

(d) the Commissioner's address, telephone number and facsimile number;

(e) a statement that the Health Education and Advocacy Unit is available to assist you or your Authorized Representative with filing a complaint about the Kaiser with the Commissioner;

(f) the Health Education and Advocacy Unit's address, telephone number, facsimile number, and electronic mail address; and

(g) Kaiser must provide notice of an appeal decision in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language. A threshold language applies to a county if at least 10% of the population is literate only in the same foreign language that is identified as a federally mandated non-English language. If Kaiser sends **y**ou a notice of an appeal decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

Filing Complaints About Kaiser

If you have any complaints about the operation of Kaiser or your care, you or your Authorized Representative may file a complaint with:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation -- Life and Health
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Telephone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260

APPEALS PROCEDURE FOR HMO DENTAL CLAIMS (GDS)

If you wish to appeal an ***HMO Dental Claim***, your appeal must be sent directly to GDS at the address found on page 57 of this Summary Plan Description. GDS will decide your appeal in accordance with the procedures set forth in this Summary Plan Description. GDS will notify you of its decision on a Post-Service Claim appeal of a HMO Dental Claim within a reasonable period of time, but not later than 60 days after it receives your request for review. If GDS denies your first level of appeal, you may request the Fund's Board of Trustees to review the GDS denial. An appeal to the Trustees is optional, and the Fund will not assert that you have failed to exhaust administrative remedies if you choose not to submit your denied appeal to the Trustees for review. The Fund also agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal to the Trustees is pending. You will not be charged any fees or costs as part of this optional appeal, and the above rules for deciding appeals will continue to apply. If you choose to submit an appeal to the Trustees, send your appeal to the Pressmen Welfare Fund Board of Trustees, c/o Carday Associates, Inc., under the rules in the following section entitled "*Other Group Health Care Claims*."

APPEALS FOR ELIGIBILITY DETERMINATIONS AND DENTAL INDEMNITY CLAIMS

This section does not apply to those claims and appeals that are within the discretion and authority of Kaiser Permanente, but does apply to determinations about whether you or a dependent are eligible to participate in the Plan.

To file a an appeal concerning the dental indemnity plan or a determination of whether you or a dependent are eligible to participate in the Plan, you must follow all of the procedures set forth in this Plan document. The definitions and procedures set forth in this section also apply.

General

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves "Urgent Care," is a "Pre-Service Claim," or is a "Post-Service Claim."

An "Urgent Care Claim" is a claim which (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of your medical condition would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a physician with knowledge of your medical condition determines that your claim is one involving urgent care, your claim will be treated as an Urgent Care Claim.

A "Pre-Service Claim" is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

A "Post-Service Claim" is any claim for a benefit that is not a Pre-service Claim. In this type of claim, you request reimbursement after medical care has already been rendered.

A "Concurrent Care Claim" is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A Concurrent Care Claim can be either an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

A claim will be deemed an "Incomplete Claim" if you do not provide enough information for the Plan to determine whether and to what extent your claim is covered by the Plan. This includes your failure to communicate to a person who ordinarily handles benefit matters for the Fund your name, your specific medical conditions or symptom, and the specific treatment or service for which you request payment of benefits.

You may designate a representative to act on your behalf in filing a claim or an appeal of a denial of a claim or other adverse determination. If the Fund Office, Trustees, or entity acting on behalf of the Fund, are uncertain whether or not you have designated a representative, they may request that you put such designation in writing and may decline to communicate with a third party claiming to be a representative until such written designation is received.

All determinations of initial claims and of appeals will be made in accordance with the Plan document, policies and rules. Plan provisions will be applied consistently, to the extent reasonable, with respect to similarly situated claimants.

Notification of Initial Benefit Determination

For *Urgent Care Claims*, the Fund Office, or applicable group health care provider, will notify you whether your claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim, unless your claim is incomplete. The Fund Office, or applicable group health care provider, will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. You may be notified orally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund Office, or applicable group health care provider, will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information, or the end of the period within which you must provide the information.

For *Pre-Service Claims*, the Fund Office, or applicable group health care provider, will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Fund Office, or applicable group health care provider, require that additional time is needed to process your claim. If an extension is needed, the Fund Office, or applicable group health care provider, will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund

Office, or applicable group health care provider, expects to reach a decision. If an extension is needed because you have submitted an incomplete claim, you will be notified within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Fund Office, or applicable group health care provider, may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Fund Office, or applicable group health care provider, to decide a claim, the period for making the benefit determination shall be tolled from the date on which you are sent notification of the extension until the date you respond to the request for additional information.

For *Post-Service Claims*, the Fund Office, or applicable group health care provider, will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Fund Office, or applicable group health care provider, require that additional time is needed to process your claim. If an extension is needed, you will be notified prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which the Fund Office, or applicable group health care provider, expects to reach a decision. If an extension is needed because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which you are sent notification of the extension until the date you respond to the request for additional information.

If the Fund or applicable group health care provider has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund or applicable group health care provider will notify you of its determination within 24 hours after receiving your claim, provided that your claim is received at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a Pre-Service or Post-Service Claim.

Denial of Claim for Benefits

If any claim for benefits described above is denied, in whole or in part, the Fund Office, or applicable group health care provider, will provide you with a written or electronic notice stating the reasons for the denial, referring to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describing any additional material or information that might help your claim, explaining why that information is necessary, and describing the Plan's review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination is based on a medical necessity or

experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning an Urgent Care Claim, the notice will also describe the shortened time frames for reviewing Urgent Care Claims. In addition, in the case of an Urgent Care Claim the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

Appeals

If your claim for eligibility or treatment under the dental indemnity plan is denied, in whole or in part, you may request a review of your benefit denial. Your written appeal must be submitted within 180 days of receiving the denial notice. (*See* below for instructions on submitting an appeal.) If the Fund, or applicable group health care provider, has approved an ongoing course of treatment to be provided over a period of time or number of treatments, it will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit decision will be final and binding.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding an adverse claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees, or applicable group health provider, can best consider your position if they clearly understand your claims, reasons and/or objections. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund Office, or applicable group health provider, did not have this information in making the initial determination.

If you wish to appeal any eligibility determination or dental indemnity claim over which the Board of Trustees had full discretion and authority in denying, your appeal must be sent directly to the Pressmen Welfare Fund Board of Trustees at:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

The review on appeal shall be made by one or more individuals, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The decision on appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who

has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained in connection with the adverse determination will be identified upon request.

In case of an Urgent Care Claim, you may request review orally or in writing, and communications between you and the Fund or applicable group health care provider may be made by telephone, facsimile, or other similar means.

The Trustees, or applicable group health care provider, will notify you of their decision on an Urgent Care Claim appeal as soon as possible, but not later than 72 hours after they receive your request for review. The Trustees, or applicable group health care provider, will notify you of their decision on a Pre-service Claim appeal within a reasonable period of time, but not later than 30 days after they receive your request for review.

The Fund will notify you of its decision on any appeal of an eligibility or dental indemnity claim over which it had discretion and authority in denying within 5 days after the Trustees review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review by the Trustees, a decision will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing, prior to the extension, of the circumstances requiring an extension and the date by which the Trustees expect to reach a decision. These time frames apply only to appeals decided by the Trustees. They do not apply to appeals decided by GDS or Kaiser Permanente.

The Fund or applicable group health care provider will provide you with written or electronic notice of the decision upon appeal. The notice will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Decision on Appeal is Final and Binding

The decision on review shall be final and binding upon all parties including any person claiming a benefit on your behalf. The Trustees, and any applicable group health care provider, have full discretion or authority to determine all matters relating to the benefits provided under this Plan (except for such matters within the full discretion and authority of the applicable group health care provider) including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If your appeal of a claim is denied, and you decide to seek judicial review, the decision on your appeal shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

SHORT-TERM DISABILITY CLAIMS

To file a claim for short-term disability benefits, you must follow all of the procedures set forth in the Plan. Mutual of Omaha will handle all benefits claims and all appeals, according to the following procedures.

Mutual of Omaha will decide claims for short-term disability benefits within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45 day period may be extended for up to two additional 30 day periods for circumstances beyond the control of Mutual of Omaha if Mutual of Omaha notifies you of the extensions prior to the expirations of the initial 45 day and first 30 day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for Mutual of Omaha to decide a claim, the period for making the benefit determination shall be tolled from the date on which Mutual of Omaha sends you the notification of the extension until the date you respond to the request for additional information.

If your application for benefits is denied, in whole or in part, Mutual of Omaha will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

If your claim is denied, you may request Mutual of Omaha to review your benefit denial by submitting a written appeal within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit determination will be final and binding.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding an adverse claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include written comments and documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if Mutual of Omaha did not have this information in making the initial determination.

The review on appeal shall be conducted by an individual who is neither the individual who decided the initial claim for benefits nor a subordinate of such individual. The decision on appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. Any medical or vocational expert(s) whose advice was obtained in connection with the adverse determination will be identified.

You will receive notice of the benefit determination on review within a reasonable time but not later than 45 days from the date your request for review is received. The initial 45 day period may be extended for up to 45 days for special circumstances. Mutual of Omaha will notify you of an extension prior to the expiration of the initial 45 day period. Any notice of extension will indicate the circumstances requiring an extension and the date by which a decision is expected to be reached. If you fail to submit information necessary for Mutual of Omaha to decide a claim, the period for making the benefit determination shall be tolled from the date on which Mutual of Omaha sends you the notification of the extension until the date you respond to the request for additional information.

Notice of an adverse benefit determination on review will set forth the specific reason(s) for the adverse determination, the specific plan/policy provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination and a statement of your right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. The decision on review shall be final and binding upon all parties including any person claiming a benefit on your behalf.

Mutual of Omaha has full discretion or authority to determine all matters relating to short-term disability benefits provided under this Plan. If your appeal of a claim is denied, and you decide

to seek judicial review, the decision on appeal shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

CONTINGENT SHORT-TERM DISABILITY BENEFIT CLAIMS

To file a claim for Contingent Short-Term Disability Benefits, you must follow all of the procedures set forth in the Plan. The Fund Office will handle all benefits claims and all appeals, according to the following procedures.

The Fund Office will decide claims for Contingent Short-Term Disability Benefits within a reasonable time but not later than 45 days from the date of the receipt of the claim. The initial 45 day period may be extended for up to two additional 30 day periods for circumstances beyond the control of the Fund if the Fund notifies you of the extensions prior to the expirations of the initial 45 day and first 30 day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. You have 45 days after receiving the extension notice to provide additional information or complete a claim. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Fund sends you the notification of the extension until the date you respond to the request for additional information.

If your application for benefits is denied, in whole or in part, the Fund will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

If your claim is denied, you may request the Board of Trustees to review your benefit denial by submitting a written appeal to the Trustees within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit determination will be final and binding. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding an adverse claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include written comments and documents that support your claim. The review of your claim will take into account all

comments and documents that support your position, even if the Fund did not have this information in making the initial determination.

The review on appeal shall be conducted by an individual who is neither the individual who decided the initial claim for benefits nor a subordinate of such individual. The decision on appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. Any medical or vocational expert(s) whose advice was obtained in connection with the adverse determination will be identified.

You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision. This notice will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based and a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination. The notice will advise you of your right to bring a civil action under 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request.

The Trustees have full discretion or authority to determine all matters relating to Contingent Short-Term Disability Benefits provided under this Plan. The decision on review shall be final and binding upon all parties including any person claiming a benefit on your behalf. If your appeal of a claim is denied, and you decide to seek judicial review, the decision on appeal shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CLAIMS

To file a claim for life and accidental death and dismemberment benefits, you must follow all of the procedures set forth in the Plan. Mutual of Omaha will handle claims and appeals for these benefits according to the following procedures.

If your claim for benefits is denied, in whole or in part, you will receive a written notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA.

This notice will be given to you within a reasonable time but not more than 90 days after the date of receipt of your claim. This 90-day period may be extended for up to an additional 90 days if

special circumstances require that additional time is needed to process your claim. If an extension is needed, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which a decision is expected to be reached. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

If your claim is denied, you may request Mutual of Omaha to review your benefit denial by submitting a written appeal. Your written appeal must be submitted within 60 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit decision will be final and binding. Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include written comments and documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if Mutual of Omaha did not have this information in making the initial determination.

Mutual of Omaha will notify you of its decision on appeal within a reasonable period of time, but not later than 60 days after receipt of your request for review, unless special circumstances require an extension of time to process your claim. If an extension is needed, you will be notified, prior to the expiration of the initial 60-day period, of the circumstances requiring an extension and the date by which a decision is expected to be reached. Such an extension will not exceed 60 days.

Notice of an adverse benefit determination on review will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under 502(a) of ERISA. The decision on review shall be final and binding upon all parties including the claimant and any person claiming a benefit on behalf of the claimant.

Mutual of Omaha has full discretion or authority to determine all matters relating to the life and accidental death and dismemberment benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If Mutual of Omaha denies your appeal of a claim, and you decide to seek judicial review, Mutual of Omaha's decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

FUND POLICIES, DETERMINATIONS, OR ACTIONS

If you disagree with a policy, determination, or action of the Fund, you may request the Trustees to review the Fund policy, determination or action with which you disagree by submitting a written appeal to the Trustees. Your written appeal must be submitted within 60 days after you

learn of a Fund policy, determination or action with which you disagree and which is not a benefits denial.

Your written appeal should state the reasons for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Fund policy, determination, or action. The Trustees can best consider your position if they understand your claims, reasons, and/or objections.

The Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review for the Trustees, you will be notified in writing.

The Trustees have full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits.

If the Trustees deny your appeal of a challenged policy, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

SUBROGATION AND REIMBURSEMENT

If you or one of your Eligible Dependents is involved in an accident or sustain an illness or injury for which a third party might be liable to you for medical expenses normally covered by the Fund, then, in order to receive benefit payments from the Fund for such an illness or injury, you must subrogate (assign) your right of recovery from the third party. Under the terms of the Plan, the acceptance of benefits by you (or an Eligible Dependent), or someone acting on your behalf, constitutes an agreement by you (or your Eligible Dependent) to reimburse the Fund for benefits paid up to the full amount of the recovery due to the injury. The Fund has a right to first reimbursement out of any recovery whether or not the amounts recovered are designated to cover medical expenses. By accepting benefits from the Fund, you (or your Eligible Dependent) agree that any amounts recovered by you (or your Eligible Dependent) by judgment, settlement or compromise will be applied first to reimburse the Fund even if you (or your Eligible Dependent) do not recover all of your losses or are not made whole. Amounts recovered by you (or your Eligible Dependent) in excess of benefits paid by the Fund are the separate property of you (or your Eligible Dependent).

An example of this would be if you were injured in an automobile accident which was the other driver's fault. If the Fund paid $5,000 in benefits to you or on your behalf due to the injuries resulting from the accident, and you recovered any money from the other driver (either from a

lawsuit, insurance company or settlement), the Fund would be entitled to receive up to $5,000 of that money as reimbursement for the benefits which it provided to you.

You must notify the Plan in writing as soon as you (or your injured Eligible Dependent) institutes a claim against another person or entity. The Fund Office will require you (or your injured Eligible Dependent) to sign a Reimbursement/Subrogation acknowledgement form before any benefits are paid. If you, your Eligible Dependent, if applicable, or your attorney refuse to sign a Reimbursement/Subrogation acknowledgment form, the Plan may withhold payment of any benefits payable as a result of your injuries and may recoup by offset or lawsuit any amount already paid. In any event, the Fund's reimbursement right and subrogation interest is established and governed by the Plan and not by the acknowledgement form.

You (or your Eligible Dependent) must also agree to notify the Fund promptly of efforts made to recover from a third party including filing a suit to recover amounts in connection with the injury. Furthermore, in the event you (or your Eligible Dependent), or someone acting on your behalf, receives payments from any source for claims related to the injury, you must notify the Fund promptly. By accepting benefits from the Fund, you (and your Eligible Dependent) agree that neither you (nor your Eligible Dependent), or anyone acting on behalf of you (or your Eligible Dependent), will settle any claim relating to the accident without the written consent of the Fund. Any amounts recovered from claims arising from the injury are assets of the Fund by virtue of the Fund's subrogation interest. Such Fund assets may not be distributed without a release from the Fund of its subrogation interest. In the event monies are recovered and the Fund is not reimbursed to the extent of its subrogation interest in accordance with Plan provisions, the Fund may bring suit against you (and/or your Eligible Dependent), insurers and any recipients of the Fund assets improperly distributed without the consent of the Fund. If it becomes necessary for the Fund to institute legal action against you for failure to reimburse it, in full, or to honor its equitable interest in the amount recovered by you from a third party, you will be liable for all costs of collection, including attorneys' fees. The Fund may recover benefits paid on behalf of the injured person by treating such benefits as an advance and deducting such amounts from benefits which become due to the injured person and his or her immediate family until the Fund's subrogation interest is recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have provided to such providers.

FRAUDULENT CLAIMS

If a fraudulent claim is knowingly submitted, all benefits will be denied. The Trustees consider the knowing submission of a claim for benefits by or on behalf of an individual who is not eligible for benefits under the Pressmen Welfare Plan to be a fraudulent claim. Thus, if you and your Spouse divorce, any claim submitted by or on behalf of your former Spouse will be deemed a fraudulent claim. Likewise, if your child reaches the age when he or she is no longer eligible for coverage under this Plan and you knowingly fail to advise the Fund Office in writing of this change in status, any claim submitted by or on behalf of your child will be deemed a fraudulent claim. It is thus imperative that you contact the Fund Office in writing as required above (*see Change in Family Status* at page 4) if there is a change in your family status. If any benefits are paid on any fraudulent claim, you and your Eligible Dependents may be denied all further

benefits from the Fund until restitution of the money improperly obtained (whether by offset or otherwise) is made to the Fund.

COORDINATION OF BENEFITS

If you or your family members are eligible to receive benefits under another Group Plan, benefits from this Plan will be coordinated with the benefits from any of your other Group Plans so that up to 100% of the "allowable expenses" incurred during a calendar year will be paid by the plans. An "allowable expense" is any Usual, Reasonable and Customary item of expense covered in full or in part under any one of the Group Plans involved. A "Group Plan" is considered to be any Group insurance coverage or other arrangement of coverage for individuals in a group which provides medical or dental care benefits or services on an insured or an uninsured basis.

The Board of Trustees of the Fund reserves the right to obtain and exchange benefit information from any other insurance company, organization or individual to determine the applicability of the Coordination of Benefits provisions. When an overpayment has been made, the Board of Trustees of the Fund has the right to recover the excess payment from the individual, insurance company or organizations to whom payment has been made.

COMPLIANCE WITH PRIVACY STANDARDS

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected Health Information ("PHI") will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law.

You may authorize the disclosure of your PHI to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Plan by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Plan has provided participants with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of PHI or your rights with regard to this information, you may request a copy of the Notice from the Fund Office.

You will also receive separate Privacy Notices and forms from Kaiser Permanente and from GDS relating to uses and disclosures of PHI with respect to each of those entities. If you have any questions about those Notices or forms, you may contact Kaiser Permanente or GDS, as applicable, or you may call the Fund Office.

PLAN INFORMATION
REQUIRED BY ERISA

BASIC PLAN INFORMATION

1. TYPE OF PLAN

This Plan is a group health plan that provides coverage for hospitalization, physician's care, disability income, life insurance benefits, dental care, vision care, and prescription benefits to eligible participants and their qualified dependents.

2. PLAN IDENTIFICATION NUMBER

Employer Identification Number: 23-7092745
IRS Plan Number: 001

3. PLAN ADMINISTRATOR

Board of Trustees
Pressmen Welfare Fund
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Union Trustees
Paul Atwill
c/o Pressmen Local 72
6037 Baltimore Avenue
Riverdale, Maryland 20737

Dennis Larkin
c/o Pressmen Local 72
6037 Baltimore Avenue
Riverdale, Maryland 20737

Janice Bort
c/o Pressmen Local 72
6037 Baltimore Avenue
Riverdale, Maryland 20737

Tim Dillon
c/o Pressmen Local 72
6037 Baltimore Avenue
Riverdale, Maryland 20737

Employer Trustees

Beth Swanson
Acme Printing Company
7 Aquarius Court
Silver Spring, Maryland 20906

Michele Cirrincione
Editors Press, Inc.
c/o The Kelly Companies
1701 Cabin Branch Drive
Cheverly, Maryland 20782

Eric Vaaler
ARIVA
350 Prince George's Boulevard
Upper Marlboro, MD 20774

Steve Bearden
Linemark Printing, Inc.
501 Prince Georges Boulevard
Upper Marlboro, MD 20774
(301) 925-9000 (W)
(301) 925-8943 (F)
sbearden@linemark.com

The Trustees have the authority to contract and manage the operation and administration of the Plan.

4. SERVICE OF LEGAL PROCESS

Service of legal process may be made upon Carday Associates, Inc. or upon any Trustee.

5. TYPE OF ADMINISTRATION OF THE FUND

The Plan is administered by the Board of Trustees. Kaiser Permanente administers the Fund's group hospitalization, medical, prescription drug, and vision benefits through Kaiser facilities and several expanded health care networks.

The HMO dental benefits are provided on an insured basis through an agreement with Group Dental Services of Maryland, Inc. The life insurance, accidental death and dismemberment, and short-term disability benefits are provided through an insurance agreement with Mutual of Omaha.

The non-HMO dental benefits, and the Contingent Short Term Disability Insurance Benefit, are provided by the Fund on a self-funded basis. Carday Associates, Inc. administers the claims for these benefits.

The names and addresses of the claims administrators and insurers are as follows:

Group Hospital, Medical, Vision, and Prescription Drug Benefits Claims Administration
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD
(301) 468-6000 (during business hours M-F 7:30 a.m. to 5:30 p.m.)
(703) 359-7878 (after business hours advice nurse)
1-800-777-7902 (outside of the Washington DC Metropolitan Area)

Non-HMO Dental Benefits Claims Administration
Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Dental HMO Services
Group Dental Services of Maryland, Inc.
11400 Rockville Pike
Suite 500
Rockville, Maryland 20852

Life Insurance, Accidental Death and Dismemberment, and Short-Term Disability Benefits
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175

Contingent Short-Term Disability Insurance Benefit
Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

A complete list of participating providers, for Medical, Vision, and Prescription Drug Benefits, in the Kaiser Permanente Select and Flexible Choice Plans are available and provided at no charge through Kaiser Permanente. A complete list of participating providers for the HMO Dental Benefits are available at no charge through GDS.

6. LABOR ORGANIZATIONS REPRESENTING PARTICIPANTS IN PLAN

This Plan is maintained by collective bargaining agreements. A copy of any such agreement may be obtained upon written request to the Fund Office. Also, collective bargaining agreements are available for examination by a Participant at the Fund Office. A complete list of Employers and Unions participating in the Fund may be obtained upon written request to the Fund Office. You may also receive from the Fund Office, upon written request,

information as to whether a particular Employer or Union is a sponsor of the Fund and if the Employer or Union is a Plan Sponsor, the address of such Employer or Union.

7. SOURCE OF CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are made by individual Employers pursuant to a collective bargaining agreement with Pressmen Local 72. Employee and other contributions are also made pursuant to written agreements approved by the Trustees of the Fund.

8. DATE OF THE END OF THE PLAN YEAR

The Plan Year ends on December 31 of each year.

9. MODIFICATION OF BENEFIT SCHEDULES, OR TERMINATION OF BENEFIT, OR TERMINATION OF THE FUND

The Board of Trustees has complete discretion, subject to the Trust Agreement and applicable law, to terminate, suspend, withdraw, amend or modify Plan benefits in whole or in part at any time. Within this broad grant of discretion, the Trustees have (among other rights) the right to reduce, eliminate, improve or modify benefits. They may do so for some or all categories of participants (Active Employees, Retirees, and Eligible Dependents). They may also modify the eligibility requirements for coverage.

The Pressmen Welfare Fund may be terminated by a document in writing adopted by a majority of the Union Trustees and a majority of the Employer Trustees. The Fund may be terminated if, in the opinion of the Trustees, the Trust Fund is not adequate to carry out the intent and purpose of the Fund as stated in its Trust Agreement, or is not adequate to meet the payments due or which may become due under the Plan of Benefits. The Fund may also be terminated if there are no individuals living who can qualify as Employees or Beneficiaries under the Plan. Finally, the Fund may be terminated if there are no longer any Collective bargaining agreements requiring contributions to the Fund. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of the termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; (d) apply the assets of the Fund in accordance with the Plan of Benefits including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing Employer or the Union either directly or indirectly.

Upon termination of the Fund, the Trustees will promptly notify the Union, the Association, Employers, and all other interested parties. The Trustees will continue as Trustees for the purpose of winding up the affairs of the Fund.

10. ACTION OF TRUSTEES

The Trustees shall be, subject to the requirements of ERISA, the sole judges of the standard of proof required in any case and the application and interpretation of this Plan, and decisions of the Trustees shall be final and binding on all parties. The Trustees shall have the exclusive right and discretionary authority to construe the terms of the Plan, to resolve any ambiguities, and to determine any questions which may arise with the Plan's application or administration, including but not limited to determination of eligibility for medical, life insurance, disability insurance, dental, vision, and prescription drug benefits. Except as provided in the Fund's Agreement and Declaration of Trust or as determined by the Trustees, all actions taken by the Trustees that are fiduciary or would otherwise be considered settlor actions shall be considered fiduciary actions within the meaning of ERISA.

Wherever in the Plan the Trustees are given discretionary powers, the Trustees shall exercise such powers in a uniform and non-discriminatory manner.

11. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Participants, Spouses and Eligible Dependents can obtain, without charge, a copy of the Plan's procedures governing qualified medical child support order (QMCSO) determinations upon request of the Plan Administrator.

YOUR RIGHTS UNDER ERISA

As a participant in the Pressmen Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income and 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 Fund Administrator's office and at other specified locations, such as work sites 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 Fund 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 the 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 Fund Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action 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 Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 Fund Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, located 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.

SCHEDULES OF BENEFITS

MEDICAL, VISION, AND PRESCRIPTION DRUG BENEFITS

SCHEDULE A

Kaiser Permanente HMO Signature Plan
and
Kaiser Permanente Select Plan

Kaiser Permanente HMO Signature Plan

The benefits provided under the Kaiser Permanente HMO Signature Plan are described below. The Kaiser Permanente HMO Signature Plan offers members a wide choice of personal physicians and specialists from Kaiser’s Mid-Atlantic Permanente Medical Group and from Baltimore's Affiliated Primary Care Physician Network (“APCPN”). Signature members must choose a primary care physician and receive care at any one of 30 medical centers. The primary care physician will coordinate all of the member's health needs, from routine visits to specialist referrals. Members have the flexibility of choosing a different primary care physician for each family member. The Signature Plan offers complete comprehensive medical plan. Under the Signature Plan, you will have access to 30 Kaiser medical facilities providing primary care, specialty care, urgent/after hours care and pharmacy. The complete list of providers available to you will be provided in a separate document without charge by Kaiser.

Kaiser Permanente Select Plan

The Kaiser Permanente Select Plan consists of the Kaiser centers available under the Kaiser HMO Signature Plan described above. The Plan also includes access to a comprehensive network of physicians and other providers throughout the Washington and Baltimore areas, including the Johns Hopkins Healthcare System.

Extension of Benefits in Case of Termination of Coverage

In those instances when your coverage has terminated, Kaiser Permanente will extend benefits for covered services, without dues, in the following instances:

- Total Disability – If you are Totally Disabled at the time your coverage ends, Kaiser Permanente will continue to provide benefits for covered services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to 12 months from the date your coverage ends, whichever comes first.
- Vision Benefits – If you have ordered eyeglasses or contact lenses before the date your coverage ends, Kaiser Permanente will provide benefits for covered eyeglasses or contact lenses received within 30 days following the date you placed the order.

DO NOT RELY ON THIS CHART ALONE. You must consult the Evidence of Coverage booklet to determine the exact details of your benefits, coverage and exclusions. No benefits will be paid unless they are determined to be medically necessary and meet all applicable requirements for coverage.

PLAN DETAILS	***SIGNATURE MEMBER PAYS***	***SELECT MEMBER PAYS***
Copayments	$10	$15
Coinsurance	Plan pays 100% / Member pays 0% except as otherwise indicated.	Plan pays 100% / Member pays 0% except as otherwise indicated.
Deductible	None	None
Maximum Annual Copayment	Individual - $3,500 / Family - $9,400	Individual - $3,500 / Family - $9,400
Lifetime Maximum Benefits	None	None
Outpatient Services		
Preventive Health Office Visit	No charge	No charge
Preventive Health Screening Tests	No charge	No charge
Office Visit for Illness	$10	$15
Primary Care Office Visit	$10 per visit (Copayment waived for children under age 5)	$15 per visit (Copayment waived for children under age 5)
Specialty Care Office Visit	$10 per visit	$15 per visit
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	No charge	No charge
Diagnostic Tests and Procedures, X-Rays & Laboratory Services	No charge	No charge
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	$50 per test	$50 per test
Outpatient Surgery (other than in a provider's office)	$50 per procedure	$50 per procedure
Hospital Services		
Inpatient hospital care, including inpatient maternity care	No charge	No charge
Inpatient physicians' services	No charge	No charge
Chemical Dependency and Mental Health Services		
Inpatient hospital care	No charge	No charge

PLAN DETAILS	*SIGNATURE MEMBER PAYS*	*SELECT MEMBER PAYS*
Outpatient services	$20 per visit for individual therapy; $10 per visit for group therapy.	$20 per visit for individual therapy; $10 per visit for group therapy.
Therapy & Rehabilitation Services		
Inpatient hospital care	No charge	No charge
Outpatient services	$10 per visit (PT limited to 30 visits per condition per contract year. ST & OT limited to 90 consecutive days per condition per contract year)	$15 per visit (PT limited to 30 visits per condition per contract year. ST & OT limited to 90 consecutive days per condition per contract year)
Infertility Services		
Office visits	50% of allowable charge	50% of allowable charge
All other covered services for treatment of infertility (In vitro fertilization benefit limited to 3 attempts per live birth and a lifetime maximum Health Plan benefit of $100,000)	50% of allowable charge	50% of allowable charge
Urgent Care & Emergency Services		
Urgent Care Office Visit	$10 per visit	$15 per visit
After hours Urgent Care or Urgent Care Center	$10 per visit	$15 per visit
Hospital Emergency Room (waived if admitted as inpatient)	$50 per visit	$50 per visit
Ambulance	No charge	No charge
Hospital Alternatives		
Skilled Nursing Facility (limited to 100 days per contract year)	No charge	No charge
<u>Other Services</u>		
Durable Medical Equipment (DME)		
Basic DME	No charge	No charge
Oxygen equipment	No charge for 1st 3 months then 50% of allowable charge thereafter	No charge for 1st 3 months then 50% of allowable charge thereafter
Prosthetics		
Internal prosthetics	No charge	No charge
External prosthetics	No charge	No charge

PLAN DETAILS	*SIGNATURE MEMBER PAYS*	*SELECT MEMBER PAYS*
Orthotics	No charge	No charge
Vision		
Office visit for medical conditions of the eye	$10 per visit	$15 per visit
Routine eye refractions to determine need for vision correction	$10 per visit with Optometrist	$15 per visit with Optometrist
Eyeglasses frames and lenses (limited to one pair of glasses per contract year)	Member receives 25% discount from Plan Providers	Member receives 25% discount from Plan Providers
Prescription Drugs*		
Covered prescription drugs (up to a 30-day supply) (Up to a 90-day supply for 2 copays)	Plan Pharmacy & Mail Order $5 Generic / $15 Preferred Brand / $30 Non-Preferred Brand Participating Network Pharmacy $15 Generic / $25 Brand / $40 Non-Preferred Brand	Plan Pharmacy & Mail Order $5 Generic / $15 Preferred Brand / $ 30 Non-Preferred Brand Participating Network Pharmacy $15 Generic / $25 Brand / $ 40 Non-Preferred Brand
Complementary Alternative Medicine		
Chiropractic Services (Limited to 20 visits per contract year)	$15 per visit	$15 per visit
Acupuncture Services (Limited to 20 visits per contract year)	$15 per visit	$15 per visit

*The following drugs are **not** covered by the Plan:

1. Drugs for which a prescription is not required by law, except if the drug is approved by Preferred Drug List guidelines.

2. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.

3. Replacement prescriptions necessitated by theft or loss.

4. Needles and syringes except for insulin.

5. Prescribed drugs and accessories that are necessary for services that are excluded under the Evidence of Coverage.

6. Drugs to shorten the duration of the common cold.

7. Special packaging (e.g., blister pack, unit doses, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.

8. Alternative formulations or delivery methods that are (a) different from the Health Plan's standard formulation or delivery method for prescription drugs and (b) deemed not medically necessary.

9. Diabetic equipment and supplies, which are covered under Section 3 of the Group Evidence of Coverage.

The following Vision services are **not** covered by the Plan:

1. Sunglasses without corrective lenses unless medically necessary.

2. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures.)

3. Eye exercises.

4. Cosmetic contact lenses.

5. All services related to contact lenses including examinations, fitting and dispensing, and follow-up visits, except as otherwise covered.

6. Replacement of lost or broken lenses or frames.

7. Orthoptic (eye training) therapy.

SCHEDULE B

Kaiser Permanente Flexible Choice Plan

The Kaiser Permanente Flexible Choice Plan is a multi-tiered option in which you have access to three options. Option 1 is the Kaiser HMO Signature Plan. Option 2 is the "PPO Plan," which provides access, through two networks, to physicians and providers throughout the mid-Atlantic region and nationwide. The complete list of participating providers will be provided to you in a separate document without charge from Kaiser. Option 3 is the "Indemnity Plan," which provides access to any licensed provider for covered services. This option also provides you and your family with total freedom of choice outside the boundaries of any network.

Extension of Benefits in Case of Termination of Coverage

Option 1: In those instances when your coverage has terminated, Kaiser Permanente will extend benefits for covered services, without dues, in the following instances:

- Total Disability – If you are Totally Disabled at the time your coverage ends, Kaiser Permanente will continue to provide benefits for covered services related to the condition causing the disability. Coverage will stop at the point you no longer qualify as being Totally Disabled, or up to 12 months from the date your coverage ends, whichever comes first.

- Vision Benefits – If you have ordered eyeglasses or contact lenses before the date your coverage ends, Kaiser Permanente will provide benefits for covered eyeglasses or contact lenses received within 30 days following the date you placed the order.

Options 2 and 3: In those instances when your coverage has terminated, Kaiser Permanente will extend benefits for the condition causing the Total Disability of a Covered Person when:

- The Covered Person becomes Totally Disabled while insured for that insurance under the Group Policy; and

- The Covered Person is Totally Disabled on the date the Group Policy terminates.

You must consult the Certificate of Insurance booklet to determine the exact details of your benefits and coverage.

DO NOT RELY ON THIS CHART ALONE. You must consult the Evidence of Coverage and/or Certificate of Insurance booklet to determine the exact details of your benefits and coverage. No benefits will be paid unless they are determined to be medically necessary and meet all applicable requirements for coverage.

Plan Details & Benefits	**Member Pays**		
	Option 1 KFHP-MAS Providers	**Option 2 Participating Providers**	**Option 3 Out-of-Network (Indemnity) Providers**
Copayments (PCP/Specialty)	$15/$20	$20/$30	N/A
Coinsurance (Plan pays / Member pays)	100% / 0% except as otherwise indicated	80% / 20% MAC* except as otherwise indicated	70% / 30% MAC* except as otherwise indicated
Deductible (per contract year)	None	Individual: $200 Family: $400	Individual: $400 Family: $800
Out-of-Pocket Maximum (per contract year)	Individual: $1,000 Family: $2,000	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000
Lifetime Maximum Benefits	Unlimited	Unlimited	Unlimited
Outpatient Services			
Preventive Health Office Visit	No Charge	No charge	20% of MAC* after Deductible met
Preventive Health Screening Test	No charge	No charge	20% of MAC* after Deductible met
Office Visit for Illness			
Primary Care	$15 per visit (Copayment waived for children under age 5)	$20 per visit	30% of MAC* after Deductible met
Specialist Care	$20 per visit	$30 per visit (Deductible waived)	30% of MAC* after Deductible met
Diagnostic Tests and Procedures, X-rays & Laboratory Services	No charge	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit	No charge	No charge	20% of MAC* after Deductible met
Specialty Imaging (e.g., CT, MRI, PET scan & Nuclear Medicine)	$50 per test	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Outpatient Surgery	$25 per procedure	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Hospital Services			
Inpatient hospital care, including inpatient maternity care	No charge	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Inpatient physician services	No charge	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Chemical Dependency & Mental Health Services			

Plan Details & Benefits	**Member Pays**		
	Option 1 KFHP-MAS Providers	**Option 2 Participating Providers**	**Option 3 Out-of-Network (Indemnity) Providers**
Inpatient hospital care	No charge	20% of MAC* after Deductible met	30% of MAC* after Deductible met
Outpatient services	Individual Therapy: $20 per visit Group Therapy: $10 per visit	Visits 1-5: 20% of MAC* after Deductible met Visits 6-30: 35% of MAC* after Deductible met Visits 31 +: 50% of MAC* after Deductible met	Visits 1-5: 20% of MAC* after Deductible met Visits 630: 35% of MAC* after Deductible met Visits 31+: 50% of MAC* after Deductible met
Therapy & Rehabilitation Services			
Inpatient hospital care	No charge	20% of MAC* after Deductible met (Limited to 60 days per contract year for Options 2 & 3)	30% of MAC* after Deductible met (Limited to 60 days per contract year for Options 2 & 3)
Outpatient Services	$20 per visit (PT limited to 30 visits per condition per contract year. ST & OT limited to 90 consecutive days per condition per contract year)	$30 per visit (Deductible waived) (Limited to 90 days per contract year for options 2 & 3)	30% of MAC* after Deductible met (Limited to 90 days per contract year for Options 2 & 3)
Infertility Services			
Office visits	50% of AC**	$30 per visit ((Limited to outpatient expenses for in-vitro fertilization in Options 2 & 3)	30% of MAC* after Deductible met (Limited to outpatient expenses for in-vitro fertilization in Options 2 & 3)
All other services for treatment of infertility (In vitro fertilization benefit limited to 3 attempts per live birth and a lifetime maximum Health Plan benefit of $100,000)	50% of AC**	20% of MAC* after Deductible met (Limited to outpatient expenses for in-vitro fertilization in Options 2 & 3)	30% of MAC* after Deductible met (Limited to outpatient expenses for in-vitro fertilization in Options 2 & 3)

Plan Details & Benefits	**Member Pays**		
	Option 1 KFHP-MAS Providers	**Option 2 Participating Providers**	**Option 3 Out-of-Network (Indemnity) Providers**
Urgent Care & Emergency Services			
After hours Urgent Care or Urgent Care Center	Office Visit: $20 per visit Other Services: No charge	Office Visit: $30 (Deductible waived) Other Services: 20% of MAC* after Deductible met	Office Visit: 30% of MAC* Other Services: 30% of MAC* after Deductible met
Hospital Emergency Room	$75*** per visit	Covered in Option 1	Covered in Option 1
Ambulance	$100 per encounter	Covered in Option 1	Covered in Option 1
Hospital Alternatives			
Skilled Nursing Facility	No charge (limited to 60 days per contract year)	20% of MAC* after Deductible met (Limited to combined maximum of 40 days per contract year in Options 2 & 3)	30% of MAC* after Deductible met (Limited to combined maximum of 40 days per contract year in Options 2 & 3)
Other Services			
Durable Medical Equipment (DME)			
Basic DME	No Charge	50% of MAC* after Deductible met	50% of MAC* after Deductible met
Prosthetics			
Internal Prosthetics	No charge	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of $3,000 combined for Options 2 & 3)	50% of MAC* after Deductible met (Limited to an annual maximum for all covered DME and prosthetics of $3,000 combined for Options 2 & 3)
External Prosthetics	No charge	Not covered except for hair prostheses, breast prostheses and mastectomy bras	Not covered except for hair prostheses, breast prostheses and mastectomy bras
Orthotics	No charge	Not covered	Not covered
Vision			
Office visit for medical conditions of the eye (PCP/Specialist)	$10/$20 per visit	$20 / $30 per visit (Deductible waived)	30% of MAC* after Deductible met

Plan Details & Benefits	**Member Pays**		
	Option 1 KFHP-MAS Providers	**Option 2 Participating Providers**	**Option 3 Out-of-Network (Indemnity) Providers**
Routine eye refractions to determine need for vision correction	Optometrist: $15 per visit Ophthalmologist: $20 per visit (Referral required)	Optometrist: $20 per visit (Deductible waived) Ophthalmologist: $30 per visit (Deductible waived)	30% of MAC* after Deductible met
Eyeglass lenses	25% discount off retail price when purchased from Plan Providers 1 per 12 months	Not available	30% discount 1 per 24 months (Limited to $150 allowance)
An eyeglass frame	25% discount off retail price when purchased from Plan Providers 1 per 12 months	Not available	30% discount 1 per 24 months (Limited to $100 allowance)
Contact lenses	15% discount off retail price on initial fitting for 1st pair only, when purchased from Plan Providers	Not available	30% of MAC* after Deductible met 1 per 24 months (Limited to $50 allowance)
Prescription Drugs	**HMO Medical Center Pharmacies**	**Participating Community Pharmacies**	**Non-Participating Pharmacies**
(up to a 30 day supply)			
Generic:	$10 Copay	$20 Copay (Deductible waived)	$20 Copay (Deductible waived)
Brand Preferred*:	$20 Copay	$35 Copay (Deductible waived)	$35 Copay (Deductible waived)
Brand Non-Preferred*:	$35 Copay	$50 Copay (Deductible waived)	$50 Copay (Deductible waived)
Maintenance Medications (covered drug anticipated to be required for six (6) months or more to treat a chronic condition, up to a 90-day supply)			
Generic:	$ 20 Copay	$ 40 Copay	$ 40 Copay
Brand Preferred:	$ 40 Copay	$ 70 Copay	$ 70 Copay

Plan Details & Benefits	**Member Pays**		
	Option 1 KFHP-MAS Providers	**Option 2 Participating Providers**	**Option 3 Out-of-Network (Indemnity) Providers**
Brand Non-Preferred:	$ 70 Copay	$ 100 Copay	$ 100 Copay
Complementary Alternative Medicine			
Chiropractic Services (Limited to 20 visits per contract year)	$20 per visit	Not Available	Not Available
Acupuncture Services (Limited to 20 visits per contract year)	$20 per visit	Not Available	Not Available

* MAC = Maximum Allowable Charge
** AC = Allowable Charge
*** Emergency Room Copayment waived if admitted.

The following are **not** covered by the Plan:

1. Drugs for which a prescription is not required by law, except if the drug is approved by Preferred Drug List guidelines.
2. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
3. Replacement prescriptions necessitated by theft or loss.
4. Needles and syringes except for insulin.
5. Prescribed drugs and accessories that are necessary for services that are excluded under the Evidence of Coverage.
6. Drugs to shorten the duration of the common cold.
7. Special packaging (e.g., blister pack, unit doses, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription medications.
8. Alternative formulations or delivery methods that are (a) different from the Health Plan's standard formulation or delivery method for prescription drugs and (b) deemed not medically necessary.
9. Diabetic equipment and supplies, which are covered under Section 3 of the Group Evidence of Coverage.

The following Vision services are **not** covered by the Plan:

1. Sunglasses without corrective lenses unless medically necessary.

2. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures.)

3. Eye exercises.

4. Cosmetic contact lenses.

5. All services related to contact lenses including examinations, fitting and dispensing, and follow-up visits, except as otherwise covered.

6. Replacement of lost or broken lenses or frames.

7. Orthoptic (eye training) therapy.

DENTAL BENEFITS

SCHEDULE C

HMO (GDS) Dental Benefits and Exclusions

GDS provides the following procedures at the cost indicated below. Any procedures not shown are not covered by GDS. Please note that when gold is used, a gold surcharge will be charged. The patient will be advised of the surcharge prior to the performance of the procedure. When dental standards indicate that a condition can be treated by a less costly professionally adequate alternative to the service proposed by the attending dentist, GDS will pay benefits based upon the less costly professionally adequate service.

THE FOLLOWING SERVICES ARE PROVIDED AT NO CHARGE

Diagnostic & Preventive
Periodic Oral Exam
Limited Oral Evaluation – Problem Focused
Comprehensive Oral Evaluation
Re-evaluation – Limited, Problem Focused
Comprehensive Periodontal Evaluation
Intraoral - Complete Series, including Bitewings (once per 3 year)
Intraoral - Periapical - First Film
Intraoral - Periapical - Each Additional Film
Intraoral Occlusal Film
Bitewings - Single Film
Bitewings - Two Films
Bitewings – Three Films
Bitewings - Four Films
Vertical Bitewings - 7 to 8 Films
Panoramic Film (once per 3 years)
Cephalometric Film
Pulp Vitality Tests

Crowns (Single Restoration)
Recement Crown
Sedative Fillings
Core buildup (including pins)
Pin retention - per tooth in addition to restoration
Crown Report, By Report

Endodontics
Pulp Cap Direct (Excluding Final Restoration)
Pulp Cap Indirect (Excluding Final Restoration)
Therapeutic Pulpotomy (Excluding Final Restoration)
Gross Pulpal Debridement Primary/Permanent

Retrograde filling (per root)

Periodontics
Full Mouth Debridement

Removable Prosthetics
Adjust Complete Denture - Upper
Adjust Complete Denture - Lower
Adjust Partial Denture - Upper
Adjust Partial Denture - Lower
Repair Broken Complete Denture Base
Replace Missing/Broken Tooth-Complete Denture Each Tooth
Partial Denture - Repair Resin Sole/Base
Partial Denture - Repair Cast Framework
Repair or Replace Broken Clasp
Partial Denture - Replace Broken Tooth - Per Tooth
Add Tooth to existing partial denture
Add Clasp to existing partial denture
Reline Complete - Upper Denture (Chairside)
Reline Complete - Lower Denture (Chairside)
Reline Upper Partial (Chairside)
Reline Lower Partial (Chairside)
Reline Complete Upper Denture (Lab)
Reline Complete Lower Denture (Lab)
Reline Upper Partial Denture (Lab)
Reline Lower Partial Denture (Lab)
Replace All Teeth & Acrylic of Cast Metal Frame (upper)
Replace All Teeth & Acrylic of Cast Metal Frame (lower)

Fixed Prosthetics
Recement Bridge

Oral Surgery
Coronal Remnants – Deciduous Tooth
Extraction, Erupted Tooth or Exposed Root
Surgical Removal of Erupted Tooth
Remove Impacted Tooth - Soft Tissue
Remove Impacted Tooth - Partially Bony
Remove Impacted Tooth - Completely Bony
Remove Impacted Tooth - Completely Bony, Unusual
Surgical Removal of Residual Roots
Alveoplasty in Conjunction w/Extractions - per Quadrant
Incision & Drainage of abscess - intraoral, soft tissue

Miscellaneous
Palliative (Emergency) Treatment of Dental Pain - Minor Procedure

Local Anesthesia
General Anesthesia - First 30 Minutes (Extractions Only).. *
General Anesthesia - Each Additional 15 Minutes (Extractions Only) ....*
Analgesia Anxiolysis, inhalation of Nitrous Oxide (Extractions Only) ....*
I.V. Sedation/Analgesia - First 30 Minutes (Extractions Only) ....*
I.V. Sedation/Analgesia - Each Additional 15 Minutes (Extractions Only) ....*
Non-Intravenous Conscious Sedation
Consultation (by Dentist other than attending Dentist) - per Session
* Anesthesia and/or general anesthesia is covered only when administered in an oral surgeon's office for extractions and related services.

COPAYMENTS ARE REQUIRED FOR THE FOLLOWING PROCEDURES

Diagnostic & Preventive
Prophylaxis - Adult (once per 6 months) $10.00
Prophylaxis - Child (once per 6 months) $10.00
Topical Application Fluoride (without Prophylaxis) - Child....................................$10.00
Space Maintainer – Fixed – Unilateral $10.00
Space Maintainer – Fixed – Bilateral..$20.00
Recementation of Space Maintainer $10.00

Basic Restorative
Amalgam - one surface, primary/permanent $30.00
Amalgam - two surfaces, primary/permanent...$30.00
Amalgam - three surfaces, primary/permanent..$30.00
Amalgam - four or more surfaces, primary/permanent $30.00
Resin one surface - anterior $30.00
Resin two surfaces - anterior..$30.00
Resin three surfaces – anterior $30.00
Resin – 4 or more surfaces or incisal angle $30.00
Resin - crown, anterior...$30.00
Resin - one surface, posterior ....*
Resin - two surfaces, posterior...*
Resin - three surfaces, posterior...*
Resin – four surfaces, posterior ....*

* Patient pays the difference between cost of amalgam and resin.

Crowns (Single Restorations)
Crown - Porcelain/Ceramic Substrate...$325.00
Crown - Porcelain fused to high noble metal..$325.00 *
Crown - Porcelain fused to predominately base metal $325.00
Crown - Porcelain fused to noble metal...$325.00
Crown - full cast high noble metal...$325.00 *
Crown - full cast predominately base metal $325.00
Crown - full cast noble metal...$325.00

Prefab stainless steel crown - primary tooth $30.00
Prefab stainless steel crown - permanent tooth..$30.00
Prefabricated resin crown $30.00
Cast post & core in addition to crown $30.00
Prefabricated post & core in addition to crown $30.00
* Plus gold surcharge

Endodontics
Anterior Root Canal Therapy (Excluding Final Restoration)..................................$250.00
Bicuspid Root Canal Therapy (Excluding Final Restoration) $250.00
Molar Root Canal Therapy (Excluding Final Restoration).....................................$250.00
Retreatment of Previous Root Canal, Anterior .... *
Retreatment of Previous Root Canal, Bicuspid .... *
Retreatment of Previous Root Canal, Molar... *
Apicoectomy/Periradicular Surgery, Anterior (first root) $250.00
Apicoectomy/Periradicular Surgery, Bicuspid (first root).......................................$250.00
Apicoectomy/Periradicular Surgery, Molar (first root) $250.00
* Patient pays the difference between cost of root canal and retreatment

Apicoectomy/Periradicular Surgery each additional root..$250.00

Periodontal Services
Comprehensive Oral Examination (by Periodontist)...$30.00
Comprehensive Periodontal Evaluation...$30.00
Intraoral Complete Services, Including Bitewings (one per 3 years) $30.00
Intraoral - Periapical First Film...$4.00
Diagnostic Casts..$20.00
Hemisection, including root removal (not w/root canal) $110.00
Gingivectomy/Gingivoplasty, per quadrant) $200.00
Gingivectomy/Gingivoplasty, per tooth... $55.00, Max $100
Gingival Flap Procedure including root planing (per quadrant)..............................$200.00
Gingival Flap Procedure including root planing, one to three teeth (per quadrant) ....
.... $55, Max $100
Osseous Surgery, including flap entry/closure (per quadrant).................................$325.00
Osseous Surgery, including flap entry/closure, one to three teeth (per quadrant).........$150
....per tooth, Max. $300
Free Soft Tissue Graft Procedure..$200.00
Periodontal Scaling and Root Planing (per quadrant)..$90.00
Periodontal Scaling and Root Planing, 1-3 teeth per Quad $45.00
Periodontal Maintenance Procedures (per visit)...$35.00

Removable Prosthetics
Complete Upper Denture (Includes adjustments)...$150.00
Complete Lower Denture (Includes adjustments) $150.00
Immediate Upper Denture (Include adjustments)...$150.00
Immediate Lower Denture (Includes adjustments)...$150.00

Upper Partial Resin Base (Includes adjustments)..$150.00
Lower Partial Resin Base (Includes adjustments) $150.00
Upper Partial - Cast Metal Frame w/Resin Base (Includes adjustments).................$150.00
Lower Partial - Cast Metal Frame w/Resin Base (Includes adjustments) $150.00

Fixed Prosthetics, per Unit (each retainer and each pontic constitutes a unit in a fixed partial denture)

Pontic - Cast High Noble Metal...$325.00 *
Pontic - Cast Predominantly Base Metal $325.00
Pontic - Cast Noble Metal...$325.00
Pontic - Porcelain to High Noble Metal..$325.00 *
Pontic - Porcelain to Predominately Base Metal $325.00
Pontic - Porcelain Fused to Noble Metal $325.00
Pontic - Porcelain/Ceramic $325.00
Retainer – Cast Metal Resin Bonded Bridge $50.00
Crown – Porcelain/Ceramic...$325.00
Bridge Crown - Porcelain to High Noble Metal ....$325.00 *
Bridge Crown - Porcelain to Predominately Base Metal..............................$325.00
Bridge Crown. - Porcelain Fused to Noble Metal...$325.00
Bridge Crown - Porcelain/Ceramic...$325.00
Bridge Crown - Full Cast High Noble Metal...$325.00 *
Bridge Crown - Full Cast Predominately Base Metal $325.00
Bridge Crown - Full Cast Noble Metal...$325.00
* Plus gold surcharge

Orthodontics

Comprehensive Orthodontic Treatment - Transitional Dentition (2 yr program) .$2,450.00
Comprehensive Orthodontic Treatment - Adolescent Dentition (2 yr program)...$2,450.00
Comprehensive Orthodontic Treatment – Adult Dentition (2 yr program)...........$2,450.00

Miscellaneous

Broken Appointment Charge per ½ hour appointment..$10.00

SCHEDULE D

Indemnity Dental Benefits and Exclusions

This chart summarizes the indemnity dental benefits available under the Pressmen Welfare Plan. These benefits are administered by Carday Associates, Inc.

PREVENTIVE DENTAL BENEFITS

The Plan pays 100% for Preventive Dental Services, as described below. The Calendar Year Deductible is not applied.

1. Routine initial and periodic examinations. Limit of two every calendar year.

2. Prophylaxis, including Cleaning, Scaling and Polishing. Limit of two every calendar year.

3. Bitewing X-Rays. Limit of two every calendar year.

4. Full mouth or Panoramic X-rays. Limit of one every five calendar years.

5. Other radiographs.

6. Topical fluoride application for Dependent Children up to age 16. Limit of two every calendar year.

7. Tooth sealants for Dependent Children up to age 14.

8. Space Maintainers to replace prematurely lost teeth for Dependents up to age 14, including adjustments after installation.

9. Emergency treatment for relief of pain.

10. Tests and laboratory studies.

11. Other preventive and diagnostic treatment.

BASIC DENTAL BENEFITS

The Plan pays 80% for Basic Dental Services, as described below. The Calendar Year Deductible is applied.

1. Direct Restorations: amalgam, silicate, acrylic, resin, synthetic porcelain and composite Filling Restorations to restore diseased or broken teeth.

2. Stainless steel or chrome Crowns.

3. Injections of antibiotic drugs by the attending Dentist.

4. Ocelusal guard for the treatment of bruxism.

5. Temporary Crown or repair for a fractured tooth.

6. Sedative Fillings.

7. Periodontics (treatment of the gums and supportive tissues of the teeth including splinting).

8. Endodontics.

9. Oral Surgery, routine Extractions and other Oral Surgery, including local anesthetic and routine post-op care.

10. Posts and pins independent of any other procedure.

11. General Anesthesia when Medically Necessary and administered in connection with oral or dental surgery.

12. Bridge repair and recement.

13. Repair and adjustments of Full or Partial Dentures

14. Recement Inlays and Crowns

MAJOR DENTAL BENEFITS

The Plan pays 50% for Major Dental Services, as described below. The Calendar Year Deductible is applied.

1. Indirect Restorations: gold foil, gold inlays, onlays or crowns (veneer, gold full cast or 3/4 cast) only if the teeth cannot be restored by direct fillings because of severe decay or fracture. Charges for porcelain veneers or similar properties of crowns (cosmetic) on the molars will be payable up to the amount paid for gold.

2. Other Prosthodontic services not elsewhere listed, including maxillofacial prosthetics, dentures, full and partial, rebasing, relining, and duplication of full and partial dentures, posts and pins with Crowns, and fixed and removable bridges.

ORTHODONTIA

The Plan pays 50% for Orthodontic services up to $1,000 per person per lifetime. Expenses are considered "incurred" at the beginning of each quarter (3 month period) of a Treatment Plan. The first quarter begins on the date the Orthodontic appliances are installed. The amount of covered Orthodontia expenses incurred in one (1) quarter are determined as follows:

1. The initial deposit, up to 30% of the total cost for the Treatment Plan, is the covered expense for the first quarter;

2. The first payment is subtracted from the total estimated cost of the Treatment Plan;

3. The balance is pro-rated over the remaining quarters of the Treatment Plan or seven (7) quarters, whichever is less.

"Orthodontia Treatment" means the movement of teeth by means of active appliances when required to correct either:

1. Overbite or overjet of at least four (4) millimeters;

2. Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp;

3. Crossbite;

4. Arch length discrepancy of more than four (4) millimeters.

A 'Treatment Plan' is a series of interdependent Orthodontic services prescribed by a Dentist to correct a specific condition. A report of such condition and Treatment Plan should be submitted by the Dentist for review and determination of allowable benefits prior to performance of services.

In the case of Orthodontia treatment which began while coverage was in force, benefits will be payable through the end of the month in which coverage was terminated.

Payment will be based on a pro-ration of any applicable quarterly installments. Contrary to any other provision of the Orthodontia Coverage, if the Plan terminates all coverage shall cease immediately.

DENTAL EXPENSES NOT COVERED

No benefits will be payable for:

1. Dental implants

2. Services or supplies for Orthodontic treatment in excess of $l,000.00 per person per lifetime.

3. All services or supplies related to temporomandibular joint disorders (TMJ) in excess of $1,000.00 per person per lifetime.

4. Any dental services or supplies which are included as covered medical expenses under this Plan or under any other plan of benefits provided by the employer.

5. Treatment by other than a Dentist. The Plan will cover some treatments by a licensed Dental Hygienist supervised by a Dentist. These are scaling of teeth; cleaning of teeth; and topical application of fluoride.

6. Services or supplies cosmetic in nature, including charges for personalization or characterization of dentures.

7. Charges for or related to cosmetic surgery.

8. Services or supplies related to oral hygiene counseling, dietary instruction, plaque control programs.

9. Replacing a lost, missing, or stolen prosthetic device, or any other device or appliance.

10. Charges incurred prior to the effective date of coverage.

11. Charges above the Usual, Reasonable and Customary allowance.

12. Dental services rendered by the employers dental or medical department.

13. Completion of claims forms or for failure to keep a scheduled appointment.

14. Charges for or related to services experimental or still under investigation by health professionals.

15. Services provided by a relative of the Employee.

16. Initial installation of dentures or Fixed Bridgework (including crowns and Inlays forming the abutments) for replacing teeth lost before the person became covered under the Plan.

17. Dentures, crowns, inlays, onlays, bridgework or other appliances, services, or supplies which were not ordered while the person was covered under the Plan.

18. Any replacement or addition of teeth to an existing partial or full removable denture or fixed bridgework, except if

a. Replacement or addition of teeth is required to replace one or more natural teeth extracted after the existing denture or bridgework was installed and while the person was covered.

b. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement.

c. The existing denture is an immediate temporary denture and replacement by a permanent denture takes place within 12 months from the date the temporary denture is first installed.

d. Services or supplies if not necessary and appropriate treatment of disease or injury.

GLOSSARY OF TERMS

Abutment
Natural teeth supporting Pontics (artificial replacement), which may be fitted cast crowns, inlays or onlays to provide attachments for the Pontic.

Anesthesia (General)
Loss of sensation when a drug is administered to prevent pain, or the patient is rendered unconscious.

Bitewing X-Ray
An intraoral x-ray showing the crown portion of the bicuspids and molars in both the maxilla (upper arch) and the mandible (lower arch) on the teeth which are in occlusion.

Crown
A Restoration covering all or a portion of the coronal surface of a tooth. Crown restorations are more complicated and time consuming than dental fillings. A crown for an anterior tooth (teeth in the front of the mouth) may also be referred to as a jacket.

Dental Hygienist
A person who has been trained to provide services to remove tartar or stains from the surface of the teeth and provide services and information on the prevention of oral disease.

Dentist
Any legally qualified Doctor of Dentistry (DD) or Doctor of Dental Surgery (DS) practicing within the scope of his or her license. A Dentist also includes a legally qualified Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who furnishes or renders dental services.

Denture Reline
Building up of an inside ridge of a denture base to provide a better fit in the patient's mouth. This may be necessary several times due to denture wear or bone loss.

Endodontics
The branch of dentistry which treats disease within the teeth by doing root canal therapy or pulp canal therapy.

Extraction
A dental procedure for the removal of a natural tooth or removal of a portion of a natural tooth.

Filling
Material which is inserted in a tooth to fill a cavity.

Fixed Bridge
Replaces only a portion of the natural teeth in a dental arch. Fixed bridges can only be removed by the Dentist when necessary for repair or replacement.

Fluoride Treatment
Preventive care in children which will harden the tooth's enamel: help prevent cavities.

Full Denture
A removable replacement for all upper teeth and/or lower teeth.

Impaction
A tooth which has a soft tissue covering over all or a portion of a tooth crown, or only a portion of the tooth erupted from the bone, or none of the tooth erupted from the bone.

Inlay
A strong wear-resistant testoration used within normal contours of a tooth. Preparation is similar to a case crown. Retentive pins may be used to add support to an inlay. Gold is the most common material used in inlays but porcelain may be utilized in some instances.

Medical Necessity
"Medical Necessity" is a broadly accepted professional term meaning services were essential to treatment of the disease or injury. Treatment determined to be Medically Necessary will follow guidelines such as consistent with symptoms or diagnosis and treatment of the condition, disease, ailment or injury; appropriate with regard to standards of good medical practice; not primarily for the convenience of the patient, the physician or other provider; and the most appropriate supply or level of services which can safely be provided to the patient. When applied to an inpatient, it means the patient's medical symptoms or conditions require the services or supplies which cannot be safely provided to the patient as an outpatient.

Oral Surgery
The dental specialty involving surgical procedures of the mouth.

Orthodontics
Dentistry dealing with irregularities of the teeth, or correction for attaining normal occlusion.

Partial Denture
Used when one or more teeth on one side of the dental arch needs to be replaced, or replacing teeth on both sides of the dental arch.

Periodontics
The examination, diagnosis and treatment of diseases of the periodontium, the tissues surrounding and supporting the tooth: the gingiva; cementum; periodontal membrane; alveolar; or supporting bone.

Pontic
An artificial replacement of a missing tooth, or part of a fixed bridge.

Prophylaxis
The dental service which is cleaning of the teeth or scaling of the teeth.

Prosthodontics
Dental specialty providing artificial replacement of one or more natural teeth and/or the associated structure.

Pulp
Vital tissue within the tooth containing the nerve and blood vessels.

Removable Bridge
A partial denture held by clasps to the natural teeth which may be removed as desired by the patient.

Restoration
A material used to restore or replace lost tooth structure, teeth, or other oral tissue and is a broad term used to describe amalgam; inlay; onlay; crown; bridge; partial denture; or full denture.

Root Canal Therapy
Performed on permanent teeth where infection is present in both the coronal pulp and pulp of the root canal. A root canal is referred to as a pulpectomy and involves the removal of all of the pulp in the pulp chamber; all of the pulp in the root canal.

Scaling
Service provided to remove stains and tartar from the teeth.

Space Maintainer
A device used to maintain the area of a missing primary (baby) tooth until the permanent tooth erupts or until the growth of the mouth will allow a prosthesis to be fitted.

Tartar
Hard mineral deposit which forms on the surfaces of the teeth.

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