GRAPHIC COMMUNICATIONS NATIONAL HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION

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Under the terms of the Graphic Communications National Health and Welfare Plan Trust Agreement and Plan document, the Board of Trustees has sole authority to make final determinations regarding any application for benefits, any interpretation of the Plan and any administrative rules adopted by the Board of Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, determine those benefits to be in compliance with the terms of the Plan. The Board of Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming benefits under the Plan except to the extent such determinations are subject to External Review as set forth under Section XI, Paragraph J: Appeals Procedures, herein. If the Plan makes any inadvertent, mistaken, excessive, erroneous or fraudulent payment of benefits, the Board of Trustees or their representative shall have the right to recover these types of payments. The Board of Trustees reserves the right to change, modify or discontinue all or part of the benefits described in this booklet at any time by action or amendment.

Graphic Communications National Health and Welfare Plan
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222-1219
(800) 943-4248 (GCIU)

June, 2014

Dear Participant:

We are pleased to present this Revised Summary Plan Description describing the benefits provided by the Graphic Communications National Health and Welfare Plan for you and your Dependents. This booklet will help you understand the medical and non-medical benefits provided by the Plan and how to use them wisely. You should review it and share it with your family members. The booklet describes:

- The benefits provided by the Plan;
- The procedures you should follow in submitting claims; and
- Your responsibilities under the Plan.

Be sure to read the Exclusions and Definitions sections as well. Remember, not every expense you incur for health care is covered under the Plan.

Please note that the benefits to which you are entitled are determined under the applicable collective bargaining agreement or other written agreement and you may not be entitled to all of the benefits described in this booklet. Please refer to your Schedule of Benefits and Deductibles provided with this SPD or your Summary of Benefits and Coverage for a summary of the benefits provided to you by your Participating Local Union Fund or Employer.

This SPD describes the Plan rules in effect as of January 1, 2012. As the Plan is amended from time to time, the Trustees will send you notices explaining the changes. Please keep those notices with your SPD. The Trustees reserve the right to amend the Plan from time to time, including retiree benefits.

This booklet is intended to be a summary of the Plan Document for the Graphic Communications National Health and Welfare Plan. Should any discrepancy arise between this Summary Plan Description and the Plan Document, the Plan Document will govern.

IMPORTANT NOTE: IN THIS BOOKLET, WORDS AND TERMS WITH INITIAL CAPITAL LETTERS ARE DEFINED IN SECTION XIV.

We are proud to bring you these benefits on a national, unified basis.

Sincerely yours,

THE BOARD OF TRUSTEES

QUICK REFERENCE CHART

For information on:	You should contact:
Plan administration, eligibility, medical, Medicare supplemental and weekly disability benefits claims	Graphic Communications National Health and Welfare Plan 60 Boulevard of the Allies, 5th Floor Pittsburgh, PA 15222-1219 Phone: (800) 943-4248 Fax: (412) 201-2250
PPO providers, precertification and medical review; utilization management	CareFirst BlueCross BlueShield PO Box 804 Owing Mills, MD 21117-9998 Phone: (800) 858-8114 www.bcbs.com
Prescription Drug Benefits	Express Scripts/NPA 711 Ridgedale Avenue East Hanover, NJ 07936 Phone: (800) 467-2006 www.expressscripts.com
Vision Benefits	National Vision Administrators PO Box 2187 Clifton, NJ 07015 Phone: (800) 672-7723 www.e-nva.com
Life Insurance, Accidental Death & Dismemberment Benefits	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166 Phone: (800) 275-4638
Dental Benefits	Delta Dental 1 Delta Drive Mechanicsburg, PA 17055 Phone: (800) 932-0783 www.deltadental.com

I. ELIGIBILITY

A. WHEN YOU ARE ELIGIBLE

Under the terms of the Plan, your eligibility for benefits is governed by the terms of the Collective Bargaining Agreement between your Employer and your Local Union or by a written agreement between your Employer and the Board of Trustees. You should contact your Employer and/or your Local Union for information about your eligibility. **Please also refer to your Schedule of Benefits and Deductibles to see which benefits are available to your group, since you may not be eligible for all of the benefits described in this booklet.**

If you were covered as an active Employee under a Predecessor Plan during the one-month period immediately preceding the date that a Predecessor Plan joins the Plan, you will be eligible for coverage on the first day of the month for which contributions to the Plan are made on your behalf.

B. ELIGIBILITY FOR YOUR DEPENDENTS

Your Spouse and children (referred to as your "Dependents") are eligible for benefits when you become eligible under the Plan. An eligible Dependent is any one of the following:

- Your lawful Spouse;
- Your child regardless of student status, marital status or financial dependency (including a natural child, stepchild, legally adopted child -or a child placed with you for adoption- or foster child) through the month in which he or she attains age 26. This age limitation will not apply if your child has a permanent mental or physical Disability that began prior to age 26 that prevents the person from engaging in any self-sustaining employment.

A dependent grandchild or other person who lives with you in a parent-child relationship is eligible for Plan benefits provided he or she meets all of the following requirements:

- Is under age 19; is under age 23 and registered as a full-time student; or is age 19 or older and has a permanent mental or physical Disability that began prior to age 26 (or 23 if a full-time student) and that prevents the person from engaging in any self-sustaining employment;
- Has the same principal place of abode as you for the full year;
- Is a member of your household; and
- Is dependent on you for over half of his or her support.

From time-to-time, the Plan may require proof that an individual you are claiming as a Dependent meets the Plan's eligibility requirements.

No person may be covered under the Plan as both an Employee and Dependent, and no person may be covered under the Plan as a Dependent of more than one Employee or Retiree. If your Dependent child becomes eligible for coverage as an Employee, your child will cease to be a Dependent and may enroll for coverage as an Employee. The Dependent coverage will terminate on the date coverage as an Employee begins.

C. ELIGIBILITY FOR RETIREES

Eligibility rules for Retirees and their Dependents are determined under the terms of the Collective Bargaining Agreement between your Employer and your Local Union, by the written agreement between your Employer and the Board of Trustees or by the rules of your Participating Local Union Fund. To be eligible for benefits under the Plan, however, you must be:

- An eligible Employee in the month immediately before the date in which your retirement is effective; and
- Eligible to receive a pension from an Employer's qualified retirement plan or from a jointly-trusteed, multiemployer pension plan established for employees in the graphic communications industry.

If you retire, and you are eligible for Medicare Supplement Benefits provided under the Plan, the Plan becomes secondary and Medicare becomes primary, as described in Section XII.

Retiree benefits may include comprehensive medical, dental, vision and prescription drug coverage and/or life insurance benefits. Retiree benefits do not include weekly disability income insurance. IMPORTANT RULE: If you decline coverage at the time you are initially eligible for Retiree coverage, or if you terminate your Retiree coverage for any reason, **you will not be allowed to reenroll in the Plan at a later date with the following EXCEPTION:**

If you or your Dependents refuse Retiree coverage at the time of your initial eligibility because you or your Dependents have coverage under your Spouse's health plan, but you or your Dependents subsequently lose coverage under that plan, you or your Dependents will be permitted to enroll under this Plan provided Retiree coverage is available to you or your Dependents under the terms of the Collective Bargaining Agreement between your former Employer and your Local Union, by the written agreement between your Employer and the Board of Trustees or by the rules of your Participating Local Union Fund.

Whether or not you must pay for Retiree coverage generally depends on the terms of the Collective Bargaining Agreement between your Employer and your Local Union or by a written agreement between your Employer and the Board of Trustees.

If you return to Covered Employment and you subsequently retire a second time, you will be eligible for Retiree benefits **only if you were eligible for and elected Retiree coverage at the time of your initial retirement unless you meet the exception noted above (you had coverage under your Spouse's health plan)**.

Coverage for your Dependents will continue until the date your Retiree coverage ends or until your Dependent no longer meets the Plan's definition of a Dependent. If you are covered under the Plan at the time of your death, your Dependents' coverage will continue in accordance with Paragraph I, Extension of Coverage Upon Death, in this section.

IMPORTANT NOTE: If any of the rules set forth in the Collective Bargaining Agreement between your Employer and your Local Union, the applicable Special Participation Agreement or your Participating Local Union Fund are more restrictive that the rules set forth above, the more restrictive rules will apply.

D. ENROLLING FOR BENEFITS

You and/or your Dependents will become covered under this Plan only upon completion of enrollment for coverage. A person who is not duly enrolled will not receive coverage for Plan benefits until an enrollment form is submitted and received by the Fund Office.

Your Participating Local Union Fund or Employer will provide you with the materials necessary for enrollment. If you wish to elect Dependent coverage, you must enroll your Dependents at the same time you enroll.

E. HIPAA Special Enrollment Rights

This Plan complies with the special enrollment rights provided under the Health Insurance Portability and Accountability Act (HIPAA). If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may request enrollment for yourself and your Dependents **within sixty (60) days** after the marriage, birth, adoption or placement for adoption. Coverage will become effective as of the date of marriage, birth, adoption or placement for adoption. **If you do not request enrollment for your newly acquired Dependent for coverage within 60 days of the date of marriage, birth, adoption or placement for adoption, their coverage will be effective on the first day of the month following a completed request for enrollment.**

In addition, if you declined coverage for yourself or your Dependents because of other health insurance or group health coverage, and you lose that coverage as a result of loss of eligibility or termination of contributions to that plan on your behalf, you may enroll yourself and your Dependents in this Plan provided that you request enrollment within sixty (60) days after your or your Dependents' other coverage ends (or after your employer stops contributing toward the other coverage). Coverage will become effective no later than the first day of the month following a completed request for enrollment.

To request special enrollment, contact your Participating Local Union Fund or Employer.

F. Qualified Medical Child Support Orders (QMCSOs)

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

G. Continuing Eligibility under Special Circumstances

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. Please note that in order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification. In addition, full premium payments must be made to your Participating Local Union Fund or your Employer. Please contact your Employer to determine if and when you are eligible.

Family and/or Medical Leave

The Family and Medical Leave Act (FMLA) allows employees to take up to 12 weeks of unpaid leave during any 12-month period in certain circumstances. You generally are eligible for leave under FMLA if you:

- Worked for an Employer for at least 12 months;
- Worked at least 1,250 hours in Covered Employment over the previous 12 months;
- Worked at a location at which at least 50 employees are employed by your Employer within 75 miles of the work site where the Employee needing leave is employed.

Please contact your Employer to determine whether you are eligible for FMLA leave.

FMLA leave may be taken for the following reasons:

- The birth, adoption or placement of a child with you for adoption;
- To provide care for your Spouse, child, or parent who is seriously ill; or
- Your own serious illness.

During your leave, you may continue all of your medical coverage and other benefits offered through the Plan. Your Plan eligibility will continue until the end of the leave, provided the Employer properly grants the leave under the FMLA, and makes the required notification. In addition, full premium payment must be made to the Plan by your Participating Local Union Fund or your Employer.

Once the Plan is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect continued coverage under the COBRA coverage rules. The date of the qualifying event entitling you to COBRA coverage is the last day of your FMLA leave. The Plan cannot condition your entitlement to coverage under COBRA on your reimbursing the contributing Employer or Participating Local Union Fund for premiums associated with the cost of coverage during the FMLA leave period, as discussed below.

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

Leave for Military Service

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires that the Plan provide the right to elect continuous health coverage for up to 24 months, beginning on the date on which the person's absence begins, to Employees who are absent from employment due to military service, including Reserve and National Guard Duty, and their eligible Dependents, as described below.

You must notify your Employer that you will be absent from employment due to military service unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. You also must notify your Employer if you wish to elect continuation coverage for yourself or your eligible Dependents under the provisions of USERRA.

If you are on military leave for a period of 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with USERRA.

If you are on military leave for a period of more than 31 days, USERRA permits you to continue coverage for you and your Dependent(s) at your own expense for up to 24 months. This continuation right operates in the same manner as COBRA. (See Section II: Continuation of Coverage for a full explanation of the COBRA coverage provisions.) In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

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

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

- within 90 days from the date of discharge if the period of service was more than 180 days; or
- within 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours) if the period of service was less than 31 days.

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

Your USERRA rights will be provided as required by law. If the law changes, your rights will change accordingly.

H. WHEN COVERAGE ENDS

When any of the following events occur, your coverage will terminate on the last day of the month:

- You terminate employment with your Employer;
- You no longer meet the eligibility requirements set forth in your Collective Bargaining Agreement or other written agreement or the eligibility requirements of your Participating Local Union Fund;
- The required monthly contribution to the Plan is not made timely on your behalf;
- Your job changes and contributions to the Plan are no longer required to be made on your behalf;
- You leave employment due to a call to active military service (*see Paragraph G* in this section for a description of your USERRA rights);
- Your Employer does not renew its Collective Bargaining Agreement with the Union or terminates a written participation agreement with the Plan;
- The Union and Employer negotiate other coverage and leave this Plan;
- Your Employer goes out of business;
- You die; or
- The date the Plan is terminated.

When any of the following events occur, your Dependents' coverage will terminate on the last day of the month:

- Your coverage terminates (except if you die; see Paragraph I in this section);
- Your child or Spouse no longer meets the definition of Dependent;
- The required monthly contribution toward the cost of family coverage is not made timely on your behalf; or
- The date the Plan is terminated.

You and your Dependents' Plan coverage will not be terminated retroactively except in the case of fraud or misrepresentation of material fact as prohibited under the terms of the Plan or in the event premium payments are not paid timely to the Plan.

In addition, your Retiree coverage will end on the earliest of:

- The date you die;
- The last day of the month in which you cease to satisfy the eligibility requirements for Retiree coverage; or
- The first day of the month in which you return to work in the graphic communications industry as a self-employed person or as an Employee, in Union or non-Union employment.

Note: If your employment is terminated, your hours decline and you lose eligibility, you leave employment due to military service, or your Employer goes out of business, you may have the right to continue coverage at your own expense (see Section II: Continuation of Coverage for more information).

I. EXTENSION OF COVERAGE UPON DEATH

Employees

If you are an eligible Employee and covered under the Plan at the time of your death, your Dependents will remain eligible for coverage for an additional 12 months. This 12-month period will begin on the first day of the month following the last month in which you worked in Covered Employment. Your Dependents' extension of coverage will end on the earliest of:

- The date the 12-month extension period expires;
- The date your surviving Spouse remarries; or
- The last day of the month in which your Dependent no longer meets the Plan's definition of Dependent.

Your Dependents will not be required to make premium payments during the 12-month extension period. At the end of the extension period, your surviving Dependents will be eligible for COBRA Continuation Coverage **for the balance** of the applicable COBRA coverage period.

If Medicare Supplemental Benefits are available for your group as described in your "Schedule of Benefits and Deductibles", a surviving Spouse who becomes eligible for Medicare at any time during the continuation period is eligible for the Plan's Medicare Supplemental Benefits, described in Section IV: Medicare Supplemental Benefits. Surviving Spouses have **sixty (60) days** after the death of the Employee or **sixty (60) days** after he or she loses COBRA Continuation Coverage due to Medicare entitlement, to elect the Plan's Medicare Supplemental Benefits coverage. The Medicare Supplemental Benefits coverage will end if the surviving Spouse fails to pay the required premium and no additional COBRA Continuation Coverage period will be available.

Retirees

If you are an eligible Retiree and covered under the Plan at the time of your death, your Dependents will remain eligible for coverage for an additional 12 months. This 12-month period will begin on the first day of the month following the Retiree's death. You Dependents' extension of coverage will end on the earliest of:

- The date the 12-month extension period expires;
- The date your surviving Spouse remarries; or
- The last day of the month in which your Dependent no longer meets the Plan's definition of Dependent.

Your Dependents will not be required to make premium payments during the 12-month extension period. At the end of the extension period, your surviving Dependents will be eligible for COBRA Continuation Coverage **for the balance** of the applicable COBRA coverage period.

A surviving Spouse who becomes eligible for Medicare at any time during the continuation period (including the 12-month extension described above) is eligible for the Plan's Medicare Supplemental Benefits, described in Section IV: Medicare Supplemental Benefits, provided Medicare Supplemental Benefits under the Plan are available to the decedent's group under the Collective Bargaining Agreement between the decedent's Employer and Local Union or by a written agreement between the decedent's Employer and the Board of Trustees. Please refer to the "Schedule of Benefits and Deductibles" provided with this SPD. Surviving Spouses have **sixty (60) days** after the death of the Retiree, or **sixty (60) days** after he or she loses COBRA Continuation Coverage due to Medicare entitlement, to elect the Plan's Medicare Supplemental Benefits coverage. The Medicare Supplemental Benefits coverage will end if the

surviving Spouse fails to pay the required premium and no additional COBRA Continuation Coverage period will be available.

J. CERTIFICATION WHEN COVERAGE ENDS

If you or your Dependents lose coverage under the Plan for any reason, HIPAA requires that the Plan provide you with a certificate showing your period of coverage. You also may request a certificate of coverage from the Plan at any time within the first 24 months after your coverage ends.

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

K. REINSTATEMENT OF COVERAGE

If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave, your coverage will be reinstated on the first day of the month for which contributions to the Plan are made on your behalf.

If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave, and is not reinstated within 62 days, the period of leave will be counted as a break in coverage.

Any period of approved family, medical, or military leave of absence will **not** be counted as a break in coverage.

Questions regarding your entitlement to such a leave and to the continuation of coverage should be referred to your Participating Local Union Fund or Employer.

L. ELIGIBILITY CONTINGENT ON PREMIUM PAYMENTS

All eligibility for coverage for you and your Dependents is contingent upon the Plan's timely receipt of monthly premium payments from your Participating Local Union Fund, your Employer or you in the case of COBRA Continuation Coverage. Premium payments are not required for the extension of coverage upon death (*see* Section I, Paragraph I: Extension of Coverage upon Death). Premium payments are required for COBRA Continuation Coverage (*see* Section II, Paragraph F: Payment for COBRA).

II. CONTINUATION OF COVERAGE

A. WHEN YOU MAY BE ENTITLED TO COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), you and your eligible Dependents may continue group health coverage temporarily at your own expense, where coverage otherwise would end due to a "Qualifying Event." Under the law, generally only "Qualified Beneficiaries" are entitled to elect COBRA continuation coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include an Employee, and his or her Spouse and Dependent(s) who were covered by the Plan when a Qualifying Event occurs. A child who becomes a Dependent child by birth, adoption or placement for adoption with the Employee during a period of COBRA continuation coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA continuation coverage is not a Qualified Beneficiary but may elect COBRA continuation coverage under Special Enrollment Rights described in Paragraph L.

There may be other coverage options for you and your family as described in Paragraph T: Health Insurance Marketplace Coverage Options in this section. As of January 1, 2014, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA continuation coverage does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for Special Enrollment Rights under another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally does not accept late enrollees, if you request enrollment within 30 days of loss of coverage.

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

If your Participating Local Union Fund or Employer provides Retiree coverage, then Retiree coverage is in lieu of *COBRA continuation coverage.* That is, if you are eligible for and elect Retiree coverage instead of COBRA continuation coverage, you will cease to be a Qualified Beneficiary and you will not be entitled to elect COBRA coverage once your COBRA election period expires. However, if you elect the Retiree coverage and your Spouse loses that coverage as a result of a Qualifying Event (such as divorce), your Spouse will have the right to extend the Retiree coverage under COBRA with a maximum coverage period of 36 months measured from the date of that Qualifying Event. Please refer to the "Schedule of Benefits and Deductibles" provided with this SPD to see if your group has Retiree coverage.

B. WHAT IS A QUALIFYING EVENT?

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

Qualifying Event	Who May Purchase Continuation Coverage	For How Long?
Voluntary or involuntary termination of your employment, (other than by reason of gross misconduct) or loss of eligibility due to a reduction of your work hours	Employee, Spouse, and Dependent(s)	18 months

Qualifying Event	Who May Purchase Continuation Coverage	For How Long?
You or your Dependent becomes disabled (as determined by the Social Security Act) at some time before the 60th day of COBRA Continuation Coverage and the disability lasts until the end of the 18-month COBRA continuation coverage period	Employee, Spouse, and Dependent(s)	29 months
You die	Spouse and Dependent(s)	36 months (no charge for the first 12 months; see Section I, Paragraph I for more info on extending coverage upon death)
You become legally separated or divorced from your Spouse	Spouse and Child	36 months
Your child(ren) is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit)	Child(ren)	36 months

Sometimes filing a proceeding in bankruptcy under Title 11 of the U.S. Code can be a Qualifying Event. If your Employer files for bankruptcy and that bankruptcy results in the loss of coverage of any Retiree covered under the Plan, the Retiree is entitled to COBRA continuation coverage with respect to the bankruptcy. The Retiree's Spouse, surviving Spouse and Dependent child (ren) will also be entitled to COBRA if bankruptcy results in the loss of their coverage under the Plan.

C. When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Fund Office has been notified that a Qualifying Event has occurred. Your Employer will notify the Fund Office when the Qualifying Event is the termination of employment, reduction of hours of employment or your death, within 30 days after any of these events occur. However, you or a family member should contact your Employer to confirm that notification of these events has been made to the Plan. Also, in the event your Employer commences a bankruptcy proceeding, you should contact the Fund Office within 30 days.

D. You Must Give Notice To Your Participating Local Union Fund or Your Employer of Some Qualifying Events

In case of your divorce or legal separation from your Spouse, or your Dependent child losing Dependent status under the Plan, you must notify your Participating Local Union Fund or your Employer no later than sixty (60) days after the Qualifying Event occurs. The notice of occurrence of any of these events must be provided in writing by using the Plan's "COBRA Event Notice Form for Covered Employees and Qualified Beneficiaries" (hereinafter, "Notice Form") This form may be obtained by contacting your Participating Local Union Fund, your Employer or the Fund Office.

In addition to the qualifying events listed above, there are two other situations where you are responsible for notifying your Participating Local Union Fund or your Employer, using the Plan's Notice Form:

- When a Qualified Beneficiary is determined by the Social Security Administration ("SSA") to be disabled during a COBRA continuation coverage period or when the SSA determines that a Qualified Beneficiary is no longer disabled (*see* Paragraph I: COBRA for Disabled Participants in this section).

- When a Qualified Beneficiary becomes entitled to (i.e., enrolls in) Medicare during a COBRA continuation coverage period. You must notify your Participating Local Union Fund or your Employer within **30 days** using the Plan's Notice Form. The Plan reserves the right to retroactively cancel COBRA continuation coverage and will require reimbursement of all benefits paid after the date of commencement of Medicare entitlement.

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

E. HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

Each Qualified Beneficiary has an independent (separate) right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for some members of the family and not others. In addition, one or more Dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA continuation coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event or became an eligible Dependent by marriage, birth, adoption or placement for adoption during the period of COBRA continuation coverage. An Employee may elect COBRA continuation coverage on behalf of his or her Spouse and a parent may elect or reject COBRA continuation coverage on behalf of a Dependent child living with him or her.

In considering whether to elect COBRA continuation coverage, you should take into account that you have Special Enrollment Rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

F. PAYMENT FOR COBRA

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

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

Payments for subsequent months are due on the first day of the month for which coverage is provided. Whether or not you are billed for subsequent months depends on the procedures established by your Participating Local Union Fund or Employer. If you have questions about their billing procedures, you should contact them directly.

G. Grace Period for Payments

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

H. Maximum Coverage Period

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

I. COBRA for Disabled Participants

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

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

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

You must notify your Participating Local Union Fund or your Employer within **30 days** of a final SSA determination that you are no longer disabled by using the Plan's Notice Form, available from the Fund Office.

J. Multiple Qualifying Events While Covered Under COBRA

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

Example: Assume you lose your job (the first COBRA-Qualifying Event), and you enroll yourself and your Dependents for COBRA continuation coverage. Three months after your COBRA continuation coverage begins, your child attains age 26 and ceases to qualify as an eligible Dependent. Your child then can continue COBRA continuation coverage for an additional 33 months, for a total of 36 months of COBRA continuation coverage.

In no case are you (the Employee) entitled to COBRA continuation coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA continuation coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA continuation coverage may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event. You must notify your Participating Local Union Fund or your Employer of a second Qualifying Event by using the Plan's Notice Form, available from your Participating Local Union Fund, your Employer or the Fund Office.

K. Termination/Reduction in Hours That Follows Medicare Entitlement

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

L. Special Enrollment Rights

If, while you are enrolled for COBRA continuation coverage you marry, have a newborn child, adopt a child or have a child placed with you for adoption, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within **30 days** after the marriage, birth, adoption or placement for adoption. Notice is to be provided to your Participating Local Union Fund or your Employer by using the Plan's Notice Form, available from your Participating Local Union Fund, your Employer or the Fund Office.

Any Qualified Beneficiary can add a new Spouse or child to his or her COBRA continuation coverage. However, the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to extend a COBRA continuation coverage period in certain circumstances, are children born to, adopted, or placed for adoption with the Employee.

If, while you are enrolled for COBRA continuation coverage, your Dependent(s) lose coverage under another group health plan, you may enroll that Dependent for coverage for the balance of the period of COBRA continuation coverage by doing so within **30 days** after the termination of the other coverage. Notice is to be provided to your Participating Local Union Fund or your Employer by using the Plan's Notice Form, available from the Fund Office.

In order to be eligible for this Special Enrollment Right, the Dependent must have been eligible for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to loss of eligibility under another plan, including, but not limited to, termination of employment, termination of contributions to the Plan on your behalf, or exhaustion of COBRA continuation coverage under another plan. Loss of eligibility does not include a

loss of coverage due to failure of the individual or participant to pay premiums on a timely basis or termination of employment for cause.

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

M. NOTICE OF UNAVAILABILITY OF COBRA

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

N. EARLY TERMINATION OF COBRA

COBRA continuation coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

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

*If Medicare Supplemental Benefits are available to your group under the Collective Bargaining Agreement between your Employer and your Local Union or by a written agreement between your Employer and the Board of Trustees, surviving Spouses have sixty (60) days after losing COBRA continuation coverage due to Medicare entitlement to elect the Plan's Medicare Supplemental Benefits coverage. *See* Section I, Paragraph I for more information.

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

O. NOTICE OF EARLY TERMINATION OF COBRA

Your Participating Local Union Fund or Employer will notify a Qualified Beneficiary if COBRA continuation coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA continuation coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period and the date COBRA continuation coverage terminated. The notice will be provided as soon as practicable after it is determined that COBRA continuation coverage will terminate early.

P. CONFIRMATION OF COBRA TO PROVIDERS

Under certain circumstances, federal rules require the Plan to inform your health care providers as to whether you have elected and/or paid for COBRA continuation coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and you are eligible for, but have not yet elected, COBRA continuation coverage, or you have elected COBRA continuation coverage

but have not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that COBRA continuation coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

Q. If You Have Questions

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

R. Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep your Participating Local Union Fund or your Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Participating Local Union Fund or your Employer.

S. Plan Contact Information

Graphic Communications National Health & Welfare Plan
ATTN: Plan Administrator
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222-1219
(800) 943-4248 Phone
(412) 201-2250 Fax

T. Health Insurance Marketplace Coverage Options

For coverage beginning January 1, 2014, the Health Insurance Marketplace is available to assist you in evaluating options for you and your family. Health insurance coverage through the Marketplace is only available if your employer does not offer you health insurance coverage or offers coverage that does not meet certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, you may be eligible for coverage through the Marketplace. Also, if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. A plan meets the minimum value standard if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. **Note that coverage under this Plan has been certified to meet the minimum value standard.**

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the benefit of your employer's contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

You can visit HealthCare.gov for more information about the Marketplace, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

III. MEDICAL BENEFITS

IMPORTANT

You may not be entitled to Medical benefits under the Plan. Please review your Schedule of Benefits and Deductibles to confirm your eligibility for this benefit.

A. HOW THE MEDICAL PLAN WORKS

The Plan provides medical benefits through a Preferred Provider Organization (PPO). Under the PPO program, medical services may be obtained either In-Network through a Participating Provider or Out-of-Network through a Non-Participating Provider.

B. PPO IN-NETWORK SERVICES

In-Network Health Care Providers agree with the Plan's Preferred Provider Organization (PPO) to provide health care services and supplies for a favorable negotiated fee applicable only to Participants in this Plan. When you use the services of an In-Network PPO Health Care Provider, you are responsible for paying only the applicable Coinsurance or Copayment for any Medically Necessary Covered Expenses. You do not have to file any claims for benefits when you use In-Network Health Care Providers; that is the responsibility of the Provider.

The In-Network PPO Provider accepts the Plan's payment, plus any applicable Deductible, Coinsurance and/or Copayment, as payment in full.

For every Provider you use, you are responsible for contacting the PPO to confirm that Provider's participating provider (In-Network) status.

C. PPO OUT-OF-NETWORK SERVICES

Out-of-Network Health Care Providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse you for the Usual and Customary Charge for any Medically Necessary Covered Expenses, subject to the Plan's Deductibles, Coinsurance, Limitations and Exclusions. You must submit proof of claim before any reimbursement will be made, and Out-of-Network Health Care Providers may bill you directly for any balance due over the amount payable by the Plan.

D. TRANSITION BENEFITS

If you are a member of a new group that has just joined the Plan, you are eligible for transition benefits in the following circumstances:

- If you or your Dependent(s) are in a course of treatment while under the care of a Provider in a PPO network other than the PPO network maintained by the Plan, you can continue your course of treatment for up to thirty (30) days at In-Network Benefit levels provided that the treatment is a Covered Expense and Medically Necessary. In order to receive In-Network Benefits for the thirty-

day grace period, you must continue to see the same Provider that you were seeing for your course of treatment on the date upon which you become eligible under this Plan. At any time during your course of treatment, you may switch to a Provider in the Plan's PPO network and receive In-Network Benefits.

- If you or your Dependent are in a course of treatment for a pregnancy, you are eligible for transition benefits provided that you are:

  - beyond the first trimester prior to the effective date of the new group's coverage; and
  - under the care of a Provider in a PPO network other than the PPO network maintained by the Plan.

  Transition benefits allow you to continue the course of treatment for your pregnancy at In-Network benefit levels through childbirth and discharge, as long as the same provider previously rendering such services to you or your Dependent renders all of the future services related to the pregnancy. At any time during your pregnancy, you may switch to a Provider in the Plan's PPO network and receive In-Network Benefits.

For purposes of this section, a "course of treatment" is a planned series of procedures or treatments prescribed by a Health Care Provider.

E. COVERED EXPENSES

You are covered for certain expenses you incur for medical services and supplies which are Medically Necessary. Services provided by a Preferred Provider Organization (PPO) Health Care Provider will be covered at the In-Network level shown in your Schedule of Benefits. Services provided by an Out-of-Network provider will be covered at the Out-of-Network level shown in your Schedule of Benefits.

The Plan will not always pay benefits equal to or based on the Health Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the Usual and Customary Charge for Out-of-Network health care services or supplies. Any amount in excess of the Usual and Customary Charge does **not** count toward the Plan's annual Out-of-Pocket Maximums.

The Health Care Providers who are members of the PPO Network have agreed to accept the designated Copayment or Deductible and Coinsurance and the amount payable by the Plan as full payment for the medical services or supplies they provide. As a result, you will not be responsible for any payment in excess of those amounts.

The Plan will not reimburse you for any expenses that are not Covered Expenses. That means you are responsible for paying the full cost of all expenses that are not covered by the Plan.

F. DEDUCTIBLES

Each year, depending on your Schedule of Benefits and Deductibles, you are responsible for paying all of your Covered Expenses for services and supplies provided by both an In-Network and Out-of-Network provider until you satisfy the annual Deductible, then the Plan begins to pay benefits. Generally, there are two types of Deductibles: Individual and Family. The Individual Deductible is the maximum amount one covered person must pay before the Plan begins to pay benefits. The Family Deductible is the maximum amount that a family of two or more must pay before the Plan begins to pay benefits. *See* your Schedule of Benefits and Deductibles for your Deductible amounts.

G. COINSURANCE

If a Deductible applies to your benefit, you must pay the Deductible before the Plan will pay the Coinsurance. This means that once you have met your annual Deductible, the Plan pays a percentage of the Covered Expenses, and you are responsible for paying the rest. The part you pay is called the Coinsurance. *See* your Schedule of Benefits and Deductibles to determine the percentage paid by the Plan.

IMPORTANT

If you fail to follow certain of the Plan's Utilization Management Programs, you may be subject to $300 penalty. That means that medical expenses covered by the Plan may be reduced by $300 in addition to any Deductibles or Coinsurance that may apply. These features are described in Section III, Paragraph L: Utilization Management.

H. COPAYMENTS

A Copayment is a set dollar amount you are responsible for paying when you incur a Covered Expense when you go to an In-Network Provider. The Plan pays the balance of the charge. When Copayments apply, there are no Deductibles or Coinsurance, unless the Plan specifically provides otherwise.

I. OUT-OF-POCKET EXPENSES

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

- Your Individual or Family Deductible
- Any applicable Coinsurance
- Any applicable Copayment
- All expenses for medical services or supplies not covered by the Plan
- All charges in excess of the Usual and Customary Charge for services provided Out-of-Network
- All charges in excess of the limitations of the Plan[1]
- Applicable penalties if you fail to comply with the Utilization Management Programs (*see* Section III, Paragraph L: Utilization Management)

J. OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the maximum amount of Coinsurance (and Deductible, if applicable to your group) each covered person or covered family is responsible for paying during a calendar year. When the Out-of-Pocket Maximum is reached, the Plan will pay 100% of any additional Covered Expenses for the remainder of the calendar year. Any expenses for medical services or supplies that are

[1] Prior to June 1, 2011, the Plan imposed limits on lifetime benefits that were covered by the Plan. For the limits in effect before that date please refer to your prior Summary Plan Descriptions and/or Summary of Material Modifications.

not covered by the Plan, and any charges in excess of the Usual and Customary Charges or non-compliance penalties, are not applied to the Out-of-Pocket Maximum.

K. MAXIMUM PLAN BENEFITS

The Plan does not impose any Annual or Lifetime Maximum Benefit for medical expenses incurred by any individual covered under this Plan and any Predecessor Plan for you and for each of your covered Dependents with the following exception[2]:

The Annual Maximum Plan Benefit for Covered Expenses incurred for or in connection with any form of outpatient in-vitro fertilization, artificial insemination or gamete intra-fallopian transfer (GIFT) under this Plan and any Predecessor Plan is $5,000 per year.

L. UTILIZATION MANAGEMENT

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

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

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

- **Precertification review** of certain proposed health care services **before** the services are provided. You must obtain admission precertification from the Utilization Management (UM) Company for:
    - all non-Emergency Hospital admissions;
    - all non-Emergency admissions to any Specialized Health Care Facility.

  In the event of an Emergency admission to any type of facility, you must notify the UM Company within 48 hours of the Emergency care.

  Some Health Care Providers may obtain precertification for you. However, you are responsible for ensuring that Hospital services have been precertified. Therefore, you should confirm precertification with your Health Care Provider prior to Hospital admission.

- **Concurrent (continued stay) review** of health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Specialized Health Care Facility.

- **Second and third opinions** through Health Care Provider consultation and/or examination designed to take a second, and, when required, a third look at the need for certain elective health care services.

- **Retrospective review** of health care services **after** they have been provided.

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[2] Prior to June 1, 2011, the Plan imposed limits on lifetime benefits that were covered by the Plan. For the limits in effect before that date, please refer to your prior Summary Plan Descriptions and/or Summary of Material Modifications.

- **Case Management**, whereby the patient, the patient's family, and Health Care Provider(s) work with the UM Company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for patients who require complex, high-technology medical services. Case management may include prior approval for treatment, discharge planning and psychiatric procedure review, among other things.

The UM Program is administered by the Plan's PPO provider, listed in the Quick Reference Chart at the front of this booklet. The UM professionals focus on:

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

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

IMPORTANT

- Your Health Care Provider's recommendation for Surgery, Hospitalization, confinement in a Specialized Health Care Facility, or other medical services or supplies does **not** mean that the recommended services or supplies will be considered Medically Necessary for determining coverage for medical Benefits under the Plan.

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

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

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

- If the UM Company determines that the services are not Medically Necessary, no Plan Benefits will be payable for those services.

- If the UM Company determines that the services are Medically Necessary, Plan Benefits will be payable for those services. However, you will have to pay an additional $300 toward the cost of services, in addition to any Deductible or Coinsurance that may apply. The additional $300 does not count towards your Deductible or Out-of-Pocket Maximum.

M. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

N. BREAST RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

In accordance with the Women's Health and Cancer Rights Act of 1998, this Plan will provide the following coverage for a Participant who is receiving benefits in connection with a mastectomy:

- Surgical services for reconstruction of the breast on which the mastectomy has been performed;
- Surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance; and
- Postoperative prostheses and physical complications for all stages of the mastectomy, including lymphedema therapy.

O. DESCRIPTION OF MEDICAL BENEFITS

(*See* Section III, Paragraph P: Exclusions and Section XIV: Definitions for important information on exclusions and limitations to these Plan benefits.)

Benefit Description	Explanations and Limitations
Hospital Services (Inpatient): ▪ Room & board in semiprivate room ▪ General nursing services ▪ Specialty care units (e.g., intensive care unit, cardiac care unit) ▪ Lab/x-ray/diagnostic services ▪ Related Medically Necessary ancillary services (e.g., prescriptions, supplies) ▪ Newborn care ▪ Hospitalization for dental services due to injury to sound natural teeth and/or certified by a Health Care Provider as necessary to safeguard the health of the patient ▪ Operating, delivery, recovery and treatment room and equipment fees ▪ Services or supplies furnished by a Hospital for treatment in outpatient department, emergency room or ambulatory surgical facility ▪ Anesthesia and its administration ▪ Oxygen and its administration ▪ Blood transfusions and blood products ▪ Inpatient treatment of Mental or Nervous Disorder ▪ Confinement for medical complications of Alcoholism or Drug Abuse (e.g., cirrhosis, delirium tremens, and detoxification)	▪ Private room is covered only if Medically Necessary. ▪ Hospitalization primarily for diagnostic study directed toward a definite Illness or Injury is not covered where treatment is by means of physical therapy, hydrotherapy or occupational therapy, unless the services can be provided only on an inpatient basis and the patient's physical condition requires hospitalization.

Benefit Description	Explanations and Limitations
Surgical Expenses: ▪ Medically Necessary surgical procedures ▪ Anesthesia fees for Health Care Providers and Certified Registered Nurse Anesthetists ▪ Assistant surgeon ▪ Dentist or Health Care Provider fees for covered dental care required as a result of Injury to sound natural teeth ▪ Surgical sterilization (e.g., vasectomy, tubal ligation)	▪ Assistant Surgeon fees not to exceed 20% of the expense of the covered surgical procedure. ▪ Multiple surgeries from the same incision are covered at 100% of Covered Expenses for the major procedure and 50% of Covered Expenses for each additional procedure. ▪ Multiple surgeries from different incisions are covered at 100% of Covered Expenses for each procedure.
Mental or Nervous Disorder Treatment: ▪ Psychological (Psychiatric) Testing ▪ *Inpatient and Outpatient Services*	▪ Benefits are payable only for services of Mental Health Practitioners listed in Section XIV: Definitions.
Alcoholism and Substance Abuse Treatment: ▪ *Inpatient and Outpatient Services*	▪ Benefits are payable only for services of Mental Health Practitioners listed in Section XIV: Definitions.
Durable Medical Equipment: ▪ Coverage is provided for the rental or purchase of Durable Medical Equipment. Purchase is payable only when expected to be less costly than long-term rental. ▪ Benefits are payable for Medically Necessary repair and servicing of Durable Medical Equipment. Benefits for replacement of Durable Medical Equipment are payable when replacement is Medically Necessary due to a change in the physical condition of the covered person or if the equipment cannot be satisfactorily repaired.	▪ **See the specific exclusions related to Durable Medical Equipment in the Exclusions section.** To help determine what Durable Medical Equipment is covered, see the definition of **"Durable Medical Equipment"** in Section XIV: Definitions. ▪ Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Health Care Provider.
***Emergency and Transportation Services*:** ▪ Hospital emergency room or free-standing Urgent Care Center for a Medical Emergency, subject to the Copayment shown in the Explanations and Limitations column. ▪ Ground transportation (*e.g.*, ambulance) to nearest appropriate facility as Medically Necessary for treatment of Medical Emergency, acute Illness or inter health care facility transfer.	▪ Covered only when services are for a Medical Emergency. See definition of "Medical Emergency" in Section XIV: Definitions. **No coverage** is provided for non-emergency use of transportation services. ▪ **Reduced coverage** is provided for non-emergency use of emergency or urgent care facilities.
Family Planning Services: ▪ In vitro fertilization, artificial insemination or gamete intra-fallopian transfer (GIFT) services provided on an outpatient basis.	▪ Covered Expenses are subject to Coinsurance, and an Annual Maximum Plan Benefit of $5,000 per family. ▪ Not covered when performed on a surrogate parent.

Benefit Description	Explanations and Limitations
Home Health Services: ▪ Part-time, intermittent **Skilled Nursing Care** and home health aide services and Medically Necessary supplies to provide Home Health Care, Physical, occupational and speech therapy. ▪ Prescription drugs and medicines, including intravenous drugs.	▪ **See the specific exclusions related to Home Health Care and custodial care (including personal care and child care) in the Section III, Paragraph P: Exclusions.** ▪ **Home Health Care must start within 7 days after the discharge from a Hospital as an inpatient.** ▪ **Home Health Services may not exceed 40 visits per year.** ▪ Each visit by a Nurse or therapist is one visit, and each visit up to 4 hours by a home health aide is one visit. ▪ Services or supplies which are not part of a Home Health Care Plan. ▪ Services or supplies provided by a person who usually lives with patient or is a member of the patient's family. ▪ Transportation.
Maternity Services: ▪ Hospital and Birthing Center charges and Health Care Provider fees for Medically Necessary maternity services. ▪ Amniocentesis or chorionic villus sampling (CVS) for pregnant women only if the procedure is Medically Necessary. ▪ Termination of pregnancy.	▪ **See the specific exclusions related to fertility and reproductive care in** Section III, Paragraph P. ▪ Exclusions. Pregnancy-related care is covered if it occurs while the mother is a Participant, Spouse, or Dependent child. ▪ *See* also the HIPAA Special Enrollment Rights for the rules for Coverage of **Newborn Dependent Children** in Section I, Paragraph E.
TMJ Services: ▪ Temporomandibular joint (TMJ) dysfunction and syndrome.	▪ **See the specific exclusions related to Dental Services in Section III, Paragraph P: Exclusions.**
Preadmission Testing: ▪ Laboratory tests, x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled Hospital admission or out-patient Surgery.	▪ Covered only when ordered by a Health Care Provider within seven days of scheduled surgery.
Second (and Third) Surgical Opinion: ▪ Consultation with a Health Care Provider. ▪ Laboratory tests.	▪ See Section III, Paragraph L: Utilization Management for details of the Second Surgical Opinion Program. ▪ Additional Medically Necessary tests are covered under other Plan provisions.

Benefit Description	Explanations and Limitations
Specialized Health Care Facilities: ▪ Birthing Center ▪ Hospice ▪ Skilled Nursing Facility (SNF)	▪ **Admission to a Specialized Health Care Facility is subject to precertification.** See Section III, Paragraph L: Utilization Management for details. ▪ Specialized Health Care Facility services must be ordered by a Health Care Provider. To determine if a facility is a **"Specialized Health Care Facility,"** see Section XIV: Definitions.
Chiropractic Services: Spinal Manipulation, including ancillary and related services (*e.g.*, visit, x-rays, physical therapy) from a Health Care Provider or Chiropractor, subject to an Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	▪ Chiropractic Services are limited to 24 visits per calendar year. ▪ Except in the event that it is specifically counter indicated, Chiropractic care shall not include a follow up visit unless a chiropractic manipulation is performed during the visit. ▪ X-Rays are considered on initial visit only.
Transplantation (Organ and Tissue): ▪ Coverage is provided only for eligible services directly related to Transplantation of human organs or tissue	▪ **See the specific exclusions related to Transplantation in the Exclusions section.** ▪ Benefits are payable only if services are preauthorized by the UM Company. ▪ Eligible expenses include only an **uninsured** prospective transplant donor's medical expenses directly associated with the evaluation to determine if the prospective donor is a good candidate for the living donation, the donation surgery and post-operative care.
Well Child Examinations and Immunizations: ▪ Coverage for preventive services as recommended by the Health Resources and Services Administration's Bright Futures Project. ▪ Outpatient newborn and well child visits and routine childhood immunizations (*e.g.*, DTP, polio, MMR, hepatitis), behavioral and developmental assessments, iron and fluoride supplements, and screenings for autism, vision impairment, lipid disorders, TB and certain genetic disorders.	▪ This benefit is available **In-Network only**. However, immunizations are covered for in or out of network providers. ▪ **Deductibles, Co-Payments and Coinsurance do not apply** to these benefits. ▪ *See* also the HIPAA Special Enrollment Rights for the rules for **Coverage of Newborn Dependent Children** in Section I, Paragraph E.
Adult Wellness Benefit (Age 13 and up): ▪ Routine exam ▪ Screenings and Counseling as recommended by the US Prevention Services Task Force rated either "A" or "B" which include screenings and counseling for depression, diabetes, cholesterol, obesity, certain cancers, HIV and sexually transmitted diseases. Counseling for tobacco use cessation and healthy eating. ▪ Adult immunizations as recommended by the Advisory Committee on Immunization Practices, including immunizations for influenza, meningitis, tetanus, HPV, hepatitis A&B, MMR, and chickenpox.	▪ This benefit is available **In-Network only.** ▪ **Deductibles, Co-Payments and Coinsurance do not apply** to these benefits.

Benefit Description	Explanations and Limitations
Well Woman Care: ▪ All services provided under Adult Wellness Benefit, Pap test and mammogram screening plus annual well woman exam and FDA-approved contraceptives and sterilization procedures, and related counseling, breast-feeding and domestic violence counseling.	▪ Coverage available In-Network only. ▪ Deductibles, Co-Payments and Coinsurance do not apply. ▪ Coverage is provided for **one** Pap smear lab test per year. ▪ Coverage is provided for one screening mammogram and interpretation of it each year between the ages of 40 and 75, or as recommended by a Health Care Provider.

P. EXCLUSIONS

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

- Medical services/supplies, including prescription drugs, considered educational (except as provided for under your Wellness Benefits), Experimental or Investigational medical treatment, including any treatment, drug, or supply not recognized as acceptable or legal medical practice in the United States or any items requiring governmental approval not granted at the time service is rendered;
- Medical services/supplies available without cost or not legally required to be paid for in absence of the Plan;
- Medical services or supplies furnished in or by a Federal, State, or local government, agency, or program or in or by a Hospital or institution owned thereby unless required by law;
- Medical services or supplies, including prescription drugs, furnished in or by a nursing home, sanitarium, rest home, convalescent home, extended care facility or similar establishment unless it satisfies the definition of Skilled Nursing Facility;
- Private duty nursing care (unless ordered by a Health Care Provider and determined to be Medically Necessary), custodial care, or domiciliary care regardless of the facility where provided;
- Medical services or supplies furnished by an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage;
- Transsexual surgery;
- Services to reverse voluntary, surgically induced infertility;
- Therapeutic devices, including, but not limited to, hypodermic needles, syringes, support garments, or other nonmedical substances purchased for self-use, except paraphernalia necessary for the administration of insulin;
- Replacement or repair of a prosthetic appliance, unless outgrown;
- Orthotics, and orthopedic shoes (except when joined to braces) or supportive devices for the feet, including, but not limited to, arch supports and heel lifts;
- Routine care of feet, including callus or corn paring, trimming or excision of toenail, or treatment of chronic conditions of the foot including, but not limited to, weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain;
- Radial keratotomy;
- Acupuncture;
- Organ Transplants that are Experimental and/or Investigational, and expenses related to non-human (Xenografted) organ and/or tissue Transplants or implants, except heart valves;
- Orthodontic supplies or services;
- Medical expenses of an organ transplant donor other than eligible medical expenses of an **uninsured** prospective donor's directly associated with the evaluation to determine if the prospective donor is a good candidate for the living donation to an eligible Plan participant, the donation surgery and post-operative care;

- Therapy for marriage-related problems;
- Physical, occupational, myofunctional therapy, or pulmonary rehabilitation, except following Illness or Injury;
- Hypnotism, stress management, or goal-oriented behavior modification therapy except as provided for under your Wellness Benefits;
- Expense for medical or surgical treatment of exogenous obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, and any complications thereof, even if those procedures are performed to treat a comorbid or underlying health condition except for counseling provided under the Plan's Wellness Benefits;
- Cosmetic, plastic, or reconstructive surgery, except to repair or alleviate damage resulting from or caused by Injury, congenital defect, or disfigurement related to a disease;
- Construction, services, purchase or rental of supplies, appliances, or equipment for personal hygiene, beautification, comfort or convenience including, but not limited to, cosmetics, air conditioners, dehumidifiers, health club fees, vaporizers, heaters, speech teaching aides, Braille training tests, exercise equipment, whirlpools, tanning beds, water beds, telephones, televisions, or other items not essential for treatment of an Illness or Injury;
- Travel or lodging, whether or not recommended by a Health Care Provider, except as approved for organ Transplants;
- Transportation of a family member or medical personnel, equipment or supplies, except local ambulance service and transportation for organ Transplantation services;
- Hearing aids;
- Fees for services and supplies in excess of the negotiated fee or the Usual and Customary level;
- Expenses that are not Medically Necessary, unless specifically stated herein;
- Vision care, except as provided in the Vision Benefits section of this SPD (Section VI);
- Dental care, except as provided in the Dental Benefits section of this SPD (Section V);
- Expenses that are not ordered by a Health Care Provider;
- Services rendered primarily for training or educational purposes except as provided for under your Wellness Benefit;
- Charges or claims for any medical or other treatment, service or supply to the extent that the cost of such charges may be recoverable by, or on behalf of you or your Dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your Dependent, or attorney may receive as a result of any accident, illness or injury (collectively "Injury"), regardless of how these amounts are characterized or who pays these amounts, as provided in Section XII-H "Subrogation and/or Reimbursement";
- Charges paid or payable by another plan, including benefits that are not paid by the other health plan due to failure by the Participant to comply with a term or condition of the other health plan.
- Covered Expenses incurred prior to the date of coverage under the Plan;
- An Injury or Illness or services or supplies that arise out of or in the course of employment and that are compensable under workers' compensation, occupational disease, or similar laws, whether or not the right therefor is asserted, except as may be provided as a nonmedical benefit under the Plan;
- An Injury or Illness resulting from past or present military service or caused by or arising from an act of war, whether declared or not, or a conflict involving armed forces;
- Claims not submitted within one year of the time the service was rendered or the event occurred;
- Charges for failure to keep a scheduled appointment or for the completion of any form; and
- Charges for any health care services and/or supplies received pursuant to a private contract with a Health Care Provider that has agreed not to submit claims to, or receive payment from, Medicare.

IV. MEDICARE SUPPLEMENTAL BENEFITS

IMPORTANT

You may not be entitled to Medicare Supplemental Benefits under the Plan. Please review your Schedule of Benefits and Deductibles to confirm your eligibility for this benefit.

MEDICARE PART A CLAIMS

If you are covered by Medicare Part A, your medical claims are automatically filed through the "Medicare Direct" program. After Medicare pays its share of your expenses, the Fund Office receives claim payment information directly from Medicare. The Fund Office will then process the claim and send you an Explanation of Benefits (EOB) statement, together with any reimbursement.

MEDICARE PART B CLAIMS

If you are covered by Medicare Part B, your medical claims are automatically filed through the "Medicare Direct" program. After Medicare pays its share of your expenses, the Plan receives claim payment information directly from Medicare. The Plan will then process the claim and send you an Explanation of Benefits (EOB) statement, together with any reimbursement.

Neither you nor your doctor should submit Medicare Part A & B claims to the Fund Office.

V. DENTAL BENEFITS

IMPORTANT

You may not be entitled to Dental Benefits under the Plan. Please review your Schedule of Benefits and Deductibles to confirm your eligibility for this benefit.

A. COVERED DENTAL EXPENSES

The Plan will reimburse you only for Covered Dental Expenses, subject to the Lifetime and Annual Maximums shown in the chart below and in your Schedule of Benefits and Deductibles. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Covered Dental Expenses that exceed the amount covered by the Plan. You must also pay any applicable Deductible and Coinsurance amounts.

B. DEDUCTIBLES

Each year, you must pay all your Covered Dental Expenses until you satisfy the annual Deductible, then the Plan begins to pay benefits. There are generally two types of Deductibles: Individual and Family. The Individual Deductible is the maximum amount one covered person has to pay before the Plan pays any benefits. The Family Deductible is the maximum amount that a family of two or more has to pay before the Plan pays benefits. See your Schedule of Benefits and Deductibles to determine your annual Deductible.

C. COINSURANCE

Once you have satisfied your annual Deductible, the Plan pays a percentage of your Covered Dental Expenses, and you pay the rest. The part you pay after the Deductible is called Coinsurance. See your Schedule of Benefits and Deductibles to determine the amount of Coinsurance paid by the Plan.

D. ANNUAL AND LIFETIME MAXIMUM PLAN BENEFITS

The Annual and Lifetime Maximum Plan Benefits payable for dental expenses for any individual under this Plan is provided in your Schedule of Benefits and Deductibles.

E. PRETREATMENT ESTIMATES

You may obtain a pretreatment estimate for any course of dental treatment. Have your Dentist submit a completed dental claim form indicating the type of work to be performed with the estimated cost to the Administrator. The Administrator will send you and your Dentist a statement showing what the Plan will pay. Then you will know your out-of-pocket cost before you begin treatment.

F. DESCRIPTION OF DENTAL BENEFITS

(*See* the DEFINITIONS section of this document for important information on exclusions and limitations to these Plan benefits.)

Benefit Description	Explanations and Limitations
Class I Preventive Services: ▪ Oral examination ▪ Prophylaxis (cleaning of the teeth) ▪ Examination for consultation purposes ▪ Bite-wing x-rays ▪ Full mouth x-rays ▪ Topical application of sodium or stannous fluoride ▪ Space maintainers, for a child after early loss of a first tooth ▪ Topical application of sealants on posterior teeth	▪ Preventive services are **subject to the Annual and Lifetime Maximum Plan Benefits.** ▪ Oral examination, prophylaxis, scaling, cleaning, polishing, and bite-wing x-rays are limited to twice in a 12-month consecutive period, with no more than one of each service in a 3-month period. ▪ Prophylaxis, scaling, cleaning and polishing limited to twice in a 12-month consecutive period. ▪ Bite-wing x-rays limited to two charges in a 12-month consecutive period. ▪ Full mouth x-rays limited to once in a 36-month period, except to diagnose a specific condition or its treatment. ▪ Fluoride limited to family members under the age of 15 and limited to not more than once in a 12-month consecutive period. ▪ Applications of sealants limited to family members under the age of 15 and limited to not more than once in a 36-month period. ▪ Consultations limited to once in a 3-month period.
Class II Restorative Services: ▪ Prescription drugs, including injection of necessary antibiotic drugs by the attending Dentist ▪ Tooth extractions ▪ Amalgam, silicate, acrylic, plastic and composite filling restoration for decayed or broken teeth ▪ Treatment of periodontal and other diseases of the gums and supporting structures of the mouth (gingiva and/or alveolar bone) ▪ Oral surgery, including extractions and surgical procedures ▪ Administration of local, general anesthesia and/or intravenous sedation in connection with oral surgery and covered dental services ▪ Endodontic treatment, including root canal therapy ▪ Drugs and medicines that are FDA-approved pharmaceuticals requiring a prescription by a Dentist ▪ Prosthodontics - first installation of full and partial removable dentures ▪ Replacement of an existing removable denture or fixed bridgework by a new denture or by adding teeth to a partial removable denture	▪ Services are subject **to Annual and Lifetime Maximum Plan Benefits**. ▪ Replacement of bridgework or dentures is covered only if at least 5 years have passed since initial placement, and if existing bridgework or denture cannot be repaired, or the existing fixture is temporary and is replaced within 12 months of initial placement. Replacement is not covered for a lost or stolen prosthetic device. ▪ Replacement of crowns, inlays and prosthetic appliances (unless the appliance replaces a missing tooth) is covered only if at least 3 years have passed since initial placement. ▪ Services or prosthetic devices, crowns, or bridges are not covered if performed or ordered prior to Plan coverage or installed more than 30 days after Plan coverage ends.

Benefit Description	Explanations and Limitations
▪ Repair, re-cementing of crowns, inlays, onlays or dentures ▪ Adjusting, relining or re-basing of removable dentures	
Class III Restorative Services: ▪ Installation of full and partial fixed bridgework, including precision attachments ▪ Inlays and crowns ▪ Replacement of an existing partial or full removable denture or fixed bridgework ▪ Prosthodontics - initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth that were extracted. Expenses on account of adjustments to fixed bridgework are covered only for the 6-month period following initial installation ▪ Precision or semi-precision attachments for prosthetic devices ▪ Gold restorations	▪ Services are **subject to Annual and Lifetime Maximum Plan Benefits**. ▪ Replacement of bridgework or dentures is covered only if at least 5 years have passed since initial placement, and if existing bridgework or dentures cannot be repaired, or the existing fixture is temporary and is replaced within 12 months of initial placement. Replacement is not covered for a lost or stolen prosthetic device. ▪ Replacement of crowns, inlays and prosthetic appliances (unless the appliance replaces a missing tooth) is covered only if at least 3 years have passed since initial placement. ▪ Services or prosthetic devices, crowns, or bridges are not covered if performed or ordered prior to Plan coverage or installed more than 30 days after Plan coverage ends.
Orthodontia Services: ▪ Necessary services related to an active course of orthodontia treatment include diagnosis, evaluation and pre-care ▪ The initial installation of orthodontic appliances for an active course of orthodontia treatment ▪ Adjustment of active orthodontia appliances ▪ This orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function.	▪ Orthodontia services **are subject to the Lifetime Maximum Plan Benefits.** ▪ Repair or replacement of orthodontia appliances is **not covered.**

G. EXCLUSIONS

Following is a list of some dental services, supplies, and expenses that are not covered by the Dental Plan.

- Expenses for home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.;
- Expenses for oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth);
- Expenses for any dental services or appliances including, but not limited to items to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear or bruxism and harmful habits, except as provided under the Orthodontic Benefit outlined in the list of Dental Benefits;
- Expenses for treatment, by any means, of jaw joint problems including Temporomandibular Joint dysfunction (TMJ), disturbance, or syndrome;
- Harmful habit appliances;
- Charges for implantology;

- Dental services and supplies rendered solely for cosmetic purposes unless required as a result of an Illness or Injury or unless expressly provided otherwise, including personalization or characterization of dentures;
- Charges for crowns and pontics placed on, or replacing, teeth other than the ten upper and lower anterior teeth;
- Charges for a plan of treatment, where a less expensive plan of treatment may be utilized to achieve a resolution of the dental problem;
- Charges in excess of Usual and Customary Charges; and
- Any dental services not included on your Dental Schedule of Benefits.

VI. VISION BENEFITS

IMPORTANT

You may not be entitled to Vision Benefits under the Plan. Please review your Schedule of Benefits and Deductibles to confirm your eligibility for this benefit.

A. COVERED VISION EXPENSES

The Plan will reimburse you only for Vision Expenses covered under the Plan. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Covered Vision Expenses that exceed the Benefit limitations and maximums.

B. DESCRIPTION OF VISION BENEFITS

Covered Vision Expenses include, among other things:

- One eye exam or vision analysis in a 12-month period, performed by a licensed optometrist or ophthalmologist.

- Prescription contact lenses, after cataract surgery, or if necessary to correct visual acuity, or for cosmetic purposes if new lenses are required due to a prescription change.

- One pair of prescription contact lenses or prescription eye glasses to correct visual acuity, including bifocals, trifocals, including oversize lenses and plastic lenses.

See your Schedule of Benefits to determine the amount and frequency covered. Vision benefits are subject to additional terms and conditions as set forth in the contract with the vision care benefit provider.

C. EXCLUSIONS

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

- Expenses incurred for a vision care service or supply which is a Covered Expense in whole or in part under the medical portion of this Plan will not be covered as a vision care expense;
- Expenses for the treatment of a condition covered by workers' compensation or occupational disease law;
- Expenses for special procedures which include, but are not limited to, orthoptics or vision training;
- Expenses for laser eye surgery performed to correct vision;
- Expenses for special supplies which include, but are not limited to, nonprescription sunglasses or subnormal vision aids;
- Expenses for anti-reflective coatings;
- Expenses for tinted lenses;
- Expenses for prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses;
- Eye examination required as condition of employment (or required by labor agreement or by government law);
- Replacement of lost, stolen or broken lenses or frames;

- Duplicate or spare eyeglasses, lenses or frames; and
- Lenses or frames ordered or furnished due to exam while not covered by the Plan.

VII. PRESCRIPTION DRUG BENEFITS

IMPORTANT

You may not be entitled to Prescription Drug Benefits under the Plan. Please review your Schedule of Benefits and Deductibles to confirm your eligibility for this benefit.

A. COVERED PRESCRIPTION DRUG EXPENSES

The Prescription Drug Plan covers expenses you incur for prescription drugs, including legend drugs, injectable insulin, or other state-controlled drugs, which must be prescribed by a Health Care Provider and dispensed by a pharmacist. Prescription Drug Benefits are subject to additional terms and conditions as set forth in the contract with the Prescription Benefit Manager (PBM). Refer to your Schedule of Benefits and Deductibles for Deductible and Copayment amounts.

Coverage is provided only for FDA-approved pharmaceuticals requiring a prescription and FDA-approved for the condition, dose, route, duration and frequency, if prescribed by a Health Care Provider authorized by law to prescribe them.

The Plan has the right to review the facts and circumstances of any prescription drug purchase or refill to ensure appropriate use of Plan Benefits.

B. PRESCRIPTION DRUG STEP THERAPY

If you are eligible for Prescription Drug Benefits, you are required to utilize the Prescription Drug Step Therapy Program. When many different drugs are available for treating a particular condition, a Step Therapy Program is helpful in finding the most appropriate, cost-effective drug treatment. The Program only applies to drugs used to treat chronic medical conditions such as arthritis, pain/inflammation, diabetes, depression, high blood pressure, GI peptic disorders, attention deficit disorder, atopic dermatitis, sleep disorders, viral diseases, allergies, high cholesterol and asthma. Step Therapy requires trial use of a step-one drug (usually generic) before a step-two or step-three drug (usually name-brands) will be covered by the Plan. Use of step-one drugs is referred to as "first-line therapy." Step-one drugs are less expensive but known to be safe and effective for most people. You pay the lowest co-payment for step-one drugs and they help contain prescription drug costs for the Plan thereby protecting your prescription drug benefit. If you have tried first-line therapy without success, the next step is to try second-line therapy (step-two or step-three drugs). A prescription for a step-two or step-three drug will only be filled at the pharmacy if the patient's claims history shows that a step-one drug was filled within the last 130 days. Express Scripts, the Plan's Pharmacy Benefits Manager, maintains a list of step-one, step-two and step-three drugs which will be available to participants and their doctors. In certain situations, the prescribing physician may contact Express Scripts to request authorization of coverage for a step-two or step-three drug without prescribing a step-one drug in the past 130 days. More information about Step Therapy is available at www.steptherapyfacts.com.

C. MAIL ORDER PRESCRIPTION DRUG PROGRAM

Important Note: This program is *not* available if your group contracts directly with Delaware Valley Health Care Coalition.

If you are eligible for Prescription Drug Benefits, you may utilize the Mail Order Prescription Drug Program for your maintenance prescription drugs. **Although the Mail Order Prescription Drug Program is not mandatory, you must contact Express Scripts to opt out.** Contact information is in the Quick Reference Chart at the beginning of this SPD. You may order three months (90 days) of your prescription medications at the cost of two months of drugs (i.e., three months of prescription medications for two co-pays). When a pharmacy fills an eligible prescription, Express Scripts will contact you with information about the discount Mail Order Drug Program. Drugs eligible for mail order may be ordered on-line, by phone or through the mail. Participants are encouraged to participate since it will reduce costs for the Participants and the Plan. Contact information may be found on the back of your member ID card. If you fail to contact Express Scripts by the third fill on a prescription, no coverage will be provided until you contact Express Scripts. Additional information about the Mail Order Prescription Drug Program is available on the Web at www.express-scripts.com.

D. SPECIALTY DRUGS[3]

Specialty Drugs are a special classification of medicines for conditions such as multiple sclerosis, hemophilia, some cancers, organ transplants and Hepatitis C. Specialty Drugs generally have one or more of the following characteristics:

1. Frequent dosing adjustment and intensive clinical monitoring
2. Need for intensive patient training and compliance assistance
3. Limited availability
4. Specialized product handling and/or administration
5. High cost

[3] If, as of the effective date of the rules regarding Specialty Drugs, you were taking a Specialty Drug which would have been subject to the new rules, your prescription was partially grandfathered, i.e. exempt from some of the new rules; you were permitted to continue taking the Specialty Drug that had been prescribed.

CuraScript

CuraScript is a specialty mail-order pharmacy that you must use to fill Specialty Drug prescriptions. You will not be able to fill Specialty Drug prescriptions at a regular retail pharmacy. However, Specialty Drug Prescriptions are shipped out overnight from CuraScript via UPS so there is generally less waiting for receipt of Specialty Drugs through mail-order since retail pharmacies often do not stock Specialty Drugs and orders can take a couple of days. Through CuraScript, a nurse will contact the patient and provide detailed information regarding the administration of the Specialty Drug they are prescribed. This education includes alerts about possible side effects so that the patient will know what to expect when taking the drug.

Note that for drugs that are needed immediately such as for release from the hospital, the patient is permitted to secure the drug through a retail pharmacy to which he or she has been directed by the hospital and which will have the drug in stock. In this case, the hospital will usually educate the patient about administration and possible side effects of the drug.

Prior Authorization

In consultation with your healthcare provider, certain Specialty Drugs will require Prior Authorization before a prescription will be filled. If a drug you have been prescribed is subject to Prior Authorization, you will be alerted by CuraScript. Drugs which are subject to these rules are those that can be used for both medical and non-medical purposes and those that are sometimes prescribed for purposes not approved by the FDA (off-label use). The Prior Authorization will confirm whether the drug has been prescribed appropriately for a medical purpose, in accordance with FDA guidelines and, if so, if it is covered by the Plan.

If your prescription is subject to Prior Authorization, your doctor should call Express Scripts at (877) 503-4073 with the information needed to confirm the purpose of the medication and whether it will be covered by the Plan. Prior Authorization phone lines are open 24/7. A list of drugs subject to these rules is available from Express Scripts. In consultation with your doctor, a different medication (referred to as a "preferred product") may be prescribed. Once a prescription is authorized, it can be refilled without additional authorization. Remember, you can always pay the full cost of the prescription if you elect not to comply with Prior Authorization.

Step Therapy

Certain Specialty Drugs will be subject to Step Therapy (See description under Section VII, Paragraph B). When several different Specialty Drugs are available for treating a particular condition, a Step Therapy Program is helpful in finding the most appropriate, cost-effective drug treatment.

E. EXCLUSIONS

FOR A LIST OF PRESCRIPTION DRUG EXCLUSIONS, CALL THE TELEPHONE NUMBER ON THE BACK OF YOUR PRESCRIPTION DRUG CARD.

VIII. WEEKLY DISABILITY BENEFITS

IMPORTANT

You may not be entitled to Weekly Disability Benefits under the Plan. Review your Participating Local Union Fund's or Employer's rules and regulations to confirm your eligibility.

A. COVERAGE

Weekly Disability Benefits are payable if you become Disabled while you are actively working in Covered Employment as a result of a non-occupational Injury or Illness. Payment of Weekly Disability Benefits starts after the applicable Waiting Period has been completed. See your Schedule of Benefits to determine the amount and period of Weekly Disability Benefits payable to you, and any applicable Waiting Period.

For the purposes of the Weekly Disability Benefits, "Disabled" means the inability of a covered Employee to perform his or her duties with the Employer as a result of non-occupational Illness or Injury. A Disabled Employee is not eligible to receive Weekly Disability Benefits from the Plan if he or she performs work for compensation or profit.

"Period of Disability" means any one continuous period of Disability that is due to one or more causes. Successive Periods of Disability will be considered to be one continuous Period of Disability if:

- the Periods of Disability are due to the same cause or a related cause and are not separated by at least 2 weeks of active work at your job; or
- the Periods of Disability are due to different causes.

"Waiting Period" means the period you must wait before Weekly Disability Benefits become payable to you.

B. WHEN PAYMENT ENDS

Payment of Weekly Disability Benefits ends at the **earlier** of:

- the date on which you are no longer Disabled; or
- after you have received Weekly Disability Benefits for the maximum benefit duration.

If, during a Period of Disability, your employment terminates involuntarily for reasons other than retirement, Weekly Disability Benefits will continue to be paid until the earlier of the dates indicated immediately above. Weekly Disability Benefits are not payable to Retirees.

C. EXCLUSIONS

For each Period of Disability, no Weekly Disability Benefits will be paid for:

- the Waiting Period; or
- more than the Maximum Benefit Period.

D. PROOF OF DISABILITY

You must submit proof of a claim for Weekly Disability Benefits. See the Claims Information section.

You may be asked to provide the medical records of your Health Care Provider(s) who provide medical care and treatment to you during the period for which Weekly Disability Benefits are being requested or paid.

You may be required to submit to periodic physical examinations, at the Plan's expense, by a Health Care Provider of its choice as often as may be reasonable during the period for which Weekly Benefits are requested or paid.

Refusal to provide medical records or submit to periodic exams is grounds for withholding or denying Weekly Disability Benefits otherwise payable under the Plan.

IX. LIFE INSURANCE

IMPORTANT

You may not be entitled to Life Insurance Benefits under the Plan. Review your Participating Local Union Fund's or Employer's rules and regulations to confirm your eligibility.

A. COVERAGE

Life Insurance Benefits are payable to your designated beneficiary upon your death. See your Schedule of Benefits for the amount of Life Insurance Benefits payable on your behalf. Life insurance Benefits are subject to additional terms and conditions as set forth in the contract with the Life Insurance Benefit provider, a summary of which has been provided to you if you are entitled to Life Insurance Benefits under the Plan.

B. DESIGNATION OF A BENEFICIARY

A person named by you to receive your life insurance proceeds is your designated beneficiary. You must designate your beneficiary on the form provided by the Fund Office. Your beneficiary designation form must be submitted to the Fund Office within 30 days of the date you sign the form. Your Life Insurance Benefit will be paid based on the most recent, valid form your Participating Local Union Fund or Employer receives prior to payment. You may designate anyone as your beneficiary. You may change your beneficiary at any time by filling out a new form and delivering it to the Plan, and only your most recent beneficiary designation form will be valid. Unless your beneficiary designation provides otherwise:

- If more than one beneficiary is designated, they will share equally;
- If one beneficiary dies before you do, any remaining beneficiaries will share equally;
- If you do not name a beneficiary or if the persons named do not survive you, payment will be made to the surviving person(s) in the following order:

    1. your Spouse,
    2. your child(ren) in equal shares (if no Spouse),
    3. your parent(s) in equal shares (if no Spouse or children),
    4. your sibling(s) in equal shares (if no Spouse, children or parents),
    5. your estate (if no Spouse, children, parents or siblings).

C. EXCLUSIONS

No Life Insurance Benefit will be payable unless a certified copy of the death certificate and written request for the Life Insurance Benefit are provided within one year following your death.

X. ACCIDENTAL DEATH & DISMEMBERMENT

IMPORTANT

You may not be entitled to Accidental Death and Dismemberment Benefits under the Plan. Review your Participating Local Union Fund's or Employer's rules and regulations to confirm your eligibility.

A. COVERAGE

The Accidental Death and Dismemberment ("AD&D") Benefit is payable to your designated beneficiary in addition to any Life Insurance Benefit under the Plan. Your designated beneficiary must be named in accordance with the procedures for naming a beneficiary for purposes of a Life Insurance Benefit. The AD&D Benefit is payable to you, the Employee, based on the loss suffered.

AD&D Benefits are subject to additional terms and conditions as set forth in the contract with the Benefit provider, a summary of which has been provided to you if you are eligible for AD&D Benefits.

B. EXCLUSIONS

No Accidental Death and Dismemberment Benefit will be payable for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
6. any incident related to:
   • travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
   • travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   • parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation;
   • travel in an aircraft or device used:
   - for testing or experimental purposes;
   - by or for any military authority; or
   - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;

8. the voluntary intake or use by any means of:
    - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
    - alcohol in combination with any drug, medication, or sedative; or
    - poison, gas, or fumes; or
9. war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Exclusion for Intoxication

No benefits are payable for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

XI. CLAIMS INFORMATION & APPEALS

A. HOW BENEFITS ARE PAID

All Plan benefits are considered for payment upon the receipt of a written proof of claim. A completed claim form usually contains the necessary proof of claim, but sometimes additional information or records may be required. However, if medical services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Provider may submit proof of claim directly to the Plan or may complete the necessary claim form and return it to you for submission to the Plan. However, you will be responsible for the payment to the PPO Health Care Provider of any applicable Copayment or Coinsurance.

B. HOW TO FILE A CLAIM

In most cases, your Health Care Provider will complete claim forms and submit them directly. In the event you need a claim form, you can obtain one from the Fund Office. Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."

The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. Your Health Care Provider or Dentist can complete the health care provider portion of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:

- a description of the services or supplies provided;
- details of the charges for those services or supplies;
- diagnosis;
- date(s) the services or supplies were provided;
- patient's name;
- provider's name, address, phone number, professional degree or license; and
- federal tax identification number.

Review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the appropriate contact listed in the Quick Reference Chart at the beginning of this booklet.** This simple step can reduce costs to you and the Plan.

Complete a **separate claim form** for each person for whom Plan benefits are being claimed. Send the completed claim form and any other required information to the appropriate Administrator listed in the Quick Reference Chart.

C. TIME LIMIT FOR FILING CLAIMS

All claims must be submitted to the Plan within one (1) year following the date on which the expenses were incurred. No Plan benefits will be paid for any claim not submitted within this period.

D. Right to Authorized Representative

You may appoint an authorized representative to act on your behalf for the purposes of filing a claim and seeking a review of a denial or an Adverse Benefit Determination; however, you must notify the Plan in advance in writing of the name, address, and phone number of the authorized representative.

E. Review Procedure if a Medical, Dental, Vision or Prescription Drug Claim is Denied or Subject to an Advantage Benefit Determination

Urgent Care Claims. An urgent care claim is one that must be processed quickly to prevent serious jeopardy to the claimant. If an urgent care claim is subject to an Adverse Benefit Determination, you will be notified of the decision via telephone within 72 hours of receipt of the claim, unless you fail to provide sufficient information to process the claim. In the event the Plan determines that more information is needed to review the claim, you will be notified as soon as possible, but no later than 24 hours after receipt of the claim, and you will have 48 hours to provide the necessary information. The Plan will notify you of the decision as soon as possible, but no later than 48 hours after receipt of the additional information.

Pre-Service Claims. A pre-service claim is one that requires pre-approval in advance of obtaining medical care under the terms of the Plan. If a pre-service claim is subject to an Adverse Benefit Determination, you will be notified of the decision within 15 days of receipt of the claim. The Plan may take an additional 15 days to review a claim if there are reasons beyond its control that prevent it from making a decision within the initial 15 days. If an extension is required, a notice will be sent to you specifically explaining the circumstances requiring the extension and the date by which a final decision is expected to be rendered. For any extension where unresolved issues prevent a decision on the claim and additional information is needed to resolve the issue, you will be notified within 5 days of receipt of the claim and given 45 days from the receipt of the extension notice to provide the specified information.

Post-Service Claims. If a post-service claim is subject to an Adverse Benefit Determination, you will be notified of the decision within 30 days of receipt of the claim. The Plan may take an additional 15 days to review a claim if there are reasons beyond its control that prevent it from making a decision within the initial 30 days. If an extension is required, a notice will be sent to the claimant specifically explaining the circumstances requiring the extension and the date by which a final decision is expected to be rendered. For any extension where unresolved issues prevent a decision on the claim and additional information is needed to resolve the issue, you will be given 45 days from the receipt of the extension notice to provide the specified information.

Concurrent Care Claims. A concurrent care claim is one for which the Plan is requested to approve, or has already approved, and is requested to extend an ongoing course of treatment or a certain number of treatments over time. If the Plan determines that treatment is no longer necessary, the claimant will be notified in advance and within a sufficient amount of time to allow an appeal before the Plan ceases or reduces coverage for the treatment. Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, but no later than 24 hours after the claim is received, provided the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

F. Review Procedure if a Life or Accidental Death and Dismemberment Claim is Denied

If a Life or AD&D claim has been denied in whole or in part, you will be notified in writing within 90 days of receipt of the claim. The Plan may take an additional 90 days to review a claim if there are

reasons beyond its control that prevent it from making a decision within the initial 90 days. If an extension is required, a notice will be sent to you specifically explaining the circumstances requiring the extension and the date by which a final decision is expected to be rendered.

G. Review Procedure if a Weekly Disability Claim is Denied

If a Weekly Disability claim has been denied in whole or in part, you will be notified in writing within 45 days of receipt of the claim. If the Plan needs more time to review the claim for reasons beyond its control, it may take an additional 30 days. Should additional time be required, you will be sent a notice of this extension before the initial 45 day period expires, specifically explaining the circumstances requiring the extension, the date by which a final decision is expected to be rendered, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues.

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

For any extension where unresolved issues prevent a decision on the claim and additional information is needed to resolve the issue, you will be given 45 days from the receipt of the extension notice to provide the specified information.

H. Content of Claim Denial Notice

If a claim is subject to an Adverse Benefit Determination or has been denied in whole or in part, the notice of denial will state the following:

- Specific reasons(s) for the denial;
- Reference to the appropriate Plan provisions(s) on which the denial is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- An explanation of the Plan's claim review procedures and the claimant's right to seek review;
- A statement about the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") if the benefits are denied after review;
- In the case of a denial of a medical, dental, vision, prescription drug and weekly disability claim, if the Plan relied on an internal rule, guideline, protocol or similar criterion in making its decision to deny the claim, the notice shall also include the specific internal rule, guideline, protocol or similar criterion, or a statement of such, as well as a notice of the claimant's right for a free copy of the internal rule, guideline, protocol or similar criterion upon request;
- In the case of a denial of a medical, dental, vision, prescription drug and weekly disability claim, if the claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit, the Plan shall provide the claimant with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation shall be provided to the claimant free of charge upon request;
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claims.

I. CALCULATING TIME PERIODS

The period of time within which a benefit determination is required to be made begins at the time your claim is filed in accordance with the Plan's procedures, without regard to whether all relevant information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended due to your failure to submit information necessary to decide a claim, the period for making the benefit determination shall be suspended from the date on which the extension notification is sent to you until the date on which you respond to the request for additional information.

J. APPEAL PROCEDURES

1. Internal Claims and Appeals Procedures

You or your authorized representative may petition the Appeals Committee for a review of an Adverse Benefit Determination or benefit denial within 180 days after you receive the notice of an Adverse Benefit Determination or benefit denial. Your petition must be in writing and delivered or mailed to the Graphic Communications National Health & Welfare Fund, ATTN: Appeals Committee, 60 Boulevard of the Allies, 5th Floor, Pittsburgh, PA 15222. The petition must state in clear and concise terms the reason(s) for disputing the Determination or denial, and include any pertinent documents not already furnished to the Appeals Committee, such as written comments, documents, records, and other information relating to the claim for benefits.

Upon request to the Appeals Committee, you will be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, free of charge. A document, record or other information is "relevant" if it: (1) was relied upon in making the benefit determination; (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination; (3) demonstrates compliance with the administrative processes and safeguards required under federal law; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Appeals Committee will also provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your benefit denial, whether or not the advice was relied upon in making the adverse decision.

The Appeals Committee will provide an impartial review that takes into account all comments, documents, records, and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental or Investigational, or not Medically Necessary or appropriate, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Should it be necessary for the Appeals Committee to consult with a health care professional, the health care professional will be an individual who was not consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor a subordinate of such individual.

Amending a Petition; Hearings. Upon good cause shown, the Appeals Committee will permit your petition to be amended or supplemented and will grant a hearing on the petition to receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence. Your failure to file a petition for review within the 180-day period or the failure to appear and participate in any such hearing will constitute a waiver of your right to a review of the denial. Such failure will not, however, prevent you from establishing eligibility for benefits at a later date based on additional information and evidence

which was not available to you at the time of the denial or hearing, provided you submit such additional evidence to the Plan within 12 calendar months of the denial notice.

Timing of Notification of Decision.

- ***Urgent Care Claims***. Appeals of urgent care claim denials can be made to the Appeals Committee either orally or in writing within 180 days from the date the initial claim denial was received by you. All necessary information is to be transmitted between the Plan and the claimant via telephone, facsimile, electronic mail or other available expeditious methods. Such appeals will be decided by the Appeals Committee as soon as possible and the claimant shall be notified of the decision no later than 24 hours after the Plan's receipt of the appeal.

- ***Pre-Service Claims***. Appeals of pre-service claim denials can be made to the Appeals Committee in writing within 180 days from the date the initial claim denial was received by you. Such appeals will be decided by the Appeals Committee and you will be notified of the decision within 30 days after the Plan's receipt of the appeal.

- ***Post-Service Claims***. Appeals of post-service claim denials can be made to the Appeals Committee in writing within 180 days from the date the initial claim denial was received by you. Such appeals shall be decided by the Appeals Committee and you will be notified of the decision within 60 days after the Plan's receipt of the appeal.

- ***Concurrent Care Claims***. Appeals of concurrent care claims are governed by the provisions stated above for urgent care, pre-service or post-service claims.

- ***Weekly Disability Claims***. Appeals of weekly disability claim denials can be made to the Appeals Committee in writing within 180 days from the date the initial claim denial was received by you. The Appeals Committee meets on a monthly basis and will make a decision on an appeal no later than the date of the Appeals Committee meeting that immediately follows the Plan's receipt of the appeal, unless the appeal is filed within 30 days before the meeting. If the appeal is filed within 30 days before a meeting, the appeal shall be decided no later than the date of the second meeting following the Plan's receipt of the appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time, the Appeals Committee will rule on the appeal no later than the third Appeals Committee meeting following the receipt of the appeal. If such an extension of time is required because of special circumstances, the Plan will provide the claimant with written notice of the extension before the extension period begins, describing the special circumstances and the date on which the appeal will be decided. The Plan will notify the claimant of the Appeals Committee's decision on the appeal, in writing, as soon as possible, but not later than 5 days after the benefit determination is made.

- ***Life and Accidental Death and Dismemberment Claims***. Appeals of life insurance and accidental death and dismemberment claim denials can be made to the Appeals Committee in writing within 60 days from the date the initial claim denial was received by you. Such appeals will be decided by the Appeals Committee and you will be notified of the decision within 60 days after the Plan's receipt of the appeal. The Appeals Committee may take an additional 60 days to review an appeal if there are reasons beyond its control that preclude it from making a decision within the initial 60 days. If an extension is required, a notice will be sent to the claimant specifically explaining the circumstances requiring the extension and the date by which a final decision is expected to be rendered.

Content of Appeal Denial Notice.

If an appeal has been denied in whole or in part, the notice of denial will state the following:

- Specific reason(s) for the denial;
- Specific references to the pertinent Plan provision(s) on which the decision is based;
- A statement that the claimant 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 claimant's claim for benefits;
- A statement describing any additional voluntary appeal procedures offered by the Plan, if any, and the claimant's right to obtain information about such procedures; and
- A statement about the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), if the benefits are denied after review;
- In the case of a denial of a medical, dental, vision, prescription drug or weekly disability claim, if the Appeals Committee relied on an internal rule, guideline, protocol or similar criterion in making its decision to deny the appeal, the notice shall also include the specific internal rule, guideline, protocol or similar criterion, or a statement of such, as well as a notice of the claimant's right for a free copy of the internal rule, guideline, protocol or similar criterion upon request;
- In the case of a denial of a medical, dental, vision, prescription drug or weekly disability claim, if the appeal was denied based on a medical necessity, experimental treatment or similar exclusion or limit, the Appeals Committee shall provide the claimant with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation shall be provided to the claimant free of charge upon request.

Decision of Appeals Committee.

The decision of the Appeals Committee on an appeal or the denial of an application or claim on which the right to an appeal has been waived, shall be final and binding upon all parties, including the applicant, claimant or petitioner and any person claiming under the application, claimant or petitioner, subject only to judicial review unless the appeal concerns a health claim that is subject to the Plan's External Appeals Procedures as set forth below. The provisions of this Section shall apply to and include any and every claim for benefits from the Plan, and any claim or right asserted under the Plan or against the Plan, regardless of the basis asserted for the claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a Participant of the Plan within the meaning of those terms as defined in ERISA.

2. External Appeals Procedures

If your medical claim is subject to an Adverse Benefit Determination and you have exhausted the Plan's Internal Appeals Procedures as set forth above, or are not required to exhaust that process[4], you may submit a request for External Review of the denial, but only if the denial involves:

[4] If the Plan fails to adhere to all the requirements of the Internal Claims and Appeals Procedures as set forth above, you may be deemed to have exhausted the Internal Claims and Appeal process and may submit a request for External Review, if External Review is available. See Paragraphs L below for more information.

- medical judgment (including but not limited to requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is Experimental or Investigational), as determined by the external reviewer; or
- a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time.

The request for External Review must be submitted to the Fund Office within four months after the date of receipt of the denial of your Internal Appeal. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

Preliminary Plan Review.

Within five (5) business days following the date of receipt of the External Review request, the Plan will complete a Preliminary Review of the request to determine whether:

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an External Review.

Within one (1) business day after completing the preliminary review, the Plan will provide written notice to you as to whether your claim is eligible for External Review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA [3272]) at the Department of Labor.

If your request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for External Review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later. If your request for External Review is complete and eligible, it will be assigned to an Independent Review Organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the External Review. The Plan has contracted with IROs to perform External Reviews and uses unbiased methods for selecting the IRO for your claim.

Review By Independent Review Organization.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility and acceptance for External Review which will include a statement that you may submit within ten (10) business days after receipt of the notice for additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten (10) business days. Within five (5) business days after assignment of the IRO, the Plan will provide the IRO the documents and information considered in making the initial denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the Plan's denial decision.

The IRO will notify you and the Plan of its decision within one (1) business day after the decision is made. The IRO will forward information submitted by you to the Plan within one (1) business day. Upon receipt of the information, the Plan may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one (1) business day after making such a decision. The IRO will terminate its External Review upon receipt of such notice. The IRO will review your claim "de novo" (as if it were new) and not be bound by any decisions or conclusions reached during the Plan's Internal Claim and Appeals Process. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

In addition to the documents and information provided, the IRO, to the extent such information is available and the IRO considers them appropriate, will consider the following in making its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO will provide written notice of the final External Review decision to you and the Plan within 45 days after the IRO receives the request for External Review. The IRO's decision will include the following information:

- a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the External Review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

Expedited External Review

Request for Expedited External Review. The Plan will allow you to make a request for an expedited External Review with the Plan at the time you receive:

(1) An Adverse Benefit Determination if the Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal as set forth above would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a health care provider's facility.

Upon receipt of the request for the expedited External Review, the Plan will conduct a Preliminary Review as described above as soon as possible, (but without regard to the 5 business day time period referred to above). Upon its determination of the Preliminary Review, the Plan will send a notice as described above, as soon as possible, and assign an IRO for review in the same manner as set forth for a standard External Review. However, the IRO must observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care and effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

Notice of Final External Review Decision. The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice of the expedited External Review decision is not in writing, then within 48 hours after the date the notice is provided, IRO will provide written confirmation of the decision to you and the Plan as set forth above.

After External Review. Upon receipt of a notice of a final External Review decision reversing the Adverse Benefit Determination or final adverse internal appeal determination, the Plan will provide coverage or payment for the claim, including authorizing or paying benefits, as soon as possible, in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan will provide benefits (including making payment on the claim) without delay, pursuant to a final External Review decision in your favor, regardless of whether the Plan intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

If the final External Review upholds the Plan's Adverse Benefit Determination or final adverse internal appeal determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the External Review determination, you may bring a civil action as permitted under ERISA Section 502(a) (See Section L below for more information).

The External Review standards provide that an External Review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under state or Federal law.

IRO Maintenance of External Review Records. After a final External Review decision, the IRO will maintain records of all claims and notices associated with the External Review process for a minimum of 6 years. An IRO will make such records available for examination by the claimant, the Plan, or state or Federal government oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

K. STATUTE OF LIMITATIONS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES

You may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Trustees, the Fund Office, or any other person, with respect to a claim for health care, dental, vision, disability, life insurance, accidental death and dismemberment benefits, Plan policy changes, determination or actions, or other claims for benefits without first exhausting the appropriate claims procedures set forth above. If you have exhausted those procedures and are dissatisfied with the decision on appeal of a denied claim, you may bring an action under Section 502 of ERISA in an appropriate court to review the Plan's decision on appeal, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the date of the decision on appeal.

The foregoing notwithstanding, in the case of health claims subject to External Review Procedures described above, if the Plan fails to adhere to its Internal Claims and Appeals Procedures set forth above for claims or rescissions of health Plan coverage, then you may initiate an External Review or bring an action under section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the date of the decision in the External Review. However, you cannot initiate an External Review or bring an action in an appropriate court without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. De minimis;
2. Not likely to cause you prejudice or harm;
3. Attributable to good cause or matters beyond the Plan's control;
4. In the context of an ongoing good-faith exchange of information; and
5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of your written request, you are entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the Internal Claims and Appeals Procedures to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

You may only renew your appeal if you have any material additional information or new arguments to present. A renewed appeal will only consider the impact of the new information or new arguments, must be submitted in writing, and the rules and limits stated above apply. In connection with an appeal or a renewed appeal, you may review pertinent documents in the Fund Office after making appropriate arrangements, or you may request that documents be provided to you. Such information will be provided free of charge.

L. WHEN YOU MUST REPAY PLAN BENEFITS

If Benefits payable by the Plan are overpaid because:

- some or all of the medical expenses were not paid or payable by you or your covered Dependent; **or**
- you or your covered Dependent received the money to pay some or all of those medical expenses from a source other than the Plan; **or**
- you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the medical or dental expenses for which Plan Benefits were paid; **or**
- the Plan erroneously paid Benefits to which you were not entitled under the terms and provisions of the Plan, **then**

the Plan is entitled to a refund, from you or your Health Care Provider, in an amount equal to the amount of Benefits actually paid for those expenses, less the amount of Benefits which should have been paid by the Plan for those expenses based on the actual facts.

XII. COORDINATION OF BENEFITS

A. IN GENERAL

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

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

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

B. ORDER OF PAYMENT

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

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

Rule 2: The plan that covers a person as an Employee, Retiree or Participant (other than as a Dependent) is the primary plan; and the plan that covers the same person as a Dependent will be the secondary plan.

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

Rule 4: If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time is the primary plan; and the plan that has covered the other parent for the shorter period of time pays second.

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If the parents are not married, or are separated or divorced, the following rules apply:

Rule 5: If there is a court decree ***assigning*** responsibility to one parent for the child's health care, the plan of that parent is the primary plan.

Rule 6: If there is no court decree assigning responsibility for the child's health care, then:

- The plan of the custodial parent is the primary plan; and
- The plan of the Spouse of the custodial parent is the secondary plan; and
- The plan of the non-custodial parent pays third; and
- The plan of the Spouse of the non-custodial parent pays last.

If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an active employee, member or subscriber (or as that person's dependent) is primary; and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. How Much This Plan Pays as a Secondary Plan

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

D. Medicare and Other Government Programs

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

If you retire, and you are eligible for Medicare Supplemental Benefits provided under the Plan, the Plan becomes secondary and Medicare becomes primary. (Note that not all Participating Local Union Funds or Employers provide Medicare Supplemental Benefits. Refer to your Schedule of Benefits to determine if you are eligible.) If you are covered by the Medicare Supplemental Benefit, you submit your claims to Medicare first; remaining expenses then can be submitted to this Plan. Applicable Deductibles and co-insurance amounts are set forth in your Schedule of Benefits. Covered Expenses under the Medicare Supplemental Benefit include only those expenses that are Medicare-eligible.

If you are covered by Medicare Part A or Medicare Part B, your medical claims are automatically filed through the "Medicare Direct" program. **Medicare Direct** means the routing and processing procedures for Medicare Part A & Part B medical claims. Claims are first submitted directly to Medicare by your Health Care Provider. Medicare then submits claims payment information directly to the Plan for additional processing. After final adjudication, the Plan will then send the participant an Explanation of Benefits.

You are responsible for enrolling in the Medicare program. While enrollment in Part A is automatic, you must enroll in Part B. As a Retiree, this Plan will treat you as though you have enrolled in Medicare Part B whether or not you actually enroll. If you fail to enroll, the Plan will calculate the approximate amount that Medicare Part B would have paid if you had enrolled and will deduct that amount from benefits paid by the Plan. You should call or visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn about Medicare.

If you obtain Medicare benefits through Medicare Advantage (formerly Medicare+Choice or Part C), you must comply with the rules of the Medicare Advantage Plan. Failure to follow the Medicare Advantage Plan's rules, including utilization, preauthorization or case management requirements, will preclude you from receiving benefits under this Plan.

This Plan will not pay benefits for any health care services and/or supplies received pursuant to a private contract with certain Health Care Providers that agree not to submit claims to, or receive payments, from Medicare.

E. MEDICAID

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

F. TRICARE

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

G. OTHER COVERAGE PROVIDED BY STATE OR FEDERAL LAW

If you are covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

H. MOTOR VEHICLE NO-FAULT COVERAGE REQUIRED BY LAW

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

In addition, if you are covered for loss of earnings by both this Plan and any motor vehicle no-fault coverage that is required by law, any Weekly Disability Benefits payable by this Plan will be reduced by the benefits available to you for loss of earnings under your no-fault coverage.

I. WORKERS' COMPENSATION

The Plan also excludes claims or charges incurred due to an Injury or Disability that is compensable under workers' compensation legislation or other similar laws. However, the Plan will advance benefit payments in an amount no greater than those allowed under the workers' compensation law (or similar laws), provided that you agree to the requirements of this Section and Section XII-J, Third-Party Liability (Subrogation and/or Reimbursement), below, and timely apply for workers' compensation benefits (or similar benefits) with your employer and provide a copy of your application to the Plan. If your employer's workers' compensation carrier (or your employer, if it does not have insurance), denies your claim, you must appeal the denial within 30 days, or such shorter period provided by law. If your employer's workers' compensation carrier (or your employer, if it has no insurance) denies your claim, you must file a claim with the workers' compensation commission ("Commission") in the appropriate form within 30 days or such shorter period provided by law, after you receive the denial letter, and provide a copy of the denial and your claim with the Commission to the Plan. You must also take all action necessary to pursue your claim with the Commission, including notifying the Plan of any hearing date set by the Commission, providing the Plan with a copy of all correspondence scheduling hearing dates, and attending the hearing. You must also obtain written approval from the Plan prior to accepting

any settlement for less than the full amount paid to you or on your behalf by the Plan. You must forward a copy of the Commission's decision to the Plan within five days of receipt, and if the Commission determines that your claim is compensable or overturns the denial of your claim, you must repay the Plan the full amount of benefits advanced within five days of having received payment.

J. THIRD-PARTY LIABILITY (SUBROGATION AND/OR REIMBURSEMENT)

If you or your Dependent are injured in an accident for which someone else may be liable, that person or his/her insurance may be responsible for paying your or your Dependent's related medical expenses. These medical expenses are not Covered Expenses under the Plan. (See Section III-P, Exclusions, of this Summary Plan Description). However, resolution of third-party claims can take a lot of time. Therefore, as a service to you, the Plan will advance you or your Dependent benefit payments related to such an accident based on the Plan's rights of reimbursement and subrogation. You must reimburse the Plan if you obtain any recovery from any person or entity as described by the rules in this Section. By your acceptance of benefits for medical expenses related to injuries for which a third party may be responsible, you agree to be bound by the policy and practices set out in this Section below:

- The Plan excludes coverage for any claims or charges for any medical or other treatment, service or supply to the extent that the cost of such charges may be recoverable by, or on behalf of you or your Dependent in any action at law, any judgment, compromise or settlement of any claims against any party, or any other payment you, your Dependent, or attorney, may receive as a result of any accident, illness or injury (collectively "Injury"), regardless of how these amounts are characterized or who pays these amounts, as provided in this Section.

- The Plan is subrogated to all rights of recovery available to you or your Dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with any such Injury, to the extent of any and all related benefit payments made or to be made by the Plan on behalf of you or your Dependent. This means that the Plan has an independent right to bring an action in connection with such Injury in you or your Dependent's name and has a right to intervene in any such action brought by you or your Dependent, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy, if benefits are payable under the Plan. If you and/or your Dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle any claims against the third party on behalf of you and/or your Dependent. If the Plan takes legal action to recover payments, the acceptance of benefits obligates you, your Dependent and attorney to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the Injury.

- If you and/or your Dependent receives any benefit payments from the Plan for an Injury and recovers any amount from any third party or parties in connection with such Injury, you or your Dependent must reimburse the Plan from that recovery the total amount of all benefit payments the Plan made or will make on behalf of you and/or your Dependent in connection with such Injury.

- The Plan's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the Injury, and regardless of whether you or your Dependent actually obtains the full amount of such judgment, award, settlement, compromise, insurance or order. The Plan's rights of reimbursement and subrogation provide the Plan with first priority to any and all recovery in connection with the Injury, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, the type of expense for which it is specified, or whether any portion of the recovery is for attorneys' fees or any other costs related to the recovery. Such recovery includes amounts payable

under you or your Dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable, provided however, that benefits are payable under the Plan's Coordination of Benefit rules. The "make-whole" doctrine does not apply to the Plan's right of reimbursement and subrogation nor shall it limit the Plan's right of reimbursement and subrogation in any way.

- The Plan's rights of reimbursement and subrogation are for the full amount of all related benefits' payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your Dependent in obtaining recovery. The "double recovery" rule, the "common fund" doctrine or any other equitable rule, doctrine or principle shall not apply to the Plan's right of reimbursement and subrogation or limit the Plan's right of reimbursement and subrogation in any way.

- The Plan shall have an equitable lien on any amount received by you and/or your Dependent or a representative of you and/or your Dependent (including an attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by you and/or your Dependent, or representative (including an attorney) for the benefit of the Plan until paid to the Plan.

- You and/or your Dependent are required to notify the Plan within ten (10) days of any Injury for which any other party may be liable. You and/or your Dependent must notify the Plan within ten days of the initiation of any lawsuit arising out of the Injury and within the conclusion of any settlement, judgment or payment relating to the Injury in any lawsuit initiated to protect the Plan's claims.

- If you and/or your Dependent submit claims for or receive any benefit payments from the Plan for an Injury that may give rise to any claim against any third-party, you and/or your Dependent will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the Plan's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by you or your Dependent's attorney, if applicable. If you and/or your Dependent fail to timely execute and submit this Agreement, your eligibility for Plan Benefits may be terminated.

- You and/or your Dependent are obligated to take all necessary action and cooperate fully with the Plan in its exercise of its rights of reimbursement and subrogation, including notifying the Plan of the status of any claim or legal action asserted against any party or insurance carrier and of you or your Dependent's receipt of any recovery. You or your Dependent shall take no action to impair, prejudice, or waive the Plan's rights.

- You or your Dependent must notify the Plan before accepting any payment from a third party prior to the initiation of a lawsuit. In the absence of such notification, you or your Dependent shall be required to repay the Plan, in full, for any benefits it has paid, regardless whether the amount received by you or your Dependent from a third party is less than the amount owed to the Plan.

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

If the Plan is required to pursue legal action against you or your Dependent to obtain repayment of benefits advanced, you or your Dependent will be responsible for all costs and expenses, including attorneys' fees, incurred by the Plan in connection with the collection of any amounts due hereunder or the enforcement of any rights provided for in this Plan regardless of whether a suit is filed. You or your Dependent will also be required to pay interest at the rate charged on delinquent premiums owed the Plan from the date of advance of benefits to the date that the Plan is paid the full amount owed under the Plan.

XIII. PLAN INFORMATION & ERISA RIGHTS

A. NAME OF THE PLAN

Graphic Communications National Health and Welfare Plan

B. PLAN TAX IDENTIFICATION NUMBERS

EIN: 52-2045099
IRS Plan Number: 501

C. PLAN YEAR

June 1 through May 31

D. TYPE OF PLAN

The Plan is an employee welfare benefits plan, including medical, Medicare supplemental benefits, dental, vision, prescription drug, life insurance, accidental death and dismemberment, and weekly disability benefits.

E. PLAN SPONSOR

The Board of Trustees
Graphic Communications National Health and Welfare Plan
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222-1219

Participants may obtain a complete list of the Employers participating in the Plan upon written request to the Fund Office, where it is also available for examination by Plan Participants.

F. PLAN ADMINISTRATION, SOURCES OF CONTRIBUTIONS & FUNDING

The Plan is self-funded through a voluntary employees' beneficiary association within the meaning of Section 501(c)(9) of the Internal Revenue Code of 1986, as amended. The Board of Trustees has engaged Central Data Services, Inc. to administer the day-to-day operations of the Plan and to pay medical, dental and weekly disability claims. CareFirst BlueCross BlueShield administers the Plan's PPO, precertification and medical review, and utilization management. Express Scripts administers payment for prescription drug claims, National Vision Administrators administers payment for vision care, and Delta Dental administers payment for dental care.

All benefits under the Plan are self-insured except the life insurance and AD&D benefits, which are fully insured by the Metropolitan Life Insurance Company. The Trustees also obtain stop-loss coverage to protect the Plan in case of large claims.

The Board of Trustees has a negotiated contract with CareFirst BlueCross BlueShield as the Preferred Provider Organization.

G. AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made on the Secretary of the Plan who may be contacted through the Fund Office.

H. TRUSTEES

The Trustees of the Plan are:

UNION/LABOR		EMPLOYER/MANAGEMENT	
Steven Aldrich GCC/IBT Local 767 19309 West Valley Highway Ste R-111 Kent, WA 98032	Andrew Douglas 25 Sandhurst Drive Mt. Laurel, NJ 08054	Patrick Dier Neenah Paper 1376 Kimberly Drive Neenah, WI 54956	Open Seat
James Bemowski GCC/IBT Local 77-P 1300 American Drive Neenah, WI 54956	Michael Sippy District Council 1, GCC/IBT 633 S. Hawley Road, Suite 100 Milwaukee, WI 53214	William Eckerle 641 Dorothy Bowen Drive Sheridan, MI 48884	Open Seat
Gordon Beukema 3007 Chapshire, SE Grand Rapids, MI 49546	Ward Wenstrup Cincinnati Web Pressmen Local 128-N 1630 Section Road Cincinnati, OH 45237	Robert Lindgren PIASC 5800 South Eastern Avenue, Ste 400 Los Angeles, CA 90040	Open Seat
Doug Brown Teamsters 572 450 East Carson Plaza Drive Carson, CA 90746	Open Seat	Open Seat	Open Seat

I. COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained under several Collective Bargaining Agreements. Plan Participants may obtain copies of any such Agreements upon written request to your Participating Local Union Fund, your Employer or the Fund Office, where it also is available for examination by Plan Participants.

J. RIGHT TO MODIFY OR TERMINATE BENEFITS

Neither this Plan nor its benefits are guaranteed. Although the Plan is intended to be permanent, the Board of Trustees reserves the right at any time to amend, change or discontinue the Plan itself, the types and amounts of benefits, and the eligibility rules. This right to amend, change or discontinue benefits applies to active as well as retiree benefits payable under the Plan. The nature and amount of Plan benefits always are subject to the actual terms of the Plan as it exists at the time the claim is incurred.

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

In carrying out their respective responsibilities under the Plan, the Board of Trustees will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination by the Board of Trustees is final and binding upon any person claiming benefits under the Plan.

L. NO LIABILITY FOR PRACTICE OF MEDICINE

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

M. PRIVACY, CONFIDENTIALITY, RELEASE OF RECORDS OR INFORMATION

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

The Plan and the Board of Trustees will not use or further disclose information that is protected by HIPAA (known as "protected health information" or "PHI") except as necessary for treatment, payment, healthcare operations, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities called, "Business Associates" to observe HIPAA's privacy rules. In

some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that organization.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

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

N. Information You or Your Dependents Must Furnish to the Plan

In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you or your covered Dependents must furnish, within **60 days** after the event, any information that may affect eligibility for coverage under the Plan. This includes, but is not limited to:

- Change of name;
- Change of address;
- Marriage, divorce, or death;
- Any information regarding the status of a Dependent Child, including, but not limited to:
    - Attaining the Plan's limiting age;
    - School status for dependent grandchildren, if over age 19; and
    - Existence of any physical or mental Disability.
- Medicare coverage; and
- Coverage under other medical or dental plans.

O. Assignment of Benefits

Benefits under this Plan are not subject to assignment; however, you may direct the Plan to pay medical benefits, otherwise payable to you, directly to the provider. The Plan will not be legally obligated to accept such a direction, and no payment by the Plan pursuant to such a direction shall be considered as a recognition by the Plan of any obligation to pay a provider, except to the extent the Plan actually chooses to do so.

P. ERISA Rights

As a Participant in the Graphic Communications National Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to:

- **Receive** information about your Plan and benefits.
- **Examine**, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- **Obtain**, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- **Receive** a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- **Continue health care coverage** for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. Notwithstanding the foregoing, no legal proceeding may be filed in any court or before any administrative agency against the Fund, Plan or its Trustees or its designees unless all of the Plan's review procedures have been exhausted.

Assistance with Your Questions

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

XIV. DEFINITIONS

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

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) of a benefit that is based on eligibility for coverage, covered benefit status, pre-existing condition exclusions, source-of-injury exclusions, network exclusions, or a procedure's status as experimental, investigational, or not medically necessary or appropriate, and any cancellation or discontinuance of coverage that has a retroactive effect.

Alcoholism and Drug Abuse means alcohol and/or drug dependency as defined by the current edition of the ICD-9-CM manual.

Annual Maximum Plan Benefit means the maximum amount of benefits payable by the Plan each Plan Year on account of certain medical and dental expenses incurred by any covered Plan Participant under this Plan and any Predecessor Plan.

Birthing Center means a public or private facility, licensed and operating according to law, other than private offices or clinics of Health Care Providers, that meets the free-standing birthing center requirements of the Department of Health in the State of where the covered person receives the services.

The Birthing Center must provide:

- a facility that has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a child born at the center; and
- supervision by at least one Health Care Provider who is a specialist in obstetrics and gynecology; and
- a Health Care Provider or Certified Nurse Midwife at all births and immediate postpartum period; and
- extended staff privileges to Health Care Providers who practice obstetrics and gynecology in an area Hospital; and
- at least 2 beds or 2 birthing rooms; and
- full time nursing services directed by a Registered Nurse or a Certified Nurse Midwife;
- arrangements for diagnostic x-rays and laboratory services; and
- the capacity to administer local anesthetic and to perform minor Surgery.

In addition, the facility must accept only patients with low-risk pregnancies, have a written agreement with a Hospital for emergency transfers, and maintain medical records on each patient and child.

Board of Trustees means the Board of Trustees of the Graphic Communications National Health and Welfare Fund as established by the Trust Agreement.

Coinsurance means that portion of Covered Expenses for which the Employee has financial responsibility, as designated in your Schedule of Benefits.

Collective Bargaining Agreement, CBA means the formal written document entered into between an Employer and a GCC/IBT or IBT local Union together with any modifications, supplements or amendments thereto which covers wages, hours, fringe benefit payments and conditions of employment.

Copayment, Copay means the set dollar amount you are responsible for paying when you incur Covered Expenses for certain services, as designated in your Schedule of Benefits.

Covered Employment means work by an Employee in a job category for which an Employer is required to make contributions to a Participating Local Union Fund or directly to the Plan pursuant to a CBA or other written agreement with the Board of Trustees.

Covered Expense means an expense for medical, vision, prescription drugs, and/or dental services or supplies, but only to the extent that it is Medically Necessary, the charges are Usual and Customary; the charges do not exceed the applicable fee schedule; coverage for the services or supplies is not excluded or limited by any Maximum Benefits, Lifetime Maximum Benefits or any other limitations or exclusions under the Plan. No amount in excess of the actual charges for a service or supply will be considered a Covered Expense.

Deductible, Individual Deductible, Family Deductible means the amount of Covered Expenses you are responsible for paying before the Plan begins to pay benefits, as designated in your Schedule of Benefits. Individual Deductible is the amount one Plan Participant must pay before the Plan begins to pay benefits for that person. Family Deductible is the amount that all covered family members must pay before the Plan begins to pay benefits for the family members.

Dentist means a person who is legally licensed and authorized to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered and acting within the scope of his or her license.

Dependent has the meaning defined in Section I, Paragraph B.

Disabled, Disability means the inability of an Employee to perform his or her duties with the Employer as a result of a non-occupational Illness or Injury, or the inability of a Dependent to perform the normal activities or duties of a person of the same age and sex, as determined by the Plan Administrator.

Durable Medical Equipment means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness, and is not disposable or non-durable. It includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Emergency (Medical) see Medical Emergency, below.

Employee means a person in Covered Employment or any other person employed by an Employer who satisfies the requirements for participation in the Plan and on whose behalf an Employer makes contributions to a Participating Local Union Fund or, by special participation agreement, directly to the Plan. An Employee does not include any person who has a direct or indirect interest in a sole proprietorship or partnership which is an Employer.

Employer means any Employer in the graphic communications industry who, pursuant to the terms of a Collective Bargaining Agreement with a GCC/IBT or IBT local Union, is required to make periodic contributions to a Participating Local Union Fund or to the National Plan on behalf of Employees. A GCC/IBT or IBT local Union, GCC/IBT or IBT entity, a joint GCC/IBT-Employer or IBT-Employer entity or a Participating Local Union Fund also can be an Employer.

Experimental and/or Investigational means a service or supply that the Board of Trustees determines to be Experimental and/or Investigational. A service or supply is Experimental and/or Investigational if, in the opinion of the Board of Trustees, there is a preponderance of authoritative medical, dental or scientific

literature published in the United States and written by experts in the field that shows recognized medical, dental or scientific experts:

- classify the service or supply as experimental and/or investigational; or
- indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

A drug will not be considered Experimental and/or Investigational if it is:

- approved by the FDA as an "investigational new drug for treatment use"; or
- classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
- approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

Fund means the Graphic Communications National Health and Welfare Fund.

Fund Office means the office where the Plan is administered on a day-to-day basis. The address of the Fund Office is listed at the beginning of this booklet.

Health Care Provider means a person legally licensed and, acting within the scope of his or her license, authorized to practice medicine, to perform surgery and to prescribe and administer drugs under the laws of the State or jurisdiction where the services are rendered, or a legally licensed health care practitioner performing services, under the direction of a Health Care Provider and within the scope of his or her license which would be covered under the Plan if performed by a Health Care Provider. Health Care Provider shall include a doctor of medicine, osteopathy, dental surgery, podiatry or chiropractic services.

Home Health Care means intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as defined below.

Home Health Care Agency means a licensed or certified agency that primarily provides skilled nursing and other therapeutic services under the supervision of Health Care Providers or Registered Nurses, is run according to rules established by a group of professional medical providers including Health Care Providers and Registered Nurses, maintains clinical records on all patients, and is certified by Medicare.

Home Health Care Plan means a plan that provides for the care and treatment of an Illness or Injury. The care and treatment must be prescribed by a Health Care Provider; and an alternative to confinement in a Hospital or Skilled Nursing Facility.

Hospice means a licensed facility or organization certified by Medicare that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons with a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home or in a home-like setting, keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and family.

Hospital means a public or private facility or institution, accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or approved by the Board of Trustees, or similar Hospital in a foreign country, which provides care and treatment by Health Care Providers and Nurses on a 24-hour basis for Illness or Injury through medical, surgical and diagnostic facilities on its premises. A

Hospital does not include rest or nursing homes, convalescent homes or institutions, sanitariums or similar institutions providing custodial or institutional care.

Illness means any bodily sickness or disease, including any congenital abnormality of a newborn child, diagnosed by a Health Care Provider. Pregnancy of a Plan Participant will be considered an Illness for purposes of Plan coverage.

Injury means any damage to a body part sustained accidentally and by an external source.

In-Network Services means services provided by a Health Care Provider in the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services provided by a Health Care Provider that is not a member of the PPO.

Medical Emergency means a sudden unexpected onset of a medical condition, not normally treatable in a Health Care Provider's office, that manifests itself by such acute symptoms of sufficient severity that urgent and immediate medical attention is required without regard to the time of day or night either to prevent serious impairment of body functions or serious and/or permanent impairment or dysfunction of any body organ or part, or because the patient's life is threatened.

Medically Necessary means a service or supply which the Board of Trustees determines is:

- provided by or under the direction of a Health Care Provider, Dentist or other licensed health care practitioner authorized to do so; and
- necessary in terms of generally accepted medical standards in the community in which it is provided; and
- consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
- not provided solely for the convenience of the patient, Health Care Provider, Hospital, or other licensed treatment facility; and
- appropriate given the patient's circumstances and condition.

Inpatient care in a Hospital is Medically Necessary when the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis.

Your Health Care Provider's or Dentist's order, recommendation or approval does not mean that a service or supply is Medically Necessary.

A service or supply that can safely and appropriately be furnished in a Health Care Provider's or Dentist's office (or other less costly facility) is not Medically Necessary if furnished in a Hospital or Specialized Health Care Facility (or other more costly facility).

Medicare means the Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Direct means the routing and processing procedures for Medicare Part A & Part B medical claims. Claims are first submitted directly to Medicare by your doctor or hospital. Medicare then submits claims payment information directly to the National Fund Office for additional processing. After final adjudication, the National Fund Office will then send the participant an Explanation of Benefits.

Mental and Nervous Disorders means certain disorders, conditions and diseases defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual, which includes, among other things, depression and schizophrenia.

Mental Health Practitioners means a Health Care Provider, certified mental health counselor, or social worker who is legally licensed or authorized to practice or provide service, care or treatment of Mental and Nervous Disorders under the laws of the State or jurisdiction where the services are rendered, acts within the scope of his or her license, and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Midwife means a person certified to practice midwifery and who is a member of the American College of Nurse-Midwifery.

Nurse means a person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the State or jurisdiction where the services are rendered, who acts within the scope of his or her license and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

Participant means the Employee, Retiree or Dependent who is enrolled for coverage under the Plan.

Participating Local Union Fund means a Taft-Hartley, GCC/IBT or IBT local Union health and welfare benefit fund which has been accepted for participation in the Plan and whose board of trustees has agreed in writing to be bound by the terms of the Agreement and Declaration of Trust.

Plan Administrator means the Board of Trustees or its designee who has been given the authority to carry out the administration of the Plan. The Board of Trustees currently engages Central Data Services, Inc., Care First Blue Cross Blue Shield Express Scripts, National Vision Administrators, Delta Dental and Metropolitan Life Insurance Company, to administer the payment of claims for certain types of benefits. Any designee may change without notice.

Predecessor Plan means the former Graphic Communications International Union Health and Welfare Pooling Fund and any other health and welfare fund or plan that agrees to participate in the Plan.

Preferred Provider Organization (PPO) means a group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at negotiated rates as payment in full, except with respect to a defined Coinsurance, Copayment, and Deductible for which the Participant is responsible.

Retiree means a person who is retired from Covered Employment who is receiving monthly pension benefits from a qualified retirement plan established for Employees in the graphic communications industry.

Schedule of Benefits means the applicable Schedule of Benefits negotiated or determined by the local Union or Employer, and set forth in this Summary Plan Description.

Skilled Nursing Care means services performed by a licensed Nurse which are ordered by and provided under the direction of a Health Care Provider, intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis, and which are so inherently complex that they can be safely and effectively performed only by or under the supervision of a Nurse. Examples include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility means a licensed public or private facility that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- maintains on its premises all facilities necessary for medical care and treatment; and
- provides services under the supervision of Health Care Providers; and
- provides nursing services by or under the supervision of a licensed Registered Nurse, with one licensed Registered Nurse on duty at all times; and
- is not a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- is not a hotel or motel.

Specialized Health Care Facilities means Birthing Centers, Hospices, and Skilled Nursing Facilities, as defined above.

Spouse means an individual to whom an Employee or Retiree is lawfully married under any state law. Spouse includes a common law spouse if the couple is married under common law in the state in which they reside.

Summary of Benefits and Coverage (SBC) means the brief outline of your Plan's benefits and coverage provided to you annually as required by the Affordable Care Act. The SBC includes a uniform glossary of insurance terms, which allows you to compare one plan to another.

Transplant, Transplantation means the transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

Union means the Graphic Communications Conference of the International Brotherhood of Teamsters (GCC/IBT) or any of its affiliated locals or councils. "Union" may also mean the International Brotherhood of Teamsters or any of its affiliated locals or councils.

Usual and Customary Charge means the prevailing charge most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply. In determining whether charges are Usual and Customary, consideration will be given to the condition being treated and to any medical complications or unusual circumstances that may require additional time, skill, or experience. In general, Usual and Customary Charges will be based upon the scale promulgated by Medical Data Research (MDR); however, other industry sources will be used if the MDR scale is unavailable or no longer determined appropriate by the Board of Trustees. Although the actual charges may exceed Usual and Customary charges, in no event will Covered Expenses up to the Usual and Customary level exceed the actual amount charged for a service or supply.