

**TRUCK DRIVERS AND HELPERS LOCAL 355
HEALTH AND WELFARE FUND**



**Actives - Plan A, C and E
Retirees - Plan 20, 25 and 30**

Summary Plan Description

**TRUCK DRIVERS AND HELPERS LOCAL 355
HEALTH AND WELFARE FUND**

BOARD OF TRUSTEES

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To All Covered Participants:

We have prepared this booklet to advise you of the comprehensive benefits provided to eligible participants and their dependents under the Truck Drivers and Helpers Local 355 Health and Welfare Plan.

This booklet explains your benefits in a brief and simple way - how you become eligible, what benefits are provided, how to submit a claim, and how you may lose your eligibility. You must be eligible for benefits before you can claim them. Please read this booklet carefully so you know how the Plan can help you.

This Plan provides coverage for certain hospital, surgical, medical, prescription, optical, and dental expenses. All hospital, surgical and medical benefits are applied to your major medical deductible before being paid by the Plan. The Plan participates with the CareFirst BlueCross BlueShield Preferred Provider Network. CareFirst BlueCross BlueShield provides a list of doctors and medical facilities, which if used by the participant, will usually, provide services at a reduced fee to the Plan. Weekly accident and sickness benefits are also provided for employees as summarized in this booklet.

It should be noted that if you are injured while at your place of work or require medical care as a result of your employment, you should obtain care through the arrangements provided by your employer under workers' compensation laws. This Plan may pay weekly benefits if you are hurt on the job provided you submit evidence of a denial of your claim from the insurance carrier and sign a Subrogation Agreement.

This booklet is just a summary of plan provisions; it is not the governing instrument. It does not contain the detailed Agreement and Declaration of Trust, other Plan Documents under which the plan is established and maintained, all of which govern the operation and administration of this Plan, or the related Collective Bargaining Agreement. The Plan must be interpreted in accordance with these documents which are available for your inspection at the Fund Office. Whenever there is a conflict between this booklet and the formal Plan Documents, the Plan Documents will be controlling.

We urge you to read your Summary Plan booklet carefully so that you are familiar with the benefits to which you are entitled and the Plan's eligibility requirements.

The Trustees intend to maintain this Plan indefinitely. However, we reserve the right to suspend, terminate, amend, modify or delete the Plan for active and/or retired participants and their dependents. Nothing in this booklet should be construed to mean that the Fund's benefits are guaranteed. We hope that you share our pride in your Plan and the measure of security it provides to those who work in the industry.

Sincerely,

BOARD OF TRUSTEES

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PREFERRED PROVIDER ORGANIZATION

The Plan participates in a “Preferred Provider Network” (PPN). A PPN is a group of select physicians, specialists, hospitals, and other treatment centers which have agreed to provide their services to Plan participants for a discount. A PPN can be used for routine or emergency medical problems. It is not mandatory, so you do not need to change your doctor or the hospital you use, even if the doctor or hospital does not participate in the PPN program. However, if you use the PPN, both you and the Plan will save money, as explained below.

By using the PPN, there are considerable savings for both you and the Plan. The PPN has special arrangements with health care providers, such as doctors and hospitals, to discount substantially their normal fees. Because you usually pay a percentage of billed charges, this will result in your paying a percentage of a smaller amount. Use of a PPN physician or hospital for medical benefits means a direct out-of-pocket cost savings to you.

Of course, the Plan’s costs are reduced as well, which means that your contribution dollars will be used more efficiently.

Directories of participating PPN physicians and hospitals are available from CareFirst BlueCross BlueShield at www.carefirst.com or by calling (800) 235-5160 for a referral. Directories are also available at the Fund Office. Check to see if your current physician already participates. In fact, there is a good possibility that you are already using a PPN physician. New physicians are being added weekly, so if you do not find your physician listed, call the number of the PPN which is on your ID card.

If you are looking for a new physician, the directory can be a help.

Your identification card verifies your participation in the PPN. When you go to a participating hospital or physician, identify yourself as a PPN participant by presenting the ID card. There is no need to complete a claim form.

The hospital or physician will submit your claim directly to the PPN which will discount the bill and forward it to the Fund Office for payment.

You should let your current physician know that the Plan is participating in the PPN. If you use a provider outside of the network you will not be eligible for the network discounts and may be responsible for any balance due up to the billed amount.

ELIGIBILITY

Employees

Initial Eligibility

You are eligible to participate in this Plan if you work for a contributing employer who is obligated by a Collective Bargaining Agreement to make contributions to the Truck Drivers and Helpers Local 355 Health and Welfare Fund.

Benefits begin on the first day of the month following the receipt of contributions from an employer on behalf of participant working in covered employment for a minimum of 120 hours in each month for two consecutive months. For example, this means that if you are hired on January 10, and you work 120 hours in January and 120 hours in February, and contributions are received by the due date of March 15, then your initial coverage will begin on April 1.

Continuing Eligibility

You and your dependents are eligible for coverage provided you work at least:

- 240 hours in the two calendar months preceding the month prior to the month of eligibility (please note there is a lag month to allow administrative time for processing your hours)..

The following chart shows how your coverage is determined:

<u>Work Period</u>	<u>Coverage Provided</u>	<u>Work Period</u>	<u>Coverage Provided</u>
January - February	April	July - August	October
February - March	May	August - September	November
March - April	June	September - October	December
April - May	July	October - November	January
May - June	August	November - December	February
June - July	September	December - January	March

Example:

To be eligible for coverage for the month of April, you must work at least 240 hours in the preceding January and February.

Eligibility on Termination of Employment

The above schedule is for continuation of eligibility only. When your employment is terminated, either by you or your employer, your eligibility shall terminate at the end of the month following the month in which your employment ceases.

Example:

If your employment terminates in March, then your coverage will terminate on April 30.

Your coverage may be continued after this date, however, under the circumstances described in the sections entitled “SELF-PAYMENT PROVISIONS” on page 7 and “CONTINUATION OF COVERAGE (COBRA)” on page 8.

Continued Eligibility While Disabled

If you become disabled while eligible for benefits under the Plan, your eligibility for coverage continues, until the earlier of:

- the end of the 12-month period beginning on the date your disability began;
- the date your disability ends;
- the date you retire; or
- the date you become eligible for Medicare.

The Trustees, in determining whether or not you are disabled, reserve the right to require you to submit to physical examination(s) at the Plan’s expense by any physician selected by the Trustees.

Reinstatement

If your eligibility for coverage ends, you must again satisfy the initial eligibility rules unless you have not been working because of: (a) total disability, or (b) have been called to active duty in the Armed Services. If you are covered under Self Payment or COBRA and have not suffered a lapse in coverage, that is you continuously made Self Payments or COBRA Payment to maintain coverage up to the month you returned to covered employment, you will be reinstated based on hours worked provided you work a minimum of 120 hours for each month until you again satisfy the Continuing Eligibility rules defined above.

Reciprocal Agreements

When no reciprocal agreement is in effect under which contributions can be made to the Plan, time spent working in the jurisdiction of a sister local is not counted in determining your eligibility for coverage under the Truck Drivers and Helpers Local 355 Health and Welfare Fund.

Military Service

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter military service are entitled to COBRA continuation rights as described on page 8. If you were eligible for coverage prior to entrance into uniformed service, gave advance notice to your employer of such service, and you return to covered employment within the required time limits of USERRA after honorable discharge or satisfactory completion of service, you and your dependents are covered from the first day of your return to covered employment.

If you enter military service before you are eligible for coverage, and the requirements of USERRA are satisfied, you will be credited with hours of employment accumulated prior to military service upon resuming employment with a contributing employer.

Dependents

Initial Eligibility

Your eligible dependents are:

- your spouse;
- your unmarried children (including legally adopted children and stepchildren) under the age of 19 (stepchildren must reside with you to be eligible);
- your unmarried children under the age of 23 if solely dependent on you for support and if full-time students attending accredited schools for at least twelve credit hours per semester, in which case the Trustees must be furnished each semester with a letter from the school's registrar containing the official school seal, confirming the dependent's full-time enrollment;
- your unmarried children who are incapable of self-sustaining employment by reason of mental retardation or physical handicap and who are chiefly dependent upon you for support and maintenance on the date they reach age 19 (or 23 if a full-time student). Eligibility will continue if they become incapacitated prior to attaining the limiting age for dependent coverage under the Plan. Proof of incapacity must be furnished to the Trustees no later than 30 days after the date the child ceases to be covered under the Plan. The Trustees reserve the right to require proof of the uninterrupted continuance of incapacity. They also have the right, at their expense, to have any physician(s) examine a child when and as often as they may reasonably require during incapacity.

For your dependents to be eligible for coverage under the Plan, you must be an eligible employee. Coverage for your eligible dependents begins on the latest of:

- the effective date of the Plan;
- the date your coverage becomes effective; or
- the date you acquire the dependent.

In the case of marriage, however, coverage for your spouse begins on the date of your marriage. You must notify the Board of Trustees within 30 days from the date you acquire a new dependent and provide a copy of your marriage license and birth certificate for each dependent child claimed. You may obtain the proper forms from the Fund Office.

Adopted Children

Coverage for an adopted child of an eligible employee will begin when the child is "placed," determined in accordance with the law, not when the adoption becomes final. Limitations on pre-existing conditions of your adopted child are not permitted. Please notify the Fund Office if you intend to adopt a child to receive additional information on the procedures necessary to allow your child to be covered under the Plan.

Qualified Medical Child Support Orders

The law now provides that an "alternative recipient," as defined below, under a "qualified medical child support order," also defined below, must continue to receive medical coverage in compliance with a court order.

A “qualified medical child support order” or “QMCSO” is a judgment or court decree that requires a group health plan to provide coverage to the children of a plan participant, under a state domestic relations law.

The term “alternate recipient” means any child of an employee who is recognized under a medical child support order as having a right to enrollment under a group health plan.

Termination of Eligibility

In general, coverage for your dependent ends when either you or your dependent loses eligibility for coverage. If you lose eligibility, your dependent’s coverage ends on the date you become ineligible for coverage. If your dependent ceases to be a dependent as defined by the Plan, his or her coverage terminates on the day he or she ceases to be an eligible dependent. When your dependent’s coverage terminates, no expenses incurred after the date eligibility ceases are payable, even if the condition which required treatment began before the termination of coverage.

In the case of a child who is incapacitated due to a mental or physical handicap, coverage automatically terminates on the earliest of:

- the end of such incapacity;
- the failure to provide required proof of the uninterrupted continuance of such incapacity or to submit to any required examination within 30 days after requested; or
- the termination of dependent coverage for reasons other than reaching the limiting age, as provided in the Plan.

There are exceptions to these rules for dependents who elect to self-pay pursuant to COBRA continuation coverage (see page 8).

Coverage after Death of Eligible Employee

If you die while covered under the Plan, your eligible dependents may continue coverage for a period of up to three years. The cost for this continued coverage is determined by the Trustees. However, coverage may terminate prior to the end of the three year period if, at any time during this period, your dependent loses his or her status as an eligible dependent under the Plan. If your spouse remarries during the three year period, coverage terminates on the date of marriage.

Your dependents may be able to elect to self-pay for COBRA continuation coverage (see page 8) when coverage under this provision ends.

Proof of Dependency

In cases where eligibility of a dependent cannot be determined by the Fund Administrator through standard enrollment procedures, you may be required to furnish additional proof of dependent status. Some examples of acceptable evidence are the following:

- a certified copy of the birth certificate;
- a certified copy of adoption papers;
- for incapacitated unmarried children age 19 or over, a statement by the dependent’s physician certifying incapacity;
- marriage certificate.

SPECIAL ELIGIBILITY RULES FOR TRANSITIONAL WORKERS (MOVIE INDUSTRY)

Participants who are employed by contributing employers working in the movie industry shall be entitled to an Hours Bank, to be used for eligibility for medical, prescription, dental and vision benefits only (death and disability are excluded from this coverage). The Hours Bank shall be accumulated for all hours over 50 hours per week received by the Plan for each employee. During a transitional time when the employee is not working and the Plan is not receiving contributions, the Administrator will draw from the bank, using the current cost of the Plan at the time of the draw to determine the number of hours to be deducted from the bank for eligibility for coverage.

The Hours Bank shall not be utilized for weekly accident and sickness benefits or death benefits from the Plan. However, transitional employees who have previously established initial eligibility may be able to convert the Plan's death benefit to an individual life insurance policy at their own cost. Please contact Fort Dearborn Life Insurance Company, 1020 31st Street, Downers Grove, IL 60515-5591, Group No.: MMLLL280, at 1-800-692-1400 x 1721 (member contact number) or at 1-800-692-1400 x 1815 (claims contact number), for more information on this option.

If you incur a lapse in coverage, you will be required to satisfy the initial eligibility rules defined on page 2. If you return to covered employment, you will be reinstated provided you work more than 120 hours per month. Please see the reinstatement rules defined on page 3.

INTERIM SELF-PAYMENT PROVISIONS (SHORTAGE OF HOURS)

Participation

To participate in the Plan under the self-payment provisions, you must have been eligible as a covered participant in the month prior to the self-payment month.

Eligibility

If you are about to lose your eligibility for benefits because of a shortage of hours worked in a month, you may retain your eligibility (and that of your dependents) by contributing directly to the Plan the difference between the hours earned and the hours required to maintain eligibility. However, you may not self-pay to obtain coverage if you are eligible for coverage under another plan.

Interim Self-Payment

The amount of the self-payment is established by the Trustees and may be changed from time to time. This Interim Self-Payment is only available for the first month of any loss of coverage. Your self-payment must be received by the Fund Office by the 1st of the month for which you are paying for coverage. During the period of self payment, you will still be eligible for the Weekly Accident and Sickness benefit provided you have not been terminated from your employer. However, once you are required to make a full COBRA payment, Weekly Accident and Sickness benefits and the Death Benefits are not payable.

Example:

If you have already established initial eligibility and you work 120 hours in June and 100 hours in July, then you will be eligible to make a self-payment equal to 20 hours in order to reach the required 240-hour threshold for coverage.

The one month coverage that you establish through self-payment under this section will count toward your COBRA coverage period (see page 8).

Termination of Interim Self-Payment

If you are eligible to make the required self-payment contribution and fail to do so within the specified time, you lose your eligibility immediately. To become re-eligible, you must again meet the requirements set forth under the section entitled "Reinstatement" (see page 3).

Reciprocal Agreements

When no reciprocal agreement is in effect under which contributions can be made to the Plan, time spent working in the jurisdiction of a sister local is not counted in determining eligibility to make an interim self-payment.

CONTINUATION OF COVERAGE (COBRA)

You and your dependents may be able to continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA continuation coverage," named for the law that sets forth the rules for it. COBRA continuation coverage is identical to the health care coverage provided under this Plan and is available to you and your dependents. However, it does not include weekly accident and sickness benefits, death benefits or accidental death and dismemberment insurance. You must pay the premium for this coverage, as determined by the Fund Office, not to exceed 102% of the group rate, as determined by the Consultant. In the event the covered person is determined to be disabled for Social Security purposes, the cost shall not exceed 150% of the group rate.

Maximum Period of Coverage

As a covered participant you have the right to continue coverage for yourself and your spouse and dependent children for 18 months if it otherwise would end because of the following:

- you leave covered employment for reasons other than gross misconduct on your part; or
- your hours of employment are reduced.

If you do not elect COBRA continuation coverage for your spouse or dependent children, they may do so for themselves.

If you lose coverage for any one of the above reasons and you and/or one of your family members becomes totally disabled (as determined by Social Security) at any time during the first 60 days of the continuation coverage, you have the right to continue coverage for the disabled individual(s) for a maximum of 29 months. This extension only applies if you notify the Plan within 60 days of the determination by Social Security and before the 18 month maximum coverage period expires. This special 11-month extension does not apply to non-disabled family members.

Your spouse and dependent children also may continue health care coverage for themselves for 36 months if their health coverage otherwise would end as a result of:

- your death;
- your divorce or legal separation;
- your becoming entitled to (that is covered by) Medicare;
- for a dependent child, no longer qualifying as a dependent under this Plan; or
- your employer filing for reorganization under Chapter 11 of the Bankruptcy Code.

Even if two or more of the events just described occur, the maximum period of COBRA continuation coverage for your spouse and dependent children is 36 months.

Note: If you were enrolled in Medicare prior to your termination of employment or reduction in hours, your dependents may be eligible to continue coverage for up to 36 months after the date on which you become entitled to Medicare, or 18 months (29 months if there is a disability extension) from the date your coverage ceased, whichever is later.

Qualifying Event	Length of Coverage
Loss of coverage due to termination or reduction in hours of employment	18 months (29 months for you or your dependents if you are disabled at the time or are determined to be disabled within 60 days of the qualifying event *)
A second qualifying event during the first 18 months of COBRA coverage	18 additional months for your dependents (not to exceed 36 months total in any event)
Your eligibility for Medicare or your death	36 months for your dependents
Any other qualifying event	36 months for your dependents

* This extension applies only if you notify the Plan within 60 days of the determination by Social Security and before the 18 month maximum coverage period expires.

Coordination of Self-Payment Rules and COBRA Continuation

The calculation of the maximum period of coverage for COBRA includes any period of self-payment. For example, if you choose to self-pay for the month permitted under the Interim Self-Payment Provisions on page 7, that month is included in the calculation of your maximum COBRA coverage period.

Coordination of Self-Payment Rules and Employer Payments for Terminated Employees

The calculation of the maximum period of coverage for COBRA includes any period for which your employer makes contributions after your severance from employment. For example, if you terminate employment, your Collective Bargaining Agreement may require your employer to continue to make contributions on your behalf for up to one year. This period of employer contribution, after your severance from employment, counts toward the maximum continuation period under COBRA. In this example, you would be entitled to elect up to six months of COBRA, or up to 17 months if you were disabled. Any employer payments after your termination of employment for dependents also count toward the maximum period of COBRA continuation for such dependents.

Notification Requirements

You (the participant) must inform the Fund Administrator in writing of a divorce, legal separation or loss of dependent status of a child within 60 days after the event occurs. By law, failure to report these events within the prescribed time will terminate your eligibility for COBRA. Your employer must notify the Fund Office of your death, termination of employment or reduction in hours within 30 days after such event occurs. Within 14 days of receipt of notice that a qualifying event has occurred, the Fund Administrator will notify you and any eligible dependents, including those not living with you (whose address is known to the Fund Office), of the right to elect COBRA continuation coverage. The Fund Office also will provide instructions about how to elect and pay for COBRA continuation coverage.

Election of Continuation Coverage

To elect COBRA continuation coverage, you must complete an election form (provided by the Fund Office) and submit it to the Fund Administrator within 60 days of the later of the date coverage would be lost as a result of the event or the date of the notice sent to you by the Fund Office of your right to elect COBRA continuation coverage.

Payment of Continuation Coverage

Timely payment of the initial premium is at the time the election is made, and every 30 days after that.

Termination of Continuation Coverage

Your COBRA continuation coverage may terminate earlier than the maximum period described earlier if:

- all health care coverage offered by the Plan terminates;
- the required premium is not paid on time;
- for each person, he or she becomes covered by another group plan (after the date of election) that does not contain any exclusion or limitation with respect to any pre-existing condition (or the exclusion or limitation does not apply to, or would be satisfied by, the covered person because of HIPAA rules);
- for each person, he or she becomes entitled to Medicare; or
- an individual who receives extended coverage for 29 months due to disability has been determined for Social Security purposes to be no longer disabled.

Once COBRA continuation coverage terminates, it cannot be reinstated.

PLAN 20 RETIREE SELF-PAY
(FROZEN PLAN - NOT ELIGIBLE FOR NEW PARTICIPATION)

Participation

To participate in the Plan under the retiree self-payment provisions, your employer must have paid to subsidize your retiree health coverage, and you must have been eligible as an active participant for benefits, retired from this Plan prior to 1996, and elected Plan 20 coverage at that time.

Eligibility

Any retiree under Plan 20 is eligible to make retiree self-payments for medical, prescription drug and death benefit coverage until death. Any spouse of a retiree at the time of application for retirement under Plan 20 is entitled to make self-payments for both medical and prescription drug until he or she is eligible for Medicare. Eligible spouses under Plan 20 who have become eligible for Medicare may self-pay for prescription drug coverage only until their death.

Interim Self-Payment

The amount of the self-payment is set by the Board of Trustees, and is subject to change at any time, based on the costs of the Plan. Payments must be received by the first day of the month for which coverage is sought.

The months for which you make self-payments under this section will count toward your COBRA coverage period (see page 8), and if your months of self-payment exceed the maximum COBRA coverage period, you will not be offered COBRA continuation coverage.

Termination of Interim Self-Payment

If you are eligible to make the required self-payment and fail to do so within the specified time, you lose your eligibility immediately. Your benefits cannot be reinstated.

PLAN 25 AND PLAN 30 RETIREE SELF-PAY

(EMPLOYER-SUBSIDIZED RETIREE PLANS)

Participation

To participate in the Plan under the retiree self-payment provisions, the following conditions must be met: your employer must pay additional contributions to the Plan to subsidize your retiree health coverage; you must have had at least 20 years of contributions received by the Health & Welfare Fund with an employer who is still participating in the Fund (or been continuously employed with the same employer from the date the employer began paying the additional contribution to support retiree benefits – “grandfathered”); and you must have been eligible as an active participant in the month prior to your retirement month.

Spouses of retirees who have met the above criteria are offered participation under Plan 25 or Plan 30 if they were married to the participant at the time of retirement from this Plan. Retiree spouses are eligible for coverage provided the member is covered under any of the retiree options. If the retired member opts out of the Fund for other alternative coverage, the spouse’s retiree coverage will terminate at the same time as the member.

Eligibility

Any retiree or spouse married to the retiree at the time of retirement and at the time of the retiree’s death meeting the participation requirements of Plan 25 or Plan 30 is eligible to make retiree self-payments under these provisions for Plan C benefits.

Any retiree under Plan 25 or Plan 30 is eligible to make retiree self-payments for medical, prescription drug and death benefit coverage until age 65. Any eligible spouse of a retiree under Plan 25 or Plan 30 (see above) is entitled to make self-payments for both medical and prescription drug until age 65. Retirees and eligible spouses in Plan 25 or Plan 30 may self-pay for prescription drug only coverage at age 65 and continuing until death.

If the member and spouse are covered under Plan 25 or 30 and the member turns age 65 (Medicare eligible), the spouse and any dependent children will then move over to retiree coverage under Plan C at the appropriate self payment amount, until the spouse turns age 65 (Medicare eligible) at which time they will return to Plan 25 or 30 for prescription only coverage.

Interim Self-Payment

The amount of the self-payment is set by the Board of Trustees, and is subject to change at any time, based on the costs of the Plan. Payments must be received by the first day of the month for which coverage is sought.

The month for which you make a self-payment under this section will count toward your COBRA coverage period (see page 8), and if your months of self-payment exceed the maximum COBRA coverage period, you will not be offered COBRA continuation coverage.

Termination of Interim Self-Payment

If you are eligible to make the required self-payments and fail to do so within the specified time, you lose your eligibility immediately. Your benefits cannot be reinstated.

OTHER RETIREE COVERAGE OPTIONS

If you are not eligible for the retiree Plans 20, 25 or 30 at the time of your retirement, you may make retiree self-payments for up to 18 months from the date of the loss of your active coverage under the Plan you were covered as an active member provided the following conditions are met.

- You must be working in covered employment up to the time you retire and you can NOT have any lapse in coverage.
- You can not elect retiree coverage once you go on COBRA.

If you are covered under Plan A, you may elect retiree coverage from Plan A, C or E. If you are covered under Plan C, you may elect retiree coverage from Plan C or E. If you are covered under Plan E, you may elect retiree coverage from Plan E.

MAJOR MEDICAL EXPENSE BENEFIT

This Plan is a “Major Medical 80%-20% Plan,” which means that almost all benefits provided under this Plan fall under the Major Medical Expense Benefit. Coverage under the Major Medical Expense Benefit provides coverage for serious injury or illness that involves extensive hospital, surgical or medical expenses, as well as physician office visits, physical therapy, laboratory expenses, x-rays, medically necessary equipment, vaccinations and other medical benefits. The Plan considers for payment “covered medical expenses” incurred during a calendar year in an amount equal to 80% of the amount which exceeds the “Major Medical Expense Deductible.” Such benefits are limited to a lifetime maximum per person as shown in the Schedule of Benefits for each plan level.

Major Medical Expense Deductible

The “Major Medical Expense Deductible” is the amount of charges incurred for “covered medical expenses” which you must pay before the Plan pays any benefits. The Major Medical Expense Deductible must be satisfied each calendar year. The Major Medical Expense Deductible for each eligible person is different for various levels of coverage which are based upon the contribution rate paid by your employer. In addition, there is a maximum family deductible.

Please refer to your Schedule of Benefits at the end of this booklet for the deductible that applies to your plan level.

Covered Medical Expenses

“Covered Medical Expenses” are the usual, customary and reasonable charges for services and supplies that are rendered or prescribed by a legally qualified physician, surgeon or licensed chiropractor. A charge is usual, customary and reasonable if the level charged does not exceed the fees a physician charges most of his or her patients for a similar service, and if the level is within the range of fees charged by physicians with similar training and experience for the same or similar services within the locality. Also taken into account are your conditions and any additional time or skills needed by your physician to treat you. All health care charges (surgeries, office visits, x-rays, lab work, durable medical equipment) are subject to usual, customary and reasonable limits. When a claim is submitted, CareFirst BlueCross BlueShield determines if the charge is within usual, customary and reasonable limits; then prices it in accordance with its then current contractual

payment rates with the provider. The Fund has access to these discounts through a Network Access Agreement. The Plan's payments are based on the provider reimbursement rates or "allowed amounts" determined by CareFirst BlueCross BlueShield. The final decision of whether a charge is usual, customary and reasonable is made by the Trustees and CareFirst BlueCross BlueShield, and is conclusive and binding.

If your provider's charge is more than the "allowed amount" for a particular procedure, the difference will not be covered. When this happens, you may be able to negotiate with your provider to reduce the fee; otherwise, you'll be responsible for the difference.

You can avoid your benefits being limited by "allowed amount" provisions if you use PPN providers, who accept the "allowed amount" as payment in full.

Covered Medical Expenses include the following charges:

the usual, customary and reasonable fees for physician office visits, physical examinations, or other out-patient services necessary for diagnosis, treatment or surgery;

- hospital room and board up to the average semi-private rate or special care unit charges, if required, and any necessary hospital services furnished by the hospital;
- the usual, customary and reasonable fees of a physician or surgeon for diagnosis, treatment and surgery;
- licensed registered nursing fees for private duty nursing services, fees of licensed practical nurses for private duty nursing services rendered in a hospital to a registered bed patient;
- fees for treatment by a licensed physiotherapist other than a nurse or physio-therapist who ordinarily resides in the same household with you or who is related by blood, marriage, or legal adoption to you or your spouse;
- diagnostic x-rays and laboratory examinations;
- X-ray, radium and radioactive therapy and administration of chemotherapy;
- blood and other fluids to be injected;

Major Medical Restoration

If you have exhausted your lifetime major medical benefit under the Fund in any given year, up to \$1,000 will be restored during the first quarter of the following Plan Year.

GENERAL BENEFITS INFORMATION

Hospital Expense Benefit

Hospital Room and Board

All acute care and rehabilitation hospital benefits will be applied to your Major Medical Expense Deductible (see page 13) and once that deductible has been met; your benefits will be paid at 80%.

If you or your dependents are confined in an acute care or rehabilitation hospital on the date coverage begins (or coverage increases due to plan improvements), such coverage (or such increased coverage) is not effective until the day you return to work under the new plan.

Hospital Miscellaneous Expenses

The Plan provides benefits for necessary hospital charges to the extent usual, customary and reasonable, in addition to charges for room and board under the Major Medical Benefit up to the limits shown in your Schedule of Benefits.

Hospital charges for an operating room, anesthesia, X-ray examinations in hospital (excluding X-ray of teeth), laboratory analysis, drugs, medication, dressings and blood transfusions are covered. However, a hospital must charge for room and board for hospital miscellaneous expenses to be covered by the Plan. If the only charges are for surgical operation or for emergency treatment of a non-occupational accident within 48 hours of the accident, a room and board charge is not required.

To be recognized as a "hospital" for Plan purposes, an institution regularly must keep patients overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24-hour nursing service by registered, graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, and places of rest for the aged, treatment facilities for drug-addiction or alcoholism do not qualify as hospitals.

Hospital Pre-Certification Program

The Hospital Pre-Certification Program requires that you or provider call Nationwide Better Health at 800-925-8573 prior to any elective, non-emergency hospital admission. For emergency admissions, you or your provider must notify Nationwide Better Health within 48 hours of admission. The Plan reserves the right to deny coverage for any admissions (or portions of admissions) which are determined to be unnecessary.

Physician Visits

Annual Physical Examination

The Plan pays for one physical examination per calendar year under the Major Medical Benefit.

Well Child Care

The Plan applies the usual, customary and reasonable charges to your Major Medical Expense Deductible for well child visits. These well-child visits are not counted toward the 20-visit limit for office visits. However, a well-child visit with an illness diagnosis will be counted toward the office visit limit.

Office Visits

In addition to the General Limitations and Exclusions on page 26, benefits for physician's visits are not payable for:

- more than one treatment on any one day;
- any treatment which is not personally rendered by or prescribed by a physician or surgeon; and
- treatment received on the day of any surgical operation or during convalescence from surgery if payment is made for such operation under the Surgical Expense Benefit (benefits are not payable for dentistry).

“Physician” means a person licensed to practice medicine and surgery acting within the scope of his or her practice. Also, a “physician” may be a licensed chiropractor in the administration of physical therapy.

Surgical Expense Benefit

The Plan pays benefits for surgical procedures as follows:

Benefits are payable whether a surgical procedure is performed in a hospital, doctor's office or elsewhere, but the procedure must be performed by a legally qualified physician while coverage is in force.

Organ Transplants

Organ transplants are considered eligible surgical procedures, provided the procedure is not considered to be experimental or investigational by Nationwide Better Health. If an organ transplant is being considered, contact Nationwide Better Health at 800-925-8573 for specific procedures.

Donor and recipient expenses for organ transplants are paid as follows:

- If both the donor and recipient are participants in this Plan, both parties will be eligible for medical coverage.
- If the donor is not a participant in the Plan but the recipient is a participant, then only the recipient's expenses will be eligible for medical coverage.
- If neither the donor nor recipient is a participant in the Plan, then neither the donor's nor the recipient's medical expenses will be covered.
- If donor is a participant, he or she will not be eligible to receive weekly accident and sickness benefits.

To ensure that your transplant is appropriate, the Board of Trustees may ask you to have a screening from a qualified medical professional.

Reconstructive Breast Surgery

As specified in the Women's Health and Cancer Rights Act of 1998, an eligible participant or beneficiary who elects breast reconstruction in connection with a mastectomy also will be covered for:

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

Diagnostic Laboratory and X-Ray Benefit

Under the Major Medical Expense Benefit, the Plan applies the usual, customary and reasonable charges for expenses incurred for X-ray or laboratory examinations for diagnosis of an illness. Mammograms are considered an eligible expense under the Diagnostic Laboratory and X-ray Benefit.

Charges Not Covered

In addition to the General Limitations and Exclusions on page 26, medical benefits are not payable for:

- dental x-rays (see dental coverage), except in the case of an accidental bodily injury (see page 8);
- examinations that are not recommended or approved by a legally qualified physician or surgeon;
- eye examinations (see optical coverage).

Maternity Benefit

Maternity benefits are provided to the eligible dependent spouse of an eligible active or retired participant as well as to the active participant. Hospital charges for room and board and miscellaneous services are covered the same as for any other illness. The fee charged by the physician for any obstetrical procedures is applied to your Major Medical Expense Deductible. Complications of pregnancy will be treated the same as any illness. Dependent children are not eligible for Maternity Benefits.

Emergency Expense Benefit

The Plan applies the usual, customary and reasonable charges for expenses incurred as a result of emergency illness to the Major Medical Expense Deductible, provided the expenses are incurred within 12 hours of the onset of the illness.

Please be advised that reimbursements for services rendered in a hospital emergency room are limited to those directly related to emergency care. Routine services obtained in a hospital emergency room are treated as office visits and paid as shown in your Schedule of Benefits.

Emergency care is defined as “a condition which poses a serious threat to the well being of the patient if not treated immediately.”

Examples of conditions which would be classified as emergency care include, but are not limited to: Heart Attacks, Severe Hemorrhage, Unexplained Fainting, Poisonings, Acute Allergic Reactions, Respiratory Distress, Convulsions, Diabetic Coma.

Visits for colds, flu, childhood diseases and nausea are not considered emergency care.

Hearing Aids

The Plan applies the usual, customary and reasonable charges to your Major Medical Expense Deductible for hearing aids, when medically necessary. Participants are eligible for one hearing aid per ear in a five (5) consecutive year period. Please refer to the schedule of benefits for benefit maximums and limitations.

Oxygen and Oxygen Equipment

The Plan will pay expenses incurred for oxygen equipment and supplies when medically necessary under the Major Medical Benefit. The Plan reserves the right, however, to determine if such equipment and supplies should be purchased, leased or rented.

Durable Medical Equipment

The Plan will pay expenses incurred for durable medical equipment when medically necessary under the Major Medical Benefit. The Plan reserves the right, however, to determine if such equipment and supplies should be purchased, leased or rented, and will pay to lease equipment only up to the maximum purchase amount for such durable medical equipment.

Outpatient Occupational, Speech, Chiropractic and Physical therapy

The Plan pays usual, customary and reasonable charges for outpatient occupational, speech, chiropractic and physical therapy visits under the Major Medical Benefit. The maximum benefit payable is limited to 25 visits per calendar year for speech therapy, 25 visits per calendar year for occupational therapy and 25 visits per calendar year for combined physical therapy and chiropractic visits. Coverage is provided for the above-referenced therapy benefits only if treatment is rendered by a duly licensed chiropractor or occupational, speech, or physical therapist acting within the scope of his or her license.

Skilled Nursing and Rehabilitation

The Plan provides benefits for skilled nursing and rehabilitation hospital care under the Major Medical Benefit for as long as those benefits are certified by Nationwide Better Health. Skilled nursing and rehabilitation hospital benefits are limited to 100 days.

Hospice Care

The Plan provides benefits for inpatient hospice care designed to meet the special needs of terminally ill participants when:

- the prognosis of probable survival is six (6) months or less and,
- the insured is receiving palliative, not curative care.

Treatment must be rendered by or through a licensed care agency and be pre-certified by Nationwide Better Health in order to be covered under this Plan. Inpatient room and board is covered under the Major Medical Benefit, and benefits are paid in accordance with your Schedule of Benefits.

Death Benefits

The Plan provides death benefits through Fort Dearborn Life Insurance Company. To receive a copy of the summary booklet explaining the Plan's death benefits, please contact Fort Dearborn Life Insurance Company, 1020 31st Street, Downers Grove, IL 60515-5591, Group No.: MMLLL280, at 1-800-692-1400 x 1721 (member contact number) or at 1-800-692-1400 x 1815 (claims contact number).

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Treatment of Psychiatric Conditions

The treatment or diagnosis of psychiatric (mental health) conditions are covered services and as such are eligible for reimbursement from the Plan subject to the following special provisions:

Inpatient Treatment

The Plan provides benefits for inpatient treatment of a mental condition, including an emotional disorder, which according to generally accepted medical standards is amenable to improvement through treatment. Coverage is provided under the Major Medical Benefit for a maximum of thirty (30) days, per calendar year for services provided in a hospital or accredited psychiatric hospital.

Outpatient Treatment

The Plan applies the usual, customary and reasonable charges to the Major Medical Expense Deductible for psychiatric visits up to the maximum amount as shown in the office visit allowance in your Schedule of Benefits.

Treatment of Substance Abuse

The treatment of substance abuse is a covered service by the Plan and as such is eligible for payment subject to the following special provisions:

Detoxification/Rehabilitation Treatment

The Plan provides benefits for alcohol abuse and drug abuse defined as a disease that is characterized by a pattern of pathological use with repeated attempts to control its use. The Plan applies the usual, customary and reasonable charges provided by a hospital or a facility licensed by the Maryland Department of Health and Mental Hygiene, to your Major Medical Expense Deductible. Such treatment is limited to a lifetime maximum per person as shown in your Schedule of Benefits.

Outpatient Treatment

The Plan pays usual, customary and reasonable charges for substance abuse visits as shown in your Schedule of Benefits.

Yearly Maximum

Total benefit payments for Outpatient Mental Health and Substance Abuse visits are limited as shown in your Schedule of Benefits.

WEEKLY ACCIDENT AND SICKNESS BENEFIT

The Plan provides a Weekly Accident and Sickness Benefit to eligible employees while you are totally disabled and prevented from working because of a non-occupational sickness or injury.

The amount of the Weekly Accident and Sickness Benefit is 60% of your basic weekly earnings or the amount shown in your Schedule of Benefits, whichever is less. This benefit begins on the first day of disability resulting from an accident. For disability resulting from an illness, the weekly benefit begins on the eighth day of such an illness. However, the waiting period will start to run only from the first day of lost wages and the day you first visit or are visited by a physician.

Weekly benefits are not payable when a participant is receiving a paid vacation, holiday pay, sick leave, retirement, lay-off, workers' compensation or is terminated from employment. Weekly benefits are also not payable while you are making COBRA payments or eligible as a result of the hours bank in the movies industry. This benefit is payable during the month you are able to self pay for coverage due to a shortage of hours only if you are still working in covered employment.

Federal law requires that Social Security and Medicare Taxes (FICA) be withheld and forwarded to the federal government. Your employer also pays their matching FICA Taxes on your Accident and Sickness weekly benefit payments while you are covered under the Baltimore Collective Bargaining Agreements. A W-2 tax form reporting the total benefits paid in a calendar year will be provided to you at year end by your employer. A copy is also sent to the Internal Revenue Service. For employees on the Eastern Shore, the Fund pays the matching FICA Taxes and issues the recipient a W-2 at year end.

Benefits are payable as shown in your Schedule of Benefits for any one disability. Successive periods of disability that are separated by less than thirty days of continuous active employment are considered one continuous period of disability.

PRESCRIPTION DRUG BENEFIT

The Prescription Drug Benefit is available to all eligible participants for medications that are prescribed by a doctor and bear the label “Caution, Federal Law Prohibits Dispensing without a Prescription.” You must pay a co-payment per prescription or refill (see your Schedule of Benefits).

Prescription Benefit Co-Payment

Generic medication	\$ 10.00
Brand medication, if no generic available	\$ 25.00

For Brand medication, if Generic is available, the participant pays the difference in cost between Generic and Brand medication.

Identification Card

Once you become eligible for prescription drug benefits, the Fund Office will send you an identification card. This card will also serve as your medical identification card. The card can be used at any pharmacy that transmits their claims electronically at the point of sale. If a participating pharmacy is not available in your area, you may pay for the prescription and submit the charges to Express Scripts for payment.

Your ID card is very important to you. It should be used only by a person covered by the program. The unauthorized or fraudulent use of this card to obtain prescription drugs results in the cancellation of this benefit.

Receiving a Prescription

Follow these three simple steps to receive a prescription under the program:

- Consult your area pharmacy to determine if they will accept your ID card.
- Present your ID card to the pharmacist along with the prescription to be filled. The pharmacist has the forms necessary to provide you with your prescription benefit. Your pharmacist will ask you the age and relationship to the patient and will require the person picking up the prescription to sign the claim form. Your card covers all the eligible members of your family.
- Pay only the co-pay, (see your Schedule of Benefits); however, the Plan requires that generic drugs be used when they are manufactured and authorized for sale in your state instead of brand-name drugs. If you wish to have your prescriptions filled with a brand-name drug, when there is a generic substitute manufactured and approved in your state, then you will have to pay the difference in price.

Charges Not Covered

Prescription Drug benefits are not payable for:

- any non-legend drug
- contraceptive drugs, in any form, unless used to treat a medical diagnosis;

- any medication which is to be taken by or administered while you or your dependent is confined in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- more than a 34-day supply for retail pharmacy or 100 days supply for mail order;
- any drug labeled “Caution - Limited by Federal Law to Investigational Use” or experimental drugs whether or not a charge is made to the patient.
- Injectables may be subject to prior authorization;

Money Saving Features of the Prescription Drug Program

Home Delivery Program

Effective November 1, 2007, your maintenance medication program covers up to two 34-day fills of each maintenance medication at your local pharmacy, then coverage is provided exclusively through the home delivery program. Maintenance medications are those drugs taken regularly for long-term conditions, and a list of those maintenance medications can be obtained by calling Express Scripts at 1-888-787-2340 or viewing the website at www.express-scripts.com.

The home delivery program includes:

Free home delivery of your medication
 Up to a 3-month supply of medication with each order
 24-hour access to a pharmacist

If you decide not to use the Express Scripts Pharmacy for home delivery, you can still get your maintenance medication from a local pharmacy, but you will need to pay the full cost of the prescription drug.

To sign up for the home delivery program, call Express Scripts at 1-888-787-2340 or access the website at www.express-scripts.com/startnow.

Step Therapy

Step Therapy is a program designed exclusively for people who have certain conditions — arthritis, high blood pressure, and high cholesterol, for example — that require them to take medications regularly.

Step Therapy is all about value — about getting the most for your money. Most simply, that means getting a tried-and-true medication that’s proven safe and effective for your condition, and getting it at the lowest possible cost.

The lowest-cost Step Therapy drugs also save money for your prescription-drug plan, and that helps make sure that your pharmacy benefit will be there for you and your family in the future.

How Does Step Therapy Work?

We group medications into two categories:

Front-Line Medications: These are the drugs recommended for you to take first — usually generic medications, which have been proven safe and effective. You pay the lowest copayment for these drugs.

Back-Up Medications: These are brand-name medications, like those you see advertised on TV. They're recommended for you to take only if a front-line medication doesn't work for you. You almost always pay more for brand-name medications.

How Can I Make Sure I Get the Best Value?

The next time your doctor writes you a prescription, ask if a generic drug is right for you. It makes good sense to ask for these drugs first because, for most everyone, they work as well as brand-name drugs — and they almost always cost less.

If you've already tried a front-line drug, or your doctor decides one of these drugs isn't appropriate for you, then your doctor can prescribe a back-up drug, but at a higher cost.

Curascripts

Curascripts is a specialty pharmacy that provides injectable, oral and infused medications that may be complex and costly and usually require special storage and handling and may not be readily available at the local pharmacy. This includes medication targeted to specific conditions such as multiple sclerosis, rheumatoid arthritis, cancer, asthma, psoriasis, Crohn's disease, multiple sclerosis, pulmonary arterial hypertension and hepatitis C. Living with a serious disease can be difficult, and Curascripts is designed to help manage treatment of these conditions. Services include:

- Calls from nurses to discuss your progress and anything that may affect your health, detect any new symptoms or medication side effects and help you take your medication correctly to receive the greatest benefit.
- Toll free access to a pharmacist 24 hours a day, seven days a week.
- Mailed educational materials and access to Curascripts Websites that can help you manage your condition.
- Access to on staff social workers that provide emotional support and help identify community assistance programs in your area.
- Coordination with patient assistance programs that can offer financial help – if needed.

You can reach Curascripts at 866-848-9870 to get additional information or request services. A representative will contact your physician to get your prescription. Once approved, the prescription is prepared and checked by a registered pharmacist for accuracy. A representative will call you to schedule delivery of your medication and supplies to your home or your doctor's office. Your medication will be discretely packaged to protect your privacy before being shipped to you.

OPTICAL BENEFIT

The Optical Benefit is available to all eligible participants. The Plan pays for optical services performed as shown in the Schedule of Optical Services and Supplies up to the maximum family allowance shown in your Schedule of Benefits.

Participants are eligible for one complete eye examination in a twelve (12) consecutive month period.

The Plan also pays for one set of lenses and one set of eyeglass frames in a twenty-four (24) consecutive month period for all eligible participants. For contact lenses, a copy of the prescription must be submitted.

Family Maximum

The Optical Benefit applies the usual, customary and reasonable charges for optical services and supplies to the Major Medical Expense Deductible, based on the eligibility rules listed above and according to the Schedule of Optical Services and Supplies up to the family maximum per calendar year as shown in your Schedule of Benefits.

Charges Not Covered

In connection with orthoptics, vision training or subnormal vision aids;
 Lenses obtainable without a prescription; or
 Any service or supply not listed in the Schedule of Optical Services and Supplies below

Schedule of Optical Services and Supplies		
Eye Examination	One Exam in a twelve (12) consecutive month period	\$50.00
Lenses	Per pair: Single Vision Bi-Focal Tri-Focal Lenticular	\$55.00 \$70.00 \$80.00 \$90.00
Frames		\$30.00
Contact Lenses	Per pair, if prescribed: Where visual activity is not correctable to 20/70 in the better eye except by the use of contact lenses; As a requirement following cataract surgery, or when such person is being treated for a condition such as Keratoconus or Anisometropia, and contact lenses are customarily prescribed as part of the treatment; Maximum amount c. If otherwise prescribed. Maximum amount The maximum amount for a single lens is 50% of the maximum amount payable for a pair of lenses.	\$150.00 \$ 50.00

DENTAL BENEFIT

Dental benefits are available for all eligible participants and their eligible dependents. Dental benefits are provided through CareFirst BlueCross BlueShield of Maryland Traditional Dental Plan, 10455 Mill Run Circle, Owings Mills, MD 21117-5559, Group No.: 7F12 DA01, phone 410-581-3675, toll free 1-800-638-6378.

Identification Card

Upon the completion of a dental application, the Plan will send you a dental identification card. Approximately 90% of the dentists in the greater Baltimore Metropolitan Area participate in this plan. If you cannot locate a participating dentist in your area, please contact the CareFirst for assistance.

Dental Procedures

The Summary of Benefits provides a brief summary of covered services and the portion covered under the Dental Benefit.

Yearly and Lifetime Maximums

For each eligible participant, there is a calendar year maximum dental benefit of \$2,000. Once the plan has paid \$2,000 in benefits for an individual in a calendar year, no further benefit is available under the dental provisions. There is a separate lifetime maximum for orthodontic benefits of \$1,000 per person (the \$2,000 annual limit does not apply to orthodontia).

Deductible

(For Class 2 and Class 3 Procedures)

A \$50 deductible per person for Class II and Class III dental procedures and services described in the Schedule of Benefits must be met before dental benefits are paid by this Plan, up to a family maximum of \$100 each year. No deductible applies for Class I dental services. Cleanings and exams are covered 2 times per calendar year.

Charges Not Covered

Dental benefits are NOT provided for:

- Treatment excluded under General Exclusions or by any other limitation in this booklet
- Dentures, bridges and crowns delivered more than 60 days after your coverage ends or ordered before your coverage begins
- Replacing lost or stolen dentures, bridges or crowns
- Professional fees to someone who is not a licensed dentist
- Replacements of dentures, bridges or crowns more than once every two years
- Engraving of dentures or cosmetic work

GENERAL LIMITATIONS AND EXCLUSIONS

The following charges are not covered under this Plan; therefore, the amount of benefits payable under the Plan is determined after these charges are deducted from covered expenses:

- charges incurred while not covered under this Plan;
- charges that would not have been made if coverage did not exist;
- charges that you or your dependents are not required to pay;
- charges for services or supplies which are furnished, paid or otherwise provided for by reason of the past or present service of any person in the armed forces unless otherwise required by law;
- charges for nursing or other services performed by a person who ordinarily resides in the patient's home or is a member of your family or your spouse's family;
- charges for services or supplies which are paid for or otherwise provided for under any laws of a government unless required by federal law;
- charges for services or supplies which are not medically necessary for treatment of an injury or illness or are not provided or prescribed by a legally-qualified surgeon, physician or licensed chiropractor;
- charges to the extent that they are not usual, customary and reasonable;
- charges for an injury or illness covered by workers' compensation laws;
- purifiers, humidifiers, air conditioners, dehumidifiers and all similar equipment, including exercise equipment and whirlpools;
- charges for education, training, and bed and board while you or your dependent are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home;
- deductibles of any type, for any reason, in any amount;
- charges for blood plasma;
- charges by an intern of a hospital;
- charges for transportation or travel except as covered under the "MAJOR MEDICAL EXPENSE BENEFIT" provisions;
- false or altered claims, or those found to be fraudulent;
- medicines which may be purchased without a prescription or are not prescribed to treat an illness or injury;
- charges for custodial care;
- charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;
- charges for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;
- charges resulting from the treatment or diagnosis of pregnancy incurred by a dependent child;
- charges incurred as a result of war, declared or undeclared, including armed aggression;
- cosmetic procedures and associated expenses;
- the services of private duty registered and licensed practical nurses, unless medically necessary;
- physical or psychiatric examinations or psychological testing for purposes of obtaining or maintaining employment, licensure, legal proceeding, registration or insurance, or conducted for purposes of medical research;

- any elective surgical procedure including all associated expenses, intended primarily for treatment of morbid obesity, unless medically necessary;
- any surgical procedure, including all associated health services, for the reversal of voluntary sterilization;
- speech therapy and evaluation, diagnosis and treatment of educable children diagnosed as having special learning disabilities, unless medically necessary;
- services related to sex transformations or sexual dysfunction inadequacies unless medically necessary;
- in-vitro fertilization and embryo transplants; and
- charges for services or supplies for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ) and any related disorders or procedures regardless of medical necessity.

The term “custodial care” means services and supplies, including room and board and other institutional services, primarily to assist a person in the activities of daily living - whether or not he or she is disabled. However, room and board and skilled nursing care for a person in a hospital are not considered custodial care if they must be combined with therapeutic services needed to improve his or her medical condition.

The Plan only covers treatments, services or supplies that are necessary, reasonable and recommended or approved by the attending physician.

COORDINATION OF BENEFITS

The benefits payable to you under this Plan are coordinated with benefits payable to you or your covered dependents from “other benefit plans” for the same expenses. It is intended to permit full payment of actual allowable expenses without duplication of benefits.

Coordination means that benefits payable from this Plan and from other benefit plans can equal but not exceed 100% of “allowable expenses.” It also determines the priority of payment between or among different plans.

The term “allowable expenses” means the usual, customary and reasonable charges for necessary services and supplies that are covered in full or in part under this Plan or any other plan under which the person making the claim is covered.

The term “other benefit plans” means any group health plan or policy (insured or self-insured) such as your spouse’s employer’s plan or Medicare.

The following determines the priority of payment of benefits under this Plan and any other benefit plan:

- This Plan always pays after a plan that does not have a coordination of benefits provision.
 - A plan covering you as an employee pays benefits before a plan covering you as a dependent.
 - A plan covering you as a laid-off or retired employee pays benefits after any other plan covering you as an employee.
 - If the other plan has a coordination of benefits provision, the plan of the parent whose birthday (month and day only) occurs earlier in the calendar year covers dependent children first.
 - If priority still is not established, the coverage that has been in effect for the longer period of time pays benefits first.
 - The following special rules apply for dependent coverage in case of legal separation or divorce:
 - If the parent with custody has not remarried, the plan covering the parent with custody pays first. The plan covering the parent without custody pays second.
 - If the parent with custody has remarried, the plan covering the parent with custody pays first. The stepparent’s plan pays second. The plan of the parent without custody pays third.
- If you or your dependents are also covered under a health maintenance organization (“HMO”), any benefits you receive under the HMO are coordinated with benefits provided under this Plan in accordance with the above coordination rules.

MEDICARE COORDINATION

Because this Plan may coordinate its coverage with your Medicare benefits, it would be wise to visit an office of the Social Security Administration during the three-month period prior to your 65th birthday to learn all about Medicare. For additional information or for help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

Active Employee Participants and Dependents at Age 65

Upon reaching age 65, you are entitled to coverage under Medicare even if you don't retire. As an active employee, even though you are covered under Medicare, this Plan will pay your claim before Medicare does.

Disabled Employee Participants and Dependents

When active employees or covered dependents become entitled to Medicare because they are totally and permanently disabled, coverage under this Plan is primary to Medicare coverage. It is important to remember that this rule applies whether or not you or your covered dependent is enrolled in Medicare.

SUBROGATION

If you or one of your dependents is injured directly or indirectly by a third party, the Plan will pay covered benefits under the following circumstances. If you receive a payment from the third party, and/or from an insurance company, employer or other agent, assign, or relative of the third party as a result of settlement or award for your injuries, the Plan will have the right to an equitable lien over the payment, and the Plan will have a right of first recovery from the payment, without deduction of attorneys' fees or costs, up to the full amount of the recovery. The Plan's right of first recovery shall apply regardless of whether the award or settlement is designated for medical benefits, damages, pain and suffering or any other designation related to the injuries. The common fund and make whole doctrines are specifically rejected, for the purposes of this section. No benefits will be paid by the Plan under this section until a fully executed Subrogation Agreement is completed by the participant, the injured party, and the injured party's attorney, if applicable. The Subrogation Agreement requires, among other things, that you and your attorney must cooperate with the Plan and provide all information regarding your lawsuit or settlement to the Fund Office and/or Plan Counsel.

For example, suppose that you and your spouse are injured in an automobile accident that was another person's or entity's fault and that the Plan pays \$1,000 in benefits to you for injuries resulting from the accident. If you and your spouse receive money from the other person or entity, or from an insurance carrier, as a result of a legal settlement, the Plan is entitled to receive up to \$1,000 of the money awarded to you as reimbursement for the benefits provided by the Plan.

If you file a claim for workers' compensation benefits and your claim is contested, you may receive benefits from the Plan until your workers' compensation claim is resolved. In order to receive these benefits from the Plan, you must sign an Indemnity Agreement, stating that if you later are awarded temporary total workers' compensation benefits or workers' compensation medical benefits, you must repay all benefits you received from the Plan for any period to which your workers' compensation award applies. If you fail to reimburse the Fund under this section, the amount owed to the Fund may be offset by future benefits.

CLAIMS PROCEDURES

Obtaining and Completing Claim Forms

The completion of a claim form is only required when filing for Accident or Sickness Benefits or for reimbursement for payment of a covered claim that you paid directly. For medical claims, your doctor's office or other medical provider will submit the claim form to the Fund Office. Please be advised that any claim filed more than one year after the date of service shall not be considered by the Plan.

To file a claim for Accident or Sickness Benefits, the following rules apply:

1. The prompt filing of any required claim form will result in faster payment of your claim.
2. You may get the required claim forms from the Fund Office. All fully completed claim forms should be sent directly to the Fund Office.

Your claim must be submitted to the Fund Office in writing. It must give proof of the nature and extent of the loss. All claims should be reported promptly. The deadline for filing a claim for weekly benefits is 20 days after the date of the loss. If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible, but not later than 12 months from the date incurred, unless you are legally incapacitated. Otherwise, late claims will not be covered.

Hospital Confinement

The Hospital Pre-Certification Program requires that you call Nationwide Better Health prior to any elective, non-emergency hospital admission. For emergency admissions, you must notify such service provider within 48 hours of admission. The Plan reserves the right to deny coverage for any admissions (or portions of admissions) which are determined to be unnecessary. Pre-Certification will make your admission easier, and any cash deposit usually required will be waived. PRE-CERTIFICATION IS NOT A GUARANTEE OF BENEFITS.

Submission of Bills

You must present your medical/prescription identification card at the time of service. This will provide the doctor or medical facility with the proper mailing address to use when submitting the claim for payment. It also identifies you as being a participant with the CareFirst BlueCross BlueShield of Maryland Preferred Provider Network and therefore eligible for any discount allowed by CareFirst BlueCross BlueShield for this service.

All Billing Should Contain The Following Information:

- a. Employee's full name,
- b. Patient's full name,
- c. Diagnosis for each date,
- d. Type of services or treatment (using CPT procedure code number),
- e. Date of service or treatment,
- f. Itemization of all charges,
- g. Name of doctor,

Other insurance coverage, and

Prefix of A42 directly in front of the participant's identification number.

All benefits are payable directly to the provider of service unless a paid receipt is enclosed.

SEND ALL BILLS TO THE PREFERRED PROVIDER NETWORK:

CareFirst BlueCross BlueShield
P.O. Box 10104
Fairfax, VA. 22038-8004

SEND ALL OTHER CORRESPONDENCE AND COMPLETED ACCIDENT AND SICKNESS DISABILITY CLAIM FORMS TO THE ADMINISTRATOR:

Truck Drivers and Helpers Local 355
Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237
Telephone: (443) 573-3632 Toll Free: (866) 621 7974
Facsimile: (410) 444-0035

For information or assistance, contact the Fund Office.

General Rules to Remember

1. When to file a claim?

File the completed claim form as soon as possible. You have 20 days from the date of commencement of the first loss for which benefits are claimed to give the Fund office written notice of injury or sickness upon which you base your claim. Any claims filed more than one year from the date of service are not covered.

2. Time for processing claims?

Allow the Fund Office time to process claims before making inquiry as to non-receipt of benefit checks. You will be notified in writing in the event of a claim being delayed for additional information or further review.

3. Misuse of benefits or fraudulently filed claims.

If a participant purposely supplies wrong information to the Fund Office or causes, or conspires with someone else to cause wrong information to be supplied to the Fund Office, in connection with the filing of a claim, the participant may be subject to the loss of eligibility and other severe penalties.

REMEMBER: Incomplete claims or improperly completed forms will cause a delay in the payment of your claim, or may result in non-payment!

How to Appeal a Denial of a Claim

If a claim is wholly or partially denied, written notice of the decision will be furnished to the claimant within the time frames specified in the chart in this section.

The notice will contain:

1. the specific reason or reasons for the denial;
2. specific reference to pertinent plan provisions on which the denial is based;
3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. an explanation of the Plan's claims review procedure.

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

If the Fund Office relied on an internal rule, guideline, protocol or similar criterion in making its decision to deny your claim, the notice will also include this information, or a statement of such, along with a notice of your right for a free copy of the internal rule, guideline, protocol or similar criterion upon request.

If your claim was denied based on a medical necessity or experimental treatment or similar exclusion or limit the Fund Office will provide you with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided to you free of charge should you request it.

A claimant whose claim has been denied may take appeal to the Trustees, in accordance with the timetable on the following chart. Your appeal need not be formal but must be in writing and delivered or mailed to the Fund Office or the Trustees at the Fund Office. The appeal must state in clear terms the reason(s) for the appeal, and must include and pertinent documents not already furnished to the Plan, such as written comments, records, and other information relating to the claim for benefits.

As part of the appeal, if you want to review the Plan's pertinent documents, and make a request to the Fund Office, you may have 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 benefit determination. The Board of Trustees will also provide the identification of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your benefit denial, whether or not the advice was relied upon in making the adverse decision.

The Board of Trustees 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 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 Board of Trustees 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 Board of Trustees to consult with a health care professional, the health care professional will be an individual who has not consulted in connection with the initial denial, and who is not a subordinate of that individual.

The Board of Trustees will make a decision on the appeal within the time frames included in the chart in this section. If special circumstances (such as the need to hold a hearing) require further extension of time, the Board of Trustees will rule on the appeal within the time required by law. If such an extension of time is required because of special circumstances, the Plan will provide you 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 you of the Trustee's decision in writing. The notice will include: (1) the specific reason(s) for the decision; (2) the specific references to the pertinent Plan provisions on which the decision is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and (4) a statement explaining your right to bring a civil action under Section 502 (a) of ERISA following an adverse benefit determination upon appeal.

The denial of an application or claim to which the right of review has been waived or the decision of the Board of Trustees with respect to a petition for review, shall be final and binding upon parties, including the applicant, claimant or petitioner and any person claiming under the application claimant or petitioner, subject only to judicial review. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, regardless of when the act of omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan.

Urgent Health Care Claim

Type of Claim:

Pre-service emergency claims (for conditions that could jeopardize life, health or ability to regain maximum function) as determined by the treating physician or a physician with knowledge of you medical condition.

Action on Claim:

- Step 1. The Fund's Administrator has 72 hours after receiving your initial claim to approve or deny the claim.
- Step 2. If the Fund denies your claim you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 3. The Board of Trustees has 72 hours after receiving your appeal to notify you of its decision.

If Your Claim is Not Proper or Complete:

- Step 1. The Fund's Administrator has 24 hours after receiving your initial claim to notify you that your claim is improper or incomplete.
- Step 2. You have 48 hours after receiving notice from the Administrator to correct or complete your claim.
- Step 3. The Administrator has 48 hours to notify you if your claim is denied.
- Step 4. If the Fund Denies your claim, you have 180 days after receiving the denial to appeal the Administrators decision.
- Step 5. The Board of Trustees has 72 hours after receiving your appeal to notify you of its decision.

Pre-Service Health Care Claim:

Type of Claim:

Claims filed prior to treatment, such as those that must be pre-approved, or pre-certified under hospital pre-certification requirements or under the Fund's utilization review requirements.

Action on Claim:

- Step 1. The Fund's Administrator has 15 days after receiving your initial claim to approve or deny the claim.
- Step 2. If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 3. The Board of Trustees has 30 days after receiving your appeal to notify you of its decision.

If Your Claim is Not Proper or Complete:

- Step 1. The Fund's Administrator has 5 days after receiving your initial claim to notify you that your claim is improper or incomplete.
- Step 2. You have 45 days after receiving notice form the Administrator to correct or complete your claim.
- Step 3. If the Administrator needs more information or provided an extension notice during the initial 15 day period, the Plan has 30 days after receiving the claim to notify you of its decision.
- Step 4. If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 5. The Board of Trustees has 30 days after receiving your appeal to notify you of its decision.

Post-Service Health Care Claim:

Type of Claim:

Claims filed after treatment, when you request benefits after medical services have been rendered to you.

Action on Claim:

- Step 1. The Fund's Administrator has 30 days after receiving your initial claim to approve or deny the claim.
- Step 2. If the Fund denies your claim, you have 180 days to appeal after receiving the denial to appeal the Administrator's decision.
- Step 3. The Board of Trustees has 60 days after receiving your appeal to notify you if its decision.

If Your Claim is Not Proper or Complete:

- Step 1. The Fund's Administrator has 30 days after receiving your initial claim to notify you that your claim is improper or incomplete.
- Step 2. You have 45 days to provide information after receiving notice from the Administrator to correct or complete your claim.
- Step 3. If the Administrator needs more information or provided an extension notice during the initial 30-day period, the Plan has 45 days after receiving the claim to notify you of its decision.
- Step 4. If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 5. The Board of Trustees has 60 days after receiving your appeal to notify you of its decision.

Disability Claim

Type of Claim:

Claims for short term disability benefits including weekly accident and sickness benefits.

Action on Claim:

- Step 1. The Plan's Administrator has 45 days after receiving your initial claim to approve or deny the claim.
- Step 2. If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 3. The Board of Trustees has 45 days after receiving your appeal to notify

you of its decision.

If the Fund Needs An Extension or More Information:

- Step 1. The Plan's Administrator has 45 days after receiving your initial claim to notify you that it needs more information or an extension.
- Step 2. You have 45 days to provide information after receiving notice from the Administrator to correct or complete your claim.
- Step 3. If the Administrator needs more information or provides an extension notice during the initial 45-day period, the Plan has 75 days after receiving the claim to notify you of its decision. If the Fund needs more time, it may notify you that a further extension of 30 days is necessary to approve or deny your claim.
- Step 4. If the Fund denies your claim, you have 180 days after receiving the denial to appeal the Administrator's decision.
- Step 5. The Board of Trustees has 45 days after receiving your appeal to notify you of its decision, or if more time is necessary, 90 days after receiving your appeal.

All Other Claims

Type of Claim:

Other claims such as eligibility to self-pay, or eligibility for retiree coverage.

Action on Claim:

- Step 1. The Plan's Administrator has 90 days after receiving your initial claim to approve or deny the claim.
- Step 2. If the Fund denies your claim, you have 60 days to appeal the Administrator's decision.
- Step 3. The Board of Trustees has 60 days after receiving your appeal to notify you of its decision.

If the Fund Needs An Extension:

- Step 1. The Plan's Administrator has 90 days after receiving your initial claim to notify you that it needs an extension.
- Step 2. If the Administrator provides an extension notice during the initial 90-day period, the Plan has 180 days after receiving the claim to notify you of its decision.
- Step 3. If the Fund denies your claim, you have 60 days after receiving the denial to appeal the Administrator's decision.
- Step 4. The Board of Trustees has 60 days after receiving your appeal to notify you of its decision, or if more time is necessary, 120 days after receiving your appeal.

Claims Review Time Limits					
	Other Claims	Weekly Accident & Sickness Claims	Urgent Health Claims	Pre-Service Health Claims	Post-Service Health Claims
Deadline for Plan Notice of Initial Claim Denial Decision	90 days after receiving the initial claim. 180 days after receiving the claim if plan needs extension for special circumstances and if plan provides an extension notice during initial 90-day period.	45 days after receiving the initial claim. 75 days after receiving the claim if plan needs more claimant information and if plan provides an extension notice during initial 45-day period. 105 days if plan needs another extension.	48 hours 1, 2 after receiving completed claim or after the 48-hour claimant deadline, whichever is earlier. 72 hours 1, 2 after receiving the initial claim, if it was proper and complete.	15 days 2 after receiving the initial claim. 30 days 2 after receiving the claim if plan needs more claimant information and if plan provides an extension notice during initial 15-day period.	30 days after receiving the initial claim. 45 days after receiving the claim if plan needs more claimant information and if plan provides an extension notice during initial 30-day period.
Deadline for Claimant to Complete Non-Urgent Claim	Not applicable	45 days after receiving extension notice.	Not applicable	45 days after receiving extension notice.	45 days after receiving extension notice.
Deadline for Claimant to Appeal Decision	60 days after receiving claim denial.	180 days after receiving claim denial.	180 days 3 after receiving claim denial.	180 days after receiving claim denial.	180 days after receiving claim denial.
Deadline for Plan Notice of Appeal Decision	60 days after receiving appeal. 120 days after receiving the appeal if plan needs an extension.	45 days after receiving appeal. 90 days after receiving the appeal if plan needs an extension.	72 hours after receiving appeal.	30 days after receiving appeal. 15 days after receiving an appeal if plan allows two levels of appeal. ⁴	60 days after receiving appeal. 30 days after receiving an appeal if plan allows two levels of appeal. ⁴
Deadline for Plan Notice of Appeal Decision	60 days after receiving appeal. 120 days after receiving the appeal if plan needs an extension.	45 days after receiving appeal. 90 days after receiving the appeal if plan needs an extension.	72 hours after receiving appeal.	30 days after receiving appeal. 15 days after receiving an appeal if plan allows two levels of appeal. ⁴	60 days after receiving appeal. 30 days after receiving an appeal if plan allows two levels of appeal. ⁴

1. Plan may provide notice orally if written or electronic notice is provided within three days after oral notification.
2. Plan notice requirement applies to claim approvals as well as claim denials.
3. Claimant may provide information on appeal by telephone, fax, or similar method.

4. Both levels of appeal must be completed within the deadline that would apply if there were only one level of appeal.

Information and Claim Forms

For information or claim forms call or write:

Truck Drivers and Helpers Local 355 Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237
Telephone: (443) 573-3632 Toll Free: (866) 621 7974

When to Notify the Administrator

You must notify the Fund Office immediately whenever:

1. You change your mailing address;
2. You are receiving worker's compensation benefits or are eligible to recover damages from, or settle for damages with, a person or organization which caused you expenses paid for by the Plan;
3. You enter, or are discharged from, the Armed Services;
4. Your dependency status changes - you marry or are divorced, a new dependent is added or removed; student dependent changes
5. You apply for retirement benefits with the Truck Drivers & Helpers Local 355 Retirement Pension Plan;
6. You become disabled or return to employment after ceasing to be disabled;
7. You or your spouse reach age 65;
8. You desire to make a self-payment into the Plan;
9. Your spouse changes employment; or
10. You or your spouse becomes eligible for Medicare.

GENERAL INFORMATION

Board of Trustees Discretion

The Board of Trustees has full and exclusive authority and discretion to determine all questions of coverage, eligibility for and entitlement to benefits, methods of providing or arranging for benefits, and other related matters.

Amendment or Termination of the Plan

Neither this Plan nor any of its benefits is guaranteed. Although the Plan is intended to be permanent, the Board of Trustees may amend or terminate the Plan, in whole or part, as it finds necessary. 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 occurs.

Name, Address and Telephone Number of the Plan

Truck Drivers and Helpers Local 355 Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237
Telephone: (443) 573-3632 Toll Free: (866) 621 7974
Facsimile (410) 444-0035

Type of Administration of the Plan

The Plan is administered by a Joint Board of Trustees.

Names and Addresses of the Trustees

Labor Trustees

David White
Truck Drivers & Helpers Local No. 355
1030 S. Dukeland Street
Baltimore, MD 21223

Ervin Williams
Truck Drivers & Helpers Local No. 355
1323 N. Salisbury Boulevard
Salisbury, MD 21801

Employer Trustees

Brian Grimm
Bakers Express, Inc.
c/o Fund Office
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Cliff Hicklin
Allen Family Foods
c/o Fund Office
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Legal Process

The name and address of the person designated as agent for the service of legal process is as follows:

Joint Board of Trustees
Truck Drivers and Helpers Local 355 Health and Welfare Fund
9411 Philadelphia Road, Suite S
Baltimore, MD 21237

Service may also be made on any Trustee at the addresses shown above.

IRS Plan Identification Number

The Employer Identification Number (EIN) issued to the Plan by the IRS is 52-0631160.

Plan Number

The Plan Number assigned by the Board of Trustees is 501.

Plan Year

The end of the Plan Year is December 31st. Plan records are maintained on a calendar year basis.

Funding Medium

Benefits under the Plan are provided from the Plan's assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement. These assets are held in custody by PNC and invested by investment managers selected by the Trustees. These assets are held in a trust for the purpose of providing benefits to covered participants and paying reasonable administrative expenses.

Source of Contributions

All contributions are made by participating employers on behalf of each eligible employee in accordance with Collective Bargaining Agreements between the Union and the Employers. In order to determine whether your employer is a contributing employer, you may contact the Fund Office.

Plan Documents and Reports

You may examine the following documents at the Administrator's Office during regular business hours, Monday through Friday, except holidays:

- Trust Agreement
- Your Collective Bargaining Agreement
- Plan documents and all amendments
- Form 5500, a full Annual Report filed with the Internal Revenue Service and the Department of Labor

YOUR ERISA RIGHTS

The following statement of your rights under the Employee Retirement Income Security Act of 1974 (ERISA) is furnished in compliance with ERISA Section 104(c).

As a participant in the Truck Drivers & Helpers Local 355 Health & Welfare Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents including insurance contracts, Collective Bargaining Agreements (if applicable) and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and summary plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Fund Office. 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, call "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 benefit under the Plan or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court. If you believe that the Plan fiduciaries have misused the Plan's money or that you have been 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. The court also may impose sanctions against you if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Labor-Management Services 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.

RIGHTS UNDER FEDERAL LAW

Health Insurance Portability and Accountability Act (HIPAA)

Right to Receive a Certificate of Health Coverage

If your health care coverage stops, you and your covered dependents will receive a certificate that shows your period of coverage under the Plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependents may also request a certificate within 24 months of losing coverage. To obtain a certificate, please contact the Fund Office.

Special Enrollment Rights

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

You may add a new spouse or child to your 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 the Fund Office by using the Fund'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 employer contributions or exhaustion of COBRA Continuation Coverage under another plan. Loss of eligibility does not include a loss of coverage due to failure of the individual or participant to pay premiums on a timely basis or termination of employment for cause. **Adding a dependent may cause an increase in the amount you must pay for COBRA Continuation Coverage.**

Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (“FMLA”) requires participating employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee’s child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the FLMA, your participating employer is required to maintain pre-existing coverage under the Plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12 week FMLA leave entitlement, or do not intend to return from leave. Your coverage will also cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described in the previous section. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA. If you fail to return from FMLA for impermissible reasons, the Fund 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.

Women’s Health and Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes). The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA)

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

Special Rules Related to Mental Health Benefits

The medical plan may not, under federal law, impose any annual or lifetime limits for mental health coverage that are lower than the annual or lifetime limits for other hospital/medical/ surgical coverages. The medical plan may, however, impose other conditions on the amount, duration, or scope of mental health benefits, such as limits on the number of visits or days of coverage, cost sharing rules, or requirements relating to medical necessity. The limit on annual or lifetime limits applies regardless of any contrary limit or statement contained in any separate written materials you may have received.

Appendix A – Schedule of Dental Procedures

The Percentage Covered column is based on the usual, customary and reasonable amount as established by CareFirst of Maryland.

<u>Procedure Code</u>	<u>Name of Procedure</u>	<u>Percentage Covered</u>
<u>Class I - Preventative</u>		
<u>Clinical Oral Examinations – 2 per year</u>		
0150	Initial Oral Examination	100%
0120	Periodic Oral Examination	100%
<u>Emergency Treatment</u>		
0140	Emergency Oral Examination	100%
<u>X-Rays, Tests & Laboratory Examinations</u>		
0210	Intra-Oral/Complete Series	100%
0220	Periapical - First Film	100%
0230	Periapical - Each Add'l film	100%
0240	Occlusal Film	100%
0250	Extra-Oral/First Film	100%
0260	Extra-Oral/Each Add'l Film	100%
0270	Bitewing - Single Film	100%
0272	Bitewing - Two Films	100%
0274	Bitewing - Four Films	100%
0290	Extra-Oral/Posterior-Antero	100%
0330	Panoramic/Single Film	100%
0460	Pulp Vitality Tests	100%
<u>Dental Prophylaxis – 2 per year</u>		
1110	Prophylaxis - 14 years of age or older	100%
1120	Prophylaxis - 14 years of age or younger	100%
<u>Topical Fluoride Treatment</u>		
1203	Topical Application of Fluoride - child	100%
1210	Topical Application of Sodium Fluoride	100%
1220	Topical Application of Stannous Fluoride	100%
1351	Sealants	100%
<u>Space Maintainers</u>		
1510	Fixed - Unilateral	100%
1520	Removable - Unilateral	100%
1525	Removable - Bilateral	100%
<u>Unclassified Treatment</u>		
9110	Emergency treatment of dental pain, minor	100%

Class II – Maintenance, Surgical & Periodontic Services*

*After \$50 deductible/
\$100 family deductible

Amalgam Restorations & Silicate Restoration

2110	Amalgam - one surface, primary	100%
2120	Amalgam - two surfaces, primary	100%
2130	Amalgam - three surfaces, primary	100%
2140	Amalgam - one surface, permanent	100%
2150	Amalgam - two surfaces, permanent	100%
2160	Amalgam - three surfaces, permanent	100%
2161	Amalgam - four surfaces, permanent	100%
5190	Pin Retention, Exclusive or Amalgam	100%

Filled or Unfilled Resin Restorations

2310	Acrylic/Plastic Restorations	100%
2330	Resin - one surface, anterior	100%
2331	Resin - two surfaces, anterior	100%
2332	Resin - three surfaces, anterior	100%
2335	Resin - four or more surfaces	100%
2337	Composite w/Ultra Violet - one surface	100%
2338	Composite w/Ultra Violet - two surfaces	100%
2339	Composite w/Ultra Violet - three surfaces	100%
2340	Acid Etch	100%
2380	Resin - one surface, posterior, primary	100%
2385	Resin - one surface, posterior, permanent	100%

Endodontics Pulp Capping

3110	Direct Pulp Cap	70%
3120	Indirect Pulp Cap	70%

Pulpotomy

3220	Vital Pulpotomy	70%
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Root Canal Therapy

3310	Root Canal - One canal, no apicoectomy	70%
3320	Root Canal - Two canals, no apicoectomy	70%
3330	Root Canal - Three canals, no apicoectomy	70%

Periapical Services

3410	Apicoectomy	70%
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Periodontics Surgical Services

4210	Gingivectomy/Gingivoplasty, per quadrant	70%
4220	Gingival Curettage & Root Planning, per Quadrant	70%
4260	Osseous Surgery, per quadrant	70%
4261	Osseous Graft, Single Site	70%
4262	Osseous Graft, Multiple Site, per quadrant	70%

	<u>Adjunctive Periodontal Services</u>	
4330	Occlusal Equilibration - Limited	70%
4331	Occlusal Equilibration - Complete	70%
4340	Periodontal Scaling - 12 or more teeth	70%
4341	Periodontal Scaling - Less than 12 teeth	70%
4910	Periodontal Prophylaxis	70%
3410	Apicoectomy	70%

Class III – Prosthetic Services*

*After \$50 deductible/
\$100 family deductible

	<u>Crowns - Single Restoration</u>	
2710	Crowns - Plastic/Acrylic	70%
2740	Crowns - Porcelain	70%
2751	Crowns - Porcelain fused to metal base	70%
2752	Crowns - Porcelain fused to metal	70%
2790	Crowns - Full cast gold	70%
2791	Crowns - Full cast with metal base	70%
2830	Crowns - Stainless Steel	70%
2891	Cast Post & Core in Addition to Crown	70%
2910	Recement Inlays	70%
2920	Recement Crown	70%
2940	Sedative Filling	70%
2950	Crown Buildup Including any Pins	70%
2954	Prefabricated Post & Core in Addition to Crown	70%

Prosthodontics

	<u>Complete Dentures</u>	
5110	Denture - complete, upper	70%
5120	Denture - complete, lower	70%
5130	Denture - immediate, upper	70%
5140	Denture - immediate, lower	70%

Partial Dentures

5211	Partial - acrylic, upper	70%
5212	Partial - acrylic, lower	70%
5213	Partial - cast base, upper, with acrylic saddles	70%
5214	Partial - cast base, lower with acrylic saddles	70%
5230	Partial - lower, gold clasps & lingual bar	70%
5250	Partial - upper, gold clasps & lingual bar	70%
5280	Partial - removable, unilateral	70%

Adjustments to Dentures

5410	Adjustments to Complete Denture, upper	70%
5421	Adjustments to Complete Denture, lower	70%

Repairs to Partial Dentures

5610	Repair Acrylic Saddle or Base	70%
5620	Repair Cast Framework	70%

5630	Replacement of Additional Teeth, per tooth	70%
5650	Add Tooth to Existing Partial Denture	70%
5660	Add Clasp to Existing Partial Denture	70%
5670	Damaged Clasps	70%
5680	Replace with New Clasp - first clasp	70%
5690	Each Additional Clasp, With Rest	70%

Denture Reline Procedures

5730	Reline Complete Denture - upper, chairside	70%
5750	Reline Complete Denture - upper, laboratory	70%
5751	Reline Complete Denture - lower, laboratory	70%
5760	Reline Partial Denture - upper, laboratory	70%

Prosthodontics, Fixed Bridge Pontic

6210	Pontic - cast gold	70%
6211	Pontic - cast metal	70%
6240	Pontic - porcelain fused to gold	70%
6242	Pontic - porcelain fused to metal	70%
6545	Cast Metal Retainer for Acid Etch Bridge	70%

Bridge Retainers - Crowns

6750	Crowns, porcelain w/gold	70%
6751	Crowns, porcelain fused to metal base	70%
6780	Crowns, ¾ cast gold	70%
6790	Crowns, full, cast gold	70%
6791	Crowns, full, base metal	70%
6792	Crowns, full, metal	70%

Other Fixed Prosthetic Services

6930	Recement Bridge	70%
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Oral Surgery

	Extractions - Includes Local Anesthesia	
7110	Simple Extractions - First tooth	100%
7120	Simple Extractions - Each Additional Tooth	100%

Surgical Extractions - Includes Local Anesthesia

7210	Surgical Extractions - Erupted	70%
7220	Impacted Tooth - Soft Tissue	70%
7230	Impacted Tooth - Partially Bony	70%
7240	Impacted Tooth - Completely Bony	70%
7250	Surgical Removal of Residual Tooth Roots	70%

Other Surgical Procedures

7285	Biopsy of Oral Tissue - hard	70%
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Alveoplasty - Surgical Preparation of Ridge for Denture

7310	Alveoplasty with Extractions, per quad	70%
7320	Alveoplasty Not with Extractions, per quad	70%

	<u>Surgical Incision</u>	
7510	Incision & Drainage of Abscess - intraoral	70%
	<u>Other Repair Services</u>	
7960	Frenulectomy - separate procedure	70%
	<u>Adjunctive General Services</u>	
	<u>Anesthesia</u>	
9220	General Anesthesia	70%
	<u>Class IV – Orthodontic Services</u>	
	Lifetime Maximum - \$1,000.00	50%

Plan A - Schedule of Benefits

FOR ACTIVE EMPLOYEE MEMBERS AND DEPENDENTS

Plan Service	Explanation of Benefits	Coverage
Office Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits, BC/BS Allowed amount considered	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board, up to Maximum of 365 days per confinement for one disability	Major Medical
Surgical Expense Benefits	Allowed amount	Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Emergency Expense Benefits	ER visits covered for emergency services only.	Major Medical

All charges submitted for any of the above benefits are eligible for coverage under the Major Medical Benefit, up to the “allowed amount.”

Major Medical Expense Benefits	Lifetime maximum benefit, per person Cash Deductible annual, Per person Per family maximum, annual Expenses payable by Major Medical Plan Expenses payable by Insured (Co-Insurance)	\$1,000,000.00 \$200.00 \$400.00 80% 20%
Major Medical Maximum Out of Pocket Expense	Up to Major Medical lifetime maximum Per person annual, excluding deductible Per family annual, excluding deductible	3,500.00 7,000.00
Maternity Benefits Participant or Spouse Only	For Obstetrical care Delivery of Child, up to Room and board for Mother, Semi-private room, up to three (3) days Additional hospital charges, Nursery charges for Child, Coverage is provided under the Major Medical Benefit.	Major Medical Major Medical Major Medical
Prescription Benefits	Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$10.00 \$25.00

Plan A - Schedule of Benefits (continued)

Plan Service	Explanation of Benefits	Coverage
Optical Benefits	Per Schedule of Optical Benefits, up to annual family maximum	\$500.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount, once every 5 years	Major Medical \$5,000.00 for up to two aids
Dental Benefits	Schedule in Summary of Dental Benefits, up to per person annual maximum Deductible applies to Class II and Class III Procedures Individual Family	\$2,000.00 \$50.00 \$100.00
Orthodontic Benefits	Braces covered at 50%, up to per person lifetime maximum	\$1,000.00
Natural Death Participant Only	Payable for Death	\$ 60,000.00
Accidental Death Participant Only	Payable for Accidental Death, in addition to Natural Death Benefit	\$ 60,000.00
Dismemberment Insurance Participant Only	For accidental loss of any two members (hands, feet, eyes) For accidental loss of any one member (hand, foot, eye)	\$ 60,000.00 \$30,000.00
Dependent Death Benefit	Payable for Death of each eligible dependent	\$4,000.00
Accident and Sickness Participant Only	Payable for non-occupational loss of time Weekly: 60% of pay, up to a maximum of Maximum (26 weeks)	\$343.75 \$8,937.50
Drug and Alcohol	Detox/Rehabilitation covered at 50% of CareFirst BlueCross BlueShield allowed amount, up to per person lifetime maximum	\$2,500.00
Hospice	Inpatient Room and Board, Six Month Maximum Benefit	Major Medical

Plan C - Schedule of Benefits

FOR ACTIVE EMPLOYEE MEMBERS AND DEPENDENTS

Plan Service	Explanation of Benefits	Coverage
Doctor Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits, BC/BS Allowed amount considered	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board, up to Maximum of 275 days per confinement for one disability	Major Medical
Surgical Expense Benefits	Allowed amount	Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Emergency Expense Benefits	ER visits covered for emergency services only.	Major Medical

All charges submitted for any of the above benefits are eligible for coverage under the Major Medical Benefit, up to the "allowed amount."

Major Medical Expense Benefits	Lifetime maximum benefit, per person Cash Deductible annual, Per person Per family maximum, annual Expenses payable by Major Medical Plan Expenses payable by Insured (Co-Insurance)	700,000.00 300.00 600.00 80% 20%
Major Medical Maximum Out of Pocket Expense	Up to Major Medical lifetime maximum Per person annual, excluding deductible Per family annual, excluding deductible	\$5,000.00 \$10,000.00
Maternity Benefits Participant or Spouse Only	For Obstetrical care Delivery of Child, up to Room and board for Mother, Semi-private room, up to three (3) days Additional hospital charges Nursery charges for Child Coverage is provided under the Major Medical Benefit.	Major Medical
Prescription Benefits	Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$10.00 \$25.00

Plan C-Schedule of Benefits (continued)

Plan Service	Explanation of Benefits	Coverage
Optical Benefits	Per Optical schedule, up to annual family maximum	\$425.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount, once every 5 years	Major Medical \$5,000.00 for up to two aids
Dental Benefits	Schedule in <i>Summary of Dental Benefits</i> , up to per person annual maximum	\$2,000.00
Orthodontic Benefits	Braces covered at 50%, up to per person lifetime maximum	\$1,000.00
Natural Death Participant Only	Payable for Death	\$ 40,000.00
Accidental Death Participant Only	Payable for Accidental Death, in addition to Natural Death Benefit	\$ 40,000.00
Dismemberment Insurance Participant Only	• For accidental loss of any two members (hands, feet, eyes)	\$ 40,000.00
	• For accidental loss of any one member (hand, foot, eye)	\$ 20,000.00
Dependent Death Benefit	Payable for Death of each eligible dependent	\$ 3,500.00
Accident and Sickness Participant Only	Payable for non-occupational loss of time Weekly: 60% of pay, up to a maximum of Maximum (26 weeks)	\$281.25 \$7,312.50
Drug and Alcohol	Detox/Rehabilitation covered at 50% of CareFirst BlueCross BlueShield allowed amount, up to per person lifetime maximum	\$2,500.00
Hospice	Inpatient Room and Board, Six Month Maximum Benefit	Major Medical

Plan E - Schedule of Benefits

FOR ACTIVE EMPLOYEE MEMBERS AND DEPENDENTS

Plan Service	Explanation of Benefits	Coverage
Doctor Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits, BC/BS Allowed amount considered	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board, up to Maximum of 180 days per confinement for one disability	Major Medical
Surgical Expense Benefits	Allowed amount	Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Emergency Expense Benefits	ER visits covered for emergency services only.	Major Medical

All charges submitted for any of the above benefits are eligible for coverage under the Major Medical Benefit, up to the "allowed amount."

Major Medical Expense Benefits	Lifetime maximum benefit, per person Cash Deductible annual, Per person Per family maximum, annual Expenses payable by Major Medical Plan Expenses payable by Insured (Co-Insurance)	\$ 300,000.00 \$ 400.00 \$ 800.00 80% 20%
Major Medical Maximum Out of Pocket Expense	Up to Major Medical lifetime maximum Per person annual, excluding deductible Per family annual, excluding deductible	\$ 6500.00 \$ 13,000.00
Maternity Benefits Participant or Spouse Only	For Obstetrical care Delivery of Child, up to Room and board for Mother, Semi-private room, up to three (3) days Additional hospital charges Nursery charges for Child Coverage is provided under the Major Medical Benefit.	Major Medical
Prescription Benefits	Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$ 10.00 \$ 25.00

Plan E - Schedule of Benefits (continued)

Plan Service	Explanation of Benefits	Coverage
Optical Benefits	Per Optical schedule, up to annual family maximum	\$300.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount, once every 5 years	Major Medical \$5,000.00 for up to two aids
Dental Benefits	Schedule in <i>Summary of Dental Benefits</i> , up to per person annual maximum	\$2,000.00
Orthodontic Benefits	Braces covered at 50%, up to per person lifetime maximum	\$1,000.00
Natural Death Participant Only	Payable for Death	\$ 26,000.00
Accidental Death Participant Only	Payable for Accidental Death, in addition to Natural Death Benefit	\$ 26,000.00
Dismemberment Insurance Participant Only	<ul style="list-style-type: none"> • For accidental loss of any two members (hands, feet, eyes) • For accidental loss of any one member (hand, foot, eye) 	\$ 26,000.00 \$ 13,000.00
Dependent Death Benefit	Payable for Death of each eligible dependent	\$2,000.00
Accident and Sickness Participant Only	Payable for non-occupational loss of time Weekly: 60% of pay, up to a maximum of Maximum (20 weeks)	\$218.75 \$4,375.00
Drug and Alcohol	Detox/Rehabilitation covered at 50% of CareFirst BlueCross BlueShield allowed amount, up to per person lifetime maximum	\$2,500.00
Hospice	Inpatient Room and Board, Six Month Maximum Benefit	Major Medical

Plan 20 (Frozen Plan) - Schedule of Benefits

FOR RETIRED PARTICIPANTS PRIOR TO 1996 WITH EMPLOYER SUBSIDY

Plan Service	Explanation of Benefits	Coverage
Doctor Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits. Maximum amount considered will apply	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board	Major Medical
Surgical Expense Benefits		Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Major Medical Expense Benefits	Lifetime maximum benefit, per person Deductible annual, Per person Per family maximum, annual Co-Insurance, Expenses payable by Major Medical Plan Expenses payable by Insured	\$100,000.00 \$200.00 \$400.00 80% 20%
Prescription Benefits	Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$10.00 \$25.00 (30 Day Supply)
Optical Benefits	Per Schedule of Optical Benefits, up to annual family maximum	\$500.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount, once every 5 years.	Major Medical. Maximum Benefit is \$300.00 per aid
Dental Benefits	Schedule in Summary of Dental Benefits, up to per person annual maximum Deductible applies to Class II and Class III Procedures Individual Family	\$2,000.00 \$50.00 \$100.00
Death Benefit	Payable for Death - Participant Only	\$5,000.00

Plan 25 - Schedule of Benefits

FOR RETIRED PARTICIPANTS WITH EMPLOYER-SUBSIDIZED BENEFITS

Plan Service	Explanation of Benefits	Coverage
Doctor Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits. Maximum considered amount applies	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board	Major Medical
Surgical Expense Benefits		Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Major Medical Expense Benefits	Lifetime maximum benefit, per person Deductible annual, Per person Per family maximum, annual Co-Insurance, Expenses payable by Major Medical Plan Expenses payable by Insured	\$250,000.00 \$200.00 \$400.00 80% 20%
Major Medical Maximum Out of Pocket Expense	Up to Major Medical lifetime maximum Per person annual, excluding deductible Per family annual, excluding deductible	\$5,000.00 \$10,000.00
Prescription Benefits	Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$10.00 \$25.00 (30 Day Supply)
Optical Benefits	Per Schedule of Optical Benefits, up to annual family maximum	\$500.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount , once every 5 years.	Major Medical Maximum benefit is \$300.00 per aid.
Dental Benefits	Schedule in Summary of Dental Benefits, up to per person annual maximum Deductible applies to Class II and Class III Procedures Individual Family	\$2,000.00 \$50.00 \$100.00
Orthodontic Benefits	Braces covered at 50%, up to per person lifetime maximum	\$1,000.00
Death Benefit	Payable for Death - Participant Only	\$5,000.00

Plan 30 - Schedule of Benefits

FOR RETIRED PARTICIPANTS WITH EMPLOYER-SUBSIDIZED BENEFITS

Plan Service	Explanation of Benefits	Coverage
Doctor Visits	For treatment of a diagnosed illness, per person annual limit of twenty (20) visits	Major Medical
Diagnostic Laboratory and X-Ray Benefits	Outpatient services	Major Medical
Hospital Expense Benefits	Daily Room and Board 275 Day Maximum	Major Medical
Surgical Expense Benefits		Major Medical
Special Charges	Additional Hospital Charges (excluding Room and Board) when admitted, or facility fee charged by hospital for outpatient surgery	Major Medical
Major Medical Expense Benefits	Lifetime maximum benefit, per person Deductible annual, Per person Per family maximum, annual Co-Insurance, Expenses payable by Major Medical Plan Expenses payable by Insured	\$350,000.00 \$300.00 \$600.00 80% 20%
Major Medical Maximum Out of Pocket Expense Prescription Benefits	Up to Major Medical lifetime maximum Per person annual, excluding deductible Per family annual, excluding deductible Generic medication Brand medication, if no Generic is available Brand medication, if Generic is available, participant pays the difference in cost between Generic and Brand	\$5000.00 \$10000.00 \$10.00 \$25.00 (30 Day Supply)
Optical Benefits	Per Schedule of Optical Benefits, up to annual family maximum	\$425.00
Hearing Aid Benefits	CareFirst BlueCross BlueShield allowed amount, once every 5 years	Major Medical. Maximum benefit \$300.00 per aid.
Dental Benefits	Schedule in Summary of Dental Benefits, up to per person annual maximum Deductible applies to Class II and Class III Procedures Individual Family	\$2,000.00 \$50.00 \$100.00
Orthodontic Benefits	Braces covered at 50%, up to per person lifetime maximum	\$1,000.00
Drug and Alcohol	Detox/Rehabilitation covered at 50% of CareFirst BlueCross BlueShield allowed amount, up to per person lifetime maximum	\$2,500.00
Hospice	Inpatient Room and Board, Six Months Maximum Benefit	Major Medical
Death Benefit	Payable for Death - Participant Only	\$5,000.00