TEAMSTERS LOCAL 641 WELFARE FUND

SUMMARY PLAN DESCRIPTION

TEAMSTERS LOCAL 641 WELFARE FUND

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TO: PARTICIPANTS IN THE TEAMSTERS LOCAL 641 WELFARE FUND

FROM: TRUSTEES OF THE TEAMSTERS LOCAL 641 WELFARE FUND

DATE: APRIL 1, 2008

This booklet is the description of the Welfare Fund as it is in effect on April 1, 2008. You will find that the benefits are described as well as the eligibility requirements that you must satisfy in order to secure any one of the benefits.

This booklet has five major parts:

A. Questions and answers;

B. Description of benefits;

C. Claim and appeal procedure;

D. Notice of privacy practices; and

E. Technical details – this section of the booklet is provided to you under the terms of the Employee Retirement Income Security Act of 1974 and contains many technical details of the Plan intended to insure that you will be able to enjoy all the rights to which you are entitled under the provision of the Plan.

The purpose of the Plan is to provide:

A. at least partial reimbursement of costs actually incurred by the covered employees, pensioners, and eligible covered dependent(s) for certain health care;

B. a partial replacement of wages lost because of disability; and

C. a Death Benefit to the beneficiary upon the death of a covered employee or pensioner.

Because it is not intended that the Plan duplicate reimbursement that you receive under certain other health care programs, no reimbursement will be made under this Plan, for health care costs, if such costs are covered under any worker's compensation or occupational disease law.

Further, reimbursement for health care costs will be integrated with Medicare and any coverage under other health care or insurance programs.

Benefits under the Plan are provided, in major part, directly by the Plan assets.

The daily operation of the Plan is maintained by the Plan Manager and staff, all employed by the Trustees and located at the Fund Office. You are encouraged to make use of the facilities of the Fund Office where you will find assistance in understanding your benefits and in complying with the requirements in order to receive your benefits.

Since the last printing of this booklet a considerable number of changes have been made in your Plan. It is in your interest and that of your family to familiarize yourself completely with this booklet. If, after having gone through the booklet, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Fund Office. If your questions are not answered to your satisfaction by the staff, you may direct questions to the Trustees in writing.

Sincerely,
Board of Trustees

IMPORTANT ASPECTS OF YOUR PLAN

! FAMILIARIZE YOURSELF WITH THE WHOLE BOOKLET.

! ALL BENEFITS MUST BE APPLIED FOR IN A TIMELY MANNER.

! MAKE SURE THE FUND OFFICE IS AWARE OF ALL YOUR DEPENDENTS AND YOUR CURRENT ADDRESS.

! MAKE SURE YOUR DEATH BENEFIT BENEFICIARY DESIGNATION IS UP TO DATE.

! ALL CLAIM FORMS MUST BE COMPLETELY FILLED IN: INCOMPLETE ONES WILL BE RETURNED.

CAUTION

This booklet and the Plan Administrator are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Health Plan. No employer, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority. No oral statements by Plan personnel or any other Plan representative may modify in any respect the written terms of the Plan.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Plan Manager or the Trustees. You will then receive a written reply, which will provide you with a permanent reference.

FUTURE OF THE PLAN AND PLAN TERMINATION

This Summary Plan Description (booklet) includes information concerning the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that a participant or beneficiary might otherwise reasonably expect the Plan to provide. We refer you to the provisions of this booklet which detail the eligibility rules, qualification rules, benefits, limitations and exclusions from coverages.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the Plan is reserved by the Trustees, in accordance with the Agreement and Declaration of Trust. In addition, the continuance of the Plan is subject to the maintenance of collective bargaining agreements which provide for employer contributions to the trust fund that provides the Plan benefits.

If it ever becomes necessary to terminate the Plan, the Agreement and Declaration of Trust (one of the Plan documents) provides that assets then held by the Trustees must be used exclusively on behalf of Plan participants and to defray the cost of reasonable administration and termination expenses. In no event may any of the assets revert to any employer or to the union. In the event of termination of the Plan, the trust fund is to be used exclusively to continue the payment of benefits provided for in the Plan to eligible employees, their dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses and to otherwise effectuate the purpose of the Plan. Upon termination, the Trustees would establish a Plan to be applied to the balance of assets in the trust fund so that assets would be applied solely for these purposes.

Upon final liquidation of the Plan, participants and beneficiaries would have no further rights or vested interest in the Plan.

MODIFICATION OF BENEFITS AND ELIGIBILITY RULES FOR PENSIONERS AND THEIR DEPENDENTS

This booklet includes information concerning the benefits provided by the Welfare Fund Trustees to pensioners and their dependents and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that a pensioner or dependent might otherwise reasonably expect a Plan to provide.

The benefits and eligibility rules applicable to pensioners and their dependents have been established by the Trustees as part of an overall benefit program for participants. The right to amend or modify the eligibility rules and Plan Of Benefits for pensioners and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for pensioners and their dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

In accordance with the rules and regulations of the Plan and the Agreement and Declaration Trust, no employee or pensioner has a vested interest in the benefits provided for pensioners and their dependents. In addition to the right to terminate welfare benefits of pensioners and/or their dependents at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the program of benefits for pensioners at any time and there shall not be any vested right by any pensioner or dependent or beneficiary nor contractual rights after the disposition of all Plan assets and the termination of the Plan. Pensioners and their dependents will have no priority with regard to the termination of this Plan. The provisions for pensioner (and dependent) coverage will be reviewed annually by the Trustees.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Important Notice of Your Right to Documentation of Health Coverage

Recent changes in federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-months) exclusion period is reduced by your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your state insurance department for further information.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new Fund Administrator to see if your new Plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, please contact Mary Anne Gerlach, Plan Manager, Teamsters Local 641 Welfare Fund, 714 Rahway Ave., 2nd Fl., Union, NJ 07083-8634, telephone: (908)687-4488.

The certificate must be provided to you promptly. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan. In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

To request special enrollment or obtain more information, contact: The Fund Office, Teamsters Local 641 Welfare Fund, 714 Rahway Avenue (2nd Floor), Union, NJ 07083.

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PART A.

QUESTIONS AND ANSWERS

ADMINISTRATION

1. Who pays for the Plan?

The employers who have collective bargaining agreements with Merchandise Drivers Local No. 641, I.B.T., that call for the contributions to the Plan are the chief sources of contributions to the Plan.

2. How are the Plan moneys managed?

All of the Plan moneys are held in the trust by the Trustees of the Welfare Fund for the participants and beneficiaries of the Plan. The Trustees have the ultimate responsibility for the management of Plan money.

3. Who is responsible for interpreting the Plan and for making determinations under the Plan?

The Trustees. In order to carry out their responsibility, the Trustees, or their designee, shall have exclusive authority and discretion to:

- determine whether an individual is eligible for any benefits under the Plan;
- determine the amount of benefits, if any, an individual is entitled to from the Plan;
- interpret all of the provisions of the Plan and this description;
- interpret all of the terms used in the Plan and in this description.

All such determinations and interpretations made by the Trustees, or their designee, shall:

- be final and binding upon any individual claiming benefits under the Plan;
- be given deference in all courts of law, to the greatest extent allowed by applicable law; and
- not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith.

4. May I pledge the claim money owed me for the purposes of obtaining a loan?

No. No benefit under the Plan is assignable or transferable by the participant, except that assignment to a provider of the health services causing the claim is permitted.

5. If the Plan is discontinued, what will happen to the assets of the Plan?

The assets of the Plan must be used only for the benefits of the participants and beneficiaries. Under no circumstances may money which has been properly contributed to the Plan ever be returned to any employer or to Local 641.

INITIAL PARTICIPATION

6. Who is eligible to participate in the Plan?

The following persons are eligible to participate:

You are eligible for coverage under this Plan if your employment is the subject of a Collective Bargaining Agreement by and between your employer and Merchandise Drivers Local 641, I.B.T., your employer is (or was) required to contribute to the Plan on your behalf and you are a member of one of the following classes:

- active employees of the contributing employer; and
- pensioners who meet the eligibility requirements of questions 13. and 14.

7. What is Covered Employment?

Covered employment means work for which your employer is required to contribute to the Plan because of its collective bargaining agreement or because it has a special agreement with the Plan Trustees. In addition, under certain circumstances this Plan will honor time for which your employer was required to contribute on your behalf to the Local 560 Welfare Plan because of a collective bargaining agreement. However, this reciprocity does not apply to the Prescription Drug Card, Dental Benefits, and the maximum Life Insurance Benefit. Furthermore, the Trustees reserve the right to discontinue this reciprocal arrangement at any time. If you have any questions regarding how the reciprocity arrangement applies to you, please contact the Fund Office.

8. Does self-employment count?

No. Under no circumstances will you receive any credit, for any purposes, under the Plan for work in self-employment.

9. Suppose my employer (or I) wishes to contribute to the Plan for me, even though it is not required to do so in a collective bargaining agreement, is it allowed?

No! Unless it is covered in written agreement between your employer and Local 641, or between your employer and the Trustees, no credit can be given to you (even if your employer, or you, contributes to the Plan) for any work you do.

10. How do I become covered in the Plan?

Most benefits become effective for you on the first day of the next calendar month immediately following six calendar months (12 months for dental) in each of which you worked at least 10 days in covered employment. This six-month period must be within 12 months of the first month in which you have worked at least 10 days. Your initial eligibility will provide coverage for the first two (2) consecutive months. Thereafter, coverage will continue for the second month following a month in which you work 10 days. Example: work 10 days in April, you will be covered for June.

CONTINUING PARTICIPATION

11. When does my coverage stop?

Your coverage under the Plan will terminate on the last day of the next calendar month in which you work less than 10 days of covered employment. Example: work less than 10 days in April, you will be terminated as of May 31.

However, the Trustees may, in accordance with rules which preclude individual selection, continue coverage until the expiration of the period specified below. Any continuation period described below will be deducted from that period for which the individual is eligible to purchase continuation coverage under the federal COBRA law. You should read the self-payment provisions addressed in this booklet.

If you are totally disabled because of sickness or injury - to the end of the sixth month following the date on which your coverage would otherwise cease. You are allowed one six month extension of benefits for a workman's compensation claim including any future reopening of that claim.

In addition, you will be considered to have maintained eligibility for three months for all coverages if you meet all of the following three requirements:

A. you are unable to work for reasons beyond your control, including such reasons as strikes, lock-outs, and temporary layoff by your employer, but not including such reasons as personal leave of absence, change in employment, discharge, resignation, or other absence due to your own decision;

B. you have been employed under a labor agreement with Local 641 of the International Brotherhood of Teamsters for at least five consecutive years (a consecutive year is one in which you work the required number of days in all 12 months) immediately prior to the date on which such inactivity commences (however, you are only entitled to one three-month extension in any consecutive five-year period); and

C. you have 120 or more days of actual work in covered employment within the jurisdiction of the 641 Welfare Fund in the period of 12 consecutive months immediately prior to the date on which layoff commenced.

However, in no event will coverage be continued beyond the date you commence active duty in the armed forces of any country or state or international organization unless your employer is required to continue contributions on your behalf due to the collective bargaining agreement.

Your coverage will also terminate on the date the participation of your employer is terminated by the Trustees in accordance with the provisions of the Agreement and Declaration of Trust.

Winter Coverage

If you are a covered employee of an employer that makes a special contribution for winter coverage in accordance with the bargaining agreement between the employer and the union, you will have eligibility continued for you and your eligible dependents for the months of January, February, and March if you had ten or more days of covered employment during the months of November or December. Eligibility for the month of April and subsequent months will be based on the Fund's regular continuing participation rules.

REINSTATEMENT

12. If my coverage is terminated, how do I become covered again?

In the event that you are reinstated to your employer as a result of grievance or arbitration proceedings, coverage will be reinstated pursuant to the terms of the arbitration or grievance decision. In all other cases reinstatement will commence on the first of the second month following the month in which you work at least ten days in covered employment provided however that your termination of coverage was within the prior consecutive 12-month period.

PENSIONERS

13. Are pensioners who retire before age 65 covered under the Plan?

If you retire before age 65 but after reaching age 57 with 25 or more years of pension service on a pension from the Teamsters Local 641 Pension Fund, and, if your retirement takes place on or after 6/1/08, you are covered under the Welfare Fund (by other than self-payment) on the effective date of your pension and were covered under the Welfare Fund (by other than self-payment) for at least 48 out of 60 months immediately preceding your retirement up until your retirement you may choose certain health benefits for you and your dependent spouse. Once you make your choice, it cannot be changed. You become eligible for this option on the date your retirement becomes effective according to the rules of the Teamsters Local 641 Pension Fund. If you elect the health benefits, coverage continues until you reach age 65 or become eligible for Medicare, if earlier, subject to continuation by the Trustees. Coverage for your spouse will also terminate when your spouse becomes eligible for Medicare or if you die, if earlier. You will have the right to continue direct payment coverage for your spouse after you become eligible for Medicare until your spouse becomes eligible for Medicare but only while you are alive. You must agree to have the direct payment to the Welfare Fund for medical benefits deducted from your pension check.

If you fail to elect this option when first eligible for it, you will not have the opportunity to elect it at a later date. If you suspend direct payments for this benefit coverage, there is no opportunity to reinstate coverage by direct payment.

If you become a pensioner and satisfy all the above requirements except you are already age 65 when you retire, you may still choose the special health benefits for your spouse until your spouse becomes eligible for Medicare.

14. Is there any special provision for those who retire after age 62 with long-time service?

Yes. If you retire at or after age 62 (on or after 1/1/96) or age 65 (before 1/1/96) and satisfy the following requirements, you will be eligible to self-pay for a continuation of the benefits for which you were covered just before retirement, except that the Disability Income Benefit will not be continued and no more than $2,000 of life insurance will be continued.

Requirements – You must receive a monthly pension from the Local 641 Pension Fund, must retire on or after 4/1/91, must be at least age 62 at retirement date, must have at least 30 years of pension service earned under the Local 641 Pension Fund (not counting reciprocal time), must have been covered continuously under the Welfare Fund (by other than self-payment) for at least 15 years up until the effective date of your pension and must agree to make the required contributions to the Welfare Fund by deduction from your monthly pension check. ***You must apply for Medicare when you become eligible for coverage under Medicare.*** Our plan becomes the secondary payer for any retiree or spouse in this category when he or she becomes eligible for Medicare.

Contributions – You will be required to contribute a monthly amount that is determined from time to time by the Trustees. You must be covered for your spouse to be covered.

Termination of Coverage – This right to extension will stop for any one person if the person dies, if the contribution for the person stops, if the pensioner's pension is suspended, if the person is a dependent and fails to continue to satisfy the definition of dependent under the Fund rules, or the person is a dependent spouse who is predeceased by the pensioner, whichever occurs first. Once stopped, this extension will not be reinstated.

DEPENDENTS

15. Who are my eligible dependents for the purposes of the Welfare Plan?

"Dependent" includes the following:

A. Your spouse (your wife or husband while not divorced or legally separated).

B. Your child, from date of birth, and as long as the child continues unmarried and is not employed on a regular and full-time basis and is dependent on you for support, and has not attained age 19. Should your child be documented to be a full-time student attending an accredited college, the child's dependent status will be extended to the child's attainment of age 23. In the case of the Prescription Benefit there is no extension past the age of 18 regardless of the child's student status.

If, on the date on which your dependent, covered child attains the age limit, he is incapable of supporting himself due to mental retardation or physical handicap, then he will continue to be deemed a dependent during the continuation of that incapacity, and while he is otherwise included in the above definition, subject to the presentation of proof of incapacity to the Trustees within 60 days prior to the child's age limit.

"Child" includes your natural child, your legally adopted child, a step-child who lives in your home or a child that is born to or placed for adoption with a covered employee.

Federal law requires the Plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce. The details of these requirements are summarized below. Be sure you read them carefully.

The process begins when the Fund Office receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decrees, or order, including approval of a settlement agreement, which:

A. issues from a court of competent jurisdiction pursuant to a state’s domestic relations law;

B. requires you to provide only the health coverage available under the Plan for your children, even though you no longer have custody; and

C. clearly specifies:

1. your name and last known mailing address and the names and addresses of each child covered by the order;

2. a reasonable description of the coverage to be provided;

3. the length of time the order applies, and

4. each Plan affected by the order.

The Fund Office will provide written notification to you and each identified child that it has received a court order requiring coverage.

DEPENDENTS (CONT'D)

If the QMCSO meets the above requirements, the Fund Office will provide written notification to you and each affected child of his or her eligibility for coverage. This notice will include any required enrollment material, a description of the procedures to be followed, and a form for designating the child's custodial parent or legal guardian as his or her representative for all Plan purposes.

If the Fund Office receives a valid QMCSO, it must permit immediate enrollment. This means the children identified will be included for coverage as your eligible dependents. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you don't.

If you have any questions about any of these requirements, contact the Fund Office.

16. When are my dependents eligible for coverage under the Plan?

Your eligible dependents will be covered during the same period of time that you are covered.

17. For what benefits is my dependent covered?

In general, your dependent will be covered for the same benefits as you except the Life Insurance Benefit (your spouse is covered for a lesser amount), Accidental Death and Dismemberment Benefit, and the Disability Income Benefit.

18. When does coverage for my dependent stop?

Your dependent's insurance will stop on the earliest of the following:

A. the date your coverage terminates;

B. the date a change in the Plan terminates your dependent's coverage;

C. the date a dependent is no longer an eligible dependent, as defined;

D. the date the participant retires (dependent children only); and

E. the date your dependent becomes eligible for coverage as an employee under the Teamsters Local 641 Welfare Fund.

BENEFITS

19. Where can I find out about the Life Insurance and Health Care Benefits provided?

Part B. of this booklet contains an outline of the benefits for you and your dependents under the Plan.

CLAIM PROCEDURES

20. If I submit my claim for reimbursement late, will I still be paid?

The answer is, generally, no! You should read the provisions regarding the submission of claims in Part C. of this booklet.

21. If I am overpaid (or otherwise paid in error) for a claim, must I return the overpayment?

Yes! You are required to return the overpayment upon notification by the Fund Office.

SELF-PAYMENT

22. If my coverage is terminated, may I continue it by self-payment?

You may elect to continue your coverage by self-payment in accordance with the provisions of the COBRA legislation. There are, however, special self-pay provisions regarding some pensioners; see the questions in the section on pensioners.

23. What is COBRA continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that you, your spouse, and your dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances if coverage would otherwise stop.

24. Which employees are eligible for COBRA continuation coverage?

If you are covered by the Plan as an employee, COBRA continuation coverage upon voluntary or involuntary termination of employment (except for gross misconduct) or if you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

25. When is a participant's spouse eligible for COBRA continuation coverage?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

A. your death;

B. voluntary or involuntary termination of your employment (except for gross misconduct) or if you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff;

C. divorce or legal separation from you; or

D. your eligibility for Medicare.

26. When does a participant's dependent child become eligible for COBRA continuation coverage?

Your dependent child may elect COBRA continuation coverage upon the occurrence of any of the following events:

A. your death;

B. the termination of your employment (for reasons other than gross misconduct) or if you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff; or

C. your child ceases to qualify as an "eligible dependent".

27. How is a person eligible for COBRA continuation coverage notified of his eligibility?

Your employer has the obligation to notify the Fund Office of the termination of your employment, your death, your eligibility for Medicare or a reduction in your hours worked causing you to lose eligibility for benefits under the Plan. You have the obligation to notify the Fund Office of your divorce, legal separation, or your child's loss of status as an eligible dependent.

Once the Fund Office is advised of an event making you, your spouse, or your dependent eligible for COBRA continuation coverage, the eligible person will be advised of his or her right to elect continuation coverage. The Fund Office will forward the materials necessary for you, your spouse or your dependent to make the proper election.

28. When must the election be made?

You will have a period of at least 60 days from the date you receive notice that you will otherwise lose coverage under the Plan to advise the Fund Office that you want COBRA continuation coverage. If you do not elect COBRA continuation coverage, your health coverage will terminate except for any other extended coverage for which you may be eligible under the Plan.

Newborns And Adoptees

A child who is born to or placed for adoption with a covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to the COBRA coverage upon written notification to the Fund Office of the birth or adoption.

29. What types of benefits are available in COBRA continuation coverage?

The benefits you are allowed to elect to receive will include all benefits you were entitled to before the occurrence of the event making you eligible for COBRA continuation coverage except that no Life Insurance, Disability Income, or Accidental Death and Dismemberment Benefits will be included.

SELF-PAYMENT (CONT'D)

30. How long does COBRA continuation coverage last?

If the election is due to termination of your employment, COBRA continuation coverage will end after 18 months. Coverage can be maintained for up to 29 months if you are so disabled that you become entitled to a Social Security disability award at the time employment ended or your work hours were reduced or within 60 days of COBRA continuation coverage.

Otherwise, such coverage is available for a maximum of 36 months.

However, COBRA continuation coverage will end at an earlier time for any of the following reasons:

A. the Plan ceases to provide health coverage;

B. you fail to pay the monthly premium on time;

C. you become covered under another employer-sponsored health plan and that Plan does not include any preexisting condition limitation or exclusion;

D. you become entitled for Medicare; or

E. your circumstances are such that your participation could be cancelled if you were an active employee or dependent of an active employee.

31. What is the cost of COBRA continuation coverage and how is the cost computed?

Each month you will be required to make payment to the Fund Office to continue your COBRA continuation coverage. The monthly premium will be based upon a formula established by law. The cost may not be increased by the Trustees more frequently than once every 12 months.

32. Are reciprocal or pro-rata pensioners who were not last employed and covered as an active employee with Teamsters Local 641 Welfare Fund entitled to COBRA coverage under this Welfare Fund?

No.

FAMILY AND MEDICAL LEAVE ACT

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

- to care for your newly born or adopted child;
- to care for your spouse, child or parent who has a serious health care problem; or
- if you have a serious health problem which prevents you form performing your job.

FAMILY AND MEDICAL LEAVE ACT (CONT'D)

In order for you be eligible for such leave, your employer must have been obligated to make contributions to the Plan on your behalf for at least 1,250 hours in the preceding 12 month-period. You must also have worked for that employer for at least 12 months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an employer must have at least 50 employees for each working day for each of 20 work weeks in the current or preceding calendar year. Additionally, you must:

- work at a location where the employer has at least 50 employees; or
- work within 75 miles of one or more work sites where the employer has 50 or more employees.

Your employer must notify the Fund Office that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance reports to the Plan, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act to a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your employer fails to make the required contributions for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

- your employer fails for any reason to make the required contributions to the Plan on your behalf while you are on leave;
- you exhaust the 12 weeks of leave which you are entitled to under the act; or
- you or your employer notifies the Fund Office that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave).

In the event your employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with the provision of the section of this Summary Plan Description on page 8.

PART B.

DESCRIPTION OF BENEFITS

INTRODUCTION

There are several benefits in the Welfare Fund with different conditions and maximum amounts associated with these benefits. Further, not all classes of covered persons are entitled to the protection of the same benefits.

The purpose of this part of the booklet is to outline the various benefits under the Welfare Fund and let you know which classes of participants are covered for which benefits.

GENERAL PROVISIONS

Coordination of Benefits Provision

Quite frequently, because husband and wife are working, members of a family are covered under more than one plan of employee benefits. Realizing there have been many instances of duplication of benefits - two plans paying benefits for the same dollar of medical expense - a "Coordination of Benefits" provision has been included for all covered benefits except Life Insurance and Accidental Death and Dismemberment Benefits and the Disability Income Benefit.

This Coordination of Benefits provision is applicable to similar benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical, hospitalization, optical, drug or dental care or treatment toward the cost of which an employer makes contributions or for which an employer makes payroll deductions, and any government or tax-supported program.

One of the two or more plans involved is the Primary Plan, and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plan then processes the claim according to its plan's schedule of benefits after consideration of the primary plan's payment. No Plan will pay more than it would have paid without this special provision. If one Plan has no coordination of benefits provision, it automatically is primary.

Information necessary for the administration of this provision will be required of the participant at the time a claim is submitted.

In determining whether this Plan or another plan is primary, the following shall apply:

A. The Plan covering the patient as an employee or in which the employee is a participant (regardless of whether such Plan deems the patient covered for the particular benefit because of other coverage) will be the Primary Plan.

B. Where both Plans cover the patient as a dependent child, the coverage of the spouse who has a birth date earlier in the year (regardless of age) will be primary over the coverage of a spouse that has a birth date later in the year. If both Plans do not have this birthday rule, the coverage of the male employee will be primary except as follows:

1. Coverage of children of divorced or separated parents is as follows: the child is covered under the Plan of the parent that was given financial responsibility for the child's medical, hospitalization, dental, and health care by court decree. In the absence of a court decree, the Plan of the parent who has custody of the child will pay first.

2. If the parent who has custody of the child has remarried, his or her Plan would pay before the Plan of the new step-parent or the parent without custody. If the parent with custody remarried, but does not have coverage, the Plan of the new step-parent would pay before the Plan of the parent without custody.

C. When rules A. and B. do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

1. The benefits of a Plan covering the person as a laid-off or retired employee or as the dependent of such person shall be determined after the benefits of any other plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person; and

2. If either Plan does not have a provision regarding laid-off or retired employees, and, as a result, each Plan determines its benefits after the other, then the provisions of 1. above shall not apply.

D. If both a husband and a wife are eligible for Welfare Fund benefits as participants under the jurisdiction of this Fund, payment will be calculated first as if this Plan were the Primary Plan and then as if the Plan were the Secondary Plan. This will give them the same coverage as if they had been covered as employees in two different plans.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Coordination of Benefits – Retirees

The Plan will be the Secondary Plan for any retiree or spouse who has coverage under another plan as an active employee or dependent of an active employee. In the case of Medicare, this Plan will be tertiary (third) after other active coverage and Medicare.

Examination to Determine Ability to Work

The Welfare Fund will pay the cost of a physical examination for a participating employee in the Welfare Fund where an examination by an impartial doctor to be selected by the Fund is required because a contributing employer is challenging the participating employee's physical ability to return to or continue work.

Legal Action

No action at law or in equity shall be brought to recover on the Plan provisions prior to 60 days after written proof of loss, as required, has been furnished, and shall not be brought more than three years after the time such proof is to be furnished. Prior to the institution of any legal proceeding, the claimant must have exhausted the administrative procedures of the Fund.

Assignment

Except for benefits that may become payable for hospital, surgical, or medical expenses, no rights or benefits may be assigned.

Definitions

Wherever the following terms are used in this booklet they shall be interpreted to have the meanings set forth below:

"medically necessary" means generally recognized in the physician's profession as effective and essential for treatment of the injury or illness for which the service, treatment, supply or confinement is ordered; and rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered "Medically Necessary" the care must be consistent with the symptoms, diagnosis and treatment of your illness or injury, based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of Medical care. In addition, service, treatment, supply or confinement will not be considered "Medically Necessary" if it is experimental, or is investigational or is primarily limited to research in its application to the present injury or illness, or is primarily for scholastic, educational, vocational or developmental testing or training or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

THE FACT THAT A PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE OR SUPPLY DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY FOR THE TREATMENT AND DIAGNOSIS OF AN ILLNESS OR INJURY OR MAKE IT A COVERED MEDICAL EXPENSE.

A drug, device, medical treatment or procedure will be considered experimental or investigational if:

A. a drug or device, it cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

B. a recognized national medical or dental society, or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

C. the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

The Trustees reserve the right to review medical care and make a determination as to whether the service, treatment, supply or confinement is or is not Medically Necessary. The Trustees may rely on an independent reviewer for determination. The fact that a physician or any other health care provider may order or recommend service, treatment, supply, or confinement does not, of itself, make it Medically Necessary.

"nonoccupational" means, with respect to injury which does not arise out of and in the course of any employment for wage or profit; and with respect to disease, means a disease in connection with which the person is entitled to no benefits under any Workmen's Compensation Law or similar legislation.

"physician" means only a person who is duly licensed (1) to prescribe and administer any drugs, or (2) to perform surgical procedures.

"surgical procedure" means only the following:

(a) a cutting operation; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment of hemorrhoids and varicose veins.

"reasonable and customary" - a charge shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals of the same sex and of comparable age and income, for a similar disease or injury. The term "locality" means a county or such greater area as is necessary to establish a representative cross-section of persons or other entities regularly furnishing the type of treatment, services or supplies for which the charge was made.

"urgent care"- services required for sudden onset severity, life threatening or covered injury incurred within 48 hours.

"hospital" is an institution that receives compensation for providing the facilities for surgical and medical diagnosis and treatment of inpatients. A staff of physicians licensed to practice medicine and surgery supervises care that is furnished by registered graduate nurses 24 hours a day. Nursing homes, rest homes, institutions for aged, or facilities primarily for the care and treatment of drug addicts are not considered hospitals.

"inpatient" is a person registered for bed occupancy in an eligible facility.

"outpatient" is a person registered for services in the outpatient department of an eligible facility.

"detoxification facility" is a health care facility licensed by the State of New Jersey as a detoxification facility for the treatment of alcoholism, or meeting the same standards if located in another state.

"Extended care facility" - either a "rehabilitation institute" or a "skilled nursing facility" as defined below:

"rehabilitation institute" - a health care facility, which is approved by either the Joint Commission on Accreditation of Hospitals or the Secretary of Health and Human Services, which mainly provides therapeutic and restorative services to ill or injured persons.

"Skilled nursing facility" - a skilled nursing facility which is approved by either the Joint Commission on Accreditation of Hospitals or the Secretary of Health and Human Services.

"residential facility" is a health care facility licensed, certified or approved y the state of New Jersey as a residential facility for the treatment of alcoholism or drug abuse, or meeting the same standards if located in another state.

"surgicenter" is a state-licensed, freestanding surgical center which provides ambulatory, same day surgery services to covered persons.

"psychiatric hospital" is an institution which, for compensation from its patients, is primarily engages in providing diagnostic and therapeutic services for the inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of physicians. Continuous nursing services are provided under the supervision of a registered nurse.

Human Organ Transplants

Benefits for hospital services for the surgical removal of human organ or tissue from a living donor to a transplant recipient are provided as follows:

1. when the transplant recipient and donor are both enrolled for coverage under this program, benefits for eligible services will be provided for both patients;

2. when only the transplant recipient is enrolled for coverage under this program, benefits may also be provided for the donor under the recipient's coverage, but only for those benefits that are not available to the donor under any other coverage; and

3. when the donor is enrolled for coverage under this program but the transplant recipient is not, benefits for eligible services rendered to the donor will be provide only if those services are not eligible under any coverage available to the recipient. Benefits will not be provided for services rendered to the transplant recipient.

Benefits will not be provided for transplant surgeries considered to be experimental by the Fund Office.

Covered Length of Stay for In-Patient Services:

Days of Care Available

Benefits are provided for you and each of your dependents for up to 120 days of inpatient care for each confinement in a hospital, detoxification facility, extended care facility, or for surgicenter visits.

However, no more than 30 of these days are available for inpatient services for mental and nervous conditions, drug and alcohol addictions, or for services received in an extended care facility.

Renewal of Benefit Days

The number of benefit days for inpatient care will renew in full when 90 days have passed from the date of the last discharge from a hospital, detoxification facility, or extended care facility.

GENERAL EXCLUSIONS & LIMITATIONS

The calculation of benefits shall not include or be based on any charges for hospital confinement, or any examination, or any surgical, medical or other treatment or any service or supply:

A. furnished without recommendation and approval of a physician acting within the scope of his license;

B. not medically necessary to the diagnostic care and/or treatment of any injury, disease, or pregnancy;

C. that is or could be furnished in connection with an occupational injury or an occupational disease, or other injury covered under the worker's compensation or similar law;

D. furnished by any government or division thereof, except a program for civilian employees of a government;

E. if the charge would not have been made in absence of Fund coverage or which you are not legally obligated to pay;

F. to the extent the Fund is prohibited by law or regulation from providing benefits for the charge;

G. furnished in connection with pregnancy, resulting childbirth or miscarriage for a dependent child;

H. that is or could be covered under a no-fault automobile coverage;

I. that is the result of an injury for which the claimant is entitled to recover from another person or organization causing the injury;

J. incurred by the claimant for injury sustained while performing or attempting to perform an act which would violate the criminal statutes of the state in which the act occurs. It is understood that this provision will not apply to injuries sustained as a result of an act of domestic violence or a medical conditions (including both physical and mental conditions). It also does not apply to suicide attempts or (self-inflicted injury) that was the result of a depression, a medical condition.

K. submitted more than one year following occurrence of the charge;

L. furnished to anyone in active military duty or for injuries sustained during active military service;

M. furnished for chiropractic, acupuncture, and physical therapy treatments, and psych office visits in excess of 25 per calendar year;

N. covered or that could be covered by a student accident and/or injury insurance plan;

O. provided for screening, research studies experimentation, mandatory consultations required by hospital regulations, routine pre-operative consultations, and standby services;

GENERAL EXCLUSIONS & LIMITATIONS (CONT'D)

P. related to reversal of elective sterilizations, treatment leading to or in connection with transsexual surgery, artificial insemination, in vitro fertilization, or treatment of sexual dysfunctions not related to organic disease;

Q. which are experimental in nature as determined by the Trustees. Experimental means any treatment procedure, facility, equipment, drugs, drug usage or supplies not yet recognized by the Fund and lacking federal or other governmental agency approval at the time services were rendered;

R. for injuries or illness resulting from engaging in any hazardous activity, including but not limited to the following: jet skiing, motorcycling, ATV's, snowmobiling, sky diving, and bungee jumping;

S. rendered in connection with a motor vehicle accident in which coverage is denied by the "No-Fault" Insurance carrier due to alcohol or substance abuse;

T. rendered by a relative; relatives will include spouse, parent, siblings, children, grandchildren, aunts, uncles and first cousins;

U. for Pain Management in excess of $1,000 per calendar year;

V. for Sleep Apnea testing, studies or supplies in excess of $1,000 per lifetime;

W. furnished in connection with weight-loss surgery or weight management treatment;

X. for telephone consultations, missed appointments or fees for filling out a claim form;

Y. for personal services such as haircuts, shampoos and sets, guest meals and radio/television rentals;

Z. furnished for personal convenience such as air conditioners, humidifiers, physical fitness equipment or other such devices which are useful in the absence of illness or injury;

AA. Incurred during a covered person's temporary absence from the eligible provider's grounds before discharge;

BB. Involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations;

CC. Furnished in connection with travel, whether or not recommended by a physician;

DD. intended solely to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes;

EE. furnished during any part of a stay at a hospital, detoxification facility or extended care facility chiefly for bed rest, rest cure, convalescent, custodial or sanitarium care, diet therapy or occupational therapy;

FF. furnished in a nursing home;

GG. furnished in connection with custodial care such as services by a sitter, homemaker or for care in a place that serves you primarily as a residence;

GENERAL EXCLUSIONS & LIMITATIONS (CONT'D)

HH. furnished for outpatient occupational therapy, respiratory therapy, or speech therapy whether services are provided in a hospital outpatient department or in a doctor's office or in the patient's home:

II. furnished in any setting other than a dentist's office for the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids, or any other care, repair, removal, replacement, or treatment of the teeth, or surrounding tissues, except, (1) when necessitated by damage to sound natural teeth or surrounding tissues as a result of a covered injury, or (2) for the excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or (3) for any other surgical procedure not involving any tooth structure, alveolar process, or gingival tissues;

JJ. for more than one treatment on any one day unless treatments are for a different diagnosis;

KK. furnished for x-rays not prescribed, rendered and charged for by a physician or surgeon;

LL. furnished in connection with injury or disease resulting from war or any act of war, whether declared or undeclared, occurring while covered;

MM. furnished for treatment received in connection with on or after the date for which a surgical procedure is paid;

NN. furnished in a **hospital** for the following:

- care of corns, bunions (except capsular or bone surgery), calluses, toenails, flat feet, fallen arches, weak feet, chronic foot sprain or symptomatic complaint of the feet;

- outpatient allergy testing;

- private duty nursing services;

- services to a blood donor;

- outpatient mental care provided in a day care/night care treatment center;

- services provided by a home health care agency;

- outpatient well baby care;

- during a hospital stay or any period of a hospital stay which is primarily for physical therapy;

- during a hospital stay or any period of a hospital stay which is primarily for diagnostic studies or examinations, unless the nature of the diagnostic procedure or the patient's physical condition is such that hospitalization is medically necessary;

- hearing aids and the examinations for prescribing and fitting them;

- eye glasses or contact lenses or the examinations for prescribing and fitting either the glasses or contact lenses (except when a patient has no lens, for example after cataract surgery, and soft lenses or sclera shells intended for use as corneal bandages);

LIFE INSURANCE FOR EMPLOYEES

(Underwritten By MetLife Through A Policy Of Insurance Purchased By The Fund)

The MetLife will pay the amount of life insurance in force on the insured employee's life, as determined from the Schedule of Benefits(please refer to page 46), at the time of the employee's death, upon receipt of due proof at its home office that the employee died while insured.

Premium Waiver in Event of Permanent and Total Disability

The MetLife will waive the payment of premiums for life insurance of an employee and will continue that insurance in force, upon receipt at its home office of due proof,

A. that the employee, while insured, under this coverage and before the employee's 60th birthday, became totally disabled by injury or disease to the extent that he was unable to perform any work for compensation or profit or to engage in any business or occupation;

B. that when the required proof is furnished, the employee does not elect to take any retirement benefits under any Pension Plan; and

C. that the employee has been continuously disabled as described in A. above, for at least six consecutive months when the required proof is furnished.

The required proof may be furnished within 12 months of the date of commencement of disability.

The initial period for which premium will be waived will commence with the date the required proof is received by the MetLife and will continue:

A. while the employee remains totally disabled; and

B. while he does not elect any retirement benefits under any Pension Plan, for up to 12 months from receipt of the required proof. Premium will be waived for succeeding periods of 12 months each while the employee continues to be totally disabled and ineligible for such retirement benefits, provided that due proof that his total disability continues is received by the MetLife at its home office during the last three months of the immediately preceding 12-month period.

A disabled employee who enters into employment in connection with a program of rehabilitation approved with respect to him by the MetLife shall nevertheless continue to be considered totally disabled for the purposes of this provision until the expiration of one year of such employment or until the MetLife terminates its approval of his rehabilitation program.

The MetLife will have the right to require proof of the continuance of total disability of the employee from time to time during the first two years following receipt of due proof and after two years proof will be required no more than once a year. As part of any proof, the employee may be required to be examined at the MetLife's expense by a medical examiner designated by the MetLife.

The amount of life insurance on which premium will be waived under this provision shall be the amount which was in force on the life of the employee on the date he became totally disabled.

If the employee dies while insurance under this coverage is being continued in accordance with this provision, the amount of life insurance on which premium is being waived at the time of his death, as determined in accordance with the preceding paragraph, shall be paid by the MetLife to the employee's beneficiary.

If the employee dies within one year after the last date for which premium was paid to the MetLife for his insurance under this coverage, but before proof of his total disability is furnished to the MetLife, and if due proof of his death, and proof

A. that he was totally disabled from the last date for which such premium was paid, to the date of his death; and

B. that on the date of his death, he was not eligible for any retirement benefits under any Pension Plan,

is furnished to the MetLife at its home office not more than one year after his death, the MetLife will pay to his beneficiary the amount of life insurance which was in force on the life of the employee on the date he became totally disabled.

No judicial proceeding shall be brought to enforce the endorsement of any employee's certificate under this provision unless brought within two years after the MetLife refuses to make such endorsement. If any time limitation of the policy with respect to the bringing of any judicial proceeding to enforce endorsement of any employee's certificate under this provision is less than that permitted by the law of the state in which the employee resides at the time the policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

If the employee:

A. ceases to be totally disabled, or

B. if he fails to submit proof of continuance of his total disability when required, or

C. if he fails to be examined medically when required, or

D. if he elects to receive any retirement benefits under any pension plan,

all rights under this provision shall cease and no further benefit will be provided for him under this provision in connection with that disability. If the employee does not return to active work in a class of employees eligible for life insurance under the policy, within 31 days after the date his benefits under this provision ceased, he may convert the life insurance that was subject to this provision, in accordance with the provision entitled "Conversion Privilege", as though his insurance had ceased on that date because of termination of employment.

If a benefit is payable under the provision entitled "Extension of Death Benefit during Conversion Period" on account of the employee's death, the amount, if any, payable under this provision will be reduced by the amount of that benefit.

If an individual policy was issued on the employee's life in accordance with the provision entitled "Conversion Privilege", no payment will be made under this provision, if the individual policy is not surrendered to the MetLife without the payment of any claim on that policy except for refund of any premium paid thereon. The designation of a beneficiary under such an individual policy or in the application therefore (if the individual policy had not become effective) different from the beneficiary under this policy shall, notwithstanding any other provisions of this policy to the contrary, effect a change of beneficiary under this policy to the beneficiary so designated.

Termination of this policy will not affect the rights of any employee who is entitled to this benefit by reason of becoming totally disabled prior to termination of this policy. Benefits provided in accordance with this provision after the date of termination of this policy will not affect that termination or continue this policy in force after that date.

Conversion Privilege

Right to Convert to an Individual Policy of Life Insurance without Evidence of Insurability.

When you can convert:

A. The employee, upon written application made to the MetLife within 31 days after the earlier of the following dates:

1. the date of termination of his coverage, as herein defined, or

2. the date of termination of his membership in the class or classes of persons insured under the policy,

or within 31 days after:

3. the date of cessation of his rights under the provision entitled "Waiver of Premium Benefit in the Event of Permanent and Total Disability", provided that his certificate has been endorsed as provided in (d) of the first paragraph of said provision and no individual policy has been issued in accordance with the provision entitled "Conversion Privilege";

shall be entitled to have issued to him by the MetLife, without evidence of insurability, an individual policy of life insurance subject to the following conditions and provisions:

i. such individual policy shall be in any one of the forms then customarily issued by the MetLife except term insurance;

ii. the premium for such individual policy shall be the premium applicable to the class of risk to which the employee belongs and to the form and amount of the policy at the employee's attained age (nearest birthday) at the date of issue of such individual policy;

iii. the amount of such individual policy shall be equal to (or at the option of the employee, less than) the amount of the employee's insurance under the policy which was discontinued on whichever date specified in paragraphs 1., 2., and 3. above is applicable;

iv. the first premium payment on such individual policy of life insurance so issued shall be made to the MetLife within the 31-day period during which application for such individual policy may be made.

B. The employee, upon

1. termination of the insurance of the class of persons of which he is a member, or

2. termination of the life insurance under the policy; or

3. termination of the policy by either the policyholder or the MetLife;

shall be entitled to the rights and benefits set forth in subdivision A of this provision, in accordance with its terms and conditions, provided his life insurance has been continuously in force for at least five years immediately preceding such termination, except that the amount of such individual policy shall not exceed the lesser of:

i. the amount of the employee's life insurance under the policy at the date of such termination, less any amount of life insurance for which he may be or may become eligible under any group policy issued by the MetLife or by any other insurer within 31 days after such termination; and

ii. $5,000.

C. Insurance under any individual policy used in accordance with this provision shall become effective at the end of the 31-day period during which application for such individual policy may be made.

Extension of Death Benefit during Conversion Period

In the event of the death of the employee during the 31-day period within which the employee may make application for an individual policy, as set forth in the foregoing provision, and provided that the employee has not become insured for life insurance again during such period under any other provision of the policy, the MetLife shall pay to the beneficiary as a Death Benefit the maximum sum for which an individual policy could have been used under the foregoing provision, whether or not the employee shall have made written application for such individual policy.

LIFE INSURANCE FOR SPOUSE

The MetLife will pay, in one sum, the amount of life insurance in force on the life of the insured dependent spouse as determined from the Schedule of Benefits, at the time of the dependent spouse's death, upon receipt of due proof at its home office that the dependent spouse died while insured provided, however, that only one such benefit shall be payable as the result of any one employee's spouse's death.

Payment will be made to the employee, as the dependent spouse's beneficiary, if living at the dependent spouse's death, otherwise to the employee's estate, but the MetLife may in such case, at its option, pay to any one or more of the following surviving relatives of the dependent spouse, children, mother, father, brothers or sisters.

Conversion Privilege for Spouse

The right of the spouse to convert to an individual policy of life insurance without evidence of insurability

When Spouse Can Convert	Amount Spouse Can Convert
When all spouse's life insurance terminates by reason of:	
Employee's termination of employment	
Spouse's classification is changed to a class of people ineligible for this coverage	Amount of spouse's insurance or less, at spouse's option
* Termination of all spouses' life insurance under the policy	Amount of spouse's life insurance less any new group insurance spouse becomes eligible under this or any group life insurance policy within 31 days, but not more than $5,000
* Termination of this coverage on the class of people of which the spouse is a member	

* Applicable only if spouse has been insured under this coverage continuously for five years.

How Spouse Can Convert

Written application and premium payment for the individual policy must be made to the MetLife within 31 days after termination of all your spouse's life insurance as noted above.

Conditions Relating to Conversion

A. Individual policy shall be one then customarily issued by MetLife, except a policy of term insurance, and shall be without disability or other supplementary benefits.

LIFE INSURANCE FOR SPOUSE (CONT'D)

B. Premium will be determined from then current MetLife rates, based upon your spouse's attained age on the birthday nearest to the date of issue of the individual policy, the class of risk to which the spouse then belongs, and the form and amount of the individual policy.

C. Insurance under the individual policy will not become effective until the end of the 31-day conversion period described in the first paragraph of this provision.

Benefit for Death during Conversion Period

Whether or not your spouse applied for an individual policy, if the MetLife receives due proof that your spouse died during the 31-day conversion period, the maximum amount of life insurance your spouse could have converted will be paid under the terms of the group policy.

If the life insurance of both you and your spouse terminates, and you are permitted to convert but your spouse is not, then if the MetLife receives due proof that your spouse died during the 31-day conversion period, the amount of life insurance which was in force on your spouse's life on the date your spouse's insurance terminated will be paid under the terms of the group policy.

ACCIDENTAL DEATH AND DISMEMBERMENT (EMPLOYEES ONLY)

(Underwritten By MetLife Through A Policy Of Insurance Purchased By The Fund)

How Benefits become Payable

You suffered any loss described in the Table of Indemnities below under the following circumstances:

A. as a result of bodily injury sustained accidentally by external means while insured;

B. the loss resulted directly and solely from the bodily injury and independently of all other causes; and

C. the loss occurred within 90 days from the date of the injury.

How Much is Payable

The amount specified for the loss in the following table will be paid by MetLife.

Table of Indemnities:

Life And Accidental Death And Dismemberment – Employee Only

Employee Covered By Fund For 3 Years Or More	$20,000.
Employee Covered By Fund For Less Than 3 Years*	$10,000.

*In This Period Of Coverage

ACCIDENTAL DEATH AND DISMEMBERMENT (EMPLOYEES ONLY) (CONT'D)

Full Amount of Insurance for Loss of:	One Half of the Full Amount of Insurance for Loss of:
Life	One hand
Both hands	One foot
Both feet	Sight of one eye
One hand and one foot	
Sight of both eyes	
One hand and sight of one eye	
One foot and sight of one eye	

Loss of hands or feet shall mean loss by severance at or above the wrist or ankle joint, and loss of sight shall mean total and irrecoverable loss of sight.

The total amount payable for all losses as a result of any one accident shall not exceed the full amount of insurance.

Life Insurance-Retired Participants

Certain retired participants who met the eligibility requirements prior to 4/1/08 had life insurance benefits up to a maximum of $3,000.00. Please contact the Fund Office for more information on this benefit.

Retiree Life Insurance is not available to participants who retired on or after 4/1/08.

Limitations

No benefits are payable for any loss caused wholly or partly, directly or indirectly, by any of the following:

A. disease, or bodily or mental infirmity, or medical or surgical treatment thereof;

B. ptomaines, or bacterial infections, except infection introduced through a visible wound accidentally sustained;

C. suicide while sane or insane or intentionally self-inflicted injuries; and

D. war, or any act of war, whether declared or undeclared.

Facility of Payment

If no beneficiary designation is in effect at your death or if there is no designated beneficiary then living, the Life Insurance Benefit is payable to your estate, but the MetLife may, at its option, pay to any one or more of the following surviving relatives - wife, husband, child or children, mother, father, brothers or sisters.

If the beneficiary is a minor or is otherwise incapable of giving a valid release, then until a guardian is duly appointed by a court of competent jurisdiction, the MetLife may, at its option, pay, for the sole benefit of such minor, at a rate not to exceed $50 a month to any relative by blood or connection by marriage of the beneficiary, or to any other person or institution appearing to it to have assumed custody and principal support of the minor.

DISABILITY INCOME BENEFIT (EMPLOYEES ONLY)

An employee will become eligible for the weekly Disability Income Benefit indicated in the Schedule of Benefits if he becomes completely disabled so that he cannot perform the usual and customary duties of his job. This benefit will not be payable if the disability was the result of occupational injury or disease covered Workmen's Compensation law.

The Weekly Benefit shown in the Schedule of Benefits is payable to you for the period of your disability, but will not exceed 26 weeks during any one period of disability, whether from one or more causes, and no benefits will be payable to you

A. for the first seven days of any disability except due to an injury; nor

B. for any day or days of any disability prior to the date on which you became eligible for Welfare Fund coverage.

Successive periods of disability separated by less than two weeks of active full-time work will be considered one continuous period of disability unless,

A. the employee produces evidence that the later disability is due to causes unrelated to the causes of the earlier disability; and

B. the later disability commenced after he returned to work and completed one full day of active service.

Limitations

No benefits are payable for any period of disability when you are not under treatment by a legally qualified physician.

Weekly Benefits are paid according to the Temporary Disability Benefits laws of New Jersey, which require that all claims for Temporary Disability Benefits are to be filed with the Fund Office within 30 days of the incurred date of illness or injury. In the event of late filing, consideration is only given to the 30 days prior to the filing date of receipt of claim proofs.

Benefits are supplementary to and in addition to benefits provided in accordance with the New Jersey State Temporary Disability Benefits Law.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PLAN ARE SUBJECT TO ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUM(S) STATED IN THIS SCHEDULE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON YOUR PLAN'S ALLOWANCE, UNLESS OTHERWISE STATED.

NOTE: BENEFITS WILL BE REDUCED OR ELIMINATED FOR NON-COMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS PLAN.

REFER TO THE SECTION OF THIS PLAN CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.

Your Plan will provide the coverage listed in this "Schedule Of Covered Services And Supplies", subject to the terms, conditions, limitations and exclusions stated within this Plan.

Services and supplies provided by an in-network provider are covered at the in-network level.

Services and supplies provided by an out-of-network provider are covered at the out-of-network level.

For New Jersey Residents:
The laws of the state of New Jersey mandate that a physician, chiropractor or podiatrist inform his or her patient of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504–6200 or (800) 242–5846.

Coinsurance In-Network	15**%** of covered charges
Coinsurance Out-Of-Network	30**%** of covered charges
Out of Pocket Maximum (In-Network)	After **$5,000**/covered person, **$10,000**/family; we provide **100%** of covered allowance – must be satisfied by **two** covered persons
Out of Pocket Maximum (Out-of-Network)	Unlimited

Note: The coinsured charge limits cannot be met with:

- non-covered charges
- deductibles
- copayments

Deductible

In-Network	**N/A**
Out-Of-Network	**$300 per person**

SCHEDULE OF COVERED SERVICES AND SUPPLIES (CONT'D)

BENEFIT PERIOD MAXIMUM

In-Network	**According to plan schedule**
Out-Of-Network	**According to plan schedule**

PER LIFETIME MAXIMUMS

In-Network	**$100,000** excluding inpatient hospital charges
Out-Of-Network	**$100,000** excluding inpatient hospital charges

Note: $100,000 is combined for both in and out-of-network

"COINSURANCE"- for purposes of the following schedule "coinsurance" is the amount the plan will pay.

A. ELIGIBLE BASIC SERVICES AND SUPPLIES

ACUPUNCTURE

In-Network	$25 per visit; 25 visits per year
Out-Of-Network	$25 per visit after deductible; 25 visits per year

ALLERGY TESTING WITH OFFICE VISIT

In-Network	Subject to **$20** copayment, and **100%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

ALLERGY SHOTS

In-Network	**85%**
Out-Of-Network	Subject to deductible and 7**0%** coinsurance

AMBULATORY SURGERY

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

ANESTHESIA

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and 7**0%** coinsurance

DENTAL CARE AND TREATMENT (facility charges)

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Not Covered

DIAGNOSTIC X-RAY AND LABORATORY (Outpatient Hospital)

In-Network	**$100** copayment; then **85%** coinsurance
Out-Of-Network	Not covered

DIAGNOSTIC X-RAY (Free Standing)

In-Network	**$50** copayment; then **85%** coinsurance
Out-Of-Network	Subject to deductible, and 70% coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES (CONT'D)

DIAGNOSTIC LABORATORY (Free Standing)

In-Network	**$20** copayment; then **85%** coinsurance
Out-Of-Network	Subject to deductible, and 70% coinsurance

DIALYSIS CENTER CHARGES (facility charges)

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Not covered

EMERGENCY ROOM (Facility)

Emergency Room services are covered for urgent care only.

In-Network	**$150** copayment, and **85%** coinsurance
Out-Of-Network	**$150** copayment, and **70%** coinsurance

FACILITY CHARGES (Inpatient Hospital)

In-Network	**85%** coinsurance for 120 days
Out-Of-Network	Not Covered

FACILITY CHARGES (Outpatient Surgery Hospital or Ambulatory Surgical Center)

In-Network	**85%** coinsurance
Out-Of-Network	Not Covered

HEALTH WELLNESS (Mammography, Ob/Gyn Exam, Pap Smear, Prostate Cancer Screening, Colorectal Screening and Well Child Immunizations-age restrictions may apply)

In-Network	Subject to **$20** copayment, and **100%** coinsurance
Out-Of-Network	Not Covered

HOME HEALTH AGENCY CARE (RN/LPN Only)

In-Network	Subject to **$20** copayment **and 100%** coinsurance
Out-Of-Network	Not Covered

INPATIENT PHYSICIAN SERVICES

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

MATERNITY/OBSTETRICAL CARE (Initial Visit)

In-Network	Subject to **$20** copayment for the initial visit, and **100%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

MATERNITY/OBSTETRICAL CARE (Pre/Post Natal and Delivery)

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES (CONT'D)

MENTAL OR NERVOUS CONDITIONS

Inpatient In-Network Subject to pre-approval, and **85%** coinsurance
Subject to a 30**-**day maximum
Inpatient Out-Of-Network Not Covered

SUBSTANCE ABUSE

Inpatient In-Network Subject to pre-approval, and **100%** coinsurance
(At plan contracted facilities only)
One course of treatment per lifetime
Inpatient Out-Of-Network Not Covered

Outpatient In and Out-of-Network Not Covered

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

In-Network Subject to **$20** copayment and **100%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

PRACTITIONER'S CHARGES FOR SURGERY (not in office setting)

In-Network Subject to **85%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

PRE-ADMISSION TESTING

In-Network Subject to **85%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

SECOND OPINION CHARGES

In-Network Subject to **$20** copayment, and **100%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

EXTENDED CARE FACILITY CHARGES (days count toward 120 hospital days)

In-Network Subject to **85%** coinsurance
Out-Of-Network Not Covered

Subject to **30-**day calendar year maximum.

AMBULANCE SERVICES

In-Network Subject to **85%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

BLOOD

In-Network Subject to **85%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

DURABLE MEDICAL EQUIPMENT

In-Network Subject to **85%** coinsurance
Out-Of-Network Subject to deductible, and **70%** coinsurance

SCHEDULE OF COVERED SERVICES AND SUPPLIES (CONT'D)

FOOT ORTHOTICS

In-Network	Subject to **85%** coinsurance; payable once per lifetime
Out-Of-Network	Subject to deductible, and **70%** coinsurance; payable once per lifetime

OXYGEN AND ADMINISTRATION

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

PROSTHETIC DEVICES

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70%** coinsurance

THERAPY SERVICES

1. CHEMOTHERAPY

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and 70% coinsurance In doctors office or home setting only

2. DIALYSIS TREATMENT

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and 70% coinsurance In doctors office or home setting only

3. INFUSION THERAPY

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Subject to deductible, and **70**% coinsurance In doctors office or home setting only

4. OCCUPATIONAL THERAPY

In-Network	Not Covered
Out-Of-Network	Not Covered

5. PHYSICAL THERAPY

In-Network	Subject to **$20** copayment, and **100%** coinsurance up to **$40**
Out-Of-Network	Subject to deductible, and **70%** coinsurance up to **$40**

Benefits subject to a **25**-visit maximum per year

6. RADIATION TREATMENT

In-Network	Subject to **85%** coinsurance
Out-Of-Network	Not Covered

7. RESPIRATION THERAPY

In-Network	Not Covered
Out-Of-Network	Not Covered

8. SPEECH THERAPY

In-Network	Not Covered
Out-Of-Network	Not Covered

THERAPEUTIC MANIPULATIONS

In-Network	$25 per visit; 25 visits per year
Out-Of-Network	$25 per visit after deductible at 70%; 25 visits per year

WIG BENEFIT

In-Network	Subject to 85%; $500 per year maximum
Out-Of-Network	Not Covered

DESCRIPTION OF COVERED SERVICES UNDER BLUE CARD PPO

Your Blue Card PPO program provides you with the freedom to choose any provider that participates with the local PPO; however, your choice of providers will determine how your benefits are paid. Network providers will accept the Plan's payment as payment in full. You will be responsible for any deductible, coinsurance and copayments that apply; however, you will not have to file claims. Network providers will accept the payment as payment in full. Out-of-network providers may balance bill to charges.

Your Blue Card PPO program shares the cost of your health care expenses with you. This section explains what you pay, and how deductibles, coinsurance and copayments work together.

How The Program Works

Benefit Period

The benefit period is from January 1st to December 31st in each year while the coverage remains in effect.

Copayments

Copayments are the amounts you must pay directly to a provider when you receive services. The Plan's payment will be reduced by the amount of the copayment.

1. You must pay a copayment for accidental injury or medical emergency services received in the emergency room of a network or non-network facility.

2. For office visits to a network physician, you must pay a **$20** copayment per office visit. Once the copayment has been made, benefits will be paid at **100%** of the Plan's applicable allowance.

3. For office visits to non-network physicians, a copayment does not apply. Benefits for office visits to non-network physicians will be paid according to the standard payment provisions for non-network physicians.

Deductible

The deductible amount that must be paid by a covered person before he or she will be eligible for benefits out-of-nework is **$300.**

The deductible applies once to each covered person in a calendar year.

Please see the "Schedule Of Covered Services And Supplies" section for additional information.

Coinsurance and Maximum Benefits

After you have paid your deductible, you share in paying the balance of covered medical expenses. This is called your coinsurance. The amount of coinsurance you pay will vary depending on whether services are provided by a network or non-network provider, and whether the services are outpatient and out-of-hospital mental care or supplemental services (e.g. durable medical equipment).

The Plan will pay a percentage of your Plan's applicable allowance for covered medical expenses incurred by each covered person in excess of the deductible. Your Plan's coinsurance amounts are shown in the "Schedule Of Covered Services And Supplies"; you will be responsible for the remainder. For example, if your Plan's coinsurance is 85%, the coinsurance you will be responsible for will be 15%. In addition, if aggregate covered medical expenses incurred by a covered person in a benefit period exceed the coinsured charge limit for in-network benefits, as shown in the schedule, the Plan will pay 100% of your Plan's applicable allowance for covered medical expenses thereafter incurred by that covered person in that benefit period (does not apply for out-of-network).

The coinsured charge limit cannot be met with non-covered charges, deductibles, or copayments.

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section lists the types of charges your Plan will consider as covered services or supplies up to its allowance subject to all the terms of your Plan including, but not limited to, medical necessity and appropriateness, utilization review features, schedule of covered services and supplies, benefit limitations and exclusions.

A. ELIGIBLE BASIC SERVICES AND SUPPLIES

ACUPUNCTURE

Acupuncture services are eligible when the acupuncture is performed for anesthetic or therapeutic (for relief of pain) purposes by a practitioner.

ALLERGY TESTING AND TREATMENT

This program covers allergy testing and treatment, including routine allergy injections and immunizations but not if solely for the purpose of travel or as a requirement of a covered person's employment.

AMBULATORY SURGERY

This program covers charges for ambulatory surgery performed in an in-network hospital outpatient department or out-of-hospital, a practitioner's office or an in-network ambulatory surgical center in connection with covered surgery.

ANESTHESIA

This program covers anesthetics and their administration.

DENTAL CARE AND TREATMENT (Facility Charge)

This program covers:

1. the diagnosis and treatment of oral tumors and cysts;

2. the surgical removal of bony impacted teeth; and

3.Treatment of a covered accidental injury to natural teeth or the jaw is covered, but only if the accidental injury was not caused, directly or indirectly, by biting or chewing. Treatment includes replacing natural teeth lost due to such accidental injury, in no event does it include orthodontic treatment.

DIAGNOSTIC X-RAYS AND LABORATORY TESTS

This program covers charges for diagnostic x-rays and laboratory tests.

EMERGENCY ROOM

This program covers services provided by a hospital emergency room. Each time the covered person uses the hospital emergency room, he must pay a copayment as designated in the "Schedule Of Covered Services And Supplies" section.

EXTENDED CARE FACILITY CHARGES

This program covers bed and board, including diets, drugs, medicines and dressings and general nursing service in a extended care facility. The covered person must be admitted to the extended care facility immediately following discharge from a hospital, following an inpatient stay of at least three days, for continuing medical care and treatment prescribed by a practitioner. Benefits are available for 30 days of care during any one benefit period. The days will also count toward 120 hospital days.

FACILITY CHARGES

This program covers charges for hospital semi-private room and board and routine nursing care when it is provided to you by a hospital on an inpatient basis.

If a covered person incurs charges as an inpatient in a special care unit, this program covers the charges the same way it covers charges for any illness.

This program will also cover outpatient hospital services including services provided by a hospital outpatient clinic. This program covers emergency room treatment.

If a covered person is an inpatient in a facility at the time your Plan ends, this program will continue to cover that facility stay in accordance with all other terms of your Plan.

HEALTH WELLNESS

This program provides benefits for certain covered services and supplies relating to preventive care including related diagnostic x-rays and laboratory tests. Coverage is limited each benefit period as described in the "Schedule Of Covered Services And Supplies". The covered preventive care benefits are as follows:

1. Gynecological Care and Examinations

This program covers routine gynecological care and examinations including one pap smear per benefit period as designated in the "Schedule Of Covered Services And Supplies".

This benefit is not available for dependent children.

2. Mammography

This program covers charges made for mammograms provided to a female covered person according to the schedule below. Coverage will be provided, subject to all the terms of your group's Plan, and the following limitations.

Your Plan will cover charges for:

i. one routine mammogram every year from ages 40 and over.

This benefit is not available for dependent children.

3. Pap Smears

This program provides benefits for charges incurred in conducting an annual routine pap smear. This benefit, except as may be medically necessary and appropriate for diagnostic purposes, shall be limited to one pap smear per benefit period.

This benefit is not available for dependent children.

4. Prostate Cancer Screening

This program covers one routine office visit per benefit period for adult covered persons age 40 and over, including a digital rectal examination and a prostate-specific antigen test for adult male covered persons.

5. Well-Child Immunizations (IN-NETWORK BENEFIT ONLY)

This program provides benefits for Well-child immunizations, including the office visit for covered dependent children through the end of the day of the child's 7th birthday. In order to be covered under this section:

i. childhood immunizations must be as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Service and the Department of Health pursuant to Section 7. of P.L. 1995, Ch 316; and

ii. Also covered are Hepatitis B, Immunization for school aged dependents as required by the New Jersey Department of Health and Senior Services.

HOME HEALTH AGENCY CARE

Home health agency care services and supplies are covered only if furnished by an RN or a LPN. The care must begin immediately following an in-patient hospital confienment of three or more days. There is a 30 visit max per hospital stay. Each visit by provider whose services are authorized under the home health care plan can last up to four hours.

INPATIENT PHYSICIAN SERVICES

Services provided to a covered person who is a registered inpatient in a facility.

MATERNITY/OBSTETRICAL CARE

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

Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child is covered as part of the obstetrical care benefits. However, if the child's care is given by a different physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

This program also covers birthing center charges made by a practitioner for pre-natal care, delivery, and post-partum care in connection with a covered person's pregnancy.

MATERNITY/OBSTETRICAL CARE FOR CHILD DEPENDENTS

A child dependent will not receive benefits for routine obstetrical care, including services provided to the child dependent's newborn infant. However, complications of pregnancy and interruptions of pregnancy, except for elective abortion, will be covered subject to the terms of your group's policy.

PRACTITIONER'S CHARGES FOR NON-SURGICAL CARE AND TREATMENT

This program covers practitioner's charges for the medically necessary and appropriate non-surgical care and treatment of an illness, accidental injury, or mental illness.

PRACTITIONER'S CHARGES FOR SURGERY

This program covers practitioner's charges for surgery. This program does not cover cosmetic surgery. Surgical procedures shall include, but are not limited to, those following a mastectomy on one breast or both breasts, reconstructive breast surgery and surgery to achieve symmetry between the two breasts.

PRE-ADMISSION TESTING CHARGES

This program covers pre-admission diagnostic x-ray and laboratory tests needed for a planned hospital admission or surgery. This program only covers these tests if the tests are done on an outpatient or out-of-hospital basis within 14 days of the planned admission or surgery.

However, this program does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred solely due to a change in the covered person's health.

SECOND OPINION CHARGES

This program covers a consultative opinion given by a qualified specialist physician who has agreed to provide second opinions, and directly related diagnostic services to confirm the need for elective surgery as first recommended by a physician. The consultant's services must be performed before the covered person is admitted to the hospital or facility for the recommended surgery. This program covers such charges if:

1. the second opinion consultant must not be the physician who first recommended elective surgery;

2. elective surgery is covered surgery that may be deferred and is not an emergency;

3. use of a second opinion is at the covered person's option;

4. if the consultant's opinion is against elective surgery and the covered person decides to have the elective surgery, the surgery is a covered service;

5. your Plan will not pay for a second opinion consultation for the following kinds of elective surgery: cosmetic surgery.

SURGICAL SERVICES

This program covers surgical procedures subject to the following:

1. Your Plan will not make separate payment for pre- and post operative services.

2. If more than one surgical procedure is performed during the same operation through only one route of access, your Plan will cover the primary procedure only. There will be no payment for any other procedures performed at the same time.

3. If more than one surgical procedure is performed during the same operation through more than one route of access, your Plan will cover the primary procedure, plus 50% of what your Plan would have paid for each of the other procedures had those procedures been performed alone.

4. Surgical procedures shall include reconstructive breast surgery, following a mastectomy on one or both breasts, as follows: surgery to restore and achieve symmetry between the two breasts, cost of breast prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer. These benefits will be provided to the same extent as for any other sickness under the your Plan.

Under the Women's Health and Cancer Rights Act of 1998, if you are receiving benefits in connection with a mastectomy and elect to have breast reconstruction along with that mastectomy, your Plan must provide in a manner determined in consultation with the attending physician and you, coverage for the following:

a. reconstruction of the breast on which the mastectomy was performed;

b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. prostheses and physical complications at all stages of the mastectomy, including lymphodemas.

These benefits will be provided to the same extent as for any other illness under your Plan.

This program also covers a hospital stay for at least 72 hours following a modified radical mastectomy and a hospital stay for at least 48 hours following a simple mastectomy, unless the covered person, in consultation with the covered person's physician, determines that a shorter length of stay is medically appropriate. While there is no requirement that the covered person's provider obtain pre-approval from your local Blue Cross Blue Shield for prescribing 72 or 48 hours, as appropriate, of inpatient care as set forth in this subsection, any notification requirements remain in full force and effect.

AMBULANCE SERVICES

This program covers charges for transporting a covered person to:

1. a local hospital, if needed care and treatment can be provided by a local hospital;

2. the nearest hospital where needed care and treatment can be given, if a local hospital cannot provide it. It must be connected with an inpatient admission; or

3. another inpatient facility when medically necessary and appropriate.

Coverage can be by professional ambulance ground service. Your Plan does not cover air transportation. This program will also not cover other travel or communication expenses of patients, practitioners, nurses or family members.

BLOOD

Blood, blood products, blood transfusions and the cost of testing and processing blood are covered. This program does not pay for blood that has been donated or replaced on behalf of the covered person.

Blood transfusions including the cost of blood, blood plasma and blood plasma expanders are covered from the first pint and only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

This program covers expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia for expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of a state approved hemophilia treatment center. Participation in a home treatment program shall not preclude further or additional treatment or care at any eligible facility if the number of home treatments, in accordance with a ratio of home treatments to benefit days established by regulation

by the Commissioner of Insurance, does not exceed the total number of benefit days provided for any other illness under this program. As used in the paragraph, "blood product" includes but is not limited to Factor VIII, Factor IX and cryopreciptate; and "blood infusion equipment" includes but is not limited to syringes and needles.

DURABLE MEDICAL EQUIPMENT (In-Network Only)

Your Plan covers charges for the rental of durable medical equipment needed for therapeutic use. Your Plan may determine to cover the purchase of such items when it is less costly and more practical than to rent such items. This program does not cover:

1. replacements, repairts or enhancements ; or

2. the rental or purchase of any items (such as air conditioners, exercise equipment, saunas and air humidifiers) that do not fully meet the definition of durable medical equipment.

FOOT ORTHOTICS

This program covers foot orthotics.Limit of one benefit per lifetime.

HOME INFUSION THERAPY (In-Network Only)

Home infusion therapy is a method of administering intravenous (IV) medications or nutrients via pump or gravity in the home. These services and supplies are eligible when rendered or used in connection with home infusion therapy:

1. solutions and pharmaceutical additives;

2. pharmacy compounding and dispensing services;

3. ancillary medical supplies; and

4. nursing services associated with patient and/or alternative caregiver training, visits necessary to monitor intravenous therapy regimen and medical emergency care, but not for administration of home infusion therapy.

Home infusion therapy includes chemotherapy, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when sole source of nutrition) hydration therapy, intravenous pain management, gammaglobulin infusion therapy (IVIG), and prolastin therapy.

Note: Home infusion therapy must be authorized by Horizon BCBSNJ.

OXYGEN AND ITS ADMINISTRATION

This program covers oxygen and its administration.

PROSTHETIC DEVICES

This program limits coverage for prosthetic devices. This program covers the fitting and purchase of artificial limbs and eyes, and other prosthetic devices. To be covered, such devices must take the place of a natural part of a covered person's body, or be needed due to a functional birth defect in a covered child dependent, or as needed for reconstructive breast surgery. This program does not cover dental prosthetics or devices.

SCHEDULE OF COVERED SERVICES AND SUPPLIES (CONT'D)

THERAPY SERVICES

This program covers charges for therapy services as outlined in the Schedule of Covered Services and Supplies.

THERAPEUTIC MANIPULATION

This program covers charges for therapeutic manipulations.

SCHEDULE OF BENEFITS FOR R1 RETIREES WITHOUT MEDICARE BENEFITS

The following schedule describes the Plan's benefits payable to those retirees or dependents with R1 coverage that do not have any Medicare benefits:

TYPE OF SERVICE	AMOUNT PAYABLE	YEARLY MAXIMUM
Office Visits	$5.00	$250.00
Hospital/Home Visit	$7.00	
Surgery	$750.00	$750.00
Diagnostic	$100.00	$100.00
Anesthesia	20% of Surgical Allowance up to $150.00	$750.00
In-patient Hospital Facility Fee **IN-NETWORK ONLY**	85% coinsurance for 120 days	N/A
In-patient Hospital Facility Fee **Out-of-Network**	$0.00	$0.00

DENTAL BENEFIT (FOR EMPLOYEES AND DEPENDENTS)

Eligibility

An employee and his eligible dependents (spouse and children age five and older) become eligible for the Dental Benefit on the first day of the month following 12 months, in each of which the employee has worked at least ten days, and for which contributions were due to the Fund.

How does the Program Work?

The Plan allows you to choose a panel dentist or your own dentist. If you use a panel dentist you will have the advantage of receiving dental services at no out of pocket cost to you up to the $1,000 yearly maximum.

The $1,000 per calendar year maximum benefit applies to both a panel dentist and a non-panel dentist. All dental procedures are paid at 80%, subject to reasonable and customary guidelines.

As with all other covered services, benefits under this benefit are subject to the Plan's Coordination of Benefit provisions for dependent claims.

How to Apply for Dental Benefits

Simply contact your own dentist or a panel dentist and arrange treatment. All claims will be processed by Dentsco at their office located at: 2185 Lemoine Avenue, Fort Lee, NJ 07024. **DO NOT MAIL CLAIMS TO THE WELFARE FUND OFFICE.**

Benefits under the Dental Benefit

The following benefits are provided to you and your eligible dependents when treated in a dentist's office:

1. Examination.
2. X-rays.
3. Fillings and extractions.
4. Prophylaxis - cleanings.
5. Dentures and removable bridges.
6. Oral surgery or root canal therapy.
7. Periodontic treatment.
8. Fluoride treatment for children.
9. Anesthesia.
10. Crowns and fixed bridges.

Orthodontic Care

Unmarried dependents up to the 19th birthday are covered for orthodontic care.

When your eligible dependent needs orthodontic care, the following rules apply:

All cases must have prior authorization. No pre-authorization treatments are covered.

No cases in process at time of the effective date (or prior) are covered. Bands must be inserted prior to the 19th birthday. The orthodontic benefit is limited to one case maximum, per patient, per lifetime.

DENTAL BENEFIT (FOR EMPLOYEES AND DEPENDENTS) (CONT'D)

Maximum payment is $2,500 payable monthly over the course of treatment.

Any member who loses eligibility for dental benefits is responsible for payments to the orthodontist after his date of termination.

Work must be performed by a specialist.

Exclusions

The following dental procedures are not covered under the dental benefit:

1. Fractured jaw.
2. Surgical procedures involving hospitalization.
3. Space maintainers.
4. Dental cosmetic treatment such as whitening.
5. TMJ

Termination

Dental Benefits shall terminate if a participant and/or his dependents no longer meet the monthly eligibility requirements.

Your Dental Benefit is administered by:

Dentsco, Inc.
2185 Lemoine Avenue
Fort Lee, NJ 07024
(201) 585-2558

OPTICAL AND HEARING BENEFITS (FOR EMPLOYEES AND DEPENDENTS)

Eligibility

You are eligible for the Optical and Hearing Aid Benefits if you have met the requirements as previously described.

OPTICAL BENEFIT

When you or your eligible dependents need eye glasses and/or an eye examination, the Welfare Fund will make a reimbursement to you. The maximum amount payable is $600 per family per calendar year.

HEARING AID BENEFIT

The plan provides a hearing aid benefit for active participants and eligible dependents. The plan will pay reasonable charges for the purchase of a hearing aid up to $500.00 per ear every 3 years. A prescription from a physician is required.

LIFE INSURANCE AMOUNTS

Life And Accidental Death And Dismemberment – Employee Only

Employee Covered By Fund For 3 Years Or More	$20,000.
Employee Covered By Fund For Less Than 3 Years*	$10,000.
*In This Period Of Coverage	

Life Insurance – Spouse Only	$5,000.

DISABILITY INCOME BENEFIT

***Weekly* Disability Income Benefit – Employee Only**	$54.14
1st Day Injury 8th Day Illness	

PRESCRIPTION DRUG BENEFIT

How the Plan Works

The Plan provides coverage for prescription drugs purchased at a participating pharmacy or through a mail-order pharmacy. You will receive an Express Scripts prescription drug card when your coverage starts.

Filling Prescriptions

Present your Express Scripts card to the pharmacist along with the prescription to be filled. You do not have to have a special prescription blank for the doctor to write the prescription on. The doctor will use his own prescription blanks. The pharmacist will have all forms necessary to provide you with Prescription Benefits. He will ask you or the person picking up the medicine, the age and relationship of the patient to the covered member and sign the claim form at the time the medication is received.

Co-Payment Amount

You must pay this amount yourself for each prescription. Keep your card in a safe place. Take care of it so it can help you when you need it.

Plan R2 Retirees: Copayment - 30%

All other plans: The prescription drug benefit has a "three-tiered" copay schedule. Each copay is subject to the plan's Generics Preferred and Step Therapy programs as described later in this section. The current plan copays are as follows:

Class	Retail 30 Day Supply	Mail Order 90 Day Supply
Generic Drugs	$7.00 copay	$14.00 copay
Preferred Brand Name	$25.00 copay	$50.00 copay
Non-Preferred Brand Name	$40.00 copay	$80.00 copay

Benefits

The Prescription Drug Benefit allows you to obtain covered prescription drugs at a participating pharmacy in your neighborhood.

Covered drugs include those which by either state laws or by federal laws may be purchased only by a prescription and for which no over the counter equivalent is available. Also covered is insulin when written on a prescription and prescriptions which must be compounded by the pharmacist. The benefit does not cover such drugs which legally may be dispensed without a prescription, such as aspirin, even though the doctor may have prescribed these. Fertility drugs are not covered under the Plan.

If for some reason you are not able to take your prescriptions to a participating pharmacy it will be necessary for you to obtain a direct reimbursement claim form. You will be reimbursed the amount which would have been paid to the participating pharmacy, which will probably be less than the actual out-of-pocket cost of the prescription.

If your pharmacist has any questions regarding the Prescription Drug Benefit, please have him contact Express Scripts.

Generics Preferred

The next time you need a refill for a brand-name drug, your pharmacist will see if a generic drug is available instead. **Choosing the generics may save you money.**

What are generic drugs?

Generic drugs are copies of brand-name drugs whose patents have run out. That is, a generics drug has the same chemical makeup as the original brand-name drug. Generics account for more than 45% of all medications prescribed in the United States. More people are choosing them because they are:

Safe-they have the same active ingredients and are used in the body the same way as their original brand-name drugs. They are also approved by the U.S. Food and Drug Administration (FDA), just like brand-name drugs;

Effective-they are just as strong and deliver the same medical benefits as the brand-name drugs;

Less expensive – they are not advertised like brand names, and they cost less to produce, so **the savings are passed along to you** in the form of a lower copayment.

How do you use the generics preferred program?

The next time you refill one of your prescriptions, you may be able to choose either the brand-name or the generic drug.

-If you choose the generic, your copayment will be less than for a brand-name drug.

-If you choose the brand-name, you'll pay your copayment **plus the difference in cost between the generic and the brand-name drug.**

Step Therapy

Step Therapy is a program especially for people who take prescription drugs regularly for ongoing conditions like arthritis and high blood pressure. **It helps you get an effective medication to treat your condition while keeping your costs as low as possible.**

In Step Therapy, drugs are grouped in categories based on cost:

Front-Line drugs – Step 1 drugs – are generic drugs proven to be safe, effective and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

Back-up drugs – Step 2 and Step 3 drugs – are brand name drugs like those that you see advertised on TV. There are lower cost brand drugs (Step 2) and higher cost brand drugs (Step 3). Back-up drugs typically cost more than front line drugs.

How does Step Therapy Work?

The next time your doctor writes a prescription for you, ask your doctor if a generic medication listed by your plan as a front-line 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. And, because these drugs have been on the market for a long time, they have a more established safety record than newer drugs.

If you have already tried a front-line drug, or your doctor decides one of these drugs is not appropriate for you, then your doctor can prescribe a back-up drug. Ask you doctor if one of the lower cost brands (Step 2 drugs) listed by your plan is appropriate. Remember, you can always get a higher cost brand name drug at a higher copayment if the front-line drug or Step back-up drugs aren't right for you.

Illegal Use of the I.D. Card

The use of the plastic I.D. card by a person who is no longer eligible constitutes a fraud. If expenses are incurred when you are not eligible, you will be responsible to reimburse the Fund for any payments made on your behalf.

The Express Scripts computer system will detect the use of the I.D. card by an ineligible person. Avoid embarrassment and legal problems by returning the I.D. card to the Fund Office if your eligibility terminates or destroying the card.

Maintenance Drug Program

A maintenance drug program covers prescriptions which are used by a patient on a steady year round basis for a supply of not less than 34 days, up to a maximum three-month supply.

This maintenance program applies to illness such as:

Diabetes
Epilepsy
Anemia
Chronic Constipation
Arthritis
High Blood Pressure
Tuberculosis
Hear Disorders
Various Gastric Diseases
Emphysema
Menopause
Nervous Tension
Emotional Instability
Thyroid Diseases
Adrenal Diseases
Ulcers
Gout

or any other physical or mental conditions which would require constant regular medication.

How does this Plan work?

A. If you are required to obtain a long-term supply of a drug, you request a maintenance drug form from your Fund Office.

PRESCRIPTION DRUG BENEFIT (CONT'D)

B. You take this form to your doctor who may prescribe up to a three-month supply. You mail the form directly to The Maintenance Drug Program as indicated on the maintenance drug form.

C. The maintenance drugs will be delivered directly to your home address.

This program only applies to a long-term maintenance drug which must be prescribed by a doctor and covers at least a 34-day supply, up to a maximum three-month supply.

This coverage will apply to all "legend drugs" which means that these drugs carry a notation that "federal law prohibits dispensing this medication without a prescription".

Exclusions from this program are diet supplements, infant formulas, and any medication that can be purchased over the counter.

MEDICARE SUPPLEMENT BENEFIT - RS65

A. DESCRIPTION. If a covered person is eligible for Medicare coverage (whether or not the person applies for it) and is not an active employee and is not the dependent of an active employee, such person will not be covered under the Comprehensive Medical Benefits described previously in this booklet. In place of these Benefits, the person will be covered for a special Medicare Supplement Benefit.

This Benefit is designed to coordinate with the government's Medicare program; so, it is very important to understand the benefits under Medicare. If you have not received an explanatory booklet from the Social Security Administration, please ask the Administration to send you it.

The government's Medicare program has two parts:

1. hospitalization (called "Part A"); and

2. other medical expense coverage (called "Part B").

B. PAYMENT. Regarding the Part A type of expense (hospitalization), the Plan will pay the covered person for the one day deductible for each separate hospital confinement, commencing while the person is covered under the Plan, and the daily deductible for the 61st through the 90th day of such confinement provided such amounts are charged to the covered person.

Further, the Plan will pay the daily deductible (that Medicare does not pay) for the 21st through the 100th day for eligible extended care for each day the person is covered.

Regarding the Part B type of expense (other medical expenses), the Plan will pay the covered person for that part of the annual deductible (which Medicare and the Plan classes as eligible), incurred while the person is covered under the Plan, that Medicare does not reimburse. In your Medicare booklet you will find a list of what expenses are considered to be "eligible" under Medicare.

Further, for Part B type expenses, the Plan will pay 20% of the reasonable eligible expenses (after the calendar year Medicare deductible) that are not reimbursed by Medicare but are incurred by the covered person while covered under the Plan and are classed eligible by Medicare and the Plan. ***The Plan will never pay more than would have been paid if you were not entitled to Medicare.***

C. COVERED EXPENSES. Only Expenses that are covered by Medicare and the Plan will be considered for payment under the Medicare Supplement Benefit.

MEDICARE SUPPLEMENT BENEFIT - R1

A. DESCRIPTION. If a covered person is eligible for Medicare coverage (whether or not the person applies for it) and is not an active employee and is not the dependent of an active employee, such person will not be covered under the Comprehensive Medical Benefits described previously in this booklet. In place of these Benefits, the person will be covered for a special Medicare Supplement Benefit.

This Benefit is designed to coordinate with the government's Medicare program; so, it is very important to understand the benefits under Medicare. If you have not received an explanatory booklet from the Social Security Administration, please ask the Administration to send you it.

The government's Medicare program has two parts:

1. hospitalization (called "Part A"); and

2. other medical expense coverage (called "Part B").

B. PAYMENT. Regarding the Part A type of expense (hospitalization), the Plan will pay the covered person for the one day deductible for each separate hospital confinement, commencing while the person is covered under the Plan, and the daily deductible for the 61st through the 90th day of such confinement provided such amounts are charged to the covered person.

Further, the Plan will pay the daily deductible (that Medicare does not pay) for the 21st through the 100th day for eligible extended care for each day the person is covered.

Regarding the Part B type of expense (other medical expenses), the Plan will pay the covered person for that part of the annual deductible (which Medicare and the Plan classes as eligible), incurred while the person is under the Plan, that Medicare does not reimburse up to the maximum Plan allowance as per the following schedule:

TYPE OF SERVICE	AMOUNT PAYABLE	YEARLY MAXIMUM
Office Visits	$5.00	$250.00
Hospital/Home Visit	$7.00	
Surgery	$750.00	$750.00
Diagnostic	$100.00	$100.00
Anesthesia	20% of Surgical Allowance up to $150.00	$750.00

PART C.

CLAIM PROCEDURE

HOW TO FILE A CLAIM FOR BENEFITS

How to File a Claim for Benefits

All claims should be reported to the Fund Office on the appropriate claim form. You should not wait until you return to work to file a claim. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

A. Life Insurance and Accidental Death And Dismemberment Insurance

Prompt notice should be given to the Fund Office upon the death of any covered employee or spouse. A copy of the death certificate and any other forms that may be deemed necessary must be submitted to the Fund Office. The Death Benefit will be paid in accordance with the rules and regulations of the Welfare Fund.

B. Disability Income Benefit

In the event that you become disabled, you should report this fact to the Fund Office as soon as possible. Once the Fund Office is notified of a disability, a claim form will be mailed. There is a 30-day filing period.

C. Hospital Benefit

When you or your dependent requires hospitalization, your doctor makes the arrangement for admission to the hospital. Just show your identification card to the admitting clerk of the hospital. In most cases you will not have to complete a claim form because the hospital will deal directly with the Fund Office.

If, for any reason, you are required to pay a hospital bill for services covered by this Plan (e.g. eligible outpatient services), you will be reimbursed up to the appropriate limits. Submit the bill to the Fund Office.

If, for any reason, your claim is not eligible, you will be notified by your Fund Office. To request a review of the claim, you should follow the instructions described in the "Claims Appeal" section of this booklet.

D. Surgical, Doctor Treatment and/or Major Medical Claims

Claim forms for surgical, doctor treatment or Major Medical care are available at your place of employment or will be mailed to you by the Fund Office upon request. When making a request for a claim form from the Fund Office, please give the following information:

your name and address
your employer
type of claim

After you complete your portion of the claim form, the reverse side must be completed by your doctor or surgeon. Submit the completed claim form to the Fund Office as promptly as possible.

Remember: Improperly completed forms may cause a delay in the payment of your claim. A separate claim form must be completed for each member of your family for whom benefits are being claimed.

E. Dental Benefits

Instructions for obtaining Dental Benefits are found in the Dental Benefit section in Part B. of this booklet.

F. Optical Benefits

Instructions for obtaining Optical Benefits are found in the Optical Benefit section in Part B. of this booklet.

CLAIM DENIAL

In order to carry out their responsibility for interpreting the Plan and making determinations under it, the Trustees have exclusive authority and discretion to determine whether an individual is eligible for any benefits under a plan; to determine the amount of benefits, if any, an individual is entitled to from a Plan; to interpret all of the Plan's provisions and to interpret all of the terms used in the Plan. All such determinations and interpretations made by the Trustees of their designee shall be final and binding upon any individual claiming benefits under a Plan; shall be given deference in all courts of law to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious or made in bad faith. All such determinations shall be based exclusively upon clearly defined and ascertainable criteria contained in the Plan.

If a claim is wholly or partially denied, the Fund Office will notify you within a reasonable period of time, not later than the following:

Type Of Claim	Time Limit For Claim Denial	Extension Permitted
MEDICAL, DENTAL, VISION:		
-Urgent Claims (as medically determined)	72 hours	None
- Pre-Service Claims	15 days	30 days
- Post-Service Claims	30 days	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
ACCIDENTAL DEATH AND DISMEMBERMENT/LIFE INSURANCE	90 days	90 days

If your claim lacks information required by the Fund Office to make a determination, you will be notified within a reasonable period of time. Extensions are permitted if the Fund Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time responding.

The Fund Office's notification of a claim denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA after you have exhausted the appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either 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 explanation will be provided free of charge upon request.

APPEAL

If your claim is denied, you or your duly authorized representative may appeal the denial to the Board of Trustees within the following timeframe:

Type Of Claim	Time Limit For Appealing Denial
Medical, Dental, Vision	180 days
Accidental Death And Dismemberment, Life Insurance	60 days

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and, in the case of a disability claim, a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

DETERMINATION OF APPEAL

The Board will make a determination of your appeal with a reasonable period of time, but not later than the following:

Type Of Claim	Time Limit For Claim Denial	Extension Permitted
MENTAL,DENTAL,VISION:		
- Urgent Claims	72 hours	None
- Pre-Service Claims	15 days	30 days
- Post-Service Claims	Board meeting (if claim received 30 days prior)	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
ACCIDENTAL DEATH AND DISMEMBERMENT/LIFE INSURANCE	Board meeting (if claim received 30 days prior)	Next Board meeting

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible but not later than five days after the determination is made.

If the denial of a claim for medical, dental, or vision benefits was based in whole or in part on a medical judgment, the Board will consult with a health care professional who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual and who has appropriate training and experience in the field of medicine involved in the medical judgment. In addition, the determination on appeal will not afford deference to the initial claim denial.

The Board will provide a written notification of the benefit determination on review. In the case of denial, the notification will set forth the following:

- The specific reason or reasons for the denial.
- Specific reference to Plan provisions on which the denial is based.
- 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 your claim for benefits.
- An internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the specific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A statement of your right to sue under Section 502(a) of ERISA.

INCOMPETENCE

In the event it is determined that a claimant is unable to care for his/her affairs because of illness, accident, or incapacity, either mental or physical, any payments due may, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, be paid to the spouse or such other object of natural bounty or the claimant, as the Trustees will determine in their sole discretion**.**

TRUSTEES' RIGHT TO INFORMATION

The Trustees have the right to require a participant or a dependent to produce and provide any and all evidence or proof of any fact which the Trustees, in their discretion, decide to be relevant or necessary. The failure to provide such information or evidence will justify any action of the trustees in denying any claim made by such participant or dependent. If any participant or dependent submits false information or false claims to the provider or to the Trustees, the Trustees shall have the right, in their sole discretion, to disqualify such participant or dependent from eligibility for benefits for any time period determined to be appropriate by the Trustees.

MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last communicated to the Trustees and a letter, sent by first class mail, to such claimant is returned, any payments due the claimant will be held without interest until payment is successfully made.

RECOVERY OF CERTAIN PAYMENTS

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statements, information, or proof submitted, as well as any benefit payment made in error to a claimant or to a third party on a claimant's behalf, such recovery may be made by reducing other benefit payments made to or on behalf of the claimant, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The Trustees have the authority to disqualify a participant and his or her dependents from coverage or from future benefits either for a specific dollar amount or for a specified period of time.

ARBITRATION

No suit at law or in equity, or before any administrative tribunal, may be maintained against the Fund or the Trustees without the claimant having followed the above appeals procedure. Should the appeal be denied, the claimant must agree to arbitrate the claim under and in accordance with the rules of the New Jersey State Board of Mediation, and agree that the decision of the arbitrator so designated by said Board will be final and binding upon the claimant and the Fund. The Trustees will advise the claimant or representative at the address to be specified in said letter of the claimant, in writing, certified mail, postmarked within 10 days of the claimant's letter, in the event that he or she agrees to such final and binding arbitration. In the event that the Trustees fail to so agree, nothing in this section will preclude the institution of a suit before an appropriate court or administrative tribunal by the said claimant. In the event that the Trustees do agree to the said arbitration, said claim will be referred to arbitration by the claimant under and in accordance with the rules of the New Jersey State Board of Mediation, and the decision of the arbitrator designated by that Board will be final and binding upon the claimant and upon the Fund and the Trustees. The arbitrator's fee will be assessed against the claimant or against the Fund, or may be divided between them, as the arbitrator will determine in an award.

SUBROGATION/REIMBURSEMENT

Subrogation/Reimbursement Right of the Fund

This Welfare Fund will make payments on your behalf in certain situations where the need for those services was caused by some other third party. In order to avoid possible double payment to you or to the service provider, this Fund is entitled to reimbursement in full of the monies paid by the Fund, if and when the claimant recovers monies from another person, organization, or entity. For example, if the Fund paid your hospital, medical or similar expense, and those expenses, or damages, were to be recoverable by way of a compensation case, law suit, or settlement from a third party or the third party's insurance company, then the Fund would have the right to be reimbursed in full by the third party, their insurer, or the claimant, the amount of the monies paid by the Fund on the claimant's behalf. The Fund has the right to obtain reimbursement from any person or entity in possession or control of the amount that is recoverable or is recovered. Where a claimant has incurred attorney's fees in obtaining a recovery, under no circumstances will the Fund pay the attorney's fees or any portion thereof.

You have the legal obligation to help the Fund in all ways possible to try to recover the amount paid by the Fund on your behalf. This obligation includes the following:

A. You must notify the Fund, if your claim is the possible responsibility of a third party, compensation case, or third party's insurance carrier.

B. You must provide the necessary information to enable the Fund to put the third party, compensation carrier, or third party's insurance carrier on notice of the Fund's claim.

C. You must sign the Fund's forms acknowledging that the payments are for claims otherwise excludable and agree to repay in full all such payments made by the Fund Office.

D. You are obligated to notify the fund office within 5 days of the date your claim against the other party is settled.

Failure to cooperate or provide the information could result in a loss of future benefits to the participant and/or claimant.

PART D.

NOTICE OF PRIVACY PRACTICES

A. Use and Disclosure of Protected Health Information (PHI)

The Group Health Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and co-payments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan) and
- reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:

  a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

  b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclosure PHI to the Teamsters Local 641 Pension Plan, disability plans, reciprocal benefit plans, and workers compensation insurers, or purposes related to administration of these plans.

C. For Purposes of this Section the Fund's Board of Trustees is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following individuals may be given access to PHI:

- Fund Trustees

F. Limitations of PHI Access and Disclosure

The persons described in section E may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

G. Non-Compliance Issues

If the persons described in section E do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

PART E.

TECHNICAL DETAILS

1. PLAN NAME: Teamsters Local 641 Welfare Fund.

2. EDITION DATE: This Summary Plan Description is produced as of April 1, 2008.

3. PLAN SPONSOR: Trustees of the Teamsters Local 641 Welfare Fund.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 22-6220289.

5. PLAN NUMBER: 501.

6. TYPE OF PLAN: Welfare Plan providing Death and Dismemberment Benefits, Disability Income Benefits, and Health Care Cost Reimbursement Benefits.

7. PLAN YEAR ENDS: February 28th.

8. PLAN ADMINISTRATOR: Trustees of the Teamsters Local 641 Welfare Fund, 714 Rahway Avenue (2nd Floor), Union, NJ 07083. Phone #: (908) 687-4488.

9. AGENT FOR THE SERVICES OF LEGAL PROCESS: Kroll Heineman, Metro Corporate Campus I, 99 Wood Avenue South, Suite 307, Iselin, NJ 08830. Phone #: (732) 491-2100. In addition to the person designated as agent for service of legal process, service of legal process may also be made upon the Plan Manager or any Plan Trustee at the Fund Office.

10. TYPE OF PLAN ADMINISTRATION: Self-administered, in major part, by the Trustees and their employees.

11. TYPE OF FUNDING: A combination of insured and self-funded.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Teamsters Local 641 Welfare Fund.

13. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with multiple collective bargaining agreements. A copy of any of those agreements may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Fund Office.

14. PARTICIPATING EMPLOYERS: You may receive from the Fund Office, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

15. PLAN BENEFITS PROVIDED BY: Life Insurance through an insured policy with Metropolitan Life Insurance Company and all other benefits directly by the Teamsters Local 641 Welfare Fund.

16. ELIGIBILITY REQUIREMENTS, BENEFITS AND TERMINATION PROVISIONS OF THE PLAN: See Part A., B., C., of this booklet.

17. HOW TO FILE A CLAIM: Application for all benefits, provided directly by the Welfare Fund must be made in writing on forms that should be obtained from the Plan Manager at the Fund Office. You may secure such forms by writing, telephoning or visiting (during the hours of 8:00 A.M. to 4:00 P.M. on regular business days) the Fund Office. The address is:

Teamsters Local 641 Welfare Fund
714 Rahway Avenue (2nd Floor)
Union, NJ 07083
(908) 687-4488

Application for insured benefits can be made by following the procedures outlined by the insurance company.

18. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Plan or to any insurance company, and it is denied, in whole or in part, you will be so notified.

If a denial takes place, you are entitled to appeal the decision by writing to the Trustees (or to the insurance company, if appropriate) .Please refer to pages 55-57 of this booklet for more specific information regarding the Plan's appeal procedure.

After review, you will be notified of the results of the review.

More specific information regarding this procedure may be obtained from the Fund Office.

19. RIGHTS AND PROTECTIONS: As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

A. Examine, without charge at the Plan Manager's office, all Plan documents, including any insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) file by the Plan with the U.S. Department of Labor.

B. Obtain, upon written request to the Trustees, copies of documents governing the operations of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Trustees may make a reasonable charge for the copies.

C. Receive a summary of the Plan's annual financial report. The Trustees are 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 this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the 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 or exercising your rights under ERISA.

If your claim for a 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 the above 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 Trustees 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 manager. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Fund Administrator.

If you have any questions about this statement or about your rights under ERISA, you may contact the nearest Regional Office of the Pension and Welfare Benefits Administration, Department of Labor.

You may also contact the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

20. NO INSURANCE UNDER THE PBGC: Since this Plan is not a defined benefit pension plan, it does not have coverage under the Pension Benefit Guaranty Corporation.

21. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Teamsters Local 641 Welfare Fund. The following are the individual Trustees that make up the Board as of April 1, 2008:

Anthony Artificio, Jr.
Teamsters Local 641
714 Rahway Avenue (1st Floor)
Union, NJ 07083

John Kerins
Metropolitan Distribution Ctr.
200 Industrial Drive
Jersey City, NJ 07305

William Cunningham
Teamsters Local 641
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Union, NJ 07083

David Mazzella
Pacific Rail Service
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Kearny, NJ 07032

TECHNICAL DETAILS (CONT'D)

Jan Katz
Teamsters Local 641
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Colonial Concrete
1196 McCarter Highway
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