TOWN OF ISLIP
Blue Collar
Unit Employees

UPSE
BENEFIT PLAN

Summary
Plan
Description

9/30/2010

UPSE Summary Plan Description for Employees and Eligible Dependents of Town of Islip Blue Collar Unit

GENERAL INFORMATION

Before we provide you with the details of your benefits, please take the time to read this general information section. It discusses eligibility requirements for you and your dependents and the Coordination of Benefits provision of the Plan.

Who Is Eligible for Benefits?

You are eligible for benefits under this Plan if:

- you are an active full-time employee in the bargaining unit covered by UPSEU in the Town of Islip;
- contributions are made to the Plan on your behalf by your employer; and
- you have completed an enrollment form and sent it to the Plan Office.

When Does Your Coverage Start?

Your coverage starts the first day you are employed and are listed on the payroll in your bargaining unit. You must be enrolled for benefits at the Plan Office. Your coverage continues until the last day you are on the payroll.

Who Are Your Eligible Dependents?

Your dependents are also eligible for certain benefits if they meet one of the following requirements and you have enrolled them. Eligible dependents include your:

- Spouse, unless you are divorced.
- Unmarried children until the end of the month in which they reach age 19.
- Unmarried dependent children who are full-time day students enrolled in an accredited college, vocational school or high school, until the end of the month in which they reach age 25 or are no longer eligible students, whichever is first.
- Unmarried dependent children 19 years and older, if they cannot support themselves because of mental or physical disability (their eligibility continues for as long as their disability continues, provided you show proof of the continued disability at least once every three years). The disability must have started before age 19 (or age 25 if an eligible student).

Your children include your natural children, children you have legally adopted, stepchildren whom you support and who permanently live with you, children for whom you are a permanent legal

guardian and children for whom a court has found you to be the parent or has ordered you to provide health insurance coverage (DNA or other lab tests are insufficient to prove paternity for coverage purposes).

Coverage for your dependents starts when your coverage starts, or when they become your dependents, whichever is later, provided you have filed an enrollment card with the Plan Office.

To continue coverage beyond age 19 for full-time day students, each year you must provide certification from the registrar's office of your child's school.

To continue coverage for your disabled child, you must notify the Plan Office in writing and provide satisfactory proof of the date the disability commenced. If you provide the notice within 30 days of your child having reached age 19 (or age 25 if applicable), benefit coverage will continue without interruption for as long as you are covered and your child remains disabled. If you provide notice to the Plan Office more than 30 days but less than one year after the child reaches age 19 (or age 23 if applicable), or within one year of your first day of coverage, if later, your dependent child will not be covered for any benefits on account of claims incurred after the applicable age but prior to the date of notice, but coverage will be restored for the period following notice and continue for as long as you are covered and your child remains disabled. If you do not inform the Plan Office of the disability within one year of the applicable age, or within one year of your first day of coverage, if later, coverage for your dependent child will terminate permanently.

When Does Coverage End?

Your coverage ends on the date where you are no longer working in a job title covered by the collective bargaining unit contract, except that death and accidental death and dismemberment benefit coverage ends 31 days after you are no longer working. If you return to work, your coverage will begin again on the first day of the next full month following your return to work. Your coverage may also end as described on page 21.

Coverage for your eligible dependents ends on the date you are no longer working in a job title covered by the collective bargaining unit contract.

Under certain circumstances, you or your spouse or dependent children may elect to continue coverage under the Plan's dental, optical, reimbursement of prescription drug co-payments, health insurance deductible reimbursement and hearing aid benefit programs for a limited period of time, as explained on page 22. Please Note: You must pay for this election; it is not paid for by the Plan.

What Is Coordination of Benefits?

Coordination of Benefits is a provision of the Plan which applies if you or any of your eligible dependents are covered for benefits from any other group plan.

For example, it you are married, your spouse may have benefit coverage through his or her job. If you are eligible for benefits from the Plan and from your spouse's group plan, the benefits from both plans will be "coordinated." This provision assures both plans that you do not receive more than

100% of your actual expenses.

The “primary” plan - usually the one that covers you or your spouse as an employee - pays benefits first. The “secondary” plan - usually covering you or your spouse as a dependent - would then pay the difference between the actual charges and what the primary plan provides. If your dependent children are also eligible for benefits from your spouse’s group plan, the primary plan of your dependent children will be the plan of the spouse whose birthday is earlier in the year, and the secondary plan will be the plan of the spouse whose birthday is later in the year, regardless of age.

The Coordination of Benefits provision applies to dental and optical benefits.

When Does the Plan Have the Right to Recover Payments Made In Error or to Suspend Benefit Coverage?

If the Plan finds that it has overpaid you for a particular benefit, it has the right to recover the excess amount. The Plan may bill you for excess payments and may also reduce future benefit payments to offset the overpayments.

The Plan also has the right to recover overpayments if they were due to an error in processing the claim or any additional information comes to light after the claim has been paid. Furthermore, the Plan has the right to recover improper or erroneous payments or to reduce or suspend one or more benefits if you have received overpayments from this Plan, or have in any way abused the Plan’s benefit programs.

YOUR BENEFITS - IN GENERAL

You and your eligible dependents are entitled to the following benefits from the Plan:

- dental (according to a schedule of benefits);
- optical (once each year);
- reimbursement of prescription drug co-payments;
- reimbursement of the State's health insurance program deductible;
- hearing aid (up to $400 if a five year period); and
- death benefit ($10,000 upon the death of the employee and $2,500 upon the death of the employee's spouse and $1,000 upon the death of a dependent child).

In addition, you are entitled to the following benefits which are not available to your dependents:

- weekly disability (50% of salary up to $175 per week for a maximum of 52 weeks)

BENEFITS AVAILABLE TO YOU AND YOUR DEPENDENTS

The following sections describe the benefits that are available to you and your eligible dependents.

DENTAL BENEFITS

Dental benefits are available to you and your eligible dependents if you meet the eligibility requirements described on page 1. These benefits are provided by the Plan for approved procedures.

How Does the Plan Work?
If you or your eligible dependents need dental care, you can go to one of the participating dentists, or you can go to the dentist of your choice.

If you use a participating dentist, most dental expenses are provided at no cost to you, subject to review by the Plan Administrator. A list of participating dentists is available from the Plan Office.

If you use a dentist that is not participating in the plan, you must pay for the services. You will be reimbursed according to a benefit schedule for services covered, as determined by the Plan. The plan does not accept assignment of benefits.

Whether you use a participating dentist or a dentist of your choice, you must do the following before receiving dental care:

- Make sure that you and all of your eligible dependents are properly enrolled at the Plan Office.
- If you are not enrolled, complete the enrollment card if it is the first claim for you or any family member, and return it to the Plan Office.
- If there has been a change in the information on the enrollment card, such as changes of address or dependents, please complete a new enrollment card and return it to the Plan Office,
- Obtain a claim form for each person to be treated from the Plan Office.
- Complete the “employee’s” section of the claim form.
- Take the claim form with you to the dentist’s office.
- Do not sign the claim form until your dentist has given you the treatment indicated on the form.

Ordinarily, you must submit a completed claim form within 30 days of the completion of your dental treatment. However, if your course of treatment extends over more than 180 days, you must submit

a completed claim form for the work in progress at the end of the initial 180 day period, and at the end of each subsequent 90 day period. Failure to submit a claim form in a timely manner, as described above, may result in the complete or partial disallowance of your benefit claim.

If your dental work is anything other than orthodontics for dependent children, crowns, bridges, partials, dentures or full mouth surgery (periodontics), you may have the work done without the approval of the Plan Administrator If you use a non-participating dentist, have the dentist complete the form indicating all work done and submit the completed claim form and all diagnostic x-rays taken by the dentist to the Plan Administrator as noted on the claim form. If you use a non-participating dentist, you will be reimbursed and must make arrangements to pay the dentist yourself; the Plan will not accept an assignment of benefits to a non-participating dentist. You will receive payment according to the benefit schedule for covered services. If you use a participating dentist, the dentist will complete the claim form and submit it to the Plan Administrator; the dentist will be paid directly.

If the dental work involves orthodontics for dependent children, crowns, bridges, partials, dentures or full mouth surgery (periodontics), you must first get approval from the Plan's provider. This is true for both participating and non-participating dentists. You must submit diagnostic x-rays taken by the dentist and a claim form to the Plan before any work is done. Approval is subject to professional review and will be handled as quickly as possible.

What If You Need Emergency Treatment?
Go to the dentist immediately. Call the Plan Office and request a claim form to be reimbursed for emergency treatment. You must submit diagnostic x-rays taken by the dentist with the claim form.

What Are Your Benefits?
In general, your dental plan provides the following benefits according to a benefit schedule for covered services which is found in a separate brochure. Whenever changes are made in this schedule, a new one will be mailed to you.

- semiannual examinations
- semiannual cleanings
- x-rays (as needed; however, a full mouth series is only allowed once every three years)
- all necessary fillings
- sodium fluoride treatment
- repairs to removable dentures and partials
- necessary extractions
- treatment of gum conditions emergency treatment
- root canal treatment
- oral surgery
- pain-relieving treatment
- full or partial removable dentures
- crown or bridgework
- apicoectomy treatment

- re-cementing of a single crown or bridge
- orthodontics for eligible dependent children

Payment is contingent upon review by the Plan and the appropriateness of the treatment received.

For a complete list of available benefits, see the dental benefit schedule for covered services for your plan. If you misplace your schedule, additional copies are available from the Plan Office.

Please Note: The maximum dental benefit provided to each eligible individual is limited to $1,700 for treatments performed in any calendar year. Benefits may not be carried over into another year.

What Is Not Covered?
Dental benefits are not provided for procedures that are not listed in your plan's benefit schedule for covered services. The following are some examples of non-covered procedures:

- any dental procedure performed for cosmetic reasons or with respect to congenital malformations;
- replacement of an existing denture, crown or bridge more often than once every five years; replacement of lost or stolen appliances; temporary fillings;
- services not performed by a licensed dentist; and
- supplies or services for which benefits are provided under any other group policy or Workers' Compensation for which any other employer makes contributions or payroll deductions or for treatment provided at a Veteran's Administration hospital or clinic.

When Does Your Coverage End Under the Dental Plan?
Your dental coverage ends as described in this SPD. However, the Plan will pay for any treatment received while you are eligible for benefits, if the claim is received within 30 days alter your coverage ends. Coverage may also end as further described in this SPD. In addition, you or your spouse or eligible dependent children may elect to continue dental coverage for a limited period of time under the circumstances described in this SPD.

OPTICAL BENEFITS

Optical benefits are available to you and your eligible dependents once in a 12-month (one year) period if you meet the requirements described herein. These benefits are provided by the Plan, which uses the services of a number of different optometrists throughout the metropolitan area.

How Does the Plan Work?
If you or any of your eligible dependents need an eye examination, contact the Plan Office and ask for a referral claim form for the optical benefit. The approved form will be dated and returned to you with a list of all participating optometrists. Complete the employee section of the claim, including your signature in the indicated place, and take it with you to the optometrist.

The form is good for 30 days. No form will be accepted by an optometrist unless it is issued by the Plan Office and used within 30 days. If you cannot use the form within that time period, contact the Plan Office; you will be required to return the original form to the Plan Office so a new one may be issued.

What Are Your Benefits?
You and each of your eligible dependents are eligible for the following benefits, without charge, once a year:

- a complete examination by a licensed optometrist, including testing for glaucoma for all adults and when indicated for a child (not available in New Jersey or Florida due to regulations on examinations in those states);

- plastic or glass single-vision, bifocal, or trifocal lenses in a standard shell frame including eyeglass case; glass grey #3 prescription lenses; oversized lenses; scratch-protected lenses; post-cataract lenses; ultraviolet protected lenses; or standard soft daily wear contact lenses; and

- adjustments and repairs of eyeglasses not requiring parts.

You and your eligible dependents are entitled to choose various types of frames from an extensive selection; however, the frame types may vary from one participating optometrist to another.

In addition, when you use your optical voucher, you may have an additional eye examination for $20. an additional pair of eyeglass frames for $40 and lenses for $40, or soft daily wear contact lenses for $80, from our participating optometrists. You may purchase additional pairs of eyeglasses or lenses, or have additional examinations, at your own expense. The amount you pay will be no more than the amount paid by the Plan.

Arrangements have also been made to provide cost protection for additional services to you and your dependents. You pay these costs, however, the cost will be at a fixed rate which the Plan has been able to obtain from the services providers. The actual cost is noted in the brochure that you will

receive when you request your form. The additional services include: progressive addition lenses, blended invisible bifocals, PGX lenses, reflection free coating, polaroid lenses, polycarbonate lenses, high index lenses, transition lenses, extended wear contact lenses, gas permeable contact lenses, toric soft daily wear contact lenses, and disposable contact lenses (one year supply).

For out of pocket costs over and above the plan, the Plan will reimburse you and/or your spouse with a paid receipt detailing the services provided and payment made for up to $25.00 in additional out of pocket expenses.

OPTICAL OUT OF NETWORK PROVIDER SCHEDULE

If you or a dependent obtain services from an out of network provider, you will be reimbursed by UPSE Benefit Plan based upon the schedule below upon submission of a detailed paid receipt with your name and social security number for the services provided.

Exam	$25.00
Frame	$25.00
Single Vision Lenses	$25.00
Bifocal Lenses	$35.00
Trifocal Lenses	$32.00
Tint	$12.00
Contact Lenses	$100.00 (no exam)
Contact Lenses	$125.00 (including exam)

The Vision Benefit entitles you or your dependent to the following, UP TO THE MAXIMUM BENEFIT SET FORTH ABOVE.

1. Choice of glass or plastic single vision, bifocal or trifocal lenses;
2. Selection from the Collection of frames offered under the Plan;
3. All ranges of prescriptions, including cataract lenses;
4. Oversize lenses;
5. Fashion tinting plastic lenses;
6. Gradient tints;
7. Grey #3 prescription sunglasses in glass;
8. Soft standard daily wear contact lenses (in lieu of all eyeglasses);
9. Photo chromatic lenses; and
10. Invisible bifocal lenses.

No payment will be made under this benefit for expenses incurred in connection with:

1. Medical or surgical treatment of the eye;
2. Lenses which are not medically necessary and are not prescribed by an Optometrist or Ophthalmologist, or frames for such lenses;
3. Special procedures, such as orthopaedics or vision training, and special supplies, such as non-prescription sunglasses and subnormal vision aids;

4. Radial keratotomy; or
5. Charges which you are not legally required to pay or for charges which would not have been made if no coverage had existed.

In addition, for in-network/out-network benefits an out pocket expense in the amount paid up to a maximum of $25.00 for member and spouse (not a dependent child) upon submission of a detailed receipt with your name, social security number and the services provided.

REIMBURSEMENT OF PRESCRIPTION DRUG CO-PAYMENTS

The Plan provides a benefit that will reimburse you for prescription drug co-payments that you have paid each year under your employer's health insurance program for prescription drugs.

How Does the Plan Work?
If you and your eligible dependents are covered under the State Health Insurance Program, the amount of any co-payment that you or your eligible dependents pay for a prescription drug will be reimbursed up to a maximum of $5.00 per prescription.

REIMBURSEMENT OF HEALTH INSURANCE DEDUCTIBLE

The Plan provides a benefit that will reimburse you for part of the out of network deductible you pay each year under your employer's health insurance plan,

How Does the Plan Work?
If you and your eligible dependents are covered under the State Health Insurance Program, a portion of the amount of the deductible fee (out of network deductible) that you pay for medical coverage will be reimbursed by the Plan. The deductible fee will be reimbursed to you after the full deductible has been met or after the end of the year for any portion that was used. You are entitled to receive 50% of the amount of your deductible; however, the maximum reimbursement for the separate deductible payable for out-of-network mental health or substance abuse benefits is limited to $250 per person or $750 per family for any year To obtain reimbursement, you must submit a copy of your insurance statement to the Plan Office.

If you do not reach your full deductible limit, you must apply for the 50% reimbursement, but only within the first 90 days of the following year

HEARING AID BENEFITS

All members and their eligible dependents as defined on page 1 are covered for hearing aid benefits.

What Is Your Benefit?
A maximum accumulated benefit of up to $400 is provided for the purchase or repair of a hearing aid in a five year period. The referral of a physician or audiologist is required for the purchase to be covered.

How Do You Obtain Benefits?
Call or write the Plan Office to request a hearing aid benefit claim form. Portions of the claim form must be completed by the member, the physician or the audiologist and the hearing aid dealer. The completed claim form should be returned to the Plan Office for processing and payment. Claims will be paid alter confirmation of the purchase of the hearing aid, following the required 30-day trial period.

DEATH BENEFITS

What Are Your Benefits?
If you or your eligible spouse dies from any cause while you are covered, a death benefit will be provided by the Plan. In the event of your death, your beneficiary will receive a $10,000 death benefit. In the event of your eligible spouse's death, you will receive a $2,500 death benefit. This benefit will be paid in a lump sum. In the event of the death of a dependent child you will receive a $1,000.00 death benefit.

Who Is Your Beneficiary?
Your beneficiary can be any person you choose. You may change your beneficiary at any time by contacting the Plan Office. However, your designation of a beneficiary must be on file at the Plan Office. You may designate a beneficiary by completing the beneficiary designation" portion of the enrollment form.

What Happens If You Become Disabled?
If you become totally and permanently disabled before age 60, and while you are covered by the plan, your death benefit will continue (at the benefits level in effect at the time of your disability) without cost to you until age 65 or until you recover, if you recover before age 65. You must contact the Plan Office between the sixth and ninth month of your disability. If you die while you are receiving Workers Compensation or while you have a Workers' Compensation claim pending, your beneficiary will still be entitled to receive a death benefit.

What Is Not Covered?
This benefit is not paid if death is caused or contributed to by insurrection or war, declared or undeclared, any act of war or participation in a riot (unless waived by the Trustees); or while committing or attempting to commit a felony.

How Should Claims Be Filed?
Your beneficiary or you should contact the Plan Office for the procedure to follow.

BENEFITS AVAILABLE TO ONLY YOU

The following sections describe the benefits which are available only to you, the employee. Your eligible dependents are not covered for these benefits.

SHORT-TERM DISABILITY BENEFITS

What Are Your Benefits?
If you become disabled and cannot work because of an injury or illness that is not job-related and is not covered by no-fault auto insurance, or you become disabled and cannot work because of pregnancy, you are eligible to receive short-term disability benefits. For maternity you will receive 8 weeks leave for normal delivery and 12 weeks for cesarean delivery, unless pregnancy results in total disability and is certified by a physician. There is a 14-day waiting period for benefits to begin. A physician must examine you within 3 days of your disability for these days to be included in the

waiting period, otherwise the 14-day waiting period begins only when you are examined. You will lose your right to this benefit if the Plan requests that you have an examination by a physician and the examination does not take place within two weeks of the Plan's request.

If you are being treated for substance abuse, your treatment at a particular center or institute must be required, in writing, by the physician who certifies that you are disabled. In addition, if the treatment continues for more than two weeks, the treatment center or institute must have a licensed physician on duty who can provide certification of your continued disability.

The amount of your benefit is 50% of your weekly salary up to a maximum benefit of $175 per week. Benefits begin on the 15th day of your disability, unless you are hospitalized; in that case, benefits are paid from the first day you are confined to the hospital. In any event, you must miss a day of work due to your covered disability for disability benefits to start.

You will be entitled to receive no more than 52 weeks of disability benefit payments during any 104-week period regardless of how many separate disabilities or recurrences you experience during that period. If you return to work before you use up your 52 weeks of disability benefit payments and you are again disabled, you will be entitled to receive benefit payments only for the remainder of the 52 weeks of eligibility you have left during the 104-week period.

How Do You Claim Benefits?
To receive these disability benefits, you must obtain a claim form from the Plan Office. There are three sections to this form; you should complete the employee section, your doctor should complete the "Attending Physician's Section," and your supervisor should complete the employer section.

Return the completed claim form to the Plan Office within 20 days from the first day of your disability. If you cannot submit a claim form within that time period, you must send a letter explaining the reason for the delay and the details of your disability. If the Plan determines that the delay in submitting the form was not for good cause, your claim for benefits may be completely or partially disallowed.

What Is Not Covered?
In general, the Plan's short-term disability benefits are not payable for the following injuries or illnesses:

- Automobile Accidents - If you are injured as a result of an automobile accident that is covered by no-fault insurance, you are not entitled to receive the Plan's short-term disability benefits. Automobile accidents that are covered by no-fault insurance include accidents involving cars, vans, SUV5, taxicabs, private car service vehicles and buses. If you are injured in such an accident, you should contact the insurance carrier covering the vehicle involved in the accident and apply for no-fault insurance benefits, as the Plan will not provide benefits in such cases.

- Job-Related Injuries or Illnesses - If your injury or illness is job-related, the Plan's short-term disability benefit would not be payable and you would need to file a workers' compensation claim for benefits. lithe Plan receives a notice (Workers' Compensation Form C-7) that the claim is controverted by your employer, then the Plan will pay its benefit, pending the resolution of your workers' compensation claim. In such case, the Plan will have a lien on the workers' compensation benefits awarded to you (if any). This means that, if you are paid by the Plan and you are later awarded workers' compensation benefits for the same illness or injury and time period, the Plan is entitled to recover the amount it paid to you, out of your worker's

compensation benefits, so that you are not paid twice for the same illness or injury.

Accidental Death and Dismemberment

A $10,000 Accidental Death and Dismemberment Policy is provided through UPSEU not through the UPSE Benefit Plan.

WHAT ELSE YOU NEED TO KNOW ABOUT YOUR BENEFITS

All your benefits are provided through the UPSE Benefit Plan.

You are not required to make contributions to help pay for these benefits. The cast of these benefits is paid for by your employer as a result of the collective bargaining agreements between your employer and United Public Service Employees Union. These contributions are held in trust by the Plan and are invested in various ways. The money held by the Plan is used solely to provide you and your eligible dependents with benefits and to pay for the necessary administrative expenses.

If any of the benefits you receive under the Plan are lost or stolen, replacements will not be provided, as you are entitled to benefits only as often as provided under the Plan, regardless of loss or theft.

What Is the Claim Review Procedure?
Any claims for benefits under the Plan should be made by filing a written statement of the claim with the Plan Office. Claims should be made in accordance with the specific procedures applicable to the covered benefits. Each claim you make will be reviewed, and approved or disapproved, within 90 days after it has been filed, unless special circumstances warrant an extension of time.

If your claim is denied in whole or in part, you (or your beneficiary) will be given written notice of the denial. The notice wili explain the reasons for the denial, refer to the specific provisions of the Plan documents on which the denial was based, and advise you (or your beneficiary) as to any additional material or information that may be necessary in order to complete the claim.

You (or your beneficiary) may have the denied claim reviewed by the Trustees by filing a written request for such review with the Trustees within 90 days of the date of the written notice of the denial of the claim. In connection with the review, you (or your beneficiary) will be entitled to examine all pertinent documents and to submit issues and comments in writing.

The Trustees ordinarily will make a decision during the next Trustees' meeting following the receipt your request. You will be notified if an extension of time is necessary. The Trusteeswill notify you of their decision within 5 days. The Trustees' decision on review will be in writing, and it will set forth the specific reasons for the decision, including reference to the provisions of the Plan documents on which the decision was based.

Who Determines My Benefits?
The Trustees have final authority to determine the amount of benefits that will be paid on any particular benefit claim. In making benefit determinations, the Trustees have the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the Plan that the Trustees in their sole discretion determine you are entitled to receive.

Are There Other Reasons My Coverage May End?

Your coverage and that of your eligible dependents ends on the earliest of the date on which:

- the Plan terminates;
- the Plan's rules are modified to end benefits for the class of persons to which you or your eligible dependents belong;
- your eligibility ends - see page 3; for example, if you are transferred to a new job title that is not eligible for benefits under the Plan;
- the benefit program is modified to end one or more of the benefits previously provided; or
- your employer fails to make the required contributions on your behalf.

Can You Continue Your Plan Coverage?
Federal law (commonly referred to as COBRA) requires that employees and their family members covered under the Plan be offered the opportunity for a temporary extension of welfare Plan health benefits coverage at 102% of the group rates in certain instances where coverage under the Plan would otherwise end. The continuation coverage provisions apply to the Plan's dental, optical, prescription drug co-payment reimbursement, health insurance deductible reimbursement and hearing aid benefits only. This section is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this section carefully.

In the case of an employee's termination of employment (for reasons other than gross misconduct), the employee, the employee's spouse and dependent children covered under the Plan have the right to choose continuation coverage. The spouse of an employee and the employee's dependent children covered under the Plan also have a right to choose continuation coverage when they lose coverage in the following cases: (1) the employee's death; (2) the employee's divorce or legal separation from his spouse; and (3) the employee becoming covered under Medicare. A dependent child also has a right to choose continuation coverage when the child ceases to be a "dependent child" under the Plan. A child born or placed for adoption with a covered employee during the period of continuing coverage is also entitled to continuing coverage.

Under the law, the employee or a family member has the responsibility to inform the Plan Office within 60 days of a divorce, legal separation or a child losing dependent status under the Plan. The employer has the responsibility to notify the Plan of the employee's death, termination or Medicare eligibility.

When notified that one of these events has occurred, the Plan will in turn notify the employee or his covered dependents of the right to continuation coverage. Under the law, the employee or his covered dependents have at least 60 days from the date coverage would be lost because of one of the events described above (or from the date of the Plan's written notice, if later) to inform the Plan that continuation coverage is being elected. If you are an employee or spouse who has the right to choose continuation coverage, continuation coverage may be elected for yourself only, or for yourself and one or more of your covered family members, If you do not elect continuation coverage for yourself, or if you elect it for yourself only, then each of your covered family members can still elect it for himself or herself.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay 102% of the cost for your continuation coverage. The cost of continuation coverage is determined annually. Payment shall be on a monthly basis.

If you elect continuation coverage, you will have 45 days from the date of your election to pay for any continuation coverage provided between the time your coverage would have ended and the date of your election. As to amounts payable for post-election coverage, a grace period of 30 days will be granted.

The law requires that you be afforded the opportunity to maintain continuation coverage for a maximum period of 36 months from the date of the event which entitles you to elect continuation coverage, unless you lose Plan coverage because of a termination of employment. In that case, the maximum continuation coverage period is 18 months; however, the coverage period will be extended to 36 months from the date of termination of employment if any of the following events occurs within the initial 18-month period: (1) the employee's death; (2) with respect to the coverage of the employee's spouse and children (not of the employee), the employee's divorce or legal separation; (3) with respect to the coverage of the employee's spouse and children (not the employee), the employee's becoming covered by Medicare; and (4) with respect to a dependent child's coverage, the child ceasing to be a "dependent child" under the Plan. When any of these events happen, you or a family member must notify the Plan in order to extend the 18-month period of continuation coverage to 36 months.

Continuation coverage will be cut short for any of the following reasons: (1) the employer no longer provides group health coverage to any of its employees; (2) the cost for your continuation coverage is not timely paid; (3) the continuation enrollee becomes covered under another group health plan which does not contain any exclusion or limitation with respect to any preexisting condition of the enrollee (in which case, the enrollee must notify the Plan); or (4) the continuation enrollee becomes covered by Medicare benefits. Once your continuation coverage terminates for any reason, it cannot be reinstated.

In addition to the above rules, there is a special rule if you or your spouse or dependent children are disabled at the time of your termination of employment or within the first 60 days of your continuation coverage. In that case, if you (or your disabled spouse or child, if applicable) are determined, under the Social Security Act, to have been disabled prior to or during the first 60 days of your continuation coverage, or in the case of child born or placed for adoption with a covered employee during the continuation coverage period, during the first 60 days after the child's birth or placement for adoption; you (or your covered family members) will be entitled to a 29-month period of continuation coverage (instead of only 18 months); however, you will have to pay 150% of the cost of your continuation coverage for each of the additional 11 months of coverage. In order to be entitled to the extended disability coverage, you or your family member must notify the Plan within 60 days after the date of the Social Security determination and within 18 months of your termination of employment that you or your family member is disabled. Also, if there is a final determination that you or a family member is no longer disabled during the additional 11-month period, you or your family member must notify the Plan within 30 days after the date of the final determination. In that case, the continuation coverage will end as of the first month that begins more than 30 days after the date of the final Social Security determination.

If you choose continuation coverage, you are entitled to coverage which is identical to the coverage then being provided under the Plan to similarly situated employees or family members. Your coverage will be subject to increases or decreases in the sane type of benefits for active employees and their family members. If any increase or decrease occurs, you will be notified and there will be a corresponding increase or decrease (effective as of the beginning of a Plan year) in the cost of your

coverage. Also, if you choose continuation coverage, you must notify the Plan Office, in writing, of any changes in address or marital status.

For further information about COBRA continuation coverage, please contact the Plan Office. f you do not choose COBRA continuation coverage, your group health benefits coverage will end as provided by the Plan.

Please Note: COBRA does not change your existing benefits. It only deals with your continuation coverage rights.
If you do not choose COBRA continuation coverage, your group health benefits coverage will end as provided by the Plan.

Please Note: COBRA does not change your existing benefits. It only deals with your continuation coverage rights.

How Do I Enroll My Dependent Under a "Qualified Medical Child Support Order"?
A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health insurance. If the Plan Administrator receives a QMCSO for your child or children, the Plan Administrator will contact you concerning the procedures for such an order.

When May the Plan Be Amended or Terminated?
The Trustees reserve the right to amend or terminate this Plan in whole or in part, at any time.

Privacy Practices
THE FOLLOWING DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Is the Plan required to ensure the privacy of your personally identifiable health information?
The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

The Board of Trustees of the Plan adopted the following procedures and practices as of April14, 2004 to comply with privacy requirements applicable to medical information. In the event that other more stringent laws further restrict the use or disclosure of medical information, such laws will prevail.

How does the Plan use or disclose my PHI?

The Plan and its business associates will use PHI to carry out treatment, payment and health care operations without your consent, authorization or opportunity to agree or object.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental Xrays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to aeating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Use and disclosure required by law. Your PHI may be used or disclosed as required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plans compliance with the privacy regulations or as otherwise required by applicable law.
Other uses and disclosures will be made only with your written authorization. If you authorize any uses or disclosures, you may change your mind and revoke your authorization at any time.

Can I request restrictions on the use and disclosure of my PHI?
You may request the Plan to restrict uses and disclosures of your ***PHI*** to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan Office.

Can I review P1-Il that the Plans has about me?
You have a right to inspect and obtain a copy of your PHI contained in a designated record set, for as long as the Plan maintains the PHI.

Protected Health Information (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals

is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan Office.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Can I have my PHI corrected or changed?
You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the Plan Office. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

Can I find out whether the Plan has disclosed my PHI?
Yes. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed it the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost based fee for each subsequent accounting.

Can I designate a personal representative to review my PHI and the use and disclosure of my PHI?
You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules

and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

What are the Plan's responsibility with respect to PHI?
The Plan is required by law to maintain the privacy of PHI and to provide you and your beneficiaries with notice of its legal duties and privacy practices. The Plan reserves the right to change its privacy policy and practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy policy or practice is changed, notice will be mailed to all past and present participants and beneficiaries for whom the Plan still maintains PHI. You will be notified of material changes the Plan's privacy policy or practices within 60 days of the effective date of the change regarding uses or disclosures, your rights, the duties of the Plan or other privacy practices.

To what extent will my PHI be used or disclosed?
When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual; disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

Does the Plan have information that is not subject to used and disclosure restrictions?
Yes. The Plan may use and disclose without restriction information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan, the health insurer or the HMO offered by the Plan may use or disclosure 'summary health information" for obtaining premium bids or modifying, amending or terminating the Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted. The Plan may also disclose PHI to the Trustees for the purpose of performing administrative functions associated with the Plan. The Trustees have adopted and certify that the restrictions on the Trustees' use and disclosure of PHI, including the restrictions on the use or. disclosure of PHI for employment decisions or in connection with any other benefit plan, have been made a part of the Plan's group health plan.

Can I file a complaint if my privacy rights were violated?
If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

The Plan will not retaliate against you for filing a complaint.

Where can I find out more about my PHI privacy rights?
PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health

Insurance Portability and Accountability Act). You may find the HIPAA rules in 45 U.S. Code of Federal Regulations Parts 160 and 164. We have provided a summary of these rules, however, the HIPAA rules will supersede any discrepancy between the information in this notice and the regulations.

Subject to certain requirements, the HIPAA rules require the Plan give out medical information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. The Plan provides information when otherwise required by law, such as for law enforcement in specific circumstances.