METRO-I.L.A. FRINGE BENEFIT FUND PLAN

SUMMARY PLAN DESCRIPTION (SPD)

EFFECTIVE JANUARY 1, 2008

AVISO: SI NECESITA INFORMACION EN ESPANOL, PUEDE VISITAR O COMUNICARSE CON LAS OFICINAS DEL PLAN

This SPD Replaces and Supersedes All Prior Fringe Benefit Fund and Welfare Plan SPDs

IMPORTANT ASPECTS OF YOUR PLAN

- FAMILIARIZE YOURSELF WITH THE **WHOLE** BOOKLET.
- **ALL** BENEFITS MUST BE **APPLIED FOR** WITHIN 30 DAYS OF THE EVENT CAUSING THE CLAIM.
- MAKE SURE THAT THE PLAN OFFICE IS AWARE OF YOUR **CURRENT** ADDRESS.
- ALL CLAIM FORMS MUST BE **COMPLETELY** FILLED IN; INCOMPLETE ONES WILL BE **RETURNED.**

PARTICIPANT'S OBLIGATION

Each Plan Participant and beneficiary is responsible and obligated to notify the Plan Office in writing, either through the Plan Administrator or the Trustees, of any change in status. This includes, but is not limited to, changes of the following nature:

- Any change in marital status, including legal separation;
- Any change in the number of the participant's dependents eligible for benefits (whether by virtue of birth, adoption, or other addition to the family, maintaining dependent status as a full time student, or by the child's aging to no longer being eligible for benefits as a beneficiary;
- Any change in determination (by any agency) of one's being disabled or any new determination maintaining one's status; any change in employment status, including retirement.

The notification to the Plan Office shall also be accompanied by all relevant documents.

In the event the Plan Administrator or a health care provider should require that the member use a specific form for submission of any information or request, the form shall be provided to the participant upon request and without charge.

Unless statutory regulations or Fund rules require earlier notification, the notice shall be provided no later than sixty (60) days after the relevant change in status (or qualifying event, as defined in this document) occurs, or twenty-one (21) days after the participant is informed by the Plan Office of any special forms needed to provide the proper notification, if later.

The Plan reserves the right to request additional information to supplement the initial notification in order for a participant or a beneficiary to maintain his status. Notice may be provided by the covered employee, a qualified beneficiary, or any representative.

Notwithstanding any lapse in notification by a participant or beneficiary, it is within the discretion of the Trustees to maintain the benefits of any person entitled to receive same.

IMPORTANT NOTICES

ATTENTION

This booklet provides a brief description, written in non-technical language, of the important provisions of the Metro-ILA Fringe Benefit Plan. Nothing in this booklet is meant to interpret or extend or change in any way the provisions of the Plan. The Trustees reserve the right to amend, modify, discontinue, or terminate all or part of this Plan as they determine, in their sole and absolute discretion.

CAUTION

This booklet and the Plan Administrator are authorized sources of Plan information. The Trustees of the Plan HAVE NOT EMPOWERED ANYONE ELSE to speak for them with regard to the Plan. No employer, union representative, supervisor, or shop steward is in a position to discuss your rights under the Plan with authority.

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 Administrator or the Trustees. You will then receive a written reply which will provide you with a permanent record.

GENERAL

Your Plan results from collective bargaining between the Metropolitan Marine Maintenance Contractors' Association and Locals 1804-1 and 1814 of the International Longshoremen's Association. By agreement, your employer contributes to the Plan when you work in employment covered by collective bargaining. Certain other employees are also covered in the health program in accordance with agreements between their employers and the Trustees of the Plan.

METRO-ILA FRINGE BENEFIT FUND PLAN

301 ROUTE 17N
7TH FLOOR
RUTHERFORD, NJ 07070-2575
TELEPHONE: (201) 842-0202

TO: PARTICIPANTS IN THE METRO-ILA FRINGE BENEFIT FUND PLAN

FROM: TRUSTEES OF THE METRO-ILA FRINGE BENEFIT FUND PLAN

DATE: JANUARY 1, 2008

This booklet is a description of the Plan as in effect on January 1, 2008. You will find that the Plan benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them. These and other matters are discussed in the three major parts of the booklet, as follows:

1. **Fringe Benefit Program;**

2. **Health Program; and**

3. **Technical Details.**
   This section of the booklet is provided to you under the terms of the Employee Retirement Income Security Act of 1974 (ERISA) and contains information intended to insure that you will be able to enjoy all the rights to which you are entitled under the provisions of the Plan.

The benefits provided by this Plan are in addition to any other benefits you may receive from any of the other Metro-ILA plans. You should read this booklet thoroughly to make sure that you are completely familiar with the Plan.

To give you an idea of the Trustees' role with regard to the Plan, you should know that we are responsible for collecting and administering the contributions to the Plan which are required by agreement between your employer represented by the Metropolitan Marine Maintenance Contractors'

Association, Inc. (MMMCA) and your union representative, the International Longshoremen's Association (ILA) Local 1814 or ILA Local 1804-1, or by agreement between your employer and the Trustees. In addition, we are required to formulate and administer the provisions of the Plan itself.

The Trustees are assisted in these tasks by professional advisors whom we hire from time to time. These may include an actuary, an attorney, an auditor, and one or more investment managers.

The daily operation of the Plan is handled by the Plan Administrator/Secretary and his staff, who are located at the Plan Office, as well as, the Member Outreach Centers in North Bergen, New Jersey and Brooklyn, New York. You are encouraged to make use of the facilities of the Plan Office, where you will find assistance in understanding your benefits.

It is our intention to continue the successful operation of the Plan in the sound actuarial fashion that has prevailed to date. Your assistance in this endeavor will be increased by your complete understanding of the Plan itself. Accordingly, it is in your interest and that of your family to familiarize yourself completely with this booklet (including the material in the medical section below) and abide by the Plan requirements. Please understand that the usage of a masculine form [e.g., "his"] is deemed to include the feminine [e.g., "her"].

If, after having gone through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Plan Office or Member Outreach Centers listed herein. If your questions are not answered to your satisfaction by the staff, you may direct them to the Trustees in writing.

Sincerely,

Plan Trustees

METRO-ILA FRINGE BENEFIT PLAN

BOARD OF TRUSTEES

EMPLOYER TRUSTEES
J. Randolph Brown
Joseph A. Ragusa

UNION TRUSTEES
Louis Pernice
J. Kenneth O'Connor

PLAN ADMINISTRATION

FUND DIRECTOR
Jerome Brancato

PLAN ADMINISTRATOR/ FUND SECRETARY
Joseph A. Ragusa

PLAN OFFICE
METRO-ILA Fringe Benefit Fund Plan
301 Route 17N, 7th Floor
Rutherford, NJ 07070-2575
Telephone: (201) 842-0202
Fax: (201) 842-0334

MEMBER OUTREACH CENTERS

New Jersey
5000 West Side Avenue
North Bergen, New Jersey 07047-6478
Telephone: (201) 854-6780
Fax: (201) 854-6444

New York
70-20th Street
Brooklyn, New York 11232
Telephone: (718) 499-9600
Fax: (718) 499-9626

PLAN ATTORNEYS
Giblin & Lynch
O'Connor & Mangan, P.C.

HIPAA Privacy Officer
Jerome Brancato

PLAN AUDITOR
Buchbinder, Tunick, & Co., LLP

PLAN ACTUARY
O'Sullivan Associates

This page purposely left blank

TABLE OF CONTENTS

NOTE: Pages 13-17 apply to all fringe benefits <u>except</u> for health benefits, which are covered on pages 18 to 70. Pages 71 to the end of the document apply to <u>all</u> benefits provided by the Metro-ILA Fringe Benefit Plan, including health benefits.

TABLE OF CONTENTS (Continued))

TABLE OF CONTENTS (Continued))

This page purposely left blank

SECTION 1: FRINGE BENEFIT PROGRAM

A. GENERAL RULES

IN GENERAL

Your employer is required to make contributions to this Plan on behalf of your covered work in accordance with the terms of a collective bargaining agreement that calls for such contributions.

Contained in that agreement are two very important provisions that affect your benefits under this Plan. These are:

1. When you become eligible for benefits; and

2. Which benefits apply to you.

PARTICIPATION AND MINIMUM ELIGIBILITY REQUIREMENT

Even though each collective bargaining agreement associated with the Plan may have different provisions, there is a certain minimum that applies to all Plan participants. This is:

- In order to be entitled to any one of the several benefits under the Plan (Paid Holiday, Vacation, Bereavement, and/or Jury Duty), you must be credited with at least 700 hours of covered work during the prior calendar year.

The first time you are credited with at least the minimum required hours of covered work within one calendar year for your labor division, you will become a Plan participant on the first day of the next calendar year. In order to maintain participation, you must be annually credited with at least the minimum number of hours of covered work applicable to your division, as established in collective bargaining or by the Fund Trustees.

TERMINATION OF PARTICIPATION AND ELIGIBILITY

Your eligibility to receive benefits and your participation in the Plan will cease on the earliest of the following dates:

TERMINATION OF PARTICIPATION AND ELIGIBILITY (Continued)

1. The last day of the calendar year in which you fail to be credited with at least the minimum number of required hours of covered work applicable to your division.

2. The date that you fail to satisfy any eligibility requirement as defined by the collective bargaining agreement that applies to you, including but not limited to your failure to continue to satisfy the definition of an eligible employee due to reduction in hours worked, termination of employment, or otherwise.

3. The date that your employer is disqualified from Plan participation, whether because of the employer's failure to make the required employer contribution or for any other reason.

4. The date that you enter the Armed Forces on active duty (except for temporary active duty of less than 31 days). Distribution of benefits for individuals in this classification may be extended at the sole discretion of the Trustees or as required by federal law.

5. The date that the Plan no longer provides benefits.

6. The date that the Trustees determine that you fraudulently or improperly sought to collect benefits under the Plan.

7. Your death.

Exception

If while covered, you become disabled, and if you had received or continue to receive Workers' Compensation payments or benefits or New Jersey Temporary Disability Benefits or New York Disability Benefits for the disability, and further provided that the combination of Credit Hours worked and Credit Hours received per week for the disability equal or exceed the minimum hours required under Class 1, 2 or 3, whichever is applicable (see page 24), then, for the purpose of continuing the coverage, you will be considered to have met the applicable Credit Hours requirement for your class for that calendar year. The maximum period for which an individual can receive Credit hours due to temporary disability benefits or worker's compensation payments is a lifetime total of three (3) years.

Exception (Continued)

Credit for hours not worked during such period of disability will be limited to a maximum of 20 hours per week.

The credits referred to in this paragraph apply only to employees in Class 1, Class 2, or Class 3 (see page 24).

NOTE: *The granting of Credit Hours due to disability does not guarantee you a benefit for the year(s) in question. It merely gives you the opportunity to reach the minimum number of hours required to entitle you to a benefit.*

SECTION 1: FRINGE BENEFIT PROGRAM

B. DESCRIPTION OF BENEFITS

There are four benefits available to an eligible participant in a calendar year. These are:

1. Paid Holiday
2. Vacation
3. Bereavement
4. Jury Duty

PAID HOLIDAY

Under this benefit, you are entitled to payment (at the straight-time rate for eight hours per day) for the number of holidays called for in the collective bargaining agreement under which you work. The following is a sample schedule.

Hours of Covered Work In Prior Calendar Year	Number of Paid Holiday Days Available to You In a Calendar Year
Less than 700	0
700 to 999	12
1000 to 1499	14
1500 or more	16

(Your own situation may be different. Please consult the collective bargaining agreement under which you work for the precise benefit to which you are entitled.)

Pay for all the holidays to which you are entitled will be made in one annual payment during the first week of December.

VACATION

Under this benefit, you may receive a payment of 8% of your gross annual pay from covered work (not counting bonuses) that you earned during the immediately prior calendar year. You are entitled to this benefit once a year, and will receive that payment during the first week of June.

BEREAVEMENT

In the event you are absent from covered work because of the death of a member of your immediate family, you are entitled to apply for a payment equal to your straight-time rate of pay for an eight-hour day for any day (or part of a day) you are absent.

There is a maximum of three days' payment for any one death under this benefit.

Your "immediate family" includes your mother, father, spouse, and children.

JURY DUTY

In the event you serve as a juror in a federal, state or municipal court and miss covered work on any regular work day, you may apply for a Jury Duty payment. The amount of the payment is the difference between what you would have received as straight-time pay for an eight-hour day and what you receive for such jury duty multiplied by the number of work days, or part thereof, that you are on jury duty.

NET PAYMENTS

All of the benefits paid to you under this Plan are net of taxes and any other authorized deductions.

SECTION 2: HEALTH PROGRAM

A. INTRODUCTION

GENERAL

The Trustees use more than one method of providing benefits under the Plan. In some instances, an insurance company may be used. In other cases, benefits may be provided directly from Plan assets. The following pages of this booklet contain information regarding what benefits you carry and how to apply for those benefits. You may always contact the Plan Office or Member Outreach Centers for additional clarification and assistance.

Nothing in this booklet is meant to interpret, extend, or change in any way the provisions expressed in the Plan's insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify, discontinue, or terminate all or part of this Plan, in their sole and absolute discretion..

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

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.

Important Notice of Your Right to Documentation of Health Coverage (Continued)

You have the right to receive a certificate of prior health coverage. You may need to provide other documentation for earlier periods of health care coverage. Check with your 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 the Fund Office. 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 coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, your dependent(s) may be able to be enrolled, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, and furnish the Plan Office with the appropriate supporting documents (i.e., marriage certificate, birth certificate(s), etc.).

Medical Child Support Orders

The Plan will provide benefits to a dependent child pursuant to the requirements of any court order (including a National Medical Child Support Notice) that the Plan Administrator determines meets the requirements of a qualified medical child support order as defined in Section 609 of ERISA [29 U.S.C. §1169].

Hospital Stays in Connection with Childbirth

In accordance with Federal law, this Plan does not restrict benefits (in connection with childbirth) for any hospital length of stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section.

Reconstructive Breast Surgery

In accordance with the requirements of a Federal law entitled “The Women's Health and Cancer Rights Act of 1998,” this Plan provides coverage for reconstructive surgery after a mastectomy as follows:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications associated with all stages of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

Mental Health Parity

Group health plans and health issuers generally may not (under Federal Law known as the Mental Health Parity Act), impose an aggregate lifetime limit on mental heath benefits if it does not impose such a dollar limit on substantially all of the medical and surgical benefits. If the plan does impose an aggregate lifetime or annual limit on medical and surgical benefits, then the limit imposed on mental health benefits must not be less than that applied to medical and surgical benefits.

Certificates of Creditable Coverage

When your (and/or your covered Dependents’) coverage under the Plan ends, your health insurance carrier will issue a Certificate of Creditable Coverage to each individual or family member whose coverage under the Plan ends. The Certificate provides the documentation of prior coverage and/or waiting periods that you (and/or your family) may need to reduce pre-existing condition limitations when enrolling in a new employer-sponsored health plan.

Your health insurance carrier must provide you with a Certificate:

1. When you lose coverage under the Plan or when COBRA continuation coverage terminates; or
2. If requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

1. If you and/or your family had up to 18 months of creditable coverage under the Plan;
2. The coverage start date (along with any eligibility waiting period); and
3. The coverage end date under the Plan.

Certificates of Creditable Coverage (Continued)

If, within 62 days after your coverage under the Plan ends, you and/or your eligible Dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a pre-existing limitation or limitation period that may apply under that plan.

For a copy of your (and/or your eligible Dependent's) Certificate of Creditable Coverage, you may contact your health insurance carrier or the Fund Office.

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 coverage.

It is anticipated that the Plan will remain in effect indefinitely. The right to amend, modify, or terminate the Plan, however, 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 purposes of the Plan. Upon termination, the Trustees would establish a liquidation plan to be applied to the balance of assets in the trust fund so that the 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 Participants and Their Dependents (Including Pensioners and Their Dependents)

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

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

No employee or pensioner has a vested interest in the benefits provided for participants and their dependents. In addition to the right to terminate welfare benefits of participants and/or their dependents at any time, the Trustees also reserve the right in their sole and absolute discretion, to terminate the program of benefits for participants at any time, and there shall not be any vested right by any participant or dependent or beneficiary nor any contractual rights thereafter. In addition, participants and their dependents will have no priority with regard to the termination of this Plan.

SECTION 2: HEALTH PROGRAM

B. ELIGIBILITY RULES

WHO MAY BECOME ELIGIBLE

You may be eligible to become covered if you are (1) an employee of a participating employer and your employment is the subject of a collective bargaining agreement between the Metropolitan Marine Maintenance Contractors' Association, Inc. [MMMCA] and the International Longshoremen's Association Locals 1814 and 1804-1; (2) an eligible retiree drawing pension benefits from the METRO-I.L.A. Pension Plan; or (3) certain employees of related employers that sign special participation agreements with the Trustees of this Plan.

Some of your dependents may also be eligible to become covered:

1. Your lawful spouse, unless legally separated;
2. Your unmarried child (including stepchild, adopted child, child placed for adoption if you are legally required to provide support until the adoption is finalized, and foster child) who:
    a. Depends on you for support and maintenance;
    b. Lives with you in a regular parent-child relationship; and
    c. Is under 19, or who is 19 but less than age 23 and is a full-time student at an accredited school, college, or university.

With respect to Health Benefits, a dependent child whose coverage under this Plan would otherwise terminate solely due to attainment of the limiting age shall continue to be considered a dependent if:

1. He is incapable of self-sustaining employment solely because of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap;
2. He became so incapable prior to attainment of the limiting age;
3. Written evidence of such incapacity is sent to the Plan Office no later than 31 days after attainment of the limiting age; and
4. Proof that he continues to be so incapacitated is sent to the Plan Office from time to time, at its request.

Individuals eligible for coverage as employees cannot be covered as dependents, and if you and your spouse are both eligible for employee coverage under the Plan, only one of you may cover your eligible dependent children. It is your responsibility to report (to the Plan Office) any change in

WHO MAY BECOME ELIGIBLE (Continued)

your status or the status of any dependent, including any change in your marital status or in the number of your eligible dependents.

WHEN DO YOU BECOME ELIGIBLE

You will become eligible for coverage under this Plan on the January 1 following a calendar year during which you worked and on whose behalf the METRO-I.L.A. Fringe Benefit Plan has received contributions for at least the minimum number of Credit Hours shown below, provided written application is made to the Fringe Benefit Plan in a timely manner following notification from the Plan Office. Applications received after the date specified by the Plan office will delay the effective date of eligibility until the first day of the subsequent month.

For Health Care Benefit Eligibility Other Than Disability (Based on Prior Year's Credit Hours):

Class 1: If you are a bargaining unit employee for an employer in any Division of MMMCA other than Ship Maintenance, you must accrue at least 1,000 Credit Hours during the previous calendar year for Tier One Benefits.

Class 2: If you are a bargaining unit employee for an employer in the Ship Maintenance Division, you must accrue at least 700 Credit Hours during 2007 for Tier One Benefits in 2008, and 800 Credit hours in 2008 (and years thereafter) for Tier One Benefits the following year.

Class 3: If you are a bargaining unit employee for an employer in the Container Maintenance/Repair Division or Weighmaster Division, who has worked at least 800 hours in the prior calendar year (but fewer than 1,000), you are eligible for Tier Two Benefits (effective January 1, 2008, and years thereafter). To qualify for Tier One benefits, you (individually) may make contributions at 120% of the rate set forth in the collective bargaining agreement or otherwise established by the Plan for hourly contributions, to bring your hours up to 1,000.

[Note that for coverage in calendar year 2008, 700 was the minimum number of hours worked in 2007 to qualify for Tier II benefits or to "pay up" for Tier I.]

Class 4: If you are a non-bargaining unit employee covered by a special participation agreement between your employer and the Trustees of this Plan, you must accrue at least 1,560 Credit Hours during the prior calendar year for Tier One benefits. There is no alternative benefit plan.

For Health Care Benefit Eligibility Other Than Disability (Based on Prior Year's Credit Hours) [Continued]:

Class 5: If you are a pensioner under the METRO-I.L.A. Pension Plan, you may be eligible for welfare benefits under this Plan. There is no Credit Hours requirement; however, you must apply for all benefits.

Eligibility for Disability Benefits

See pages 41-48.

EFFECTIVE DATE OF YOUR COVERAGE

You will become covered on the date you become eligible.

CONTINUATION OF YOUR COVERAGE

Once covered, your coverage will continue, provided you have at least the minimum number of Credit Hours required for your Class each calendar year.

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:

1. To care for your newly born or adopted child;
2. To care for your spouse, child, or parent who has a serious health care problem; or
3. If you have a serious health problem which prevents you from performing your job.

In order for you to be eligible for such leave; your Employer must have been obligated to make contributions to the Fringe Benefit Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that Employer for at least twelve (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 fifty (50) employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year. Additionally, you must:

1. Work at a location where the Employer has at least 50 employees; or
2. Work within 75 miles of one or more work sites where the Employer has 50 or more employees.

FAMILY AND MEDICAL LEAVE ACT (Continued)

Your Employer must notify the Plan 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 Fund, 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:

1. Your Employer fails for any reason to make the required contributions to the Fringe Benefit Fund on your behalf while you are on leave;
2. You exhaust the twelve (12) weeks of leave which you are entitled to under the act; or
3. You or your Employer notifies the Fund 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 provisions set forth on pages 31-34.

Termination of Your Coverage was discussed above at pages 13-14.

REINSTATEMENT OF COVERAGE

If your eligibility for coverage terminates for any reason, you may again become eligible for coverage by satisfying the requirement for eligibility as a new employee as shown in the paragraph titled WHEN DO YOU BECOME ELIGIBLE.

EFFECTIVE DATE OF DEPENDENTS' COVERAGE

Normally, coverage for your eligible dependents starts on the date your coverage starts.

If, however, you gain a dependent after that date, your dependent will become insured on the date the individual meets the definition of dependent, following written notification to the Plan Office.

A newborn child will be covered from birth. If a newborn child incurs charges for an injury or illness, such child will be covered whether or not dependent coverage is in force. Coverage shall include the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

In addition, a newly born infant who is to be adopted by you shall be covered from the moment of birth, as described above, provided that you take physical custody of the infant upon such infant's release from the hospital and you file a petition to adopt within 30 days after birth. This coverage is not available under this Plan where the natural parent has coverage available for the infant's care.

Children are eligible for the Life Insurance Benefit when they are 14 days old.

COURT ORDERED COVERAGE

Qualified Medical Child Support Order

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 Plan receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

1. Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;
2. Requires you to provide only the group health coverage available under the Plan for your children, even though you no longer have custody; and

Qualified Medical Child Support Order (Continued)

3. Clearly specifies:
    a) Your name and last known mailing address and the names and addresses of each child covered by the order;
    b) A reasonable description of the coverage to be provided;
    c) The length of time the order applies; and
    d) Each plan affected by the order.

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

If the QMCSO meets the above requirements, the Plan 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 Plan 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 an appropriate state agency can make application for coverage, even if you do not.

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

Non-Enrollment of a Dependent

If you are required by a Court or Administrative Order to provide health coverage for a dependent child, and you do not enroll the child:

1. The custodial parent;
2. The state Medicaid Agency; or
3. The state Child Support Enforcement Agency; may make application for dependent insurance on behalf of the child without regard to any enrollment period restrictions. A pre-existing condition limitation contained in this Plan, if any, will not apply.

Fund Administration

The custodial parent or state agency will also be entitled to:

1. Obtain from the Plan the information necessary to obtain covered benefits for the dependent child;
2. Submit claims for covered services without your approval or that of the non-custodial parent; and

Fund Administration (Continued)

3. Request that the Plan pay all or a part of the benefits to the custodial parent, the provider, or state agency, but not later than at the time proof of claim is given to the Plan.

DEPENDENT COVERED BY A COURT OR ADMINISTRATIVE ORDER

Termination

In addition to the termination dates shown below, for a dependent covered by a Court or Administrative Order, coverage under this Plan will terminate when written notice is received that the Order is no longer in effect.

Exception

Upon termination, a dependent may be entitled to pay the premium and continue his coverage under this Plan. Please refer to <u>CONVERSION</u> on page 34.

TERMINATION OF YOUR DEPENDENTS' COVERAGE

Your dependents' coverage will terminate on the earliest of the following:

1. The date your coverage terminates;
2. The date a change in the Plan terminates dependents' coverage;
3. The date a dependent is no longer an eligible dependent, as defined; or
4. The date the Plan is amended to terminate insurance for the class to which the dependent belongs.

Exception

If your dependents' coverage would otherwise terminate due to your death, your eligible dependents will continue to be covered until the earliest of the following:

1. **The last date of the balance of your eligibility as existing at the time of your death;**
2. **The date a dependent would have ceased to be your dependent, if you were living;**
3. **The date a dependent becomes covered under the Plan as a covered person; or**

Exception (Continued)

4. **The date of discontinuance of all dependent coverage under the Plan.**

PENSIONERS

If you start receiving a monthly pension benefit under the METRO-I.L.A. PENSION PLAN, you may be eligible for certain coverage under this Plan for yourself and your dependent spouse (no other dependents may be eligible).

Life Insurance

If you were covered under this Plan at the time your pension is effective, your life insurance coverage will be $10,000 and will continue until the end of the calendar year in which your pension is effective. If you were not covered under this Plan at retirement, there is no life insurance coverage under this Plan for you as a pensioner.

Health Insurance

If you were covered under this Plan at the time your pension became effective and were also covered under the health care portion of the Plan for (a) at least three of the last five years immediately preceding the year in which you retire; or (b) at least 20 years total, you will be eligible for health care coverage for yourself and your spouse as follows:

If you or your spouse is age 65 or older and eligible for Medicare, enrollment in a Medicare Supplement Plan is available. If, when you retire, you or your spouse is under age 65, you or your spouse may be eligible for a partial medical expense reimbursement until you or your spouse become 65 years of age (and therefore Medicare eligible) or for a maximum of three years from the date of retirement, whichever is less.

Effective 1/1/2005, Normal Retirees age 62 to 64 with 25 (or more) years, who do not qualify for enrollment in Medicare, may be eligible for a modified health, medical, and pharmacy plan (“Tier 3” coverage). Eligibility for this plan is offered to the retiree and his eligible spouse and is based upon the retiree’s age. Eligibility for both will end upon the retiree reaching age 65. If the spouse is not yet 65, he/she will be offered the benefits in the paragraph listed above.

Further, if you are a covered pensioner and do not wish to enroll in any of the fund's health programs you may apply for an "Opt Out" Benefit, which is

currently $50 per person per month payable quarterly following the end of the quarter.

NOTE: Once you become a pensioner, any coverage you may have under this Plan as an active member will cease and be replaced by the coverage set forth herein for pensioners if you meet the foregoing criteria. If a member is entitled to health care coverage when he becomes a pensioner and has no dependent spouse, no other person will be added after the effective date of the pension to the pensioner's health benefit eligibility.

CONTINUATION OF COVERAGE (SELF-PAY) AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

You and your eligible dependent(s) have the right to continue your medical coverage (and dental, vision or prescription drug coverage, if applicable) under this Plan on a self-pay basis, as described under the subsection below titled, CONTINUATION PERIOD, if insurance would otherwise terminate due to a Qualifying Event. You and your eligible dependents do not have a right to continued coverage if you or they are covered by another group health plan.

Qualifying Event:

A qualifying event is any of the following occurrences which would terminate your or your dependent's coverage in the absence of this provision:

1. Termination of your employment, other than for gross misconduct;
2. Your work hours are reduced below the minimum number needed for coverage;
3. Your retirement;
4. Your death;
5. Your entitlement to Medicare;
6. With respect to your spouse, your divorce or legal separation; or
7. With respect to your dependent child, his ceasing to satisfy the Plan's definition of an eligible dependent. See page 29.

ELECTION PERIOD

You or your eligible dependent(s) may elect to continue coverage within 60 days of the later of:

ELECTION PERIOD (Continued)

1. The date you or your dependent would otherwise lose coverage due to the Qualifying Event; or
2. The date you or your dependent are notified of your right to elect the continuation coverage.

It is your or your dependent's responsibility to notify the Plan Office of any of the following Qualifying Events: your divorce or legal separation; or your dependent child ceases to be an eligible dependent. You or your dependent must provide such notification within 60 days after the later of:

1. The date of the Qualifying Event; or
2. The date your dependent would otherwise lose coverage due to the Qualifying Event.

Your request for continuation of coverage must be in writing, on a form provided by the Plan Office. Coverage will be continued provided:

1. The election form is duly completed and returned to the Plan Office within the 60-day period noted above; and
2. The required premium is paid to the Plan Office within 45 days of your or your dependent's written request for continuation of coverage.

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 Plan Office of the birth or adoption.

CONTINUATION PERIOD

Coverage may continue, on a self-pay basis, as follows:

1. Coverage for you or your dependent(s) may be continued for up to 18 months*, if coverage terminated due to your:
    a. Termination of employment, other than for gross misconduct;
    b. Reduced work hours below the minimum number needed for coverage, except in the case of a bankruptcy proceeding under Title 11 of the United States Bankruptcy Code with respect to the Employer; or
    c. Retirement.

CONTINUATION PERIOD (Continued)

*The 18-month period of continuation may be extended to 29 months if at the time of the Qualifying Event or during the first 60 days of COBRA coverage, you or your dependent are determined to be disabled by the Social Security Administration.

2. Coverage for your dependent(s) may be continued for up to 36 months, if coverage terminated due to:
    a. Your death;
    b. Your entitlement to Medicare;
    c. Your divorce or legal separation; or
    d. With respect to your dependent child, his ceasing to satisfy the Plan's definition of an eligible dependent.

If your dependent's coverage is continued for reasons listed under item 1 of this subsection, and, during the initial Continuation Period, a Qualifying Event occurs which entitles the dependent to continue coverage under item 2 of this section, your dependent may elect to continue coverage up to a combined maximum of 36 months.

You or your dependent who elects to continue coverage, shall be solely responsible for the payment of the premium for such continued coverage. If coverage is elected after the Qualifying Event, premium payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid in monthly installments.

TERMINATION OF COVERAGE

The continued coverage will cease on the first of the following dates:

1. The date the Plan terminates;
2. The date a required premium is due and unpaid, plus any applicable grace period;
3. The date you or your dependent become covered under another group health plan;
4. The date you or your dependent becomes eligible for Medicare. This does not apply in situations where the Qualifying Event is the Employer's bankruptcy proceeding under Title 11 of the United States Bankruptcy Code; or the date the applicable period of continuation is exhausted.

CORE VERSUS NON-CORE BENEFITS

You will be able to continue core medical (that is, hospital, medical, and pharmacy) benefits, or core and non-core benefits. (Non-core benefits consist of dental and vision care benefits.) You may not continue non-core benefits only. Life insurance and disability benefits are not eligible for COBRA continuation.

CONVERSION

If you or your dependent chooses not to elect continuation under this provision, you will retain the right to elect whatever individual conversion coverage is offered by any insurance companies providing you coverage under the Plan. In this case, you or your dependent have only 31 days from the date coverage would have otherwise terminated to request conversion.

Conversion to individual coverage is also available to you or your dependent at the end of the continuation period under COBRA, provided all required premiums have been paid. You or your dependent will be notified of this conversion privilege within 180 days before your coverage under this provision terminates.

Contact the Plan Office as soon as possible when a qualifying event has occurred for information about your (and your dependent's) right to continuation of coverage.

SECTION 2: HEALTH PROGRAM

C. BENEFITS

SCHEDULE OF BENEFITS

Benefit	Tier 1	Tier2	Pensioner**
Life Insurance	Yes	No	Yes***
Dependent Life	Yes	No	No
Hospital*	Yes	Yes	Yes**
Comprehensive Medical*	Yes	Yes	Yes**
Prescription Drugs	Yes	No	Not All**
Dental	Yes	No	No
Vision	Yes	No	Yes**

*Actives: Please refer to Tab #2 "Medical/Pharmacy" of this binder for a full description of the Plan's Hospital and Comprehensive Medical Benefits.

**A detailed description of pensioner health care benefits is available from the individual insurance carriers. Please refer to the Plan description(s) that apply to you.

Benefit	Amount
Life Insurance Benefit (Active)	**$20,000**
***Life Insurance Benefit for pensioners is reduced to $10,000.00 and terminates at the end of the calendar year in which retirement occurs.	
Dependent Life Insurance Benefit	
Spouse	**$ 2,500**
Each child, from 14 days to age 19, or to age 23 if full-time student	**$ 2,000**
Accidental Death and Dismemberment Benefit (For Participants Only)	
Principal Sum	**$20,000**

PRESCRIPTION DRUG BENEFIT

Members eligible for prescription drug benefits will find details of the program on their Cigna identification card. [A separate drug card will not be issued.] **An annual Pharmacy Deductible applies to all brand-name drugs (not generics) in the amount of $150 for a single participant and $300 for a married participant. One annual deductible will apply for brand-name drugs, whether purchased retail or by mail order.**

At a Participating Retail Pharmacy:

Co-Payment Amount (Per Prescription or Refill—30 Day supply)	
Generic	**$ 0.00**
Brand Name	**$15.00**
Non-preferred brand	**$30.00**
Maximum Annual Benefit (Combined)	**$5,000**

Mail Order for Maintenance Medications

Maintenance medication prescriptions may be filled up to three times at a Retail Pharmacy (30 day supply each). All refills for maintenance medications must be purchased by mail thereafter (up to a 60 day supply each).

Co-Payment Amount (Per Prescription or Refill—60 Day supply)	
Generic	**$ 0.00**
Brand Name	**$30.00**
Non-preferred brand	**$60.00**
Maximum Annual Benefit (Combined)	**$5,000**

NOTE: Prescription drug charges in excess of the Combined Maximum Annual Amount ($5,000.00 per individual) will be payable under the Comprehensive Health Benefits provision and will be subject to any applicable deductible and coinsurance amounts.

VISION BENEFITS

An Optical Benefits Certificate is available every two years. An eligible participant should call the Plan office and request the certificate and list of participating providers.

PARTICIPANTS' LIFE INSURANCE BENEFIT

If you die from any cause while you are insured, the proceeds, as shown in the Schedule of Benefits, will be paid to your beneficiary. The proceeds will be paid as a lump sum.

Beneficiary

You may name anyone you wish as your life insurance beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the METRO-I.L.A. Fringe Benefit Fund Plan receives the completed form at the Plan Office.

DEPENDENTS' LIFE INSURANCE BENEFIT

Life Insurance is provided for your Eligible Dependents in the amounts shown in the Schedule of Benefits. If one of your Dependents dies, the life insurance proceeds will be payable to you. However, if you predecease your Dependent and your Dependent remains covered under this Plan, your Dependent's life insurance proceeds will be payable, on his or her death, to the executor or administrator of his estate or, at the insurance company's option, to any one or more of his or her surviving relatives: father, mother, child [or children], brothers, or sisters.

Conversion Privilege

If your Dependent's life insurance terminates because of: (1) termination of your membership in an eligible class; (2) your death; (3) your Dependent child marries or reaches the limiting age; or (4) your divorce or annulment, your Dependent may convert that benefit to any form of life insurance usually offered by the insurance company, except for term insurance.

A medical examination will not be required to convert but the application form and the **first** premium payment must be sent to the insurance company no later than 31 days after the life insurance coverage has terminated. If your Dependent dies during this 31-day period, the insurance company will pay the life insurance benefits whether or not your Dependent had applied for conversion.

The face value of the new policy cannot be more than the amount under the group Plan. The rate charged will depend upon your Dependent's age and class of risk at the time of conversion, and the face amount of the new policy.

Conversion Privilege (Continued)

The new policy will become effective on the 32nd day following the date your life insurance coverage terminated.

The Amount of Insurance that Is Continued

The amount of life insurance that will be continued, while you are Totally and Permanently Disabled, will be the amount, which was in force at the time premium payments were discontinued on your behalf as a result of your disability.

The Meaning of Totally and Permanently Disabled

This means that, due solely to illness or injury, you are prevented from engaging in any business, occupation or employment for remuneration or profit in the industry.

Coverage will continue under this extension until the earliest of:

1. 31 days after the date you are no longer Totally and Permanently Disabled;
2. The date you fail to furnish the METRO-I.L.A. Fringe Benefit Fund with proof of your continued disability (which must be no later than three months after the anniversary date when the initial proof of disability was received); or
3. The date you fail to be examined by a physician designated by the Plan Office, if so requested by the Plan Office. Such an examination will not be required more than once a year after your insurance has been continued under this extension for two full years.

Your Total and Permanent Disability

If you submitted written proof to the Metro-ILA Fringe Benefit Fund (or its predecessor, the Metro-ILA Welfare Fund), that you are or were Totally and Permanently Disabled and you had not reached age 60, you may continue to be covered for Life Insurance Benefits under this Plan, provided you remain Totally and Permanently Disabled, and continue to provide proof of disability. Continued proof of disability must be provided within three months of the anniversary date when the initial proof of disability was received.

Conversion Privilege

You may convert to an individual contract of life insurance if your insurance:

1. Terminates because:
    a. You are no longer a member of one of the classes eligible; or
    b. Your employment terminates; or
2. Is reduced on or after your attainment of age 60 in any increment or series of increments aggregating twenty percent or more of the amount of coverage in force before the first reduction on account of such age.

You must make written application for such contract and pay the **first** premium within 31 days after insurance ceases. A medical examination is not required. You may choose to convert to an amount equal to, or less than, the amount which terminated under this Plan. Such insurance will be on one of the forms then being written by the Plan's insurance company, except term or disability insurance.

The premium for such contract will be based on:

1. Your age;
2. The class of risk to which you belong; and
3. The amount of insurance.

The new contract may, if you choose, be preceded by term insurance for not more than one year.

You may also convert to an individual contract of life insurance if your insurance terminates because:

1. This Plan terminates; or
2. The insurance on the class to which you belong terminates.

You will have the right to convert under the same conditions and limitations as set forth above. However, the amount of such individual contract will not be more than the amount of the insurance on your life on the date of termination less any amount of life insurance for which you may become eligible under any group contract within 45 days after the date insurance ends.

The individual life insurance contract will be effective at the end of the 31 day period; the premium must be paid before that period ends.

Conversion Privilege (Continued)

If you should die during the 31-day period allowed for conversion, the insurance company will pay the group life insurance benefits you could have converted to the last Beneficiary you named, whether or not you have applied for conversion or paid the first premium.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (24-HOUR COVERAGE [ELIGIBLE ACTIVE PARTICIPANTS])

This benefit will be payable if, while insured, you sustain any of the losses listed below as a result of an accident. For benefits to be payable, the loss must take place within 90 days from the date of the injury.

Who Will Receive Benefits

For loss of life, benefits will be paid to the beneficiary you name. For any other loss, the benefits will be paid to you.

The Benefits

For Loss of:	The Benefit Is
Life	**$20,000**
Two Feet	**$20,000**
Two Hands	**$20,000**
Sight of Two Eyes	**$20,000**
One Hand and One Foot	**$20,000**
One Hand and Sight of One Eye	**$20,000**
One Foot and Sight of One Eye	**$20,000**
One Hand or One Foot	**$10,000**
Sight of One Eye	**$10,000**

If you suffer more than one loss in any one accident, payment will be made only for that loss for which the largest amount is payable.

Definitions

1. **Loss of hand or foot** means that the limb is severed at or above the wrist or ankle joint, respectively.
2. **Loss of sight** means the total and irrecoverable loss of sight.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the completed form is received by the Plan Office.

Losses that Are Not Covered

No benefit is payable under this section if your death or any loss is caused directly or indirectly, wholly or partly, by:

1. Bodily or mental illness, or disease of any kind, or medical or surgical treatment thereof;
2. Ptomaine or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
3. Intentional self-destruction or self-inflicted injury;
4. Participation in the commission of an assault or a felony;
5. War or an act of war, whether declared or undeclared, or taking part in a riot or insurrection;
6. Service in any military, naval or air force of any country while such country is engaged in war;
7. Police duty as a member of any military, naval or air organization; or
8. Travel or flight as a pilot or crew member in any kind of aircraft.

NEW YORK—WEEKLY ACCIDENT AND SICKNESS BENEFIT UNDER THE NEW YORK DISABILITY BENEFITS LAW

When Your Coverage Begins

.

If you are currently employed by a participating employer, your coverage under this benefit will begin after you have worked at least four weeks for that participating employer (provided the employer's business has been operating for at least 30 days). A new four-week waiting period is not necessary if you have changed employment and your previous employer was subject to the New York Disability Benefits Law.

If this was the case, you would be covered immediately on your new job, as long as:

1. You had worked at least four weeks with your previous employer and you began working for your new employer within four weeks of terminating from your old employer; or
2. If unemployed when your disability commences, and you:
   a. Had worked at least 20 weeks with your previous employer before becoming unemployed;
   b. Received at least $13.00 per week for such work; and

When Your Coverage Begins (Continued)

c. Became disabled within 26 weeks after the date you became unemployed.

Part-time employees become eligible on the 25th working day, even if they only work 1 hour a day for 25 days.

What the Plan Covers

If you are under a doctor's care for an accident or illness not related to your job, and such accident or illness prevents you from working your normal work week schedule, this benefit can help provide you with income.

You will become eligible for benefits on:
1. the first day of absence caused by an accident; or
2. the eighth day of absence due to an illness.

Payments can continue for up to 26 weeks for any one period of disability.

How Benefits Are Paid

The METRO-I.L.A. Fringe Benefit Fund currently provides the following benefit:

- **50% of your average weekly earnings, to a maximum of $170.00 per week and a minimum of $10.00 per week.**

For any one scheduled day of disability absence, payment is made at one-seventh of the weekly amount.

To initiate a Temporary Disability claim, you must call The Hartford, the Benefit Provider, directly at: 1.800.538.8439. You will be instructed on the procedures to follow in order to process your claim effectively. For employees in NEW YORK, the policy is number 620325.

Exclusions

This benefit cannot be paid in any of the following situations:
1. If you are not under the care of a doctor;
2. If your disability is the result of a self-inflicted injury or illness;
3. If your injury or illness is sustained while perpetrating an illegal act;
4. If you performed work for remuneration or profit during your disability;

Exclusions (Continued)

5. If your disability is due to any act of war, declared or undeclared; or
6. If the disability is covered by Workers' Compensation or other similar laws;
7. If you were not employed by a participating employer at the time of your disability.

Reinstatement of Benefits

The maximum time period for which you can receive benefits is 26 weeks within a 52 week rolling period.

If your coverage under this benefit is terminated (either because all the weekly benefits payable to you are exhausted or because of absence from work on account of disability for which no benefits are payable), your coverage shall automatically be reinstated upon return to active work on a full-time basis.

When Coverage Ends

Your coverage under this benefit will terminate immediately if the group policy is cancelled. However, if you became disabled prior to cancellation of the group policy, benefits will be paid for such disability in accordance with the provisions stated above.

NEW JERSEY TEMPORARY DISABILITY BENEFITS

Benefits Shall Be Based Upon the Following:

- **Maximum Weekly Amount (in 2008): $524.00***

***The maximum benefits will automatically be adjusted to comply with any future changes in the New Jersey Temporary Disability Benefits Law.

The weekly benefit is computed at 2/3 of your average weekly wage (rounded off to the next lower multiple of $1.00, if not already a multiple thereof) up to the maximum weekly amount. The benefit amount for each day of disability is payable at one-seventh of the weekly rate, and is computed in the next lower multiple of $1.00, if not already a multiple thereof.

Benefits Shall Be Based Upon the Following (Continued):

To initiate a Temporary Disability claim, you must call The Hartford, the Benefit Provider, directly at: 1-800.538.8439. You will be instructed on the procedures to follow in order to process your claim effectively. For employees in NEW JERSEY, the policy is number 410835.

Waiting Period

An employee becomes eligible on the later of (1) the policy effective date, or (2) the date an employee enters an eligible class. Benefits are payable from the first day of disability due to an accident or from the eighth day due to sickness. Benefits shall be payable for the waiting period if the disability lasts for more than three consecutive weeks.

Period of Benefits

Benefits are paid for the period that you are disabled, but not for more than 26 weeks.

Successive Periods of Disability

Successive periods of disability separated by a period of not more than 14 disability days shall be considered one continuous period of disability, unless they arise from different and unrelated causes. The Employee must have earned wages during the 14-day period immediately after the first disability with the Employee's last Employer immediately preceding the first period of disability to qualify for another disability period.

Class(es) of Employees Eligible

All New Jersey employees of an employer who are in a job classification covered under the terms of a collective bargaining agreement existing between Metropolitan Marine Maintenance Contractor's Association. Inc., on behalf of the employer, and Local 1804-1 of the International Longshoremen's Association (AFL-CIO), or who are covered by a contribution agreement between the employer and the Metro-ILA Fringe Benefit Fund Plan.

Eligibility

An employee shall be entitled to benefits when he or she can satisfy one of the following two criteria:

Eligibility (Continued)

1. The individual has established 20-base weeks. A base week means any calendar week during which the individual earned not less than 20% of the state-wide average weekly wage;
2. The individual meets the requirements of the Alternate Earnings Test, an amount equal to 12 times the state-wide average weekly wage.

Upon receipt of written proof that an Employee has become disabled, the Plan shall pay benefits within the Plan's limitations and provisions.

Termination of Insurance

Your insurance hereunder shall terminate upon the occurrence of the first of the following events:

1. The date you cease to belong to an eligible class (see page 13-14);
2. The end of two weeks from the date your employment ends, but not beyond the date you secure other employment; or
3. The date the Plan terminates; however, if your employment ended before such date, coverage shall continue for a period of two weeks, unless you secure other employment.

Payment of Benefits

Upon receipt of proof that you, while insured under the Plan, sustained a disability and became totally unable to perform the duties of your employment as a result of:

1. a non-occupational accidental injury; or
2. a sickness not compensable under the Workers' Compensation Law,

then, the Fringe Benefit Fund will pay benefits (subject to the Waiting Period) as set forth above.

Exclusions and Limitations

No benefits are payable:

1. For any period of disability during which you are not under the care of a legally licensed physician, dentist, podiatrist, optometrist, chiropractor or practicing psychologist. When requested by the Fringe Benefit Fund, the provider shall, within the scope of his license, certify:
    a. The Employee's disability;

Exclusions and Limitations (Continued)

b. The probable duration of the disability; and
c. The medical facts within his knowledge.

The provider's failure to certify the above will delay, and may deny, your right to receive benefits.

2. In a weekly amount which, together with any remuneration you continue to receive from your Employer, would exceed your wages immediately prior to the disability;
3. For any period of disability due to intentionally self-inflicted injury;
4. For any injury sustained in the perpetration by you of a crime;
5. For more than 26 weeks for any one period of disability;
6. For any period during which you would be disqualified for unemployment compensation benefits under the applicable provisions of law (New Jersey Statute R.S. 43:21-5). If the disability commenced prior to such disqualification, you would be eligible to receive disability benefits. The reason for disqualification or ineligibility to receive disability benefits is limited to the provisions under the Plan and the New Jersey Temporary Disability Benefits Law; or
7. For the first consecutive seven days of each period of disability due to accident or sickness. Benefits shall be payable for the first consecutive seven days of disability due to accident or sickness if with respect to any period of disability, your benefits are payable for three consecutive weeks.

Non-Duplication of Benefits

Benefits will not be payable for any period of disability:

1. Which is payable under any State or Federal Unemployment Compensation, Disability or Cash Sickness Benefit or similar law; and
2. Due to accidental injuries arising out of and in the course of your employment or for any period of disability due to occupational disease which are payable under the New Jersey Workers' Compensation Law, Occupational Disease Law, or similar legislation, except as provided by R.S. 43:21-30 of the New Jersey Temporary Disability Benefits Law, other than benefits for permanent partial or permanent total disability.

If your claim for compensation for temporary disability is contested pursuant to R.S. 34:15-1 et seq. of the New Jersey Workers' Compensation Law, and

Non-Duplication of Benefits (Continued)

is thereby delayed, and you are otherwise eligible for benefits under the Plan, you will be paid the benefits provided by the Plan until such time that you receive compensation under the New Jersey Workers' Compensation Law.

Except for benefits for permanent partial or permanent total disability, in the event you receive workers' compensation benefits during or after receiving disability benefits under the Plan, the Fringe Benefit Fund will be entitled to be subrogated to your rights to the extent of the amount of disability payments made. Any disability benefits payable under the Plan shall be reduced by any amounts paid concurrently under any governmental or private retirement pension or permanent disability benefit or allowance program to which your most recent employer contributed on your behalf.

Notice of Claim

Written notice of disability must be given to the Plan Office within 30 days from the start of the disability. If you give a Notice of Claim to the Division of Unemployment and Disability Insurance, New Jersey Department of Labor and it is determined that such claim should have been made under the Plan, and if such notice was within the required period for giving notice, you will be deemed to have complied with the Notice of Claim provision.

The Plan Office shall provide claim forms for filing proof of disability within 15 days from the date the notice is received. If such forms are not sent within 15 days, you are deemed to have complied if you have sent written proof of: (1) the date the disability started; and (2) the cause of the disability. Failure to furnish notice within the time required shall not invalidate or reduce any claim if it is shown: (a) notice could not be reasonably furnished within the required time; and (b) notice was furnished as soon as was reasonably possible. Otherwise, your claim may be reduced or denied.

Denial of Benefits and Appeals

If your claim is denied in whole or in part, or you do not agree with the Plan Office as to the benefits, you may appeal. The Plan shall give you written notice of the denial or reduction of benefits. The Plan shall also send a written copy to the Division of Unemployment and Disability Insurance (the "Division"). The notice will state the reasons for the denial and your right to a hearing, in accordance with the provision of the Temporary Disability

Denial of Benefits and Appeals (Continued)

Benefits Law. You have a right to appeal within one year after the beginning of the period for which benefits are claimed. Such appeal shall be filed by a written complaint in a form satisfactory to the Division. The Division shall conduct such investigation, including formal hearings, as it deems proper.

Your complaint may be delivered in person or by mail to the Division of Unemployment and Disability Insurance, Bureau of Private Plans, New Jersey Department of Labor, CN 957, Trenton, New Jersey 08625-0957.

Action at Law

No action at law or in equity shall be brought to recover disability benefits under the Plan: (a) prior to the end of 60 days after proof of claim has been submitted as required by the Plan; (b) nor more than three years after the end of the time within which the proof of claim is required. If the time required by the Fund for giving notice of claim, or furnishing proof of disability, or beginning an action at law or in equity, is less than permitted by the state in which you reside at the time your insurance is effective, the time is extended to agree with the state's law. This provision does not affect your right of appeal under the New Jersey Temporary Disability Benefits Law.

PRESCRIPTION DRUG BENEFIT

The Plan's prescription drug benefit will be payable if you or your dependents, while insured, incur expenses for covered drug charges prescribed by a physician for treatment of a non-work related injury or illness. You pay the co-payment amount shown on the Schedule of Benefits.

Definitions

1. **Covered Drug Charges** means the Reasonable and Customary charges for prescription drugs which are:
   a. Obtainable **only** through a physician's written prescription; and
   b. Dispensed by a licensed pharmacist.
2. **Legend Drugs** means drugs which have the following statement printed on the bottle or container: "Caution: Federal Law Prohibits Dispensing Without a Prescription."
3 **Generic Drug** means a drug that is approved by the Food and Drug Administration and is identified by its official or chemical name, not by a brand name given to it by the manufacturer.

Definitions (Continued)

4. **Prescription Drug** means:
   a. Legend Drugs;
   b. State Restricted Drugs - a drug or medicine which can be dispensed in a state or jurisdiction by prescription only;
   c. Compounded Medications - a drug or medicine mixture which has in it at least one Legend Drug or State Restricted Drug; or
   d. Insulin on Prescription only.

Dispensing Limitation

The amount of prescription drugs that may be dispensed shall be limited to the amount normally prescribed by a physician, but not to exceed a 34-day supply or 100 unit doses, whichever is greater.

Expenses that Are Not Covered Under the Prescription Drug Benefit

In addition to the **GENERAL EXCLUSIONS**, no benefits are payable under this section for:

1. All contraceptive medications or devices, regardless of their intended use;
2. Drugs that are not prescription drugs as defined above;
3. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances regardless of their intended use;
4. Drugs whose sole purpose is to promote or stimulate hair growth;
5. Drugs labeled: “Caution—limited by federal law to investigational use”, or experimental drugs, even if a charge is made to the individual;
6. Any charge for the administration of a prescription drug;
7. Drugs for which the charges are recoverable under any Workers’ Compensation Laws;
8. Drugs to be taken or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
9. Prescription refills over the number of times specified by the Physician;
10. Prescription refilled after one year from the order of a physician;

Expenses that Are Not Covered Under the Prescription Drug Benefit (Continued)

11. Immunizations agents, biological sera, blood or blood plasma;
12. Tretinoin, all dosage forms (e.g. Retina-A), for individuals 26 years of age or older;
13. Drugs to counteract infertility or erectile dysfunction;
14. Smoking deterrent drugs containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.);
15. Levonorgestrel (Norplant);
16. Minoxidil (Rogaine) for the treatment of alopecia; or
17. Drugs dispensed by a hospital pharmacy for take-home drugs.

PRESCRIPTION PLAN QUESTIONS AND ANSWERS

What is a Generic Equivalent?

A generic drug is a copy of a brand-name drug whose patent protection has expired. A generic drug is typically sold under its generic name, which is usually a derivative of its chemical name. (For example, Motrin and Advil are brand names for the generic drug Ibuprofen. Generic Ibuprofen is sold under this name as well as names like Ibu and Rufen).

Must I Get A Generic Drug If I Have Been Taking A Brand Name Drug?

No. If your doctor specifically writes "dispense as written" (or checks the box next to "D.A.W." on your prescription form), you will receive the brand name drug (subject to meeting co-payment and deductible requirements). If, however, your physician has written a prescription for a generic drug and you request the pharmacist to fill it using a brand name, you will be required to pay the difference between the cost of the generic drug and the brand name drug. This cost will be *added* to the copayment when you pick up your prescription. Please recall that there are annual deductibles for brand-name drugs ($150/single participant; $300/family participant.)

Why Would I Want To Take A Generic Instead Of A Brand Name Drug?

All generic drugs are approved by the Food and Drug Administration (FDA), using a process similar to the brand name drug. The generic manufacturer has to prove that its product is the bioequivalent of the brand name, meaning

Why Would I Want To Take A Generic Instead Of A Brand Name Drug? (Continued)

that it is released and absorbed in the body like the brand name drug. The generic product is usually identical to the brand name drug except for color and shape. Liquids may have a different flavor.

DENTAL BENEFIT

Dental Benefits are provided by Cigna Health Care and explained in detail in a separate booklet supplied by the Provider.

VISION CARE BENEFIT

Eye care services are available to each covered individual once every two years. Services provided by Vision Screening participating optical centers include a comprehensive 11-point eye examination that includes Glaucoma testing, basic frames, lenses and tinting; or monetary allowances on more expensive designer styles. To utilize Vision Care, you must follow this procedure;

1. Call the Plan Office (201.842.0202) or the Member Outreach Centers (NJ: 201.854.6780, or NY: 718.499.9600) and request an Eye Care certificate.
2. If you are eligible, the certificate will be mailed to you which will be valid for 30 days from date of issue. If you do not use the certificate within the 30-day period, it must be returned to the Plan Office.
3. Sign the certificate when you receive it and again at the Selected Vision Center when you receive eye care services.

The certificate is good at any of the participating optical centers listed on the back of the certificate.

SECTION 2: HEALTH PROGRAM

D. OTHER BENEFIT MATTERS

GENERAL EXCLUSIONS TO HEALTH BENEFITS

In addition to any limits described under the sections, which describe the health benefits, there are specific limitations and exclusions with regard to all medical benefits. Covered charges do not include and no benefits are payable for:

1. Services, supplies or treatment, which are not prescribed as medically necessary by a physician. This exclusion also applies to any hospital confinement (or any part of a confinement) that is not recommended or approved by a physician;
2. Any portion of an expense that exceeds the reasonable and customary charge for the services, supplies or treatment;
3. Cosmetic surgery, unless required because of:
   a. an accidental bodily injury occurring while insured;
   b. reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection, or other disease of the affected body part; or
   c. reconstructive surgery due to congenital disease or anomaly of a Dependent child which has resulted in a functional defect;
4. Expenses incurred as a result of war or an act of war, declared or undeclared;
5. Expenses incurred as a result of participation in a felony, riot, or insurrection;
6. Charges incurred as a result of:
   a. an injury which arises out of or in the course of any employment with any employer; or
   b. an illness for which you or your dependent:
      1) are entitled to benefits under any Workers' Compensation Law or Occupational Disease Law; or
      2) receive any settlement from a Workers' Compensation or Occupational Disease carrier;
7. Charges for treatment, services or supplies provided or paid for by the Federal Government for an injury or illness related to military service and which were incurred by:
   a. you or your dependent at a Veteran's Administration facility; or
   b. you, as an armed service retiree, or your dependent;

GENERAL EXCLUSIONS TO HEALTH BENEFITS (Continued)

8. Any charges which you or your dependents are not legally obligated to pay;
9. Charges for dental care or treatment, or dental x-rays, unless explicitly provided for in a case-by-case determination in exceptional circumstances;
10. Charges incurred for Custodial Care; **Custodial Care** means treatment, services, or confinement, regardless of who recommends, prescribes, or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. Custodial Care includes:
    a. personal care such as help in: walking, getting in and out of bed, bathing, eating (including tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema;
    b. homemaking, such as preparing meals or special diets;
    c. moving the patient;
    d. acting as companion or sitter; and
    e. supervising medication which can usually be self-administered. The determination of Custodial Care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under this Plan;
11. Charges incurred for Experimental Procedures;
    Experimental Procedure means:
    a. any medical procedure, equipment, treatment (or course of treatment), or drug or medicine that is under investigation or is limited to research;
    b. techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
    c. procedures which are not proven in an objective way to have therapeutic value or benefit; and
    d. any procedure or treatment whose effectiveness is medically questionable;
12. Charges incurred for recreational or leisure therapy;
13. Charges incurred in connection with any of the following procedures:
    a. artificial insemination;
    b. in-vitro fertilization; or
    c. in-vivo fertilization;

GENERAL EXCLUSIONS TO HEALTH BENEFITS (Continued)

14. Charges made by an individual who is a member of your or your spouse's immediate family not otherwise an eligible dependent; and
15. Charges for hearing aids, eye refractions, eyeglasses, or their fitting, unless explicitly provided for in a case-by-case determination in exceptional circumstances.
16. Charges incurred to treat baldness.

CAUTION: Other exclusions may apply. Please check your Cigna Health Care plan for further details.

EXTENSION OF DISABILITY HEALTH BENEFITS

If you or your dependent is Totally Disabled due to an illness or an injury on the date coverage under this Plan terminates, benefits may be extended for expenses incurred due to that disability if the following conditions are met:

1. The expense would have been covered if the insurance had continued;
2. You or your dependent remains Totally Disabled to the date such expense is incurred; and
3. You or your dependent is not entitled to similar benefits for such injury or illness under any other group plan when each expense is incurred.

Benefits That Are Extended

Benefits will be extended and payable only for treatment of the illness or injury which caused the Total Disability. The benefit payable will be subject to the limitations and maximums which were in effect under the Plan at the time insurance terminated.

How Long Benefits Will Continue

Benefits will continue until the earliest of:

1. The date you or your dependent is no longer disabled;
2. The date you or your dependent becomes covered for such injury or illness under another group insurance plan which provides similar benefits;
3. The end of three consecutive months after coverage under this Plan for hospital, medical, and pharmacy benefits terminates; or
4. The end of 12 consecutive months after coverage under this Plan for hospital, medical, and pharmacy benefits terminates.

Definition of Totally Disabled

1. **Totally Disabled,** with respect to you, means that, due solely to injury or illness that is not employment-related, you are prevented from engaging in your regular or customary occupation.

2. **Totally Disabled,** with respect to a dependent, means that due solely to injury or illness that is not employment-related, he is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense. To avoid this costly problem, your health Plan provides a Coordination of Benefits provision. This provision affects all of your medical coverage. It does not apply to Life Insurance and Accidental Death and Dismemberment Insurance.

How Does Coordination Work?

If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of "allowable expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit on his insurance.

Definitions

1. **"Allowable Expenses"** means any reasonable and customary item of expense for services, supplies or treatment covered, in whole or in part, by one of the medical plans. When a plan provides service instead of cash payment, the Plan will view the reasonable cash value of each service as an Allowable Expense and as a benefit paid. The Plan will also view benefits payable by another plan as an Allowable Expense and as a benefit paid, whether or not a claim is filed under that plan.
2. **"Plan"** means any of the following that provide full or partial medical benefits or services, on an insured or uninsured basis:
    a. Group or blanket***** insurance;
        *** "Plan"** shall not include blanket school accident coverages or substantially similar coverages such as contracts issued to organizations that sponsor youth programs covering youth groups.

Definitions (Continued)

3. **"Plan"** means any of the following that provide full or partial medical benefits or services, on an insured or uninsured basis:

a. Group or blanket***** insurance;
   *** "Plan"** shall not include blanket school accident coverages or substantially similar coverages such as contracts issued to organizations that sponsor youth programs covering youth groups.
b. Union welfare plans, employer organization plans, or labor-management trustee plans;
c. Governmental programs or coverages required or provided by law. "Plan" does not include Medicaid or any government program coverage with which the Plan is not allowed, by law, to coordinate; and
d. Medical benefits paid, or which would be payable, under group and individual mandatory no-fault and traditional mandatory automobile "fault" type contracts.

"Plan" shall apply separately to each contract, agreement, or other plan for benefits or services; and to that part of such contract, agreement or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

4. "Claims Determination Period" means January 1st to December 31st, or that portion of a calendar year during which the individual is covered under this Plan.

Order of Benefit Determination

A Primary Plan is one whose benefits for a person's health coverage must be determined without taking the existence of any other plan into consideration. There may be more than one Primary Plan. A Secondary Plan is one which is not a Primary Plan. The Primary Plan pays first. The Secondary Plans then pay the remaining unpaid Allowable Expenses. No plan pays more than it would have without this provision.

A plan is a Primary Plan if either:

1. It does not have an order of benefit determination rules, or it has rules which differ from those permitted by this section; or
2. All plans which cover the person use the order of benefit determination rules required by this section and under those rules the plan determines its benefits first.

Order of Benefit Determination (Continued)

The order of benefits payments is determined using the first of the following rules which applies:

1. The benefits of a plan which covers the person as an employee are determined before those of a plan which covers the person as a dependent;
2. Except as stated in subparagraph 3 below, when a plan and another plan cover the same child as a dependent of different persons (parents):
    a. The benefit of a plan of the parent whose birthday (excluding year of birth) falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year;
    b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; and
    c. If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in this Plan will determine the order of benefits;
3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, it is the plan of the natural parent with custody;
    b. Then, it is the plan of the spouse of the parent with custody;
    c. Finally, it is the plan of the parent not having custody of the child; and
    d. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has such actual knowledge.
4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee’s dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule 4 is ignored; and

Order of Benefit Determination (Continued)

5. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that person for the shorter time.

Effect on Benefits

This provision applies in determining the benefits payable under this Plan for allowable expenses an individual incurs during a Claims Determination Period when the total benefits payable:

This provision applies in determining the benefits payable under this Plan for allowable expenses an individual incurs during a Claims Determination Period when the total benefits payable:

1. Under this Plan, without this provision, exceed the allowable expenses incurred; and
2. Under all other plans, without a provision similar to this provision, exceed the allowable expenses incurred.

The amount payable under this Plan, if it is the Secondary Plan, will be reduced to the extent necessary so that the total amount payable under all plans will not be greater than 100% of the “allowable expenses.”

Right to Receive Necessary Information

In order to apply this provision, the Plan may release to or obtain from any other insurance company, organization, or person any information it deems necessary, acting within the guidelines of the HIPAA legislation and regulations. This may be done without the consent of or notice to any individual, except when such notice or consent is required by law.

Facility of Payment

Whenever payments which should have been made under this Plan have been made under any other plan, the Benefit Provider will have the right to repay the plan the amount it determines will satisfy the intent of this provision. Any amount so paid will be considered to fully satisfy the Provider’s liability under this provision.

Right of Recovery

Whenever the Plan pays out more than is necessary to satisfy the intent of this provision, the Plan has the right to recover the excess payment from: (a) any person to or for whom such payments were made; (b) any other insurance company; or (c) any other organization.

Credits

Whenever the METRO-I.L.A. Fringe Benefit Fund group Plan is considered the Secondary Plan and a claim payment is reduced because of the Coordination of Benefits provision, the amount of the reduction will be carried for the balance of the calendar year as a credit for the member of your family for whom the claim was made. This amount may be used for other medical expenses, due to any cause, incurred by the same family member in the same calendar year, if the individual finds that he must pay for such medical expenses because the normal benefits under both plans have been paid. A claim record is maintained only for a calendar year, and a new record starts with respect to each insured person as of January 1.

COORDINATION OF BENEFITS AND MEDICARE

Medicare Benefits at Age 65

If you or your Dependent is entitled to benefits under Medicare (by attaining age 65), the following rules will determine which plan is primary under the Coordination of Benefits (COB) provision. Medicare means the health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act, as amended.

For Active Members and Their Dependents

This Plan will be the Primary Plan to Medicare for an active Member, or a Dependent of an active Member, who is age 65 or older.

For Pensioners and Their Dependents

This Plan will be a Secondary Plan to Medicare for a Metro-I.L.A. pensioner or a Dependent of a pensioner, who is age 65 or older, if the pensioner is covered under the Plan. To determine the amount of reduction for purposes of COB, CIGNA will include all benefits for which you or your Dependent are eligible under Medicare Parts A and B. Such benefits will be considered payable under Medicare, whether or not the individual registered for Part A

For Pensioners and Their Dependents (Continued)

benefits or enrolled for Part B benefits. Medicare participants should also be aware of Part D, relating to drugs.

Medicare Benefits Due to Total Disability

You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. The following rules apply with respect to COB and Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB and Medicare at age 65 will apply.

During Medicare Waiting Period

This Plan will be a Primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease.

After Medicare Waiting Period

After the Medicare waiting period has been met, and you or your Dependent is entitled to Medicare benefits, this Plan will be *either:*

1. A Primary Plan to Medicare for an active Member, or his or her Dependent, who is entitled to Medicare benefits due to total disability for other than end stage renal disease; *or alternatively*
2. A Secondary Plan to Medicare for:
    a. An active Member, or his or her Dependent, who is entitled to Medicare benefits due to end stage renal disease; or
    b. A pensioner, or his or her Dependent, who is entitled to Medicare benefits due to total disability or end stage renal disease.

Electing Medicare as Primary Plan for Active Members

If you or your Dependent are entitled to Medicare benefits at age 65 or as a result of total disability, you or your Dependent may elect to have Medicare as the Primary Plan by giving notice to the Plan Office. If Medicare is elected as the Primary Plan, then the Plan will not provide secondary coverage for you or your dependent.

SUBROGATION

If you or your Dependent, including a surviving spouse or a surviving Dependent child, is legally entitled to recover from a third party all or a portion of the cost of a service or treatment covered under this Plan, the METRO-I.L.A. Fringe Benefit Fund will have the equitable right of restitution to recover any benefit payments it has made with respect to such service or treatment from such third party. This right of recovery exists regardless of whether you or your dependent is fully compensated for the injuries incurred. Furthermore, the Fringe Benefit Fund will have no obligation to pay, in whole or in part, any attorneys' fees or other costs incurred by you or your dependent in such claim or suit against a third party, and you or your dependent shall have no right of setoff or counterclaim against the Fund with respect thereto. This right of recovery does not apply, however, when a third party is an insurer of an individual surgical or medical policy issued to you or your Dependent.

If you or your Dependent is involved in such a case, by accepting benefits under this Plan, you agree to furnish any information and assistance and to sign any appropriate form the Fringe Benefit Fund may reasonably request to enforce its right of recovery.

Also, you and your Dependent shall take no action to prejudice such rights of the Fringe Benefit Fund.

GENERAL INFORMATION

Facility of Payment

If you or your Dependent is not legally capable of giving a valid receipt for a benefit payment, the Plan has the right (if there is no legal guardian) to pay the party it believes is entitled to such payment by reason of having incurred funeral or other expenses incident to the last illness or death of the claimant, but not to exceed the amount allowed by state law.

Once such a payment is made, the Plan has no further obligation with respect to the amount so paid.

Beneficiary

If a beneficiary is designated, the beneficiary's consent is not required to change the beneficiary.

Beneficiary (Continued)

If your beneficiary predeceases you, such beneficiary's interest will automatically terminate.

If you name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries. If there is no living beneficiary when you die, the Plan will make the payment to your surviving spouse; if none, to your surviving children in equal shares; if none, to your surviving parents in equal shares; and if none, to your surviving brothers and sisters in equal shares. The Plan has the option, however, to make the payment to the administrators of your estate.

Examinations

The Plan will have the right and opportunity through its medical representatives to examine any living insured during the pendency of a claim and so often as it may reasonably require.

The Plan will also have the right to request an autopsy in case of death, where it is not prohibited by law.

Cooperation

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply promptly (and in good faith) with such requests will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulae, methods, and procedures as they consider advisable.

IMPORTANT: The Trustees reserve the right to terminate eligibility in the Plan of anyone who knowingly provides misleading, incorrect, or fraudulent claim information, or withholds money to which the Trustees are entitled by right of subrogation or otherwise.

Plan Change or Termination

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan and/or the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan Change or Termination (Continued)

Plan benefits and eligibility rules for active, retired, or disabled participants:

1. are not guaranteed;
2. may be changed or discontinued by the Trustees;
3. are subject to the rules and regulations adopted by the Trustees;
4. are subject to the Trust Agreement which establishes and governs the Plan's operations; and
5. are subject to the provisions of the group insurance policies purchased by the Trustees.

The nature and amount of the Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect you or your beneficiary's right to any insured claim which may have previously accrued and to which you have already become entitled.

Authority of Plan Trustees; Plan Expenses

The Plan gives the Trustees full discretion and authority to make the final decision regarding all areas of Plan interpretation and administration, including:

1. eligibility for benefits;
2. the level of benefits provided;
3. interpretation of Plan language (including this summary plan description); and
4. administrative procedures.

All expenses of administering the Plan are paid from the assets of the Plan. The costs and expenses (including counsel fees) of any action or proceeding brought by or against the Trustees or any other Fiduciaries (who are or were Fund employees, or any of them in their capacity as a Fund Fiduciary) shall be paid by the Fund unless it is adjudged that such person acted in bad faith or was grossly negligent.

Mailing Address of Claimant

If a claimant fails to inform the Plan Office of a change of address, and the Plan Office is unable to communicate with the claimant at the address last recorded by the Plan Office, 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 have the right to recover any overpayment or mistaken payment made to a claimant or to a third party on the claimant's behalf. Such a recovery may be made by reducing or eliminating 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 sole and absolute discretion, determine to be appropriate, including termination of the claimant's right to remain a Plan participant.

CLAIM PROCEDURES

Application for all benefits provided directly by the Fringe Benefit Plan must be made in writing on forms obtained from the Plan Secretary at the Plan Office. You may secure such forms by writing, phoning, or visiting (during the hours of 9:00 A.M. to 5:00 P.M., on regular business days) the Plan Office. The address is:

METRO-ILA Fringe Benefit Plan
301 Route 17 North, 7th Floor
Rutherford, NJ 07070-2575
Telephone #: (201) 842-0202
Fax #: (201) 842-0334

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

Notice of Claim

Written Notice of Claim must be given to the Plan by the end of the following year after a covered loss occurs. If this is not possible, the notice must be sent at the earliest possible date. Notice, by or on behalf of the claimant, should be sent to the Plan Office. The information should be sufficient to identify the claimant.

Claim Forms

When the Plan receives a written Notice of Claim, it will send you the required claim form. If such a form is not sent to you within 15 days after the giving of such notice, you will be deemed to have complied with the requirements as to Proof of Loss.

Proof of Loss

Written Proof of Loss must be sent to the Plan within 90 days after the date of loss. If this is not possible, proof must be sent at the earliest possible date.

Failure to give Notice of Claim or Proof of Loss within the time required shall not invalidate or reduce any claim if:

1. it was not reasonably possible to do so; and
2. such proof was given as soon as reasonably possible.

Furthermore, the time limits herein are extended to comply with the minimum requirements of the state in which the claimant resides at the time his insurance under this Plan is in effect.

CLAIMS AND APPEAL PROCEDURES

If a claim is denied, the first and second level appeals, as described below, are referred to (and handled by) Cigna. If a denial reaches a third level appeal, the matter will be addressed by the Board of Trustees of the Fund for its determination.

Claim Denial

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

Type of Claim	**Time Limit for Claim Denial**	**Extension Permitted**
Medical, Dental, Pharmacy, Vision:		
Urgent Claims (as Medically Determined)	72 hours	None
Pre-Service Centers	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
Weekly Accident and Sickness	45 days	45 days

Claim Denial (Continued)

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 for 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 provision 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.

Appealing a Claim

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

Type of Claim	Time Limit for Appealing Denial
Medical, Dental, Pharmacy, Vision	180 days
Accidental Death and Dismemberment, Life Insurance	72 hours
Weekly Accident and Sickness	180 days

Appealing a Claim (Continued)

To appeal, you must write to the Trustees within the appropriate time after receiving the Plan's adverse benefit determination. Your (or your representative's) correspondence must include the following statement: "I am writing in order to appeal the decision to deny me or my beneficiary benefits. Your adverse benefit determination was dated _____, 20__." If this statement is not included, the Trustees may not understand that you are making an appeal (as opposed to a general inquiry). If you have chosen someone to represent you in making the appeal, then your (or your representative's) letter must state that you have authorized him or her to represent you with respect to your appeal, and YOU MUST SIGN such statement. The Trustees do not wish to communicate about your situation with someone unless they are sure he or she is your chosen representative.

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. A document, record, or other information is relevant to a claim if it was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required in making the benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Determination on Appeal

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

Determination on Appeal (Continued)

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Medical, Dental, Vision: **Urgent Claims (as Medically Determined)**	72 hours	None
Pre-Service Centers	15 days	30 days
Post-Service Claims	Next Board Meeting *	Next Board Meeting
Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Accidental Death and Dismemberment, Life Insurance	Next Board Meeting *	Next Board Meeting
Weekly Accident and Sickness	Next Board Meeting *	Next Board Meeting

- *When a claim is received by the Fund office thirty (30) (or fewer) days before a meeting of the Fund's Trustees, a decision on the claim may not be forthcoming until the following Trustees' meeting (approximately three months later). If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension describing the special circumstances requiring the extension.

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible, with notice being transmitted by the Plan Office no later than five days after the determination is made.

If the denial of a claim for medical, prescription drug, 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 (1) 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 (2) someone who has appropriate training and experience in the field of medicine involved in the

Determination on Appeal (Continued)

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 the Plan provision(s) 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 scientific 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; and
- A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act.

To reiterate, the Trustees shall have exclusive discretion and authority to make the final decision regarding all areas of Plan interpretation and administration, including eligibility and entitlement for benefits, the level of benefits, or interpretation of Plan language (including this summary plan description) or administrative procedures.

The Trustees' final decision with respect to their review of your appeal shall be final and binding on you and all parties claiming benefits or otherwise dealing with the Plan. The decision of the Trustees shall be upheld in any action or proceeding brought to challenge the decision, unless the court therein finds that the decision was arbitrary and capricious. Nonetheless, if you disagree with the final decision of the Trustees with respect to your appeal, then you may commence a legal action to challenge that decision. You must follow the above claims procedures before you are entitled to challenge the Trustees' decision in court. No legal action of any type may be

Determination on Appeal (Continued)

commenced or maintained against this Plan more than six (6) months after the date of the Plan's written letter notifying the claimant of the Trustees decision on appeal.

SECTION 3: TECHNICAL DETAILS

A. ERISA RIGHTS

ERISA RIGHTS

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:

1. Examine, without charge, at the Plan Office all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Office. The Trustees may make a reasonable charge for the copies, but no more than $.25 per page.
3. Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of the summary annual report.
4. Submit written comments about the Plan to the Plan Secretary.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan participants, including yourself.

No one, including your employer, your union, or any other person, may terminate your employment (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 order the Plan Secretary to provide the materials, unless the materials were not sent because of reasons beyond the control of the Plan Secretary. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in federal or state court. If it should happen that Plan

ERISA RIGHTS (Continued)

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 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 Plan Secretary.

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, U.S. Department of Labor. This office is located at 1633 Broadway, Room 226, New York City, NY 10019; the phone number is (212) 399-5191; the fax number is (212) 399-5245.

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.

SECTION 3: TECHNICAL DETAILS

B. SUMMARY PLAN DESCRIPTION

1. **PLAN NAME:** The METRO-I.L.A. Fringe Benefit Fund Plan.

2. **EDITION DATE:** January 1, 2008.

3. **PLAN SPONSOR:** The Board of Trustees of the METRO-I.L.A. Fringe Benefit Fund Plan.

4. **PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER (EIN):** 13-3050863.

5. **PLAN NUMBER:** 501.

6. **TYPE OF PLAN:** Plan providing Fringe Benefits such as: Health Insurance, Paid Vacation and Holiday, Jury Duty, and Bereavement Benefits, Temporary Disability, and Life and A.D&D. Insurance.

7. **PLAN YEAR ENDS:** December 31st.

8. **PLAN ADMINISTRATOR:** The Board of Trustees of the METRO-I.L.A. Fringe Benefit Fund Plan.

9. **AGENT FOR THE SERVICE OF LEGAL PROCESS:** Trustees of the METRO-ILA Fringe Benefit Fund Plan, 301 Route 17 North - 7th Floor, Rutherford, NJ 07070-2575. Phone #: (201) 842-0202.

10. **TYPE OF PLAN ADMINISTRATION:** Direct employees of the Trustees.

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

12. **SOURCES OF CONTRIBUTIONS TO PLAN:** Employers required to contribute to the METRO-I.L.A. Fringe Benefit Fund Plan.

13. **COLLECTIVE BARGAINING AGREEMENTS:** This Plan is maintained in accordance with collective bargaining agreements. A copy of the agreement applicable to your employment may be obtained by you upon written request to the Plan Secretary and is available for examination by you at the Plan Office.

14. **PARTICIPATING EMPLOYERS:** You may receive from the Plan Secretary, 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:** Either directly by the METRO-I.L.A. Fringe Benefit Fund Plan or through the following insurance carriers:

    - **CIGNA Health Care (Medical, Hospital, Dental and Prescription Benefits, plus Employee Assistance [regarding substance abuse and counseling])**
    - **Hartford Medicare Supplement Plan**
    - **Aetna**
    - **The Hartford**
    - **Met Life Insurance Company**
    - **Vision Screening**

16. **ELIGIBILITY REQUIREMENTS, BENEFITS AND TERMINATION PROVISIONS:** See Parts A through B of this booklet.

17. **HOW TO FILE A CLAIM:** See page 47 of this booklet.

18. **REVIEW OF CLAIM DENIAL:** See page 48 of this booklet.

19. **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.

20. **THE BOARD OF TRUSTEES:** The Plan Sponsor and Plan Administrator is the Board of Trustees of the METRO-ILA Fringe Benefit Plan. The following are the individual Trustees that make up the Board:

Employer Trustees	**Union Trustees**
J. Randolph Brown	Louis Pernice
Joseph A. Ragusa	J. Kenneth O'Connor

21. **DISTRIBUTION ON TERMINATION:** In the event of the termination of the Plan, the Trustees shall distribute the assets of the Plan at the time of distribution in such manner as shall best effectuate the Plan's intent and in accordance with applicable law.

22. DISCLAIMER: This summary plan description is not a complete statement of the Plan's contents. For a full statement of the Plan, you may want to review the Collective Bargaining Agreement under which you work and the Agreement and Declaration of Trust of the METRO-ILA Fringe Benefit Fund Plan. Those documents are available for your review at the Plan Office, and you may obtain copies of such documents for a reasonable charge.