



SHOPMEN'S LOCAL 527

BENEFIT FUND

SUMMARY PLAN DESCRIPTION

Updated June 1, 2004

The Board of Trustees of the Benefit Fund is pleased to present your Summary Plan Description. This Summary Plan Description is furnished to each eligible participant to describe the benefits available to you through your Benefit Fund and it replaces all prior versions. Once you have had an opportunity to review this booklet, should you have any questions or require any additional assistance, please contact the Fund Office at:

**2945 Banksville Road
Pittsburgh, Pennsylvania 15216
(412) 341-6183
Toll Free 1-800-858-7870
Website: 527.ORG
Email, sl527bp@earthlink.net**

BOARD OF TRUSTEES

The Board of Trustees governs the entire operation of the Fund. The Board, who represents Labor and Management, establishes rules of eligibility, strives constantly to improve benefits, supervises the investment of the Fund's money and ensures that the Fund is in compliance with all applicable laws. Official interpretation of the Plan may only be made by the Board of Trustees. At the time this Summary Plan Description was prepared, the Board was comprised of the following members:

UNION TRUSTEES

Ernie Heinauer
Martin Marinack

EMPLOYER TRUSTEES

John M. Mihm
Donald H. Landis

LEGAL COUNSEL

Stephen J. O'Brien, Esquire
71 Mc Murray Road
Pittsburgh, Pennsylvania 15241
412-833-5949

AUDITOR

McElhaney & DiClaudio

FUND MANAGER

Mrs. Debby Mitchell

TABLE OF CONTENTS

	PAGE
Schedule of Benefits	4
Eligibility Rules	5
Uniformed Service Under USERRA	7
Reinstatement	9
Continuation of Coverage (COBRA)	9
Benefits for Dependents	15
Term Life Insurance	16
Accident and Sickness Benefits	19
Safety Glass Program	20
Supplemental Unemployment Benefits (S.U.B.)	21
Coordination of Benefits with Medicare	24
Overpayment of Benefits	25
Claims and Review Procedure	25
Family and Medical Leave Act of 1993	26
Women's Health and Cancer Rights Act of 1998	28
Newborns and Mothers Health Protection Act	29
Qualified Medical Child Support Order	29
Military Service (USERRA)	29
Subrogation	30
Claims and Appeal Procedures	31
Information Required by the Employee Retirement Income Security Act of 1974	37
Statement of Rights Under the Employee Retirement Income Security Act of 1974	39
Attachment 1 – Qualified Medical Support Orders	41
Attachment 2 - Military Service	43
Attachment 3 – Subrogation Agreement	44

BENEFIT FUND PACKAGE

Effective 1/1/07

MEDICAL COVERAGE	(See booklets provided by Highmark)
PPO BLUE	\$20.00 doctor visit/\$40.00 specialists, copayments
Deductible	\$300/\$600
Lifetime maximum	\$1,000,000

Family Coverage available	\$150.00 for spouse
Additional monthly premium	\$150.00 for member and one child
	\$200.00 for family

PRESCRIPTION COVERAGE	(See booklets provided by Highmark)
Provided by Highmark	

RETAIL:	\$15.00 copayment for generic
FORMULARY	\$30.00 copayment for brand name
NON-FORMULARY	\$45.00 copayment-non-formulary
30 day supply	

MAIL ORDER :	\$30.00 copayment for generic
FORMULARY	\$60.00 copayment for brand name
NON-FORMULARY	\$90.00 copayment non-formulary
90 day supply	
	(Combined Limit: \$7,500 per individual annual maximum)

ACCIDENT AND SICKNESS BENEFITS

12 week Benefit, \$250.00 per week

LIFE INSURANCE

\$20,000 Group term insurance

\$20,000 AD&D

SUPPLEMENTAL UNEMPLOYMENT BENEFITS

\$15.00 Minimum/\$40.00 maximum

SAFETY GLASSES

One pair of safety glasses will be supplied for each eligible employee every year

ELIGIBILITY RULES

BASE RATE CONTRIBUTION

The Hourly Base Rate of contribution is set by the Board of Trustees. If your employer does not contribute the entire current base contribution rate then, your employer's contract may provide for a wage and benefit re-allocation which will complete the entire current base contribution rate from your wages. Otherwise, you must pay the necessary contributions yourself, either through payroll deduction, MSA transfer or self-pay.

NEW EMPLOYEES

You will become eligible on the first day of the month following the completion of 60 work days with the accumulation of 480 hours of employment with contributing employers, *provided that this occurs within a period of six months from the date you were first employed by a contributing employer.*

EMPLOYEES OF NEW CONTRIBUTING EMPLOYERS

If your employer starts participating in the Benefit Fund on the first day of the calendar month, and you are employed on that date, you will be eligible on that date, provided that you were employed by that employer in the previous month.

If your employer starts participating on a day other than the first day of a calendar month, providing the participation has been approved by the Board of Trustees, you will become eligible on the first day of the next following calendar month, provided that you were employed by that employer in the previous month.

If you do not become eligible under the above paragraphs because you were not employed by your employer on the date he starts participation, you must meet the eligibility requirements as a NEW EMPLOYEE.

NOTE: All of your benefits and the benefits for your dependents will become effective on your normal effective date. Life, Accidental Death and Dismemberment, and Accident and Sickness Insurance are payable if the claim is incurred on and after the effective date of your insurance. Benefits are not available for exclusions which are permitted under Section 701(a) of ERISA. The Plan excludes, with respect to a participant or beneficiary, any pre-existing condition if (1) such exclusions relates to a condition (whether physical or medical), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the normal effective date; (2) such exclusion shall extend for a period of 12 months (or 18 months in the case of a late enrollee) after the normal effective date ; and (3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection 701(c)(1) of HIPAA) applicable to the Participant or beneficiary as of the enrollment date.

The Plan does not base initial or continued eligibility upon any health factor, such as health status, medical condition (including physical and mental illnesses) , claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

CONTINUATION OF ELIGIBILITY

Once you are eligible, your insurance will continue as long as your employer continues to make a minimum contribution of 150 hours per month to the Benefit Fund. The number of months of continuation depends upon your employer's collective bargaining agreement. Under certain other conditions, your eligibility may be extended for additional months as discussed below.

TERMINATION OF ELIGIBILITY

Quit or Discharge

Your eligibility for insurance will terminate immediately upon a quit or discharge. This will normally occur if you, as an employee, voluntarily quit, fail to return on recall or are discharged from covered employment. You will be given the option to purchase COBRA effective on the first of the month of your quit or discharge. Weekly Income Accident and Sickness Benefits Insurance will terminate immediately upon a voluntary quit from or discharge by a contributing employer.

Layoff, Strike, Etc.

If you, as an employee, become unemployed due to a layoff, strike or through no fault of your own and remain available for employment, your eligibility may be extended in accordance with the provisions of your employer's collective bargaining agreement. These provisions vary by agreement and you should request a copy of specific collective bargaining agreement for details.

If an employee is recalled to work for any part of a month during an extended eligibility period, the month or months he worked will not be counted towards his maximum extended eligibility period.

For example, if an employee was laid off at the end of June, was entitled to six months of extended eligibility starting in July and was not recalled by his employer, his coverage would terminate after six months, at the end of December. If the employee is recalled and works during the months of August and September, those months will not be counted as months of extended eligibility. His coverage would then terminate at the end of February when he has received a total of six months of extended eligibility.

Your Accident and Sickness benefits will terminate at the end of the month in which you become unemployed. However, if the disability occurs during the period while you are still eligible for all other benefits, and this results in your loss of unemployment compensation, you will be eligible for Weekly Accident and Sickness benefits; *otherwise Accident and Sickness Insurance is reinstated immediately upon returning from lay-off, provided you are eligible.*

Voluntary Suspension of Benefits

If your employer does not contribute the current base contribution rate and you do not pay the necessary contributions yourself, either through payroll deduction, MSA transfer or self-pay,

then your medical insurance will be suspended for non-payment. The effective date of suspension will be effective the first of the month after failing to make payment.

Employees of Delinquent Employers

If employer contributions for a month are not received when due, you and your dependent's insurance benefits provided by the Benefit Fund shall cease as of the first day of the month for which the contributions were due. For example, if employer contributions based on work performed in January are not received by the Fund when due, you and your dependents insurance will terminate as of January 1. If this occurs, you will be permitted to make necessary contributions on your behalf for COBRA extension of coverage.

If your eligibility is terminated for this reason, the Fund Office will notify you of this by mail, and will also advise you of the amount of your COBRA payments, and when the payments are due.

Disability

If you become totally disabled while insured, your insurance will be continued for up to three (3) months beyond the period, if any, your employer continues to remit the appropriate contribution on your behalf during your disability. If no extension provision exists in your employer's contract, the three-month continuation period will commence on the date your eligibility through employer contributions would otherwise end.

Retirement

Your eligibility for insurance will be continued for six months, including any period of continuation provided under the above "*Disability*" section, past the month for which contributions were last received, provided that you are eligible for and are receiving a retirement pension through the Shopmen's Local 527 Pension Fund, the pension plan of a contributing employer or Social Security.

Military Service

Your benefits and those of your dependents will immediately cease upon entrance into active duty in the U.S. Armed Forces. If you return to active employment at the trade upon discharge from active duty, you may apply for reinstatement of benefits for yourself and your dependents. Upon reinstatement you will be covered for the balance of the Benefit Period based upon your eligibility at the time active duty commenced. Contact the Administrative Office for proper procedures.

Continued Eligibility During Service In the Uniformed Serviced Under USERRA

USERRA is the Uniformed Service Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

1) Continuation of Group Health Coverage for You and Your Eligible Dependents. If Health Coverage ends because of your service in the uniformed services, you may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 18 consecutive months after coverage ended.

To continue coverage, you or your dependent must pay the required premium, (including your former employer's share and any retroactive premium). If you are called into uniformed service for up to 31 days, you must pay your share, if any, of the premiums for your Medical, Dental, and Vision benefits. The Plan Administrator will inform you or your dependent of procedures to pay premiums.

2) End of Continuation. A covered person's continued Health Coverage will end at midnight on the earliest of:

- the day your former employer ceases to provide any group health plan to any employee; or
- the day premium is due and unpaid; or
- the day a covered person again becomes covered under the plan; or
- the day Health Coverage has been continued for the period of time provided in above; or
- the day the plan terminates

3) Other continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the uniformed services). Following your discharge from such service, you will be reinstated for all eligible benefits on the day you commence work within a period of 90 days of your date of discharge; otherwise you will be treated as a new employee for the purposes of determining your eligibility.

After reemployment, credit will be given, if applicable, for the period of such uniformed service, if required to determine your benefit amounts, eligibility of costs.

NOTE: In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer will apply.

REINSTATEMENT

This reinstatement provision will only apply if you meet the following requirement and are reinstated within 24 months of the date of termination or the date of your last COBRA payment.

If your coverage is terminated, you may be reinstated as a fully insured member on the first day of the month following completion of three consecutive calendar months during which you are credited with a minimum of 200 hours of work for a contributing employer.

For example: If you had been terminated at the end of January, 1996 and returned to covered employment in April, 1998, you must meet the requirements of eligibility specified for NEW EMPLOYEES. A minimum of 200 hours of employment must have been completed in three consecutive calendar months before February 1998. If your employment is not sufficient for you to become eligible as of February 1998, you will have to meet the eligibility requirement for a NEW EMPLOYEE.

Reinstatement after Voluntary Suspension

If you are an active member of the Union, and your benefits are suspended, due to a voluntary non-payment of your employee contribution rate, then you must submit a written request to the Fund Office if/when you decide to reinstate your medical coverage.

As of the first of the month, following the month the Fund receives your written request to reinstate, you must accumulate 480 hours worked, make payment of all past contributions unpaid when benefits were provided, and make the employee contributions payments for all hours worked during the period the 480 hours are accumulated. Benefits will not be reinstated until all three (3) conditions are satisfied, i.e. (1) the 480 hours are actually worked, (2) employee contributions are received by the Fund, and (3) unpaid contributions are made for past months that benefits were provided before suspension became effective.

* * * * *

If an employee has his coverage extended under the collective bargaining agreement which requires contributions for non-work periods, the employer shall be obligated to make the specified monthly contribution for the period of his extension up to six months if that employee is receiving the extension as a result of work with that contributing employer.

If the employee is receiving a six-month extension as a result of participating in the Fund with a number of different employers, the employer shall only be obligated to contribute for three months.

CONTINUATION OF COVERAGE

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA continuation coverage," named for the federal law that sets forth the rules for it. Upon the occurrence of a qualifying event as defined in COBRA, qualified participants and their dependents shall have the

right to continue health care coverage provided under this Plan. You must pay the premium for this coverage, but the cost of the coverage is based on group rates rather than individual rates. This notice is intended to inform you, in a very general way, of your rights and obligations under the COBRA coverage provisions. **Both you and your spouse should take the time to read this notice carefully.**

A. QUALIFYING EVENT

A "qualifying event" is a situation that involves a covered participant and/or their eligible dependents that results in the loss (or termination) of group health coverage (for reasons other than gross misconduct).

The following is a list of Qualifying Events and the period of time COBRA coverage can be continued:

<u>Qualifying Event</u>	<u>Qualifying Beneficiaries</u>	<u>Continuation Coverage</u>
Employees termination of employment or reduction in hours of employment	Employee, spouse and dependent child	18 months (29 months if qualified beneficiary is disabled)
Death of employee	Spouse and dependent child	36 months
Employees divorce or legal separation from spouse	Spouse and dependent child	36 months
Employees entitlement to Medicare	Spouse and dependent child	36 months
Dependent child is no longer an eligible dependent	Dependent child	36 months

B. NOTIFICATION OF QUALIFYING EVENT

Under the law, the Participant or a family member has the responsibility to notify the Fund of a divorce, legal separation or a child's loss of dependency status within 60 days of the event. An unmarried child who attains age 19, or an unmarried dependent student who attains age 23, or an unmarried dependent student who is no longer a full time student prior to age 23, will lose their dependent status. If notice is not received within the 60 day time period, the Participant, spouse and/or dependents will not be entitled to choose COBRA Continuation Coverage.

C. COBRA ELECTION FORM

Within 14 days of receipt of notice that one of the qualifying events has occurred, the Fund Office will notify you and any eligible dependents, including those not living with you (whose

address is known to the Fund Office), of the right to elect COBRA continuation coverage. The Fund Office also will provide instructions about how to elect and pay for COBRA continuation coverage.

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

If you do not choose COBRA coverage, your Fund health coverage will end.

D. COBRA BENEFITS

If you choose COBRA coverage, the Plan is required to make available coverage which, as of the time of the Qualifying Event, is identical to the coverage being provided under the Fund to similarly situated Participants or family members. However, the life insurance, the accidental death and dismemberment coverage, and the weekly disability benefit will not be available under COBRA continuation coverage.

E. DISABILITY

The 18 months of COBRA continuation coverage may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) at any time during the first 60 days of the determination by Social Security and before the 18-month maximum coverage period expires. This special 11-month extension does not apply to non-disabled family members. The affected individual must also notify the Fund Administrator within 30 days of any final determination that the individual is no longer disabled.

F. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for Plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cutoff rule with these new limits as follows:

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

G. COBRA PREMIUM PAYMENT

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the

Fund Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

If you elect the continuation coverage, you have to pay all or part of the premium for your continuation coverage. There is a grace period of 45 days for payment of the initial premium from the date you elect to continue COBRA coverage. COBRA continuation coverage will not be in effect until premiums are paid. There is a grace period of at least 30 days for payment of the regularly scheduled premium. At the end of the COBRA continuation coverage period, you may be allowed to enroll in an individual conversion health plan provided under the Fund. The law permits the Fund to charge any person who elects COBRA continuation coverage up to 102% of the full cost to the Plan. If the cost changes, the Plan will revise the self-payment amount you are required to pay, but this change will not occur more than once every twelve (12) months. In the case of those who receive extended coverage for 29 months due to total disability the Plan is permitted to charge up to 150% of the cost for those additional 11 months.

H. TERMINATION OF COBRA CONTINUATION COVERAGE

The law provides that COBRA coverage may be discontinued for any of the following reasons:

1. The Plan no longer provides group health coverage to any employees;
2. The premium for your COBRA coverage is not paid on time;
3. The qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. You become eligible for Medicare;
5. Your coverage extended for up to 29 months due to your disability and there has been a final determination that you are no longer disabled;
6. The date the 18 month or 36 month coverage period ends.

If you have any questions about the law, please contact the Fund Office.

If you do not elect to continue coverage in accordance with these provisions, you still have the opportunity to exercise your conversion privilege as described below.

I. CONVERSION PRIVILEGE

This conversion provision is available if you do not wish to continue group coverage as outlined under "Continuation of Coverage," above. Furthermore conversion is available to anyone who has elected to continue coverage whenever such coverage is discontinued.

If your coverage under this Program is terminated for any reason (except as specified below), you may arrange to continue coverage under the type of Subscription Agreement available to those who pay directly.

This conversion opportunity is not available if either of the following applies:

1. You are eligible for another group health benefits program through your place of employment
2. When this Program is terminated and replaced by another health benefits program

If you have not earned sufficient Employer Contributions during a Work Period to maintain eligibility, you have the option of making Voluntary Contributions during the Lag Period, subject to the rules for Voluntary Contributions described above, or making self-payments under COBRA continuation coverage. If you retire, you also have the option of making the Voluntary Contributions required for retirees or making self-payments under COBRA continuation coverage. Should you die while you and your dependents are eligible for coverage under the Plan, your dependents will have the option of making Voluntary Contributions or making self-payments under COBRA.

Full details of COBRA continuation coverage and any other options available will be furnished to you and your dependents when you are about to lose eligibility for coverage for any of the reasons mentioned above.

WHEN A SPOUSE OR DEPENDENT CHILD MUST NOTIFY THE PLAN OF A QUALIFYING EVENT

In order for a spouse or dependent child to be entitled to continue coverage the employee, spouse or dependent child must notify the Fund of:

1. The death of the employee;
2. The divorce or legal separation from the employee; or
3. The event under which a dependent child loses dependent status

within **60 days** after the event occurs. **If the Fund does not receive written notice of any such event within that 60-day period, the spouse and/or dependent child(ren) will not be eligible for COBRA continuation coverage.**

NOTICE THAT YOU OR YOUR DEPENDENT(S) ARE ENTITLED TO CONTINUATION COVERAGE

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Fund, or the Fund is notified on a timely basis that you died, divorced or were legally separated, became entitled to Medicare, or that a dependent child lost dependent status, you and/or your dependent(s) will be notified that you and/or they have the right to continue their health care coverage(s). You and/or your dependent(s) will then have 60 days to apply for COBRA continuation coverage. If you and/or they do not apply within that time, their health care coverage will end as of the last day of the calendar month in which the qualifying event occurs.

COVERAGE THAT WILL BE PROVIDED IF YOU ELECT CONTINUATION COVERAGE

1. If you and/or your dependent(s) choose COBRA continuation coverage, the Plan is required to provide coverage that is identical to the current coverage under the medical plan that is provided for similarly situated employees or family members.
2. If, during the period of COBRA continuation coverage, you marry, have a newborn child, or have a child placed with you for adoption, that spouse or dependent child may be enrolled for coverage for the balance of the period of COBRA continuation coverage on the same terms available to active employees.

Enrollment must occur within 30 days after the marriage, birth, or placement for adoption. A child born or placed for adoption with you while you are on COBRA Continuation Coverage (but not a spouse you marry while you are on COBRA Continuation Coverage) will have the same COBRA rights as your spouse or dependent children who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about dependent status and qualifying changes in family status and qualifying changes in family status that apply to active employees will apply to those dependents. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

3. If, during the period of COBRA continuation coverage, the Plan's benefits change for active employees, the same changes will apply to you and/or your dependent(s).

WHEN THE MAXIMUM PERIOD OF CONTINUATION COVERAGE MAY CHANGE

1. Multiple Qualifying Events

If your continuation coverage (according to the table above) is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a spouse or dependent child to a 36-month period of continuation coverage, the 18-month period will be extended for that spouse or dependent child. The total period of coverage for any spouse or dependent child will never exceed 36 months from the date of the **first** qualifying event. For example, if you terminated employment and elected COBRA continuation coverage for 18 months for you and your covered spouse and/or dependent child(ren), and died during that 18-month period, the continuation coverage for your spouse and/or dependent child(ren) could be extended for the balance of 36 months from the date your employment terminated.

However, if you become entitled to COBRA continuation coverage because of termination of employment or reduction in hours worked that occurred less than 18 months after the date you became entitled to Medicare, your spouse and/or dependent child(ren) would be entitled to a 36-month period of COBRA continuation coverage beginning on the date you became entitled to Medicare. For example, if termination of employment occurred less than 18 months after the date you become entitled to Medicare, your spouse and/or dependent child(ren) would be entitled

to COBRA continuation coverage for a 36-month period beginning on the date you became entitled to Medicare.

2. Entitlement to Social Disability Income Benefits

If you, your spouse or any of your covered dependent children are entitled to COBRA continuation coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security disability income benefits, and for any other covered family members, for up to 11 additional months if:

- the disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage;
- the disabled covered person receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration within the 18-month COBRA continuation period; and
- you or the disabled person notifies the Plan of such a determination within that 18-month period.

This extended period of COBRA continuation coverage will end at the **earlier** of the end of 29 months from the date of the qualifying event or the date of the disabled individual becomes entitled to Medicare.

OTHER INFORMATION ABOUT COBRA CONTINUATION COVERAGE

1. If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

2. At the end of the 18-month or 36-month COBRA continuation coverage period, you may convert your medical coverage to an individual policy of medical care insurance at the full premium cost for that policy, provided that the Plan permits conversion when the COBRA continuation coverage ends.

BENEFITS FOR DEPENDENTS (FAMILY COPAYMENT REQUIRED)

If an employee becomes eligible under the Fund rules, his spouse and dependent children as defined below, *may be* covered for benefits currently provided by the Fund. Arrangements must be made with the Fund Office for payment of the monthly family copayments. Benefits for dependents shall terminate as of the date an employee's eligibility terminates or as of the date they no longer meet the definition of eligible dependents.

BENEFITS FOR ELIGIBLE DEPENDENTS OF DECEASED ELIGIBLE EMPLOYEES

In the event of an employee's death while eligible under the Benefit Fund, the benefit program which had been in effect for the employee shall continue for his eligible dependents for a period

of six (6) consecutive months following the month in which his death occurred. The dependents must continue to be eligible under the following provisions of the Benefit Fund.

DEFINITION OF DEPENDENTS

Your eligible dependents are any of the following individuals who are not Employees:

1. Your legal spouse and unmarried children under nineteen (19) years of age. Such children include (1) a blood descendant of the first degree providing the child is a product of a legitimate marriage or, if not, is residing in the household of the employee, (2) a child whom the employee has been specifically ordered by a court of law to provide health care coverage --a general order of child support will not suffice. According to federal law, a Qualified Medical Child Support Order (QMCSO) is a child support order of a court that usually results from a divorce or legal separation, that designates one parent to pay for a child's health plan coverage. (3) a legally adopted child (including a child living with the adopting parents during the period of probation), (4) a stepchild residing in the employee's household, or (5) a child permanently residing in the household of which the employee is the head and is being supported solely by the employee, provided the employee is related to the child by blood or marriage or is the child's legal guardian. A birth certificate or court order evidencing a judicial determination of paternity shall be the only acceptable proof for purposes of determining whether or not a child is a blood descendent,

2. Each of your children who is unmarried and over nineteen (19) years of age and under TWENTY-THREE (23) YEARS OF AGE IF ENROLLED AS A FULL-TIME STUDENT IN AN ACCREDITED SCHOOL, COLLEGE, OR UNIVERSITY; WITH THE INTENT OF OBTAINING A DEGREE and is dependent on you for principal support (the Board of Trustees will have the right and opportunity to require proof of a child's status as a student and the right to verify any information submitted as evidence) and

3. Each of your unmarried children who is incapable of self-sustaining employment because of mental or physical handicap, and who became so incapable before age nineteen (19) or age twenty-three (23) if a full-time student, and while eligible for benefits under this Plan.

Proof of such dependent child's incapability must be furnished to the Fund Office not later than thirty-one (31) days after attainment of age nineteen (19).

The Trustees, upon receipt of such incapability, have the right to have a physician they designate, examine such dependent when and so often they may reasonably require, but not more than once every year after such incapability has continued uninterruptedly for at least two (2) years beyond the date the initial written proof is received by the Fund Office.

TERM LIFE INSURANCE

Your Group Term Life Insurance, in the amount indicated in the Schedule of Benefits, will be paid to any beneficiary you name if you die from any cause. You may change your beneficiary whenever you wish.

INSURANCE DURING TOTAL DISABILITY

If you become totally disabled before you reach age 64 your Term Life Insurance, shown in the schedule, may be continued at no cost to you while you remain totally disabled and are less than age 65. You must furnish proof of total disability between nine and 12 months after total disability starts, and as required thereafter. Should you die during the first 12 months of total disability, your insurance will be paid even if you had not furnished proof of the disability or premiums had not been continued.

If your continuation of Life Insurance terminates after you have furnished proof of total disability, either because you reach age 65 or for any other reason, you may convert your insurance to an individual policy, as described below, just as if you had then terminated employment.

The above provisions are provided by Shopmen's Local 527 Benefit Fund in accordance with an agreement with MetLife.

CONVERSION TO AN INDIVIDUAL POLICY

During the 31 days following termination of your coverage, you may convert your Group Term Life Insurance, without having to furnish evidence of good health, to one of a number of Metropolitan individual life policies. The policy will be effective at the end of the 31-day period, and the premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. If you die during this 31-day period, your Group Term Life Insurance will be paid whether or not you have applied for an individual policy.

POLICY AND CERTIFICATES

For simplicity, the Group Life and Accidental Death and Dismemberment Insurance Plan has been described in a rather general manner in this booklet. The benefits are described more fully in the individual booklet given to insured employees. The extent of the insurance for each individual is governed at all times by the complete terms of the master Group Insurance policy or policies issued by Metropolitan Life Insurance.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

This insurance will be paid for any of the following losses as the result of an accident occurring on or off the job while you are insured. It is payable regardless of other insurance.

Covered Losses (Subject to Exclusions)	Benefit Amounts
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand a foot or sight of an eye	Full Amount One-quarter of the Full Amount
Thumb and Index finger of same hand	
Speech and Hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	One-half of the Full Amount
Hemiplegia	One-half of the Full Amount

EXCLUSIONS

We will not pay for any Covered Loss shown above if it in any way results from, or is caused or contributed by:

1. Physical or mental illness, diagnosis of or treatment for the illness; or
2. An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or
3. Suicide or attempted suicide; or
4. Injuring oneself on purpose; or
5. The use of any drug or medicine voluntarily taken, unless used on the advice of a Doctor; or
6. A war, or a warlike action in time of peace, including terrorist acts; or
7. Committing or trying to commit a felony of other serious crime or an assault; or
8. Any poison or gas, voluntarily taken, administered or absorbed; or
9. Service in the armed forces of any country or international authority, except the United States National Guard; or
10. Operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation), or
11. Driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

The total payment for all losses due to any one accident will not exceed the full amount of insurance for each item listed in the schedule.

BENEFICIARY PROVISIONS

DESIGNATION OF BENEFICIARY

In order to designate a beneficiary, you must complete, sign and return to the Fund Office a "Designation of Beneficiary" form. You may change the designated beneficiary at any time by completing, signing and returning to the Fund Office a "Change of Beneficiary" form. If you submit a "Change of Beneficiary" form due to divorce, a copy of the divorce decree must also be submitted. The Fund Office must be in receipt of these forms before any intended beneficiary will be eligible for Death and Accidental Death Benefits. If you die before the "Designation of Beneficiary" or "Change of Beneficiary" form is received, your designation or change will not be considered effective.

PAYMENT OF BENEFITS

Benefits become payable to the designated beneficiary if you die and the claims procedure as outlined is followed, except when:

1. No Beneficiary designation has been received; or
2. The designated beneficiary dies before you; or
3. The designated beneficiary is your divorced spouse, and
 - A. Your divorce decree does not specify your divorced spouse as beneficiary, and
 - B. No "Change of Beneficiary" form was filed.

If any of these three situations exist, benefits become payable in the following order:

1. To your surviving spouse
2. To each of your natural or legally adopted surviving children in equal portions:
3. To your parents: or
4. Brother or sister
5. To the executor or administrator of your estate.

ACCIDENT AND SICKNESS BENEFIT

The Fund will pay you benefits for periods during which you are disabled and prevented from working as a result of accident or illness, on or off the job. The amount of your weekly benefit is \$250.00. *Members actively working and collecting a pension from Shopmen's Local 527 Pension Fund are **not** entitled to Accident and Sickness benefits.*

Benefits will commence on the first day of disability resulting from an accident, first day of hospital confinement, or the 6th day resulting from an illness. For surgical procedures performed on an outpatient basis, your benefits will start on the day of such surgical procedure. Benefits will be paid for the first five days of illness provided that you were disabled for at least 16 days.

All Accident and Sickness claims where there is a third party involved, i.e. car accident, etc., will require a mandatory signed subrogation agreement to protect the Benefit Fund's interest in reimbursement of medical claims.

Accident and Sickness claims will be for a 12 week maximum per calendar year. New illnesses or accidents after the 12 week maximum is paid will not be covered.

To be eligible for benefits, you must be under the care of a medical doctor (M.D.) or doctor of osteopathy (D.O.). Such care must be professional medical care received on a regular basis, in the hospital, or a physician's office or in your home. A statement from your doctor is required to apply for benefits and benefits will be paid for the first day you saw the doctor subject to the provisions above. **Physician statements signed by a Chiropractor or Dentist are not accepted as proof of disability.**

The benefits will continue as long as you are disabled and under doctor's care up to a maximum of 12 weeks. Benefits will not be paid for any holidays paid by your Employer during the first 14 days of continuous disability.

Upon becoming disabled, you must contact the Benefit Fund Office immediately and request a claim form to be completed by your physician. Forms also may be obtained from our website, 527 ORG. This will enable the Fund Office to promptly process your claim for payment. The Fund requires that you provide written evidence of a final denial of Workers Compensation in order to receive weekly income accident and sickness benefits for a job related injury or illness. ***It is your responsibility to notify the Fund Office when you have returned to work.***

It is not necessary to be confined to your home to collect benefits, but no benefits are payable for any period during which you are not under the care of a licensed qualified physician.

Benefits are not payable if you are receiving unemployment benefits or workers compensation

AUTHORIZATION OF CHECK-OFF OF UNION DUES

If you are receiving Accident and Sickness Benefits, you may authorize the Benefit Fund Office to deduct reduced union dues from your benefit check. This is a voluntary authorization in order to protect your death benefit provided by the International Union. This authorization in no way affects your eligibility under the Benefit Fund.

SAFETY GLASS PROGRAM

Eligible employees ***in active work status*** will be reimbursed for the cost of purchasing safety glasses once every 12 months. Reimbursement is based on a schedule, which is updated periodically. Prescription safety glasses can be purchased through Cabot or directly by the participant through any eye care supplier.

You may purchase safety glasses on of two ways: You may order from the Fund's supplier, Cabot Safety Corporation or purchase them from any supplier who makes OSHA approved safety glasses. The Fund will reimburse you for the cost of the safety glasses based on a standard allowance or any oversize allowance. The oversize allowance applies to safety glasses which are required to fit people with heads larger than size 52. The allowances vary from \$27.85 for single vision to \$63.05 for oversize trifocal.

If safety glasses are purchased from a supplier other than Cabot, they must be OSHA approved and be equipped with permanent side shields in order to be eligible for reimbursement. The side shield may be ordered either in mesh or with a plastic cup.

Progressive bifocal lenses may also be ordered from Cabot at an additional cost to the member. The Fund is billed for the standard allowance and the member for the balance cost of the progressive lenses. The member's charge for progressive lenses range from \$53 to \$113. The Fund Office will make arrangements for special orders.

Contact the Fund Office to request the necessary forms.

SUPPLEMENTAL UNEMPLOYMENT BENEFITS

The Shopmen's Local 527 Supplemental Unemployment Benefits Plan is designed to provide you with weekly income to supplement the state unemployment benefits you may be entitled to receive while unemployed due to a lay-off. The Plan is operated as part of the Benefit Fund. The Plan is administered by the Board of Trustees of the Benefit Fund.

BASIC ELIGIBILITY

To be eligible for Plan benefits, you must first complete at least one year of work in covered employment that is not interrupted by a break-in-service and have earned at least ½ Credit Unit under the Plan.

CREDIT UNITS

Credit Units are the way in which the Plan measures employment under the Plan. Credit Units are used to determine the length of time you will be entitled to receive Plan benefits during layoff periods. For each 32 hours of work completed for which you employer contributes to the Plan, you will receive ½ Credit Unit. You may receive up to 2 ½ Credit Units for each calendar month, up to a maximum of 52 Credit Units. Credit Units are not earned by the minimum hours contributed by your employer for periods of layoff or disability.

For each full week of S.U.B. benefits that you receive, one Credit Unit will be subtracted from your total Credit Units.

When all of your Credit Units have been used, you will not be entitled to further benefits until you have accumulated additional Credit Units.

The Trustees reserve the right to change the number of Credit Units to be subtracted from your accumulated total for each week of Plan benefits you receive. This is necessary to protect the reserves of the fund from rapidly becoming exhausted if unemployment in the industry becomes severe and widespread.

If an adjustment is made, the change will not apply until 30 days after the end of the month in which the change is approved by the Trustees. Adjustments in the number of Credit Units required for a weekly benefit may not be made more often than every 3 months.

BREAK IN SERVICE

A Break in Service under the Plan happens when you fail to work in covered employment during a period of 52 consecutive weeks. A break in service also happens if you fail to return to covered employment within a 52 week period following the last week for which you received a Plan benefit during a period of continuous layoff or at the time you fail to return to covered employment when requested to do so. When you have a break in service, all of the Credit Units you have accumulated are cancelled and you must complete the Plan's basic eligibility requirements to again be eligible for Plan benefits.

You will receive a grace period and avoid a break in service that would otherwise occur if you retain recall rights with your employer. This grace period is limited to a period of twelve consecutive months.

DEFINITION OF LAYOFF

A layoff shall be deemed to exist if the termination of employment with an Employer occurred because of either temporary or permanent suspension of all or part of the production activities of an Employer or because of either temporary or permanent suspension of all or part of the work force of an Employer and was not for disciplinary reasons.

A layoff shall not be deemed to exist if the termination of employment with an Employer was due to any labor dispute, any fault attributable to the applicant or any act of God.

PLAN RULES

You are eligible to receive benefits from the Plan for each week during which you receive state unemployment benefits. To receive benefits, you cannot refuse to accept suitable employment offered by an employer who contributes to the Plan, or to which you are referred by the Union or by the state unemployment office. You also cannot continue to receive benefits if you refuse to return to work when recalled by your employer.

There are other circumstances in which you will not be eligible to receive Plan benefits. These include weeks when you are receiving weekly Accident and Sickness Benefits from the Shopmen's Local 527 Benefit Fund or other similar disability benefits, periods when you are serving in the military, and periods when you are receiving any form of unemployment benefits not required to be provided by state or federal law.

BENEFIT FORMULA

The weekly benefit provided by the Plan will range between a minimum benefit of \$15 and a maximum benefit of \$40. The actual amount you will be entitled to receive depends on your basic hourly wage rate and the amount of the state unemployment benefits you are entitled to receive.

The S.U.B. benefit amount will be calculated so that you will receive 66.6% of your weekly wages, based on a 40 hour week. To determine the amount the Plan will pay, your state unemployment benefit amount is subtracted from the maximum weekly benefit as shown on the

formula below. The remainder, up to a maximum of \$40, is the weekly benefit amount paid by the Plan. The Plan pays the minimum of \$15 if the Plan benefit amount determined by this formula is less than \$15.

The formula to determine your S.U.B. benefit is as follows:

Hourly rate X 40 hours X 66.6%. This amount is then subtracted from your State Unemployment amount. The S.U.B. payment is rounded to the next highest dollar.

If you receive state unemployment benefits for a partial week, the Plan will pay a daily benefit equal to 20% of the weekly benefit amount you would be entitled to receive. If the exact number of days of benefits you are entitled to receive cannot be determined, the plan will pay the minimum weekly benefit of \$15.

APPLICATION OF BENEFITS

To apply for Supplemental Unemployment Benefits (SUB) take the following steps, within a reasonable period of time:

1. Complete an application for Supplemental Unemployment Benefits (SUB) form. Forms may be obtained by contacting the Fund Office or downloading from our Website, 527.ORG.
2. Submit the SUB form along with a copy of the Pa. Unemployment check stub. Make sure you don't sign up for direct deposit as you won't get proof of payment.

GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining claim liability and administering the provisions of this Plan, the Trustees may, without the consent of or notice to the employees, release or obtain from any insurance company, other organization or person, information with respect to any eligible employee or dependent.

Any eligible employee or dependent claiming benefits under this Plan will be required to furnish information to the Trustees for the purpose of determining claim liability and administering the provisions of this Plan.

RIGHT OF EXAMINATION

The Trustees or their representatives have the right to have a physician examine any person claiming benefits for injury or sickness. The physician will be chosen by the Fund's

representative and the frequency of examination will be as often as reasonably necessary to substantiate a claim for benefits.

NOTICE OF CHANGE IN BENEFIT SCHEDULES

If a change in benefits is made, the change will generally become effective for deaths, accidents and illnesses which occur or begin on or after the effective date of the change and for treatments or services which are received on or after the effective date of the change, unless the Board of Trustees expressly provides otherwise. (see page 36 ... Trustees Right to Amend or Terminate the Plan)

INCAPACITATION

If you should become incapacitated and be unable to prepare, complete or execute the forms and documents prescribed by the Trustees or the Fund Office for filing of claims and receipt of benefits, the forms and documents may be signed on your behalf by other persons, as follows:

1. A guardian appointed for you by a court of competent jurisdiction;
2. If no guardian has been appointed, then the persons in the following order of priority after being found acceptable by the Trustees:
 - A. Spouse,
 - B. A child,
 - C. A parent,
 - D. A brother or sister,
 - E. Your estate.

COORDINATION OF BENEFITS WITH MEDICARE

If you, your covered spouse or dependent child becomes covered by Medicare, either because of disability or age, you may either retain or cancel your coverage under this Plan.

- If you, your spouse, and/or dependent child are covered by the Plan and by Medicare, and you retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will continue to provide the same benefits and your contributions for coverage will remain the same and this Plan pays first and Medicare pays second.
- If you cancel your coverage under this Plan, your spouse and/or your dependent child(ren)'s coverage will terminate, but they will be entitled to COBRA continuation coverage.

If you become totally disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for a limited period of time (30 consecutive months) starting the earlier of:

- (i) the month in which Medicare ESRD coverage begins; or
- (ii) the first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after Medicare ESRD coverage begins, Medicare pays first and this Plan pays second.

OVERPAYMENT OF BENEFITS

In the event an overpayment is made with respect to any claim for benefits by a Fund participant on behalf of the participant or the participant's dependent, the Fund reserves a right to recover the overpayment. Such recovery shall be affected by reducing future benefits to which the participant or his dependents are entitled, including the withholding of eligibility for specific benefits or by any other means selected by the Trustees.

CLAIMS AND REVIEW PROCEDURE

FILING OF CLAIMS

All claims for benefits, except for benefits underwritten by Highmark Blue Cross Blue Shield, must be submitted on claims forms made available by the Fund Office. *Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims.* Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. The Fund Office will forward claims forms to the carriers if the benefit is not self-insured.

APPEAL OF DENIED CLAIMS

The following procedure is followed to appeal a wholly or partially denied claim for benefits under the Fund:

1. Within 90 days after submission of a claim, written notice will be sent from the Fund Office which includes:
 - A. why the claim was denied,
 - B. what Plan provisions the decisions were based on,
 - C. what additional information is needed to complete the claim and why, and
 - D. how you can have your claim reviewed.
2. Within 60 days from the date the claim denial notification was received, a written request for review can be filed with the Fund Office.
3. You are entitled to be represented by an authorized person. Both you and your representative may review documents related to your claim and submit issues and comments in writing for initial review. Written notice of the Fund Office's decision will be sent within 20 days. It shall include specific reasons for the decision and referral to the Plan provisions on which it was based.

4. If after initial review the claim is not settled, a second review can be requested by a Review Committee, consisting of one Employer Trustee and one Union Trustee. This review request must be in writing and directed to the Fund Office no later than 60 days after receipt of the decision on the initial review.

5. The Committee's decision will be final and binding on all parties concerned. If the Committee is unable to agree, the initial review decision will stand.

6. You will receive written notice of the Committee's final decision, which includes specific reasons for the decision and references to the Plan provisions on which it was based.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) creates a new federal right for you to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child.

The Family and Medical Leave Act applies to Employers if they employed 50 or more employees for each working day during each of 20 or more work weeks in the current or preceding calendar year.

To be eligible for FMLA benefits, you must:

- work for a covered Employer;
- have worked for the Employer for at least 12 months;
- have worked at least 1,250 hours over the previous 12 months; and
- work at a location where at least 50 employees are employed by the Employer within 75 miles.

A covered Employer must grant up to a total of 12 work weeks of unpaid leave during any 12-month period for one (1) or more of the following reasons:

- for the birth or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child or parent) with a serious health condition; or
- to take medical leave when you are unable to work because of a serious health condition.

Spouses employed by the same Employer are jointly entitled to a combined total of 12 work weeks of family leave for the birth or placement of a child for adoption or foster care, and to care for a child or parent (but not a parent-in-law), who has a serious health condition.

Leave for birth or adoption (including foster care placement) must conclude within twelve (12) months of the birth or placement.

Under some circumstances, you may take FMLA leave intermittently - which means taking leave in blocks of time, or by reducing your normal weekly or daily work schedule.

- Where FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the Employer's approval.
- FMLA leave may be taken intermittently whenever it is medically necessary to care for a family member's serious health condition, or because you have a serious health condition and are unable to work.

"Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves:

- any period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility;
- any period of incapacity requiring absence of more than three (3) calendar days from work, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a Health Care Provider; or
- continuing treatment by (or under the supervision of) a Health Care Provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days, for prenatal care.

"Health Care Provider" means:

- doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctor practices; or
- podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to manual manipulation of the spine to correct subluxation as demonstrated by x-ray to exist) authorized to practice, and performing within the scope of their practice, as defined under state law; or
- Christian Science practitioners listed with the First Church of Christ Scientist in Boston, Massachusetts.

A covered Employer is required to maintain health coverage for you on FMLA leave equivalent to the coverage that was provided before the leave was taken and on the terms as if you had continued to work.

A covered Employer must continue to make contributions on your behalf while you are on FMLA leave as though you are continuously employed.

Upon return to work from FMLA leave, you must be restored to your original job, or to an equivalent job with equivalent pay, benefits, and other employment terms and conditions.

Your use of FMLA leave cannot result in the loss of any employment benefit that you earned or were entitled to before going on FMLA leave. The obligation to maintain health care coverage during an FMLA leave ends on the earliest of:

- when you return to work; or
- when 12 weeks of FMLA leave ends.

You need not accrue additional benefits or seniority during an unpaid FMLA leave, but you cannot lose benefits that accrued before a leave.

Welfare benefits, other than health care, must be reinstated when you return to work, without any new conditions or the requirement to re-qualify.

If you seek FMLA leave, your Employer may require you to provide:

- thirty (30) days advance notice of your need for FMLA leave when the need is foreseeable;
- medical certifications supporting your need for leave due to serious health condition affecting you or an immediate family member;
- second or third medical opinions and periodic recertification (at your Employer's expense) and periodic reports during FMLA leave regarding your status and intent to return to work.

When leave is needed to care for an immediate family member or for your own illness, and is planned medical treatment, you must schedule treatment so that it will not unnecessarily disrupt your Employer's operations.

You and your Employer must certify to the Trustees, in writing, that you have been granted FMLA leave in order to protect your rights to health care coverage during the 12-week period.

If you and your Employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

REPAYMENT OF CONTRIBUTIONS TO EMPLOYER

If you take a leave under the FMLA and you fail to return to your employer for any reason after such absence, under the Act, your employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and prevent possible repayment of all contributions to your employer, you should return to work at the end of your leave of absence under the FMLA.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under federal law, group health plans, insurers, and HMO's that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October, 21, 1998. In the case of a

participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

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

This coverage is subject to a plan's annual deductibles and coinsurance provisions.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

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

A copy of the Plan's procedures are attached hereto as Attachment 1.

MILITARY SERVICE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), participants who enter military service may be entitled to continue health coverage for themselves and their families while they are on active duty or away from work as a reservist. However, in order to secure such benefits a participant must notify the Fund Office and Union before he leaves work for military service. For further information on the requirements and benefits available under USERRA, please refer to the document attached at the back of this Summary Plan Description as Attachment 2.

SUBROGATION

This Plan will take advantage of its right to subrogation if you or your dependent are paid benefits for expenses due to accidental injuries for which someone else may be liable.

Subrogation means that the Plan can regain from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical malpractice or tortious conduct by a third (3rd) party. The right to Subrogation is not subject to reduction for your attorney fees. However, the Fund shall have no right of subrogation against an insurance company arising out of an individual policy of insurance maintained by you.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain responsibilities to the Fund. When you or your dependent submit a claim for injuries, the Administrative Office will have you complete a form requesting information as to how the injuries occurred and the identity of any potentially responsible third (3rd) parties. At the request of the Administrative Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Fund's Right of Subrogation. You shall notify the Fund whenever you have commenced litigation, or any administrative proceeding in connection with any illness or injury for which the Fund has paid benefits. You must notify the Fund of any attorney that is engaged to represent you in any such proceeding. Further, you shall notify the Fund of the discharge of such attorney and the further employment of any successor attorney. When an attorney is retained, your attorney shall acknowledge the existence of the Fund's right of Subrogation. You must not do anything to impair or negate this Right of Subrogation, and if any of your acts or omissions to act compromise this Right of Subrogation, the Fund will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents.

All terms and conditions of this Summary Plan Description and the Agreement and Declaration of Trust for the Fund are hereby incorporated, including but not limited to those provisions setting forth the Fund's priority in subrogation.

The Fund also retains a subrogation right to seek reimbursement of amounts paid for the benefit of Participant's Spouse and/or Dependent(s) which are subsequently recovered by said Spouse and/or Dependent(s) or by someone acting on his or her behalf from an insurer or other source. In order to receive benefit payments, Participant's Spouse and/or Dependent(s) shall be required to execute the Fund's subrogation form. In addition, if the Participant's Dependent(s) is a minor, the Participant shall be required to sign the Fund's subrogation form on behalf of the Participant's minor Dependent.

The Participant is not entitled to reimbursement by the Fund for expenses incurred as a result of an illness or injury which is work-related or for which benefits may be paid through Workers' Compensation Laws of the State of Pennsylvania or any other state.

Reimbursement to the Fund shall not exceed the amount that the Participant has received. The Fund shall be reimbursed to the extent of any payments made by the Fund to or on behalf of a Participant. If any balance remains from such recovery, it shall be applied to reimburse the Participant.

The Fund shall be entitled to first dollar recovery even though the Participant may not have been fully compensated for all losses incurred by the Participant.

Participant agree to reimburse the Fund for such benefits paid by the Fund regardless of whether or not the recovery made by the Participant is for the purpose of compensating for pain and suffering, medical expenses, dental expenses, attorneys fees, loss of income, loss of consortium or other losses and without regard to whether the recovery is specifically designated as a recovery for certain damages or expenses. There shall be no reduction in the amount of reimbursement paid by the Participant to the Fund for attorney's fees incurred or paid by the Participant in connection with said claim.

Attached is a copy of the subrogation agreement that the participant is required to execute in the event of commencing a lawsuit against a third (3rd) party for recovery of damages. (See attachment 3)

CLAIMS AND APPEAL PROCEDURES

A. OBTAINING AND COMPLETING CLAIM FORMS

The type of benefit being claimed will determine whether you must file any required claim forms and/or appeals through your health-care provider or the Fund. Depending upon the benefit involved, you may obtain the required claim forms from your health-care insurer or the Fund Office. REMEMBER, the prompt filing of any required claim form will result in faster payment of your claim.

B. TIME REQUIREMENTS

1. When to file a claim - File the completed claim form as soon as possible. Refer to your health care booklets to determine when your claim must be filed.
2. Time lines for deciding claims – Different time limits apply to initial and appeal decisions on (1) urgent health-care claims; (2) non-urgent claims for pre-service and post-service health care; (3) disability claims; and (4) all other benefit claims.

Urgent care claim - An urgent care claim is a claim for medical care with respect to which applying the time periods for making pre-service claims decisions could seriously jeopardize the claimant's life, health or ability to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without the care that is the subject of the claim. A claim that a physician who knows the claimant's medical condition, determines such claim meets any of these criteria must be treated as an urgent care claim. A claimant's request to extend a previously approved course of treatment that is an urgent care claim must be decided within 24 hours.

A. TIMELINES FOR DECIDING URGENT AND NON-URGENT HEALTH CARE CLAIMS

Your health-care Insurer (which, for purposes of this Section, may refer to either your health-care provider or the Plan depending upon the benefit involved) must comply with the following time requirements:

Once a claim has been received, the timelines for deciding claims are as follows:

Urgent Health Care

Participant must be notified of all incomplete information needed to perfect the claim within 24 hours.

Participant has 48 hours to provide the requested information
Insurer must make an initial benefit decision within 72 hours of receiving notice of the claim, or 48 hours after receiving the added information needed to perfect the claim

Urgent Health Care

Participant may appeal the claim orally or by phone, as well as in writing (materials must be accepted by phone or facsimile)

No mandatory and binding arbitration of claims

Final appeal decided within 72 hours

Non-Urgent Health Care

Participant must be notified of all incomplete information needed to perfect the claim within 5 days.

Participant has 45 days to provide the requested information
Upon receipt of the additional information (or at the end of the 45 day limit), the initial benefit decision must be made within 15 days for pre-service claims or 30 days for post-service claims. (There may be one 15-day extension for reasons beyond Insurer's control).

Non-Urgent Health Care

Participant has 180 days to appeal the decision in writing.

No mandatory and binding arbitration of claims.

Final appeal decided within 30 days for pre-service claims or 60 days for post-service claims

B. TIMELINES FOR DISABILITY AND ALL OTHER BENEFIT CLAIMS

Disability Benefits

Participant must be notified of all incomplete information within 15 days of the claim

Initial benefit decision made within 45 days of receiving the claim

Participant has 60 days to appeal a benefit decision and supplement the information

Final decision rendered within 45 days of the appeal or receipt of supplemental information

Insurer may obtain a 30-day extension to decide an initial claim or an appeal for reasons beyond the control of the Insurer, provided that the participant is notified in writing of the specific reasons for the extension. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

All Other Benefit Claims

Participant must be notified of all incomplete information within 45 days of the claim

Initial benefit decision made within 60 days of the claim

Participant has 60 days to appeal a benefit decision and supplement the information

Final decision rendered within 45 days of the appeal or receipt of supplemental information

Insurer may obtain a 45-day extension to decide an appeal for reasons beyond the control of the Insurer.

C. APPEALING THE DENIAL OF A CLAIM

A claimant whose claim has been denied may take an appeal to the Insurer. There is a toll-free telephone number on the back of your enrollment card - call this number to start the appeal process on urgent claims. There may not be more than two levels of appeal for denied claims. If more than one level of appeal is used, then both levels must be completed within the aggregate time frame applicable to the particular type of appeal, described above.

- 1. Time for Appeal** - As set forth above, with respect to urgent and non-urgent health care claims, no appeal of a denial of a claim shall be considered unless it is submitted within 180 days of the denial. After receipt of such appeal, the claimant will be notified of the date, time and place of hearing, and will be advised to furnish any records of employment or other data he thinks will substantiate his claim of eligibility for benefits.
- 2. Your rights on Appeal** - The claimant or his authorized representative must be permitted to review pertinent documents including all records and expert reports "relevant" to the benefit claim, even if those records were not relied upon; copies will be provided free of charge upon request. Further, Participants may review all of the Insurer's internal rules, guidelines, and scientific or statistical research relevant to the benefit claim, and, for those health benefit claims involving a reduction in physician fees, Participants may review the Insurer's schedule of usual and customary fees. The Insurer must disclose the name of any medical professionals who were consulted during the claim review process, even if the Insurer declined to follow their advice.
- 3.** In addition, Participants may submit any written comments, documents, or other information to support their claim, and the Insurer has an obligation to consider all this information. The Insurer must review every appeal on a de novo basis, without any deference to the initial decision-maker's choice. Any appeal must be reviewed by a different decision-maker than the initial decision and he or she may not be the subordinate of the initial reviewer. Similarly, if a health care professional is consulted on the initial benefit decision, neither that health care professional nor his or her subordinate may be consulted on an appeal.
- 4.** No fees may be charged to appeal benefit claims, and no prior approval is needed to appeal benefit claims. Further, Participants may not be barred from using representatives (including physicians) as advocates during the claim review process. However, the Insurer may establish reasonable procedures for determining whether a representative has been authorized to act on behalf of a Participant.
- 5.** Additionally, claimants must be notified of any decision to terminate or reduce previously granted benefits for an ongoing course of treatment ("concurrent care decisions") early enough to complete an appeal before the reduction or termination becomes effective.
- 6. Notice of Determination on Appeal** - Upon completion of the hearing, and the checking of any further records required, the Trustees will render a decision on the claims for benefits, and will notify the claimant of their decision in writing.

The decision will include specific references to any provisions on which the decision is based.

If a claim is wholly or partially denied, written notice of the decision will be furnished to the claimant. The notice will contain:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent Insurer provisions on which the denial is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. An explanation of the Insurer's claims review procedure, applicable time limits, and the right to sue.

All decisions of the Insurer on appeal will be final and binding.

ERRORS IN BENEFIT PAYMENTS

The Trustees specifically retain the right to recover all money paid in error to or on behalf of any person, from such person.

Upon the discovery of the payment made in error, the Trustees will notify the recipient or beneficiary of the error, indicating the circumstances and amount of payment in error, together with a request for repayment. If the recipient fails to repay the amount due within a reasonable time after such notification, the Trustees may take whatever legal action they deem necessary. In the case of a Plan participant, the amount of payment made in error may be deducted from any future benefit payments that the participant or his dependents or beneficiary may become entitled to under this Plan.

FRAUD

Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Medical Plan, may be prosecuted in whatever manner the Trustees deem advisable.

TRUSTEES' RIGHT TO REQUIRE A PHYSICAL EXAMINATION

The Trustees, at their expense, shall have the right and opportunity to have any participant or dependent examined as often as is reasonably required while a claim is open or pending. If a claimant is notified to report to a physician designated by the Trustees for a physical examination and fails to do so without reasonable cause, at the Trustees' discretion the claimant may be disqualified from receiving further benefit payments.

TRUSTEES' RIGHT TO AMEND OR TERMINATE THE PLAN

In accordance with the Agreement and Declaration of Trust, the Board of Trustees are empowered to amend, alter, modify or terminate the plan of benefits for active or retired employees. Benefits under the Plan are not guaranteed. The Board of Trustees in their absolute discretion and in what they deem appropriate retains the right to modify or terminate benefits provided to active or retirees at any time. The plan of benefits shall terminate upon the occurrence of any one or more of the following events: if the plan assets are, in the opinion of the Board, inadequate to carry out the intent and purpose of the plan or are inadequate to meet the payments due or which may become due to Participants and Beneficiaries; if there are no individuals living who can qualify as Employees; if the Union and Employers agree to terminate the Plan; if the Plan is merged into another employee benefit plan; any other event which may, by law, require termination.

In the event of termination of the Plan, the Board shall make provision out of the Plan assets for the payment of expenses incurred up to the date of termination and the expenses incidental to termination; arrange for a final audit and report of the Board's transactions and accounts for the purposes of ending the trusteeship; and apply the Plan assets to the extent available to pay the obligations of the Plan and distribute and apply any surplus in a manner that will inure to the exclusive benefit of the Participants and Beneficiaries in accordance with the purposes of the Plan and the requirements of law.

TRUSTEES' AUTHORITY

The Plan Fiduciaries shall have the authority to interpret all Plan documents, construe all uncertain terms and determine eligibility on behalf of participants for all benefits.

SUMMARY OF MATERIAL MODIFICATION

If there is a modification or change that is a material reduction in covered services or benefits provided under a group health plan, a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative the plan sponsors may provide such description at regular intervals of no more than 90 days.

**INFORMATION REQUIRED
BY THE EMPLOYEE RETIREMENT
INCOME SECURITY ACT OF 1974**

Name and Address of Plan.

Shopmens' Local 527 Benefit Fund
2945 Banksville Road
Pittsburgh, Pennsylvania 15216
(412) 341-6183

A complete list of the employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination.

Employer Identification Number.

The Employer Identification Number (EIN) issued to the Board of Trustees is 23-7311912. The Plan is further identified as Plan No. 501.

Type of Plan

The benefits provided under the Plan include hospitalization, medical-surgical, major medical, life insurance, accidental death and dismemberment, and weekly sick and accident benefits.

Type of Administration of the Plan.

The Plan is administered by the Board of Trustees of the Shopmen's Local 527 Benefit Fund.

Name and Address of Plan Administrator.

Board of Trustees of Shopmen's Local 527 Benefit Fund
2945 Banksville Road
Pittsburgh, Pennsylvania 15216
(412) 341-6183

Name and Address of Administrative Manager.

Debby Mitchell
2945 Banksville Road
Pittsburgh, Pennsylvania 15216
(412) 341-6183

Name of Person Designated as Agent for Service of Legal Process.

Stephen J. O'Brien, Esquire
71 McMurray Road
Pittsburgh, Pennsylvania 15241
Service of legal process may be made on a Plan Trustee or the Administrative Manager

Name of Organization Designated as Consultant to the Trustees.

The Segal Company
130 East Ninth Street, Suite 1900
Cleveland, Ohio 44114

Name and Address of Certified Public Accountant.

McElhaney & DiClaudio
1725 Washington Road, Suite 202
Pittsburgh, PA 15241

SHOPMEN'S LOCAL 527 BENEFIT FUND TRUSTEES

UNION TRUSTEES

Ernie Heinauer
Martin Marinack

EMPLOYER TRUSTEES

John M. Mihm
Donald H. Landis

The Trustees can be contacted at:

Board of Trustees of the Shopmen's Local 527 Benefit Fund
2945 Banksville Road
Pittsburgh, Pennsylvania 15216
(412) 341-6183

Collective Bargaining Agreements

Copies of Collective Bargaining Agreements may be obtained by participants and beneficiaries through written request to the Administrative Office or a Trustee. For information on Collective Bargaining Agreements, call the Administrative Office.

Sources of Contributions to the Plan

The Plan is financed through Employer Contribution made in accordance with Collective Bargaining Agreements in force with The Shopmen's Local Union No. 527.

Funding Medium

The Plan is financed primarily by employer contributions, the amount of which is specified in the Collective Bargaining Agreement between your employer and The Shopmen's Local Union No. 527. The Plan assets are held in a trust which is administered by the Board of Trustees.

Date of End of the Plan Year

The date of the end of the fiscal year is December 31.

Procedure to be Followed In Presenting Claims for Benefits Under the Plan

Remedies are available under the Plan for the redress of claims which are denied in whole or in part, including provisions required by Section 503 of the Employee Retirement Income Security Act.

For a complete description, see the Claims and Appeals Procedure earlier on in this booklet.

Statement of Participants' and Beneficiaries' Rights under ERISA

As a participant in the Shopmen's Local 527 Benefit Fund, 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:

- Examine, without charge, at the Plan Administrator's 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 annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.
- File suit in a federal court, if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to \$110 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. These persons are referred to in the law as "fiduciaries." Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one - Employer, Union, or any other person - may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your rights under ERISA.

If your claim for a Welfare Benefit is denied, in whole or in part, you must receive a written explanation for the denial. You have the right to ask for a review and reconsideration of your claim by the Plan Administrator. If your claim, in full or in part, is again denied, you have a right to file suit in a federal or state court.

If Plan fiduciaries are misusing the Plan's money, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor.

If you are successful in your lawsuit, of whatever classification, the court may, if it so decides, require the other party to pay your legal costs, including attorney's fees. However, if you lose, the court may order you to pay these costs and fees; for example, if it finds your allegation or claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

ATTACHMENT 1

QUALIFIED MEDICAL SUPPORT ORDERS

Medical child support orders must be "qualified" before a plan is required to honor them. A Qualified Medical Support Order must clearly specify the following:

- (1) The name and last known mailing address of the plan participant;
- (2) The name and last known mailing address of each alternate recipient covered by the Order;
- (3) A reasonable description of the coverage to be provided by the plan or the manner in which the type of coverage is to be determined;
- (4) The period to which the order applies; and
- (5) Each plan the Order covers.

A Qualified Medical Support Order cannot require a plan to provide any type or form of benefit or option not otherwise provided under the plan, except to the extent necessary to meet the requirements of laws relating to medical support orders as described in Section 908 of the Social Security Act. A child cannot be denied coverage on the grounds that he or she was born out of wedlock or is not the tax dependent of the plan participant or does not reside with the plan participant or in the insurer's service area.

The plan participant and the alternate recipient must be promptly notified by the Plan Administrator of the receipt of a medical child support order and the plan's procedures for determining whether the medical child support order is a Qualified Medical Support Order. Within a reasonable period after receipt of the order, the plan administrator must determine whether the medical child support order constitutes a Qualified Medical Support Order and notify the plan participant and the alternate recipient of the determination. The child must be allowed to designate a representative for the receipt of copies of notices with respect to such order.

A child who is an alternate recipient under a Qualified Medical Child Support Order is considered a beneficiary under the plan for purposes of ERISA. Thus, the child is entitled to summary plan descriptions and other disclosures to which a plan participant is entitled and has standing to bring actions under ERISA.

PROCEDURES

Upon receipt of a Medical Child Support Order that has been determined to be qualified, written notice of receipt shall promptly be sent to the employee and each alternate recipient named in the Order. The written notice should say that the child(ren) will be allowed to enroll in the employee's health/dental insurance plan(s). Alternate recipients may designate a representative (e.g. custodial parent/legal guardian/state Department of Human Services/county human services department) to receive this information.

If the employee currently has dependent health/dental insurance, the employee must complete an Address and Dependent Change Form and send the form and a copy of the medical support order to the Plan Office. The Plan Office will forward a copy of the form and the Order to any appropriate carriers. Effective date of coverage will be the date of the Court Order.

If the employee does not have dependent health/dental insurance, the employee must complete an Application for Basic Coverage adding dependent coverage for the child(ren). Coverage must be under the same plan in which the employee is enrolled. The effective date will be the first day of a pay period following the date of the Court Order.

The employee MAY NOT change plans at this time. If the employee is enrolled in an HMO health or dental plan, and the child(ren) lives outside of the Plan's approved service area, the child(ren) may need to travel to the HMO for service. Children who reside with the employee's ex-spouse will receive "in network" benefits no matter where they live. The HMO cannot deny enrollment to child(ren) living outside of the approved service area.

The Plan Office will enroll the child(ren) as required by the Court Order, inform the insurance carrier(s) of the enrollment and begin payroll deductions. The computer system will be marked to indicate that there is a Court Order in effect and coverage may not be cancelled before the date specified in the Court Order. Employees will not

be allowed to drop dependent coverage prior to the date specified in the Court Order, unless it is subsequently revised.

If an employee who is the subject of a medical child support order terminates employment, is laid off, retires or goes on leave of absence etc., the Plan Office must give information to the alternate recipient or his/her representative about continuing insurance. The information must be given in the same timeframe as required by COBRA law.

Attachment 2

MILITARY SERVICE

Under the Uniformed Services Employment and Reemployment Act (USERRA), if you enter military service or are called for active military service from reserve status you can continue health coverage for yourself or your family, similar to COBRA coverage, while you are on active service or away from work as a reservist.

TO SECURE YOUR BENEFITS YOU MUST:

FIRST: NOTIFY THE FUND OFFICE AND THE UNION BEFORE YOU LEAVE WORK FOR MILITARY SERVICE.

The notice may be oral or written. Failure to notify due to military necessity, impossibility or unreasonable circumstances will not automatically disqualify you.

SECOND: NOTIFY THE FUND OFFICE AND THE UNION OF YOUR INTENTION TO RETURN TO WORK UPON YOUR DISCHARGE FROM MILITARY SERVICE.

The notice to the Plan Office shall include a copy of your discharge papers. An Honorable Discharge is required. A time limitation exists to return to work. Failure to follow the re-employment time limits will disqualify you. The applicable time limits are as follows:

Length of Military Service	Re-employment Deadline:
Less than 31 days	1 work day after discharge (allowing 8 hours for travel)*
31 through 180 days	14 days after discharge**
More than 180 days	90 days after discharge

* or as soon as possible after the expiration of the eight hours travel time if such is impossible or unreasonable.

** or if such is impossible, then the next day when it becomes possible after the 14 days.

An absence for examination for service is treated as a period for less than thirty-one days. If hospitalization occurs during service, then the time periods above apply after recovery, but such time shall not exceed two years.

These rights have limitations and you should contact the Plan Office for further details. This notice is not intended to explain all rights and limitations of USERRA.

Attachment 3

SUBROGATION AGREEMENT

This Agreement, entered into this ____ day of _____, 20____, by and between, _____, residing at _____, a participant or participant's spouse and/or dependent in the Shopmen's Local 527 Benefit Fund (hereinafter referred to as "Participant"), and the Trustees of the Shopmen's Local 527 Benefit Fund (hereinafter referred to as "Fund").

RECITALS

- A. Participant (for purposes of this agreement, unless otherwise specifically stated, "Participant" includes a Beneficiary of or Spouse or Dependant of Participant) is entitled to receive benefits from the Fund for medical expenses incurred which have not been reimbursed by other sources, provided that they come within the coverage limitations set forth in the Plan of Benefits and the Summary Plan Description of the Fund.
- B. The Fund has retained a subrogation right to seek reimbursement of amounts paid to a Participant, which the Participant, or its agent, subsequently recovers from an insurer or other source. Specifically, the Fund will pay benefits pursuant to the Plan of Benefits, but is entitled to receive from the Participant reimbursement of benefits previously paid on behalf of the Participant to the extent the Participant is reimbursed from a third party. In addition, the Participant is required by the Fund to sign a Subrogation Agreement to ensure that the Fund will receive reimbursement pursuant to its subrogation policy. All terms and conditions of the Summary Plan Description and the Agreement and Declaration of Trust for the Fund are hereby incorporated and made part of this Agreement, including but not limited to those provisions setting forth the Fund's priority in subrogation.
- C. The Fund also retains a subrogation right to seek reimbursement of amounts paid for the benefit of Participant's Spouse and/or Dependent(s) which are subsequently recovered by said Spouse and/or Dependent(s) or by someone acting on his or her behalf from an insurer or other source. In order to receive benefit payments, Participant's Spouse and/or Dependent(s) shall be required to execute the Fund's subrogation form. In addition, if the Participant's Dependent(s) is a minor, the Participant shall be required to sign the Fund's subrogation form on behalf of the Participant's minor Dependent.
- D. The Participant is not entitled to reimbursement by the Fund for expenses incurred as a result of any illness or injury which is work-related or for which benefits may be paid through the Workers' Compensation Laws of the State of Pennsylvania or any other state.
- E. The Participant has filed a claim for medical expenses incurred, or other benefits, with the Plan Administrator of this Fund and, in addition, may be entitled to recover such expenses from another source or sources.

NOW, THEREFORE, the parties hereto agree as follows:

- 1. The Fund agrees to pay to or on behalf of Participant, according to the Plan of Benefits currently in effect, medical expenses, disability benefits and benefits for time away from work, even though Participant may later recover such expenses from another source, but subject to the Fund's right to recover such payments in accordance with the terms of this Agreement.
- 2. Participant agrees to reimburse the Fund for all payments the Fund has made or will make to or on behalf of Participant for medical benefits, disability benefits and/or other benefits paid by the Fund if Participant has recovered any judgment, payment or settlement from a third party

with respect to the injury or illness which resulted in a claim for benefits being paid by the Fund to or on behalf of Participant. Such reimbursement to the Fund shall not exceed the amount that the Participant has received. The Fund shall be reimbursed to the extent of any payments made by the Fund to or on behalf of a Participant. If any balance remains from such recovery, it shall be applied to reimburse the Participant.

3. Participant agrees that the Fund shall be entitled to first dollar recovery even though the Participant may not have been fully compensated for all losses incurred by the Participant.
4. Participant agrees to reimburse the Fund for such benefits paid by the Fund regardless of whether or not the recovery made by the Participant is for the purpose of compensating for pain and suffering, medical expenses, dental expenses, attorneys fees, loss of income, loss of consortium or other losses and without regard to whether the recovery is specifically designated as a recovery for certain damages or expenses. There shall be no reduction in the amount of reimbursement paid by the Participant to the Fund for attorney's fees incurred or paid by the Participant in connection with said claim.
5. Participant shall notify the Fund whenever the Participant has commenced litigation, or any administrative proceeding in connection with any illness or injury which is the subject of this Agreement, giving the Fund the names of the parties to the proceeding and the venue for such proceeding. This is a continuing obligation and the Participant shall notify the Fund at the time this Agreement is signed of any such proceedings, and Participant shall have a continuing obligation to notify the Fund at any time that such proceedings are commenced.
6. The Participant agrees to notify the Fund of any attorney that is engaged to represent the Participant in any such proceeding. Further, the Participant shall notify the Fund of the discharge of such attorney and the further employment of any successor attorney. In addition, if an attorney is retained at the time that this document is signed, the attorney shall acknowledge the existence of this representation.

However, subrogation specifically does not apply to an insurance policy issued to and in the name of the subscriber.

Dated this ____ day of _____, 20__.

Participant

Participant's Spouse

Participant's Dependent

IF THE DEPENDENT IS A MINOR, THE PARTICIPANT SHALL ALSO SIGN ON BEHALF OF THE MINOR DEPENDENT:

Participant on Behalf of Minor
Dependent

