The Lithographers & Photoengravers Local 285 Welfare Fund

SUMMARY PLAN DESCRIPTION

Effective March 1, 2012

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March 2012

To All Eligible Participants:

We are pleased to present you with this summary of the benefits available under the Lithographers and Photoengravers Local 285 Welfare Fund ("Fund"). This Summary Plan Description ("SPD") also includes information applicable to groups formerly covered by the old Bookbinders Welfare Fund who continue to be governed by separate eligibility rules. Because healthcare is so vitally important to you and your family, we urge you to read this booklet carefully.

We are also pleased to point out that the benefits provided by the Fund are in compliance with the mandates of the Patient Protection and Affordable Care Act ("PPACA"). In particular, the Fund provides coverage for comprehensive preventive care without any deductibles or copayments and includes no annual or lifetime limits on essential medical benefits. One important improvement you will notice is that dependent children are now covered through age 25, without any showing of full-time student status.

This SPD furnishes a summary of the benefits to which you and your family are entitled, the rules governing these benefits and the procedures that should be followed when filing a claim for benefits. The benefits provided by the Fund are insured. Those benefits, including benefits from Kaiser Permanente, National Vision Administrators, L.L.C., Group Dental Service, and Mutual of Omaha are governed by the terms of the insurance policies and statements of coverage issued by the carriers, and this is only a summary. You will receive additional materials from the carrier. The Fund's eligibility rules are governed by this SPD.

The Board of Trustees of the Fund has the sole and exclusive power to make all final determinations regarding eligibility, benefits or any other matter relating to the Fund, including all interpretations of the Fund's governing documents, and those determinations are binding on all parties. Only the administrator and the full Board of Trustees are empowered to speak for the Fund.

The Trustees have the responsibility for overseeing the operation of the Fund. Part of their duty is to seek to maintain the financial stability of the Fund so that it can continue to pay benefits into the future. Consequently, as conditions change, the Board of Trustees may change, modify or eliminate any of the benefits offered by the Fund at any time.

Sincerely,

BOARD OF TRUSTEES

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HIGHLIGHTS*

The Fund offers comprehensive medical coverage. For active employees and their dependents, as well as retirees and their dependents who pay the required premium and who are not yet eligible for Medicare, the Fund provides benefits through Kaiser Permanente. All active employees will automatically be placed in the Kaiser Signature HMO Plan. This will give you access to medical care through the Kaiser Permanente Medical Centers located throughout the region. For an additional premium, you may elect to use the Kaiser Select network, which gives you the option of accessing care either through the Kaiser Permanente Medical Centers or from the thousands of other providers who have joined their network. *See* p. 12. Furthermore, if you live or work more than 50 miles from a Kaiser Permanente facility, for an extra fee, you can take advantage of the Kaiser Permanent Out-Of-Area Network. For both the Kaiser Select and Out-of-Area Networks, you can choose between the Standard Plan and the High Plan. Retirees and their dependents who are Medicare-eligible and who pay the required premium can obtain care from any Kaiser Permanente Medical Center. *See* p. 3. In general, Kaiser Permanente provides comprehensive medical care, along with prescription drug coverage. Retirees have the additional option of getting coverage from the Graphic Communications National Health and Welfare Fund. *See* p. 3.

Whichever program of medical benefits you choose, you will also be eligible for the following additional benefits:†

- **Vision Care Benefits** provided through NVA. *See* p. 14.
- **Dental Benefits** provided through Group Dental Service of MD, Inc. *See* p. 14.
- **Life Insurance and Accidental Death and Dismemberment Insurance** provided through Mutual of Omaha**.** *See* p. 15.
- **Weekly Sickness and Accident Benefits** provided through Mutual of Omaha. *See* p. 16.

ELIGIBILITY AND COVERAGE

WHO IS ELIGIBLE?

Determining Your Group

The eligibility requirements are different, depending on whether you are in the "Lithographers Group" or the "Bookbinders Group." If your group was covered by the Bookbinders Welfare

*The coverage described here is only a very brief summary provided solely for your convenience. The actual program of benefits, along with the terms and conditions of coverage, any applicable limitations and exclusions, the required claims and appeals procedures, and other important information is described in separately available materials.

†Retirees and their dependents must pay an additional premium for Vision Care Benefits and Dental Benefits. Retirees may pay an additional premium for a reduced Life Insurance Benefit. Accidental Death and Dismemberment Insurance and Weekly Sickness and Accident Benefits are not available for retirees or their dependents.

Fund prior to its merger into the Fund, you are in the Bookbinders Group. Otherwise, you are in the Lithographers Group. You can find out which group you are in by checking with the Fund Office.

Active Employees – Lithographers Group

You are eligible for benefits during any month following a month for which a contribution is made on your behalf, provided you make any required employee contribution. Generally, your employer is required to make contributions for any month in which you worked at least eight (8) days.

Special Rule for New Employees -

A new employee of a participating Employer becomes eligible for benefits on the first day of the month following the month for which his or her Employer first owes contributions to the Fund on the employee's behalf, provided that the Employer notifies the Fund of the employee's employment and commits that it will pay its contribution for the employee along with its regular monthly contributions for the rest of its employees and it deducts any required employee contribution.

Active Employees – Bookbinders Group

You will become eligible for benefits if you are a regular full-time employee employed by an Employer under a collective bargaining or other agreement requiring contributions to the Fund, provided you do not elect to waive coverage. Your effective date of coverage is the first of the month for which your Employer begins to pay contributions to the Fund on your behalf, which is determined under your collective bargaining agreement. Your coverage will remain effective for any month for which your Employer is required to pay, and pays, contributions to the Fund.

If you have opted out of coverage from the Fund, you may not opt back in except as provided in the Special Enrollment section.

Active Employees – Special Enrollment

Under some collective bargaining agreements (including most of the former Bookbinders contracts), you may elect to decline coverage. Once you have done so, neither you nor any member of your family may reenroll, except as follows:

- You may reenroll during "open season", which is generally conducted in January and February of each year, with coverage effective March 1.

- If you declined enrollment because you or your family had other health insurance or group health plan coverage, you may enroll yourself and your dependents in this Fund if you or your dependents lose eligibility under that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).*

- If you or your dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility for such coverage or your or your dependents are determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Fund.

- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Fund Office at 866-559-6512.

Active Employees – Rates and Cost of Coverage

Your Employer is required to contribute to the Fund at the rates set in its collective bargaining or other agreement. You are responsible for paying the difference between the contributions paid by your Employer and the cost of your coverage, as determined by the Board of Trustees. Ordinarily, the amount of your required contribution will be deducted from each of your paychecks. In the event that you are off work during a period when your Employer is required make contributions on your behalf, it is your responsibility to make arrangements with your Employer to pay your share of the required contributions. If you fail to pay your required contributions, your coverage will terminate.

Retirees

The Fund also covers Employees who retire from Covered Employment. A former Employee is considered to have retired from Covered Employment if he or she begins to receive a pension from the Inter-Local Pension Plan, the GCIU Supplemental Retirement and Disability Fund, or any other pension plan sponsored in part by the GCIU or its affiliates, immediately upon terminating Covered Employment at or after reaching age 55.

Retirees have several options, depending upon their ages. Retirees who are not yet Medicare-eligible and non-Medicare-eligible dependents of a retiree may elect to receive medical coverage from the same Kaiser Permanente plans available to active employees. Upon reaching eligibility

*You must provide a written statement, along with evidence of the other coverage, in order to receive coverage from the Fund. If you fail to submit such a statement and evidence, you will not receive coverage from the Fund.

for Medicare, retirees and dependents may elect between two Medicare Advantage plans offered by Kaiser Permanente, "Plan A" or "Plan C++". Medicare-eligible retirees and dependents may choose between these two plans annually during Kaiser's open season, which normally takes place in October and November..

Alternatively, a Retiree may elect coverage under the Graphic Communications National Health and Welfare Fund ("GCN Fund"). The required contribution rates and the schedules of benefits for the GCN Fund are available upon request.

A Retiree receiving medical coverage may also elect to receive optical and dental care (*see* p. 14) and a reduced life insurance benefit (*see* p. 15), provided he or she pays the required additional premium. No other benefits are available to Retirees or their Eligible Dependents.

A Retiree who wishes to continue coverage under this Fund must elect such coverage immediately upon retirement. Employees who retire and do not immediately elect to continue coverage under this Fund will not be permitted to elect retiree coverage under this Fund at a later time. A Retiree may also elect coverage for his or her Eligible Dependents, but must do so at the same time he or she elects coverage for him- or herself.

Furthermore, a Retiree must elect any available options at the time he or she initially elects retiree coverage. Although some or all coverage may be dropped at any time (including life, dental or optical coverage, or coverage for a dependent), unless specifically provided for otherwise, ***once coverage is dropped, it is permanently lost and may never be resumed.***

A Retiree electing coverage under this Fund must pay the premiums determined by the Trustees by the twenty-fifth day of each month prior to the month for which coverage is sought. Failure to pay a premium by the tenth day of the month for which coverage is sought will result in the permanent termination of coverage for the Retiree and any Eligible Dependents. Furthermore, the Fund does not send monthly bills. It is your responsibility to make sure all premiums are paid on a timely basis. ***If you fail to pay a premium when due, your coverage will be terminated without notice.***

Eligible Dependents

This Fund also covers Eligible Dependents of Active Employees and Retirees. Eligible Dependents include your Spouse and children until they turn age 26.

Coverage for an Eligible Dependent begins when the Employee's coverage begins.

Children are defined as your natural children, adopted children, and stepchildren. An adopted child is covered as of the day the child is placed with you for adoption, even if the adoption is not yet final. The term "placement," as used in this definition, means your assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Children are eligible for coverage under the Fund up to their 26th birthday. A child who is 26 or older may also be eligible for group coverage if he or she is physically or mentally incapable of self-support, either of which occurred while a dependent, and is not married. To extend a child's coverage under this provision, proof of incapacity must be received by the Fund Office within 30 days after the date coverage would normally terminate. Additional proof will be required each year thereafter.

In order for your Eligible Dependents to receive their coverage, you must submit with your application to the Fund a copy of your marriage certificate (if applying for coverage for your spouse) and copies of birth certificates and other necessary legal documents for your children (if applying for coverage for your eligible children).

The Fund will comply with any special enrollment rules required by the Health Insurance Portability and Accountability Act.

Special Rule for Spouse of Retirees: In general, once a dependent of a retiree drops coverage for any reason, that coverage is permanently lost and may never be resumed. The spouse of a Medicare-eligible retiree may, however, temporarily discontinue coverage from the Fund and later resume coverage provided:

- The spouse is covered under a comparable health plan maintained by his or her employer;
- The spouse remains continuously covered under such health plan during the entire period prior to the resumption of coverage by the Fund; and
- The required monthly premium is paid to the Fund no later than 30 days following the termination of the other coverage.

Dependents Covered under Qualified Medical Child Support Orders

The Fund will also enroll any of your natural or adopted children in accordance with a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order that the Fund determines is a "Qualified Medical Child Support Order" ("QMCSO"), as defined in the Social Security Act and the Employee Retirement Income Security Act of 1974 ("ERISA"). QMCSOs may compel this Fund to provide health benefit coverage for your children even if you do not have custody of them. To be a QMCSO, a judgment, decree, or order must require enrollment in the Fund as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support and must include:

- Your name and last known mailing address, and the name and mailing address of each child covered by the order,
- A reasonable description of the type of coverage to be provided by the Fund,
- The period of coverage to which the order pertains, and
- The name of the Fund.

Such an order is not a QMCSO if it requires the Fund to provide any type or form of benefit not otherwise provided under the Fund except to the extent necessary to comply with a state law

relating to medical child support orders. Upon receipt of an order, the Fund will notify you and each child covered by the order submitted for determination that the order has been received and of the Fund's procedures for determining whether the order is a QMCSO. You may also obtain upon request and without charge a copy of the Fund's QMCSO procedures. The Fund will notify you and each affected child in writing of its determination as to whether an order is a QMCSO.

Change in Family Status

You have an obligation to advise the Fund Office in writing of any change in family status (*e.g.*, divorce, addition to or deletion from the family, *etc.*), within 21 days of such change, and provide any documentation deemed necessary by the Fund Office relating to such change.

This information is necessary to avoid any delays in the processing of your claims. Furthermore, it is necessary because members of your family who would otherwise lose coverage may have a right to self-pay for continuing coverage, a right that will be forfeited if the Fund Office does not receive proper notice. *See* pp. 8 - 10. Advising the Fund Office of any change in family status is also important to avoid any mispayment of claims for individuals who are no longer entitled to coverage under the Fund. If the Trustees pay a claim for benefits by or on behalf of you or your family member who is no longer eligible for benefits under the Fund because you have failed to advise the Fund Office in writing of a change in family status as required above, the Trustees will hold you financially responsible. If any benefits are paid to or on behalf of your ineligible family members, you and any Eligible Dependents may be denied all further benefits until restitution of the money improperly obtained (whether by offset or otherwise) is made to the Fund.

MAINTAINING COVERAGE DURING ABSENCES

Short-Term Absences from Covered Employment

Except as required under the Family and Medical Leave Act, your Employer's obligation to make contributions on your behalf is governed by the terms of the applicable collective bargaining agreement. Under many of those agreements, Employer contributions to the Fund are owed for you if you are absent from Covered Employment due to a disability for up to six months. Additionally, under these contracts, Employer contributions are generally due for you if you experience a second period of absence due to disability, provided that you have returned to full-time employment from a prior absence for a period of at least 30 days.

During any period when you are on unpaid leave and your Employer is required to continue making contributions to the Fund on your behalf, you must make arrangements with your Employer to continue to pay your Employee Contributions. ***Failure to pay your Employee Contributions will result in the termination of your coverage,*** even if your Employer continues making contributions on your behalf. If you are receiving Sickness and Accident Benefits, your Employee Contributions will be automatically deducted from your weekly benefit, so that you will not have to make separate arrangements with your Employer. Once your Sickness and Accident Benefits cease, however, if your Employer continues to be required to make

contributions to the Fund on your behalf, you must make arrangements with your Employer for payment of your Employee Contributions or your coverage will be terminated.

Family and Medical Leave Act of 1993

If you are off on leave that qualifies under the Family and Medical Leave Act ("FMLA") of 1993, your Employer will continue to be required to make contributions on your behalf in order to maintain your coverage. That obligation will cease, however, if you fail to pay your required employee contributions. If you do not return to work after your period of leave has ended, your Employer may have the right to recover its share of contributions from you. As with any other form of leave where your Employer is required to make contributions on your behalf, you must make arrangements with your Employer to continue to pay your Employee Contributions or your coverage will be terminated.

The FMLA generally entitles employees to take up to 12 weeks of unpaid leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent. (State law may provide different leave periods.) In addition, the FMLA provides leave for the birth or placement of a child with the employee in the case of adoption or foster care. Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the Contributing Employer and who have provided at least 1,250 hours of service to the Employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees within a 75 mile radius of that employee equals or is greater than 50.

Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to report and make contributions for the period of your absence. In addition, if you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration.

TERMINATION OF COVERAGE

The following circumstances will result in termination of your coverage:

Failure of a Contributing Employer to make contributions on your behalf to the Fund;

Failure of an Employee to make any required contribution or premium payment for coverage.

Failure of a Retiree (or his Spouse, where applicable) to make timely contribution or premium payments to the Fund, as required by the Trustees;

Entry into the Uniformed Services, as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination. Notwithstanding the above, or any other provision of the

Fund to the contrary, contributions, benefits, and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code. Check with the Fund Office if you believe you may be eligible for benefits or coverage under the Fund in accordance with federal law governing military service; or

Cessation of work in Covered Employment—Lithographers Group

Your coverage will cease as of the last day of the month for which contributions (including both employer and any required employee contributions) are paid to the Fund on your behalf. Generally, this is the month following the month in which you last worked eight days.

Cessation of work in Covered Employment—Bookbinders Group

Your coverage will cease as of the last day of the month in which you cease your employment.

CONTINUATION OF COVERAGE (COBRA)

In certain circumstances when coverage for benefits from the Fund would otherwise end, a Participant or Eligible Dependent can self-pay to continue benefits for a limited period. This extended coverage is called COBRA Continuation Coverage and is available to both Participants and Eligible Dependents. The COBRA rates are established by the Trustees based upon the actual cost of providing benefits, and will change from time to time. COBRA Coverage does not include Life Insurance Benefits, Accidental Death and Dismemberment Benefits or Weekly Accident and Sickness Benefits.

COBRA Rules for Employees

An employee who would otherwise lose coverage because of the loss of his job or a reduction in hours of employment (other than as a result of gross misconduct) may choose COBRA Continuation Coverage for him- or herself and/or his or her spouse and/or Eligible Dependent children. An Employee may pay for up to 18 months of continued coverage from the date he or she would otherwise lose coverage.

Under certain circumstances, a disabled person and his or her family may extend coverage for up to a total of 29 months (an additional 11 months) following termination of employment or a reduction in hours of employment. To qualify for the additional 11 months of coverage, the Social Security Administration must determine that the Employee became disabled within the first 60 days of COBRA continuation coverage, and that determination must be submitted to the Fund during the first 18 months of coverage. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members. If the Social Security Administration makes a final determination that an Employee receiving this extended disability coverage has ceased to be disabled, the Employee must notify the Fund within 30 days. In any case, the opportunity to self-pay for continued coverage ends on the earlier of the date the

Employee becomes eligible for Medicare or the expiration of the 29-month period.

COBRA Rules for Dependents

An Employee's spouse and/or Eligible Dependent children have their own rights to self-pay for COBRA Continuation Coverage. Thus, if an Employee loses coverage for failing to self-pay under circumstances where he or she would be eligible for COBRA Continuation Coverage, his or her spouse and/or dependent children may self-pay for COBRA Continuation Coverage for the same period that the Employee could have maintained such coverage. Additionally, an Employee's spouse and dependent children may self-pay for COBRA Continuation Coverage for up to 36 months if their coverage would otherwise end because of:

- The death of the Employee;
- The divorce or legal separation of the Employee and spouse;
- A child's loss of status as an Eligible Dependent under the Fund; or
- The Participant becomes eligible for Medicare.

If an Employee's spouse and dependent children become eligible for COBRA Continuation Coverage as the result of two or more of the occurrences listed above, the maximum period during which they can self-pay for COBRA Continuation Coverage is no more than 36 months from the date they first would have lost coverage.

Notification Requirements for COBRA Continuation Coverage

An Employee, spouse or dependent child must notify the Fund in writing within 60 days of:

- A divorce or legal separation; or
- A child's loss of eligibility as a Dependent under the Fund.

A spouse or dependent child must notify the Fund in writing within 60 days following:

- The Employee's death.

An Employer must notify the Fund within 30 days of:

- An Employee's death;
- An Employee's termination of employment or reduction in hours; or
- An Employee becoming eligible for Medicare.

Following receipt of a notice or after an Employee's loss of eligibility due to termination of Covered Employment or reduction in hours of Covered Employment, the Fund will notify the Employees and his Dependents of their rights to purchase COBRA Continuation Coverage and the cost of the coverage.

Election of COBRA Continuation Coverage

To elect COBRA Continuation Coverage, an Employee, spouse or dependent child must complete an election form provided by the Fund and submit it to the Fund within 60 days after the later of the date coverage would otherwise end or the date the Employee spouse or dependent child receives the notice of the right to elect COBRA Continuation Coverage.

Benefit Options

At the time you are first offered the opportunity to self-pay for COBRA Continuation Coverage, you will be permitted to buy basic medical coverage. If you elect basic medical coverage, you will also be permitted to buy various optional forms of coverage (including prescription drug coverage, dental coverage and vision care benefits) Additionally, you may also buy continued life insurance coverage (for the former Employee only). If you select an optional form of coverage, you will be permitted to drop that coverage at any time. However, once you have dropped any optional form of coverage, or if you do not choose an optional form of coverage when it is first offered to you, will not be permitted to resume it later.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- All health benefits provided by the Fund terminate;
- An Employee, spouse or dependent child who has elected COBRA Continuation Coverage does not make the required payments to the Fund on time;
- An Employee becomes covered under Medicare; or
- An Employee, spouse or dependent child becomes covered by another group health plan, unless that replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to the individual.
- Failure to pay a premium when due. Furthermore, the Fund does not send monthly bills. It is your responsibility to make sure all premiums are paid on a timely basis. ***If you fail to pay a premium when due, your coverage will be terminated without notice.***

CERTIFICATE OF CREDITABLE COVERAGE

If you lose coverage under the Fund, the Fund Office will issue you a Certificate of Creditable Coverage showing how long you were covered under the Fund. You will receive the certificate automatically when you lose coverage or become entitled to COBRA Continuation Coverage, and when your COBRA Continuation Coverage ceases. Also, you may request that the Fund Office provide you with a Certificate within 24 months after losing coverage under the Fund.

The Certificate is your proof of the benefits for which you were eligible under the Fund. You may need to furnish this Certificate if you or your dependents become eligible under a group

health plan or insurance policy that excludes certain medical conditions that existed prior to enrollment in the new plan.

COORDINATION WITH OTHER HEALTH BENEFITS

In general, each of the Fund's benefit providers have their own coordination of benefits policies and procedures. Those rules are explained in materials that have been provided separately to you, and are incorporated by reference. For additional information on these policies and procedures, please review the materials provided by the particular provider, or call the provider or the Fund Office.

In the event one of the Fund's benefit providers does not have its own coordination of benefits policies and procedures, or if the benefit is provided directly by the Fund, the following policy applies. A plan is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group which provides medical or dental benefits or services on an insured or self-insured basis, and any government program providing benefits or services of a similar nature, including insurance which you are required by law to purchase, *e.g.*, state mandated no-fault auto insurance. An "allowable expense" is any necessary, reasonable and customary item of expense covered in full or in part under any one of the plans involved. A plan also includes any individual contract of insurance which covers a participant of this plan or a dependent.

The Fund Office may exchange benefit information with other insurance companies, organizations and individuals, and has the right to recover any overpayment made to you if you neglect to report coverage under any plan. In order to obtain all benefits available to you, a claim should be filed under each plan.

With respect to any two plans which provide coverage, one is primary, the other is secondary. The primary plan pays benefits first and without consideration of the other plans. The secondary plan or plans, in order of priority, then makes up the difference up to the total allowable expenses. No plan will pay more than it would have paid without this special provision.

A government or tax supported plan (unless otherwise required by applicable federal law), or a plan which has no coordination of benefits provision, is automatically primary.

A plan is primary if it covers the individual as a present employee and secondary if it covers the individual as a dependent or otherwise. However, if the individual is covered as a dependent under two or more plans, the primary coverage is that of the parent whose birthday is earlier in the calendar year. In the event there is a coordination rule conflict, the Fund will use the rules adopted by the National Association of Insurance Commissioners.

In the event that the Fund is secondary with respect to a particular claim, and the primary plan will not pay as a result of your failure to properly follow the procedures of the primary plan (including the failure to use participating providers, etc.), the Fund will pay no more than the amount it would have paid had you followed the primary plan's procedures. Information

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

SUBROGATION

Benefits provided are generally subject each of the Fund's benefit provider's subrogation rules. Those rules are explained in materials that have been provided separately to you, and are incorporated by reference.

The following rules apply if you receive benefits from the Fund directly or from a Fund provider that does not have subrogation rules:

If someone else (including an insurance company) is responsible for paying your medical expenses, in order to receive any benefits from the Fund, you must assign and subrogate your right to collect from that person to the Fund. To that end, if someone else is responsible for your expenses, each of the Fund's benefit providers will generally have their own subrogation forms and procedures that you must follow in order to be eligible to receive benefits from that provider. Those procedures are described in more detail in the materials provided by each such provider. In the event that the individual provider does not have such forms or procedures, or in the case of benefits provided directly by the Fund, before receiving any benefits in such a case, you and your attorney are required to complete a subrogation form supplied by the Fund Office. In all such cases (regardless of whether you actually sign a subrogation agreement), the Fund is only providing benefits for your convenience, and retains the right to recoup what it has paid from any amounts you may receive from the responsible person.

MEDICAL BENEFITS
KAISER PERMANENTE SIGNATURE, SELECT AND OUT-OF-AREA PLANS

The following is a general description of the benefits, services, exclusions, and limitations provided under the Kaiser Permanente Signature Plan, the Kaiser Permanente Select health benefit plans ("Select Plans") and the Kaiser Permanente Out-of-Area Preferred Provider Plans ("Out-of-Area Plans"). This is only a summary and does not fully describe your benefit coverage. For details on your benefit coverage, please refer to the Group Agreement Face Sheet, Group Evidence of Coverage and applicable Riders. The Evidence of Coverage is the legally binding document between Kaiser Permanente and its members. In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control. Additionally, you should have received additional materials from Kaiser Permanente describing its Select Plan and Out-of-Area Plan, which are incorporated by reference.

- **If you are an active employee or an eligible retiree not yet eligible for Medicare, or a dependent not yet eligible for Medicare, your benefits will be provided through one of the Kaiser Permanente Plans.**
- **Your benefits from Kaiser Permanente will be provided from the Kaiser Permanente Signature Plan unless you elect a different plan.**
- **If you or a dependent live or work more than 50 miles from a Kaiser Permanente center, you have the option of paying an additional monthly fee to enroll in the Kaiser Permanente Out-of-Area Plan.**

- **If you are a retiree or dependent and you are eligible for Medicare, your benefits will be provided by a Kaiser Permanente Medicare Plus Plan. (*See* p. 13.)**

The Kaiser Signature, Select and Out-of-Area Plans each use different groups of providers. Benefits under the Kaiser Permanente Signature Plans, as well as the Kaiser Permanente Medicare Plus Plans, are provided through the Kaiser Permanente Health Centers. If you elect to use one of the Select Plans, you have your choice of using a Kaiser Permanente Health Center or any of the thousands of participating providers located throughout the region. You can locate the nearest Health Center and find participating providers by consulting the directory provided in your enrollment materials or, for more up-to-date information, by calling Kaiser at (301) 468-6000, toll free at (800) 777-7902, or by visiting them on the web at www.kp.com.

Under the Out-of-Area Plan, you have your choice of an even larger, nation-wide network of providers to choose from. The Kaiser Out-of-Area Plan uses the Private Healthcare Systems ("PHCS") Network. To find providers in this network, visit them on the web at www.phcs.com.

With the exception of Emergency Services and Out-of-Area Urgent Care Services, all covered in-plan services must be provided by, or authorized and arranged by your Plan Primary Care Physician. Gynecology, behavioral health, substance abuse, and optometry services may be obtained without a referral from your Primary Care Physician; however, they must be provided by a Plan Physician or other Plan Provider.

Because the Out-of-Area Plan uses providers who are not part of Kaiser's own network, you are also responsible for precertifying all hospital admissions by calling SHPS at 1-800-448-9776 prior to your admission. In case of emergency, you must notify SHPS within 48 hours of admission or by the end of the first business day following treatment (whichever is later). SHPS is open 24 hours a day, 7 days a week. Failure to precertify may result in penalties.

A schedule of benefits, along with a listing of the terms and conditions of coverage for each (sometimes known as the "Certificate of Insurance" or "Evidence of Coverage"), has been provided to you and is incorporated by reference. If you need an additional copy of any of these documents, please contact the Fund Office or Kaiser Permanente.

KAISER PERMANENTE MEDICARE PLUS PLAN

If you are an eligible retiree who is also eligible for Medicare, or if you are the dependent of an eligible retiree and are also eligible for Medicare, you may enroll in the Kaiser Permanente Medicare Plus Plan A ("Medicare Plan A") or the Kaiser Permanente Medicare Plan C++ ("Medicare Plan C++") (collectively the "Medicare Plans"). Under the Medicare Plans, you will generally use one of the Kaiser Permanente Health Centers located throughout the region, unless you are referred to an outside provider. Detailed information on Kaiser's Medicare Plans is available from the Fund Office, and is incorporated herein by reference.

VISION CARE BENEFITS

Vision Care Benefits are provided through National Vision Administrators, L.L.C. (NVA). NVA maintains a network of providers, who offer complete eye examinations, as well as frames and corrective lenses, subject to the Fund's copayments, deductibles and maximum benefits. A listing of network providers is available from the Fund Office. In addition, you can obtain an up-to-date listing of providers by calling NVA at 1.800.672.7723, or by visiting their Web site at www.e-nva.com. You are also permitted to use non-network providers. However, if you do, you will end up paying more out of your own pocket.

The terms of the benefit, including any applicable limitations, restrictions, exclusions and pre-authorization requirements are detailed in the separate booklet provided by NVA, which is incorporated by reference. If you do not already have a copy of that booklet, you may receive one upon request, either directly from NVA or from the Fund Office. Additional information is available on the NVA Web site at www.e-nva.com.

DENTAL BENEFITS

Dental benefits are provided through Group Dental Service of MD, Inc. (GDS). GDS utilizes a network of participating dentists and other dental providers. When you utilize a participating network provider, most diagnostic, preventative and basic restorative services are covered in full, at no charge to you. Other services are covered, subject to a fixed copayment, and may need to be pre-authorized by GDS.

Benefits are not available when you use a non-network provider. Moreover, there are no benefits for purely cosmetic treatments, cleanings more frequently than once every six months, and services not specifically listed as covered in the Dental Plan document. Furthermore, benefits are only provided to children who are age four or older.

With GDS, you must select a participating dental provider to serve as your primary care dentist, who will oversee all aspects of your dental care and treatment. To find a conveniently located participating dentist, you must call GDS at 301-770-1480 or 800-242-0450 between the hours of 10:00 a.m. to noon and 1.00 p.m. to 4:00 p.m., Monday through Friday.

Broken Appointment Fee–As you can appreciate, many participants will need dental services. As available dental time is limited, broken appointments may keep some participants from obtaining treatment. Therefore, any broken appointment will be charged to you at a rate of $10.00 per half-hour unless the GDS provider is notified a day before the appointment time. Unless the broken appointment fee is paid, no further dental work will be done. You should plan to be at the dentist's office at least ten minutes in advance of your scheduled time. If you arrive ten minutes late for an appointment, it will be considered a broken appointment and a broken appointment charge will apply.

Co-payments, if any, are due at the beginning of treatment.

The terms of the benefit, including and any applicable limitations, restrictions, exclusions and pre-authorization requirements are detailed in the separate booklet provided by GDS, which is incorporated by reference. If you do not already have a copy of that booklet, you may receive one upon request, either directly from GDS or from the Fund Office.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance provides you and your family with financial protection in the event of your death or serious injury. The Policy is underwritten by Mutual of Omaha Insurance Company. Life Insurance benefits are available only to active, full-time Employees and to Retirees. Life Insurance coverage is not provided to Dependents. AD&D Benefits are only available to active, full-time Employees. AD&D Benefits are not available to Retirees or Dependents. Furthermore, your coverage does *not become effective* until you have properly filled out an enrollment form provided by Mutual of Omaha. If you do not have a form, it will be provided to you by the Fund Office. Once you have enrolled, you will receive a Certificate of Insurance from Mutual of Omaha.

SCHEDULE OF BENEFITS

	Active Employee	**Retiree**
Life Insurance Benefit	$20,000	$4,000
AD&D Maximum Benefit	$20,000	None

This table and description provides only a brief summary of the benefits under the Policy and is provided for your convenience. The actual terms of the benefits, including any applicable limitations, restrictions, exclusions and requirements are detailed in the policy itself available from Mutual of Omaha, and in the Certificate of Insurance, which are incorporated by reference. If you do not already have a copy of the Policy or Certificate, you may receive one upon request, either directly from Mutual of Omaha or from the Fund Office.

Living Benefit

If you suffer from a condition that is expected to result in your death within 12 months, and from which there is no reasonable prospect of recovery, you or your legal representative may request Living Benefits in an amount up to one-half of your life insurance amount. Living Benefits will be paid in a lump sum, and the amount of your Life Insurance will be reduced by the amount you receive.

Exclusions

Life Insurance and AD&D Benefits are generally not payable for a loss that results from an intentionally self-inflicted injury, while sane or insane; any act of war, declared or undeclared; participating in a riot or civil disorder of any kind; engaging in an illegal occupation; any attempt to commit, or commission of, a felony; active military duty; release of nuclear energy; flying in

an aircraft other than as a fare-paying passenger; or being under the influence of any drug (other than one prescribed by a licensed physician that was used as prescribed).

Beneficiary

In order to name a beneficiary to receive the proceeds of your life insurance policy following your death, you must properly fill in and return the form provided by Mutual of Omaha. Generally, a beneficiary designation does not become effective until it is actually received by Mutual of Omaha. If you do not properly designate a beneficiary before your death (or if you are predeceased by all of your designated beneficiaries), your life insurance benefit will be paid to your estate.

Conversion Privilege

If your coverage ends for any reason except non-payment of premiums, you may contact Mutual of Omaha regarding the issuance of a policy of individual life insurance.

Accidental Death & Dismemberment Insurance Benefit

AD&D Benefits are available only to Active Employees are payable if you suffer the loss of a limb, eyesight, hearing, etc., as the result of an accident or other injury not subject to an exclusion. This benefit is *in addition* to any life insurance benefit you may be entitled to receive, and does not reduce the amount of any life insurance benefit to which you may ultimately become entitled.

SICKNESS AND ACCIDENT BENEFIT

If, while you are covered and actively at work, you become unable to work due to accidental bodily injury, disease or pregnancy, the Fund will pay you a weekly Sickness and Accident Benefit of $200 per week. Benefits will begin after you are forced to miss work, subject to a five day waiting period for disabilities due to sickness, and will continue until you are well enough to return to work up to the maximum duration shown in the table. If you remain unable to return to work as the result of a separate accidental bodily injury, disease or pregnancy occurring while you are off work, your benefits may continue, but not beyond the original 26-week period.

Successive absences from work separated by fewer than two weeks of continuous full-time active work will be considered as one period in determining the benefits available to you, unless the subsequent absence is due to an injury or disease entirely unrelated to the causes of the previous absence and commences after you return to full-time active work. Sickness and Accident Benefits are not assignable, and may only be paid to the disabled employee.

This benefit is provided through an insurance policy with Mutual of Omaha. This is only a brief summary of the benefit, which is subject to the terms of that policy. The policy is incorporated by reference. You may get a copy of the policy from the Fund Office.

LIMITATIONS

Sickness and Accident Benefits will not be payable for disability due to any of the following causes:

- Injury, disease or pregnancy for which you are not under treatment by a physician.
- Disease or injury that are work-related, regardless of whether you are entitled to benefits under any Workers' Compensation Law or Act.
- Benefits cease to be payable once you have retired under any pension plan maintained wholly or in part by your employer, including the Inter-Local Pension Plan and the GCIU Supplemental Retirement and Disability Fund.

CLAIMS AND APPEALS PROCEDURES

All claims and appeals relating to your benefits under the following programs are subject to the claims and appeals procedures (including any pre-service procedures) of the organization providing the benefit:

- Kaiser Permanente
- Graphic Communications National Health and Welfare Fund
- National Vision Administrators, L.L.C.
- Group Dental Services of Maryland, Inc.
- Mutual of Omaha

Information and procedures about how to make and file claims and appeals with each of these organizations are detailed in the materials provided from those organizations. You may obtain those materials directly from the organization or from the Fund office. You should be aware that it is important that you follow the procedures in making your claims and appeals. Otherwise, your claims will not be paid.

Claims and appeals relating to the following are to be sent to the Fund:

- Eligibility
- Other Issues Not Governed by the Insurance Contracts

THE CLAIM FORM

When required, claim forms are generally provided by the organization delivering the benefit. Contact the organization or the Fund Office for a claim form. A new claim cannot be processed without a FULLY COMPLETED claim form. So make sure you answer all the questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

PAYMENT OF CLAIM

No action at law or in equity shall be brought to recover from the Fund prior to 60 days after proof of expense has been furnished in accordance with these provisions, and until the administrative remedies provided under the Fund have been exhausted, nor shall such action be brought at all unless brought within 3 years following the time the service is, or would have been, provided. If any time limitation specified above is less than that permitted by federal law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Address of Fund Office and Trustees:

Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152
866-559-6512

NOTICE OF CLAIM DETERMINATION

The Fund Office will notify you of its decision regarding your claim within a reasonable period of time, but no later than 45 days from receipt of your claim. The Fund Office may extend the period to notify you of its decision for up to an additional 30 days if the extension is necessary due to matters beyond the plan administrator's control. If the Fund Office decides to extend the notification period, it will notify you of that decision prior to the expiration of the initial expiration period, including the reason for the extension and the date it expects to make its determination. The Fund Office may extend the date for responding to your claim for a second 30-day period, if required due to matters beyond the control of the Fund Office. If an extension is required because you have failed to submit all necessary information, you will be allowed 45 days to provide any necessary information not included in the initial claim.

CLAIM REVIEW PROCEDURE

If a claim is denied or partly denied, you will be notified in writing within the applicable time period and given the opportunity for a full and fair review.

The written denial will give: (a) specific reason(s) for denial, (b) a reference to the specific Plan provision(s) on which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed, (d) an explanation of the Fund's claim review procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review, (e) if any internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request and, (f) if the denial is based on medical necessity, experimental treatment, or a similar exclusion or limit, the denial

must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge of charge upon request.

If your claim is not acted on within a reasonable time, you may proceed to the review procedure, described below, as if the claim had been denied.

- Where a claim has been denied or partly denied, you may appeal the denial and have it reviewed by the Board of Trustees.

- Within ninety (90) days after you receive written notice your claim has been denied, you or your representative may make a written request for a review to:

Board of Trustees of the Lithographers and
Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
866-559-6512

- You may obtain pertinent documents relating to the denial and you may submit issues and comments in writing. You may also provide the Trustees with any additional documents you consider relevant to your appeal.

A decision by the Board of Trustees will be made promptly and no later than the next scheduled meeting of the Board of Trustees that immediately follows receipt of your request for a review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a decision by the Board of Trustees will be made no later than the date of the second meeting of the Board of Trustees following receipt of the claim. If special circumstances require a further extension of time for processing, the Board of Trustees will decide your appeal no later than the third meeting of the Board of Trustees following receipt of the request for review. If such an extension of time for review is required because of special circumstances, you will be provided with written notice of the extension, a description of the special circumstances and the date the benefit determination will be made, prior to the commencement of the extension.

The Board of Trustees will not give any weight or deference to the original decision. If the Board of Trustee makes any determination on review based in whole or in part on medical judgment, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in the initial denial.

Once the decision is made by the Board of Trustees, you will be notified within five days. The decision on review will be in writing and will include the specific reasons for the decision and the specific plan provisions upon which the determination was made. The decision on review will include a statement that you are entitled to receive, upon request and without charge, all documents, records and other information relevant to the claim. If any internal rule, guideline, protocol or other similar criterion was relied on in making the determination on review, the

notice of the decision will include a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the determination on review and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request. If the determination on review is based on a determination of medical necessity, experimental treatment, or a similar exclusion or limit, the denial will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge of charge upon request. If the Fund consulted with any medical or vocational experts on your case, the identity of such experts will be disclosed to you upon request. The decision by the Board of Trustees will be final and binding on all parties.

PRIVACY AND SECURITY INFORMATION

NOTICE OF PRIVACY PRACTICES

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

- The Fund's Duties

The Lithographers and Photoengravers Local 285 Welfare Fund (the "Fund") are required by law to maintain the privacy of Protected Health Information. The purpose of this Notice ("Notice") is to inform you of the Fund's legal duties and privacy practices with respect to Protected Health Information, and of your rights regarding such information. If you have any questions about this Notice, or about any other matter concerning the privacy of your health information, please contact the Fund's Privacy Officer. For information on how to contact the Privacy Officer, *see* page 23.

The Fund reserves the right to amend or revise this Notice and the practices described herein. The Fund will notify Participants of any material change to this Notice. This Notice is effective April 14, 2003, and will remain in effect until the Fund publishes a revised Notice.

- Use and Disclosure of Protected Health Information

The Fund will use or disclose your Protected Health Information:

- To determine your eligibility for benefits and to process and pay your claims;
- To administer their health care operations;
- To your health care providers to assist the provider in treating you, to pay your claim, and to notify them whether certain medical treatments or devices are covered by the Fund, along with any restrictions on payment of claims by the Fund.
- To their business associates, such as insurers, third party administrators and professional service providers, including their attorneys, accountants and actuaries, for payment purposes, health care operations, planning and other professional services necessary for the operation of the Fund.

- To otherwise allow the Fund to operate efficiently;
- To other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for payment of your claim.
- For planning purposes.
- To business associates, such as actuaries and accountants for business planning purposes or attorneys who are providing legal services to the Fund. The Fund will secure agreements from its business associates to ensure that the privacy of your health information is protected.

In any case, the Fund will only use or disclose the minimum necessary information to accomplish the purpose of the use or disclosure.

The Fund may also disclose Protected Health Information for the following purposes:

- As required or permitted by applicable law or regulation, including to comply with workers' compensation laws.
- For public health activities and health oversight.
- To public officials regarding victims of abuse, neglect or domestic violence.
- For judicial and administrative proceedings and law enforcement.
- To coroners, medical examiners, and funeral directors so that those professionals can perform their duties.
- For organ donation and transplantation.
- For research.
- To avert an imminent threat to health or safety.
- For specialized government functions (such as intelligence and national security activities).
- To a person subject to the jurisdiction of the FDA for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities.
- For the purpose of furthering fraud and abuse investigations.

3. Consensual Disclosures

In addition to the permitted disclosures, the Fund may also disclose your Protected Health Information to your designated representative or upon your written authorization (the Fund will provide you with a standard authorization form upon request). You may revoke your authorization to use or disclose your Protected Health Information at anytime. If you do so, the Fund will honor your revocation of authorization, except to the extent that the Fund already relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Generally, the Fund is prohibited from disclosing to your Union and your Employer your Protected Health Information, other than to tell them whether you are enrolled in or have disenrolled from the Fund. This means that if you want a Union official or your Employer to assist you with your health claims, you must submit a signed authorization to permit the Fund's

Staff to discuss your case with them.

4. Other Uses and Disclosures

On a case-by-case basis, the Fund will determine whether to disclose Protected Health Information to your family members, close friends, or other people assisting in your care, as well as to government agencies and other organizations conducting disaster relief. Under state law, parents generally have access to their children's Protected Health Information and may authorize disclosure of such information, except if the parent's authority to consent to health care for the child has been specifically limited by a court order. Unless notified to the contrary, the Fund will assume that a parent has the authority to consent to health care for a minor child. The Fund will also disclose Protected Health Information to court-appointed guardians of incompetent individuals.

The Fund and its business associates will not use your Protected Health Information for marketing purposes, without your express consent.

5. Use by the Trustees

The Trustees may use your Protected Health Information to the extent necessary to fulfill their responsibilities to manage the Fund and oversee its operations, and for any other permitted purpose. The Trustees will not use or further disclose the information other than as permitted. The Trustees will report to the Fund any use or disclosure of the information that is inconsistent with the use or disclosures provided for which they become aware. The Trustees will generally not retain possession of any Protected Health Information received from the Fund once the information is no longer needed for the purpose for which the disclosure was made.

With regard to appeals of claims determinations, to the extent possible, the Fund will submit de-identified information to the Trustees. If you have filed an appeal of a claim determination and do not want your Protected Health Information to be de-identified for disclosure to the Trustees, you may submit an authorization to have your Protected Health Information disclosed to the Trustees. This is entirely your choice, and your appeal will not be prejudiced in any way if you do not submit such an authorization.

6. Individual Rights

You have the right to inspect and copy Protected Health Information that relates to you. If your request to inspect or copy information is denied, the Fund will tell you in writing the reason for the denial and a description of the complaint procedure.

You may request restrictions related to the uses or disclosures of Protected Health Information. You may request that the Fund only communicate with you confidentially at a certain location or in a certain manner (*e.g.*, only by calling you at work or at home, or only in writing). The Fund will try to accommodate your request, but are not required to agree to your request. If your request is denied, you will be notified in writing. To request any restrictions related to use or disclosure of health information, contact the HIPAA Privacy Officer.

You have the right to receive an accounting of disclosures made by the Fund for purposes other than treatment, payment or health care operations. You may request an accounting of disclosures made up to six years prior to the request. An accounting needs not include disclosures of Protected Health Information made: (1) to carry out treatment, payment or health care operations; (2) to you; or (3) prior to the HIPAA compliance date. The Fund may charge reasonable costs associated with any such accounting. The privacy regulations also exempt from the accounting requirements incidental disclosures and disclosures of a limited data set. To request an accounting, contact the HIPAA Privacy Officer.

You may request that the Fund amend any health information that refers to or relates to you if there are any inaccuracies or incomplete information. The Fund has up to ninety (90) days to act upon your request to amend health information. The Fund will make a decision on any request for amendment. If your request for amendment is denied, in whole or in part, the Fund will tell you the reason for the denial in writing. To request an amendment of your health information, contact the HIPAA Privacy Officer.

If you received this Notice electronically, you are entitled to receive a paper copy of the Notice.

7. Glossary of Terms

You and *your* refer to Participants and their spouses and dependents who are eligible for benefits from the Fund.

HIPAA means the Health Insurance Portability and Accountability Act of 1996. HIPAA's privacy regulations are located at 45 CFR § 160.101 *et seq*.

Business Associate means one who is not an employee of the Fund, but who, on behalf of the Fund, performs or assists in a function which involves the use or disclosure of individually identifiable health information.

Protected Health Information means individually identifiable health information created, received or maintained by a covered entity in its health care capacity, such as: name; address; employer; date of birth; contact information (phone numbers, fax numbers, Email address); social security numbers, medical record numbers, member or account numbers.

8. Questions and Complaints

If you have any questions or complaints about the Fund's privacy practices or this Notice or if you wish to obtain additional information about the Fund's privacy practices, please contact:

HIPAA Privacy Officer
Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
866-559-6512

You may file a complaint regarding the Fund's practices regarding Protected Health Information with the Fund's Privacy Officer. The Privacy Officer will inform you of the disposition of your complaint. If you believe that your privacy rights have been violated or that the Fund is not complying with the privacy requirements of HIPAA, you may file a complaint with the Secretary of the United States Department of Health and Human Services. The Fund will not take any action against you if you file an internal complaint or a complaint with the Secretary.

DATA SECURITY POLICY

The Trustees have a duty to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;

2. Ensure that the adequate separation required by HIPAA privacy rules (42 CFR § 164.504(f)(2)(iii)) is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Board of Trustees provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

   Report to the Fund any security incident of which they become aware.

BASIC PLAN INFORMATION

1. TYPE OF PLAN

This Fund provides coverage for hospitalization, physician's care, disability income, life insurance benefits, dental care, vision care, and prescription benefits to eligible participants and their qualified dependents.

2. PLAN IDENTIFICATION NUMBER

Employer Identification Number: 23-7237228
IRS Plan Number: 501

3. PLAN ADMINISTRATOR

Board of Trustees
Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152
866-559-6512

The Trustees have the authority to contract and manage the operation and administration of the Fund.

4. SERVICE OF LEGAL PROCESS

Service of legal process may be made upon any Trustee.

5. TYPE OF ADMINISTRATION OF THE FUND

The Fund is administered by the Board of Trustees.

Kaiser Permanente administers the benefits provided through the Kaiser Permanente Select Plan, Kaiser Permanente HMO and Kaiser Permanente Out-of-Area PPO on an insured basis.

Dental benefits are provided on an insured basis through an agreement with Group Dental Services of Maryland, Inc. Vision care benefits are provided on an insured basis from NVA. The life insurance, accidental death and dismemberment benefits and sickness and accident benefits are provided through an insurance agreement with Mutual of Omaha Insurance Company.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20849

Group Dental Services of Maryland, Inc.
11400 Rockville Pike
Suite 500
Rockville, Maryland 20852

Graphic Communications National Health and Welfare Fund
60 Boulevard of the Allies, 5th Floor,
Pittsburgh, PA 15222-1219

National Vision Administrators, L.L.C.
1200 Route 46 West
Clifton, New Jersey 07013

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Policy No.: GLUG-ADJN – Life/AD&D
Policy No.: GUG-ADJN – Sickness & Accident

6. LABOR ORGANIZATIONS REPRESENTING PARTICIPANTS IN PLAN

This Fund is maintained by collective bargaining agreements between Lithographers and Photoengravers Local 285, GCC, IBT and participating employers. A copy of any such agreement may be obtained upon written request to the Fund Office. Also, collective bargaining agreements are available for examination by a Participant at the Fund Office. A complete list of Employers participating in the Fund may be obtained upon written request to the Fund Office. You may also receive from the Fund Office, upon written request, information as to whether a particular Employer or Union is a sponsor of the Fund and if the Employer or Union is a Fund Sponsor, the address of such Employer or Union.

7. SOURCE OF CONTRIBUTIONS TO THE PLAN

Individual Employers contribute to the Fund pursuant to collective bargaining agreements with Lithographers and Photoengravers Local 285, GCC, IBT, which also generally provide for Employee contributions. Contributions are also made pursuant to written participation agreements approved by the Board of Trustees.

8. DATE OF THE END OF THE PLAN YEAR

The Plan Year ends on the last day of February of each year.

9. MODIFICATION OF BENEFIT SCHEDULES, OR TERMINATION OF BENEFIT, OR TERMINATION OF THE FUND

The Board of Trustees has complete discretion, subject to the Trust Agreement and applicable law, to terminate, suspend, withdraw, amend or modify Fund benefits in whole or in part at any time. Within this broad grant of discretion, the Trustees have (among other powers) the authority to reduce, eliminate, improve or modify benefits. They may do so for some or all categories of participants and beneficiaries (Active Employees, Retirees, and eligible Dependents). They may also modify the eligibility requirements for coverage.

Although it is the intention to continue the Fund indefinitely, the Fund may be terminated by a document in writing adopted by Trustees. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of the termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; (d) apply the assets of the Fund in accordance with the Plan of Benefits including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any

contributing Employer or the Union either directly or indirectly.

10. ACTION OF TRUSTEES

The Trustees shall be, subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the sole judges of the standard of proof required in any case and the application and interpretation of this Fund and its governing documents, and decisions of the Trustees shall be final and binding on all parties. The Trustees shall have the exclusive right and discretionary authority to construe the terms of the Fund and its governing documents, to resolve any ambiguities, and to determine any questions which may arise with the Fund's application or administration, including but not limited to determination of eligibility for medical, life insurance, disability insurance, dental, vision, and prescription drug benefits.

Wherever in the Plan the Trustees are given discretionary powers, the Trustees shall exercise such powers in a manner permitted by law.

11. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

12. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

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

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Fund Office or Kaiser Permanente for more information.

YOUR RIGHTS UNDER ERISA

As a participant in the Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.
- Examine, without charge, at the Fund Office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor.
- Obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Fund on the rules governing your COBRA continuation coverage rights. *See*, pp. 8 - 10.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. *See* p. 10.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation for the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you

may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Fund Office.

Assistance With Your Questions

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1730 K Street, N.W., Washington, D.C. 20006, (202) 254-7013 or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.