

**MARBLE INDUSTRY
TRUST FUND**

Health and Welfare Benefits

Summary Plan Description/Plan Document

**MARBLE INDUSTRY
TRUST FUND**

253 West 35th Street
12th Floor
New York, NY 10001
(212) 505-5050

BOARD OF TRUSTEES

UNION TRUSTEES

James Beecher
Saverio Demercurio
Christopher Guy
Ernesto Jimenez
Mortimer Lynch
Ronald Nicastrì

EMPLOYER TRUSTEES

Patrick Barrett
Kevin Ennis
Thomas McNamara

Counsel

Colleran, O'Hara & Mills, L.L.P.
Goldberg & Connelly, P.C.

Auditor

Gould, Kobrick & Schlapp, P.C.

Consultant

Federation Pension Bureau, Inc.

Administrator

Daniel H. Cook Associates, Inc.

Dear Plan Participant:

The Board of Trustees of the Marble Industry Trust Fund is very proud to present this revised Program of Benefits (Plan Document). It has always been the policy of the Trustees, since the very inception of the Fund, to provide greater and more extensive benefits to Covered Employees and their eligible dependents, whenever it was economically sound and prudent.

This Plan is effective September 1, 2007, and replaces the Plan Document and Summary in effect prior to this date.

This booklet describes in detail the complete program of benefits provided by the Marble Industry Trust Fund. You will find in this booklet a description of the benefits to which you and your family are entitled, the Plan eligibility rules and regulations, and the procedure you should follow in order to obtain benefits provided by the Plan.

Please read this entire book so that you are familiar with the protection available to you and your family and keep the booklet handy for future reference. Do not rely on statements made by any individuals. The only authorized information concerning your benefits must be in writing from the Board of Trustees acting in their official capacity. No employer, union representative, supervisor, or shop steward is in a position of authority to discuss your rights under this Plan.

The Fund Office is available to help you and your family at all times. If you have any questions, please do not hesitate to call or visit the Fund Office at:

**The Marble Industry Trust Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street
12 Floor
New York NY 10001
(212) 505-5050**

TABLE OF CONTENTS

Section	Page
Important Information You Must Give To the Plan	4
Eligibility Provisions	5
Enrollment	11
Employee Benefits Summary	13
Retiree Benefits Summary	15
Health Care Benefits for Active Participants Age 65 or Older	17
Death Benefits	18
Vision Care for Active Employees and Retirees	19
Dental Benefits for Active Employees and Their Dependents	20
Medical Benefits (General Information)	21
Review of Certain Procedures (Pre-certification/Pre-Authorizations)	24
Other Plan Information	28
Hospital Length of Stay for Childbirth	28
Reconstructive Services and Breast Reconstruction after Mastectomy	28
Qualified Medical Child Support Order (QMCSO)	29
Explanation of Medical Benefits	30
Acute Rehabilitation	30
Allergy Services	30
Ambulance Services	31
Anesthesia	31
Annual Physical (Adult Well Care)	31
Behavioral (Mental) Health Benefits	32
Chemotherapy and Cancer Treatments	32
Corrective Appliances	33

TABLE OF CONTENTS (continued)

Section	Page
Explanation of Medical Benefits (continued)	
Diagnostic Studies	33
Durable Medical Equipment (DME)	33
Emergency Room & Urgent Care	34
Hearing Aids	34
Home Health Care	35
Hospice Benefits	35
Hospital Services	35
Maternity Services	36
Office (Physician) Visits	36
Pain Management	36
Physical and Occupational Therapy (Out Patient)	37
Preadmission Testing	37
Radiation Therapy	37
Substance Abuse Benefits	38
Supplies (Medical/Surgical Supplies)	38
Surgery	39
Well Child Care	39
Prescription Drug Benefits	40
Retiree Benefits Regarding the Prescription Plan/Medicare Part D	42
Plan Exclusions	44
General Exclusions	44
Exclusions Applicable To Specific Medical Services and Supplies	48
Disability Benefits	57

TABLE OF CONTENTS (continued)

Section	Page
Additional Security Benefit Account (ASBA) “Supplemental”	58
Vacation Fund	61
Leave of Absence	63
Family and Medical Leave Act (FMLA)	63
Leave for Military Duty in the United States Armed Forces	64
COBRA Continuation of Coverage	66
Coordination of Benefits	77
Which Plan Pays First: Order of Benefit Determination Rules	78
Coordination with Medicare	82
Coordination with Other Government Programs	84
Workers’ Compensation	85
Third Party Liability	86
Claims and Appeals Procedure	88
Request for Review of Denied Claim	94
Limitation on When a Lawsuit may be Started	96
Definitions	97
HIPAA Privacy Rules	110
Statement of Rights Under Employee Retirement Income Security Act of 1974	111
Important Plan Information	113

IMPORTANT INFORMATION YOU MUST GIVE TO THE PLAN

In addition to any information you must submit in support of any claim for Plan benefits, you must immediately submit any information you have that either affects eligibility for coverage under the Plan, or the Fund Office's ability to properly administer your benefits. This information includes, but is not limited to:

- change of name;
- change of address (advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage);
- addition of any Dependent by marriage, birth or adoption;
- divorce, or legal separation between you and your covered spouse;
- death of any covered individual;
- any information regarding the status of your Dependent child(ren), including, but not limited to:
 - the school status of a Dependent child over age 19;
 - the existence of any physical or mental handicap; or
 - the marriage of your Dependent child;
- Medicare enrollment or unenrollment;
- Social Security disability benefits award or termination; and
- The existence of other medical or dental coverage.

Change in Beneficiary

Contact the Fund Office to obtain the necessary form if you wish to change the beneficiary for your Death Benefits. Otherwise, the permanent records may not reflect your current wishes regarding your choice of beneficiary.

Please notify the Fund Office as soon as possible of any changes to the information described above and forward that information in writing to the Fund Office at:

The Marble Industry Trust Fund

Daniel H. Cook Associates

253 West 35th Street

New York, NY 10001

(212) 505-5050

ELIGIBILITY PROVISIONS

Eligible Employee

Eligibility for benefits from The Marble Industry Fund is based on hours worked in Covered Employment under the Collective Bargaining Agreement that obligates Employers to pay contributions to this Fund on behalf of Employees. You must satisfy certain eligibility requirements, as described in this section, in order to be eligible for benefits under this Plan.

Definitions of Terms Used Under the Eligibility Provisions

- An **Active Participant** is an Employee whose eligibility for benefits is based on hours worked for which his/her Employer must make contributions.
- **Agreement** means the Collective Bargaining Agreement between the Union and the Employers' Association, or the Union and an Employer, which requires Employer Contributions to the Fund.
- **Children** means natural, biologic children, legally adopted children, foster or step children for whom a member has been appointed as legal guardian by court order or who live with the Participant and depend on him or her for full support.
- A **Contributing Employer** is an employer who is obligated and actually makes contributions to the Marble Industry Trust Fund.
- **Covered Employment** means employment as an Employee covered by a Collective Bargaining Agreement between the Union and an Employer, pursuant to which such Employer is obligated to contribute to the Marble Industry Trust Fund with respect to such Employee.
- An **Eligible Participant** is an Employee who has satisfied the requirements for eligibility for benefits from this Fund as described in this Plan Booklet and who is currently eligible for benefits. Therefore, Employees who are eligible under the Plan based completely on payment of COBRA premiums and Employees who are eligible because of coverage during periods of disability are considered Eligible Participants but are not Active Participants.
- An **Employee** is a person who is employed in a bargaining unit covered by the Collective Bargaining Agreement and/or full time paid Union officials provided contributions are made to the Fund at the same rate made by other Contributing Employers as agreed to in the Collective Bargaining Agreement.
- An **Employer** is any persons, firms, or corporations who are members of the Employers' Association and persons, firms or corporations who are not members of said association but who execute Collective Bargaining Agreements with the Union and who employ members of the Union. The Union shall also be considered an Employer under the Restated Agreement and Declaration of Trust solely and

exclusively for the purpose of permitting each of them to contribute to the Fund on behalf of their full-time union officials, and to permit their said employees to participate in the Plan. Except for their right to make such contributions to the Fund, the Union shall have no rights, privileges or powers as an Employer under the Restated Agreement and Declaration of Trust.

- **Employer Contributions** are the payments which an Employer is required to make to the Fund pursuant to the Collective Bargaining Agreement.
- An **Employer Trustee** means a trustee designated by the Employers' Association.
- The **Employers' Association** is the Marble Industry of New York, Inc.
- **He** or **Him** or **His** refers to either male or female unless a distinction is specified.
- A **Participant** means any employee or former employee, or any member or former member of the Union who is or may become eligible to receive a benefit from the Fund, or whose beneficiaries may be eligible to receive any such benefit, under the criteria established by the Trustees.
- A **Pensioner** is a former employee who is eligible for and actually receiving a pension (in any form) from the Marble Industry Pension Fund.
- **Plan** or **Plan of Benefits** are used interchangeably to mean this plan of benefits as promulgated and from time to time amended by the Trustees.
- **Restated Agreement and Declaration of Trust** means the instrument so titled and dated September 22, 1994, including amendments.
- A **Retired Employee** or **Retiree** is an Employee who has qualified for and is receiving Retiree Benefits from this Plan. An Employee is a Retired Employee on the effective date of his Pension, provided he or she meets the requirements described in the "Retiree Eligibility" subsection later in this section.
- **Trustees** means the parties so designated herein and includes their successors.
- **Union** means the B.A.C. Local 7, Tile, Marble and Terrazzo of New York and New Jersey.
- **Union Trustee** means a trustee designated by the Union.

Requirements for Initial Eligibility (Coverage) for Active Participants

An Employee's coverage is effective on the first day of the month following the completion of 960 hours in Covered Employment (1,280 hours for Marble Restoration Finishers) during a period of twelve (12) consecutive months.

Maintaining Eligibility

Thereafter, to continue to be covered for benefits for the subsequent six months, the Employee must have worked not less than 480 hours in Covered Employment (640 hours for Marble Restoration Finishers) during the preceding six (6) consecutive months

OR

not less than 960 hours in Covered Employment (1,280 hours for Marble Restoration Finishers) during the preceding twelve (12) consecutive months.

If you return to Covered Employment after a period during which you were eligible for COBRA benefits and did not elect to be covered under the COBRA rules, you must meet the requirements for Initial Eligibility described above.

Initial Eligibility for Dependents

Your Dependents are eligible for Medical, Dental, Prescription Drug and Optical benefits under the Plan.

Your Eligible Dependents include:

- 1) Your spouse, to whom you are legally married.
- 2) All unmarried children under 19 years of age.
- 3) Unmarried children under 23 years of age, if attending an accredited College on a full-time basis. A letter of certification from the registrar of the school must be submitted each term.
- 4) Unmarried, mentally retarded or physically handicapped dependent children over the age of 19; who became so incapacitated while an eligible dependent, and who is incapable of self-sustaining employment. The Dependent Child must be dependent upon you for lifetime care and supervision; and be considered to be handicapped upon reaching age 19. You must provide the Administrator (Daniel H. Cook Associates) with medical evidence of the child's disability within thirty-one (31) days of the child's 19th birthday.

Dependent children are eligible subject to the following provisions:

- The Dependent Child must not provide over one-half of his or her own support for the year.

- The Dependent Child must have the same principal place of abode as the Employee for more than one-half of the year. However, this requirement does not apply if the Dependent child's parents are divorced or separated and the Dependent child is in the custody of one or both parents for more than one-half of the year.

A child named in a qualified medical child support order (QMCSO) is also an eligible dependent under this Plan. See the section on QMCSOs for details.

When Coverage Ends For You

Coverage will end on the earlier of the following:

- The date the Fund discontinues the group plan;
- The last day of the month the employee fails to have at least 480 hours worked in Covered Employment (640 hours for Marble Restoration Finishers) during the preceding six (6) consecutive month period or at least 960 hours worked in Covered Employment (1,280 hours for Marble Restoration Finishers) during the preceding twelve (12) consecutive month period; or
- The date you enter the armed services on an active basis for more than 31 days.

When Coverage Ends For Your Dependents

Coverage for your Dependent(s) will end on the earlier of the following:

- When the Eligible Participant's coverage is terminated;
- Five years after the date of the death of the Eligible Participant;
- The date the widow or widower remarries within five years after the date of the death of the Eligible Participant;
- The date the Dependent becomes an Active Participant under the Plan;
- The date the Dependent enters the armed services on an active basis for more than 31 days;
- The date the Dependent no longer meets the definition of Dependent; or
- The date that Dependent coverage is discontinued under the Plan.

Coverage ends for your Dependent child on the date the child ceases to meet this Plan's definition of a Dependent child because the child:

- Marries;
- Reaches age 19
- Who is between age 19 and 23, ceases to be a full time student.

Coverage ends for your Spouse on the date you and your Spouse are divorced or legally separated.

When coverage ends for you and/or your Dependents, you may be able to continue coverage for certain benefits under COBRA continuation coverage; see the COBRA section for details.

Reinstatement of Eligibility

Upon termination of eligibility for coverage, you must reestablish eligibility in accordance with the initial eligibility requirements of 960 hours of Covered Employment (1,280 hours for Marble Restoration Finishers) during a (12) month period.

A worker whose coverage was terminated by the Fund shall become a new member when re-employed by a Contributing Employer, and will again become eligible for benefits only in accordance with the eligibility rules as described above.

Disability Extension

Any Employee who is unemployed due to disability and is in receipt of Weekly benefits under the applicable Disability Benefits Laws or Worker's Compensation Law will remain eligible for benefits for up to two years from the date that he would have otherwise terminated. Any Employee claiming this exception must give written notice to the Trustees within three months of the date of last employment by a Contributing Employer and shall once a year furnish to the Trustees such medical evidence of physical or mental incapacity, as may be required. In addition, the Trustees may require such worker to submit to examination by a doctor of their choice once each year, in which event the cost of the examination shall be paid by the Fund

Certification of Coverage When Coverage Ends

When your coverage ends, you and/or your covered Dependents are entitled by law to, and will be provided with (free of charge), a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. In addition, such a certificate will be provided upon receipt of a written request for such a certificate, if the request is received by the Fund Office within two years after the date coverage ended. See the COBRA section for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

RETIREE ELIGIBILITY PROVISIONS

In order to be eligible for Retiree Welfare Fund benefits, you must be in receipt of a **Normal, Disability, or Early Pension Benefit**, as well as meet the other Criteria listed below. An Employee who has ceased to work for any Employer and is entitled to a **Vested Pension Benefit** from the Marble Industry Pension Trust Fund is not eligible for any benefits provided by this Fund. Please see MARBLE INDUSTRY PENSION FUND - PROGRAM OF BENEFITS for more information regarding the definitions and qualifications for types of pension benefits.

A Retiree who is in receipt of a **Normal Pension Benefit** from the Marble Industry Pension Trust Fund is eligible for certain retiree benefits provided by this Fund provided that he was covered for benefits from this Plan for at least thirty-six (36) months out of the sixty (60) month period immediately preceding retirement.

Effective January 1, 2005, a Retiree who is in receipt of a **Disability Pension Benefit** from the Marble Industry Pension Trust Fund is eligible for certain retiree benefits provided by this Fund provided that he had at least 15 years of coverage from this Plan.

Effective January, 1, 2005, a Retire who is in receipt of an **Early Pension Benefit** from the Marble Industry Pension Trust Fund is eligible for certain retiree benefits provided by this Fund provided that:

1. He was covered for benefits from this Plan for at least thirty-six (36) months out of the sixty (60) month period immediately preceding retirement; and
2. He makes monthly payments to the Fund at the same rate as is in effect for a similarly situated Participant who has elected coverage under COBRA, until the month following:
 - His 62nd birthday, if he has been covered continuously in this plan for at least 15 years or
 - His 65th birthday, if he has been covered continuously in this plan for fewer than 15 years.

Your Retiree benefits are outlined beginning in the section entitled, “Retiree Benefits”.

ENROLLMENT

Initial Enrollment

The Fund Office will notify you when you are eligible for coverage under the Plan and send you a *Designation of Beneficiary – Fund Office Record Card*. If your Employer fails to remit the required contributions and you are working in Covered Employment and contributions are required on your behalf, you may still be entitled to coverage, provided you furnish the Fund Office with a copy of your pay stubs indicating that a sufficient number of hours were worked to reach eligibility. It is a participant's responsibility to provide such records of Covered Employment to the Fund Office. The Trustees are the sole judges of whether or not to accept the proof submitted and credit the participant for those hours.

Please note that if you do not enroll yourself and/or your Dependents as described, benefits will not be payable by the Fund. Claims that you submit will be denied and will have to be resubmitted after you have properly enrolled.

How to Enroll

To enroll for benefits provided by the Welfare Fund, you must submit a completed *Designation of Beneficiary – Fund Office Record Card*. To enroll your eligible Dependents for Fund coverage, you need to enroll them when you are enrolled for coverage. You must provide the Fund Office with proof of dependent status. The Fund Office will accept a copy of any of the following documents as proof of dependent status:

- **Marriage:** copy of the certified marriage certificate and a notarized *Affidavit of Spousal Coverage* to notify the Fund of other coverage for your spouse or family.
- **Birth:** copy of the certified birth certificate.
- **Adoption or placement for adoption:** court order signed by a judge.
- **Full-time student status:** Birth certificate (if not already on file) and a copy of current semester official class schedule reflecting full-time student status or signed statement from the Registrar.
- **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically handicapped (as that term is defined in this document). The Plan may require that you show proof of support and maintenance such as a copy of your income tax return showing you claim the child as a Dependent on IRS tax forms.

Special Enrollment

If you decline enrollment for (or do not enroll) your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if their employer stops contributing towards the other coverage). However, you must request enrollment and enroll for benefits as described above, after your or your

Dependents' other coverage ends (or after their employer stops contributing towards the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your Dependents. However, you must request enrollment after the marriage, birth, adoption, or placement for adoption and complete the proper enrollment paper work, as described above.

To request special enrollment or obtain more information, contact the Fund Office.

Start of Coverage for Dependents Following Enrollment

Coverage for your Dependents cannot begin until the Fund Office receives a completed enrollment form (the *Designation of Beneficiary – Fund Office Record Card*) along with the necessary documentation (e.g., birth certificate, marriage certificate, adoption papers) and the *Affidavit of Spousal Coverage*. **Once the Fund Office receives a complete enrollment form and the necessary documentation, coverage will be effective retroactive to the date your coverage started or as described below, for newly enrolled Dependents.** If the Fund does not receive the necessary enrollment material (including proof of dependency), claims will be denied and will need to be resubmitted once enrollment is complete.

Your newborn biological child will be covered from the date of birth.

Your adopted Dependent child will be covered from the date that child is adopted or “placed for adoption” with you, whichever is earlier. Newborn adopted children will be covered from the date of birth. A child is “placed for adoption” with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Coverage for your new spouse begins on the day you marry, provided you properly enroll your spouse.

Qualified Medical Child Support Order (QMCSO)

According to federal law, you might be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state administrative agency that usually results from a divorce or legal separation. The Fund Office can provide more details about enrolling your children in such cases. A statement that describes the QMCSO procedures is available from the Fund Office at no cost to you. To receive a copy of these procedures, please contact the Fund Office.

EMPLOYEE BENEFITS SUMMARY

The following is a summary of the benefits available to Eligible Participants and their dependents. Please see each benefit section for more details.

For Pensioners and Dependents 65 years of age or older, please refer to the next section “Retiree Benefits Summary”

Hospital, Medical, Mental Health, and Prescription Expenses

Effective January 1, 2007, all eligible hospital, medical, mental health, and prescription expenses are covered up to \$150,000.00 per person per calendar year and up to \$250,000.00 per person per lifetime.

Effective January 1, 2008, all eligible hospital, medical, mental health, and prescription expenses are covered up to \$150,000.00 per person per calendar year and up to \$500,000.00 per person per lifetime.

Please see section entitled, “Explanation of Medical Benefits” for a description of eligible hospital, medical, mental health, and prescription expenses.

Prescription Drug Coverage

As of March 1, 2007, prescription benefits will be administered through General Prescription Programs, Inc. Prescription benefits expenses covered by the fund are also included in the maximums listed above.

Dental Care

Dental care is covered up to \$2,000.00 per person per year. The fee schedule and a list of participating providers are available in separate booklets.

Optical Benefits

Up to \$110.00 per person will be paid for an eye examination by an ophthalmologist or optometrist and for prescription eyeglasses once every year.

EMPLOYEE BENEFITS SUMMARY (continued)

Death Benefits

A death benefit of between \$2,000.00- \$5,000.00 will be paid upon the death of the employee to the named beneficiary.

Weekly Accident and Sickness Benefits (Short Term Disability)

The current New York State rate for short term disability will be paid for a maximum of 26 weeks for an off-the-job accident or illness.

Additional Security Benefit Account (ASBA) (also known as “supplemental”)

Supplemental benefit payments are available for unemployment, medical costs, or death of the participant.

Vacation Fund

Payments from the vacation fund are disbursed twice a year.

RETIREE BENEFITS SUMMARY

Hospital and Medical Expenses

Non-Medicare-Eligible Retirees: If you are a retiree or dependant and under age 65 and not otherwise eligible for Medicare Part A or B, your Medical benefits are the same as those for Active Participants.

Medicare-Eligible Retirees: If you are age 65 or over and/or eligible for Medicare, this Plan supplements Medicare benefits. Please see the section entitled “Coordination with Medicare” in this booklet for details.

When the Plan Participant Is Eligible, but Not Covered by Medicare

If you are eligible for, but are not enrolled in Medicare, this Plan pays benefits as if it were coordinating with Medicare. Therefore, you will only receive the benefits the Plan would have paid had Medicare paid benefits first (generally the applicable Medicare deductible or coinsurance for a particular service or supply). In addition, the Participant will have the burden of demonstrating what the applicable Medicare deductible or coinsurance would have been before such payments are made.

When the Plan Participant Enters Into a Medicare Private Contract

If a Medicare participant enters into a Medicare private contract with a Health Practitioner, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

Prescription Drug Coverage

As of March 1, 2007, prescription benefits will be administered through General Prescription Programs, Inc. Retirees are entitled to a benefit of \$2,250.00 per year after applicable co-payments. Alternatively, retirees eligible for Medicare Part D may join a prescription drug program for Part D benefits and the fund will pay up to \$300.00 per year towards the premium of such a program. The \$2,250.00 prescription benefit is included in the hospital, medical, mental health, and prescription annual and lifetime maximum limitations listed on page 13.

Optical Benefits

Up to \$110 per person will be paid for an eye examination by an ophthalmologist or optometrist and prescription eyeglasses once every year.

RETIREE BENEFITS SUMMARY (continued)

Death Benefits

A death benefit of \$2,500 will be paid upon the death of the retiree to the named beneficiary.

Additional Security Benefit Account (ASBA) (also known as “supplemental”) Supplemental benefit payments are available for medical costs or for death of the participant.

HEALTH CARE BENEFITS FOR ACTIVE PARTICIPANTS AGE 65 OR OLDER

Medicare Participants who are actively Working May Retain or Cancel Coverage under This Plan:

If an eligible individual under this Plan becomes covered by Medicare, Part A, B, or D while actively working whether because of end-stage renal disease (ESRD), disability or age, that individual may either retain or cancel coverage under this Plan. If the eligible individual under this Plan is covered by both this Plan and by Medicare, as long as the eligible employee remains actively employed, that employee's medical expense coverage will continue to provide the same benefits and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible employee's Dependents are covered by Medicare and the employee **cancels** that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

DEATH BENEFITS

The Fund provides a Death Benefit in accordance with the following schedule, in case a Covered Employee or Retiree dies from any cause.

Amount	Continuous Coverage in Plan
\$2,000	Less than 5 Years
3,000	5 Years but less than 10 Years
4,000	10 Years but less than 15 Years
5,000	15 Years or more
2,500	Retirees

BENEFICIARY

Your beneficiary is a person you choose to receive any benefit payable as a result of your death. In order to name or change a beneficiary, obtain a *Designation of Beneficiary Card* from the Fund Office. The change will be effective when the Fund Office receives the updated *Designation of Beneficiary Card*. You do not need consent of your beneficiary to make a change. Your beneficiary may be changed at any time.

If you name more than one beneficiary, they will share equally in the benefit unless you indicate otherwise.

If the named beneficiary dies before you, or you have not named a beneficiary at the time of your death, the amount will be paid to the following: (a) your spouse, or if your spouse is not living; (b) to your child(ren), or if no living children survive you; (c) your parents in equal shares or to the one surviving parent, or if neither parent has survived you; (d) to your estate.

When circumstances necessitate it, the Trustees will recognize a bill for burial expenses up to one-fourth the amount of the Death Benefit. This amount will be deducted from the Death Benefit at the time of final payment.

APPLYING FOR BENEFITS

Beneficiaries can submit a claim for the Death Benefit by contacting the Fund Office. Completed claims forms should be forwarded to the Fund Office along with proof of death (i.e., death certificate). For tax reasons, the death benefit must be paid under the social security number of the beneficiary and not the deceased member.

Death Benefits cannot be assigned. Any attempt by the beneficiary to assign benefits will be considered null and void.

VISION CARE FOR ACTIVE EMPLOYEES AND RETIREES

The Marble Industry Welfare Fund provides you and each of your Dependents who are enrolled for coverage with a certain level of vision care benefits. An allowance up to the amounts shown below will be paid once every year for an examination of your eyes by an optometrist or ophthalmologist. In addition, you will be reimbursed once every year for one pair of corrective eyeglasses (lenses and frames) provided the prescription is filled by a dispensing optician.

FOR EMPLOYEES AND RETIREES:

Eye examination.....	\$ 10.00
Eyeglasses.....	100.00

Voucher program -- call the Fund Office for a list of union optical centers near you.

In order to encourage the broadest utilization of this Benefit a simplified claim form has been designed. Reimbursement for both the examination and the eyeglasses will be made on the basis of this single form, which you may obtain from your Local Union or the Fund Office.

No Optical Benefits will be paid for benefits covered by Workers' Compensation legislation, or for services or benefits provided by a Federal or State agency.

**NO REIMBURSEMENT WILL BE MADE FOR SUNGLASSES OR FOR COLORED
CONTACT LENSES**

DENTAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

The Welfare Fund provides dental benefits for active employees and their dependents. There is no dental benefit for Retirees or for their dependents.

The Plan's Fee Schedule and Dental Panel

Dental Care Benefits are provided for Participants and dependents in accordance with the Fee Schedule of Dental Care Benefits. If you did not receive the fee schedule along with this booklet, please contact the Fund Office or your Union Hall for the current fee Schedule.

The Fund has a list of participating providers who have agreed to accept the Fund's reimbursements as payment in full after the patient co-payment. Because this list is updated periodically, please contact the Fund Office for a current list of participating providers if you did not get a list along with this booklet.

You may choose to receive dental care from a provider that does not participate with the Fund's panel. However, the payment made to the dentist will not exceed the amount that would have been paid to a participating provider on the fee schedule. You will be responsible for the balance of the bill to the non-participating dentist.

Limitations

- The yearly maximum is \$2,000 per eligible participant.
- Pre-Authorization is not required.
- The Fund will pay a lifetime Orthodontic benefit of \$1,800 per eligible participant.
- Oral Exams and Cleanings are covered twice per year.
- Oral Surgery is not covered under the Dental Benefit.
- Coverage for dental conditions which existed prior to eligibility for such benefits from this Fund will be provided, but no payment will be made for any dental procedures which were performed prior to the date of eligibility for Dental Care Benefits.
- The Fund will not be liable for any dental work which takes place after the termination of eligibility for Dental Care Benefits, regardless of circumstances.
- No Dental Care Benefits will be paid for accidents and illnesses covered by Worker's Compensation Legislation or for treatments received in hospitals or clinics, etc., operated by Federal or State agencies.
- No benefits are payable for Cosmetic procedures.

MEDICAL BENEFITS

The Fund's medical coverage provides benefits for Medically Necessary Eligible Medical Expenses either on an In-Network or Out-of-Network basis. Your out-of-pocket expenses differ, depending on whether you use an In-Network provider or an Out-of-Network provider, as described below in the *Explanation of Medical Benefits*.

The Plan reimburses Eligible Medical Expenses up to the Plan's Allowance. In general, the Plan's Allowance is based on the MultiPlan Negotiated Rate.

Eligible Medical Expenses

You are covered for expenses you incur for "eligible medical expenses," which are limited to those that are:

1. determined by the Plan Administrator or its designee to be "Medically Necessary," but only to the extent that the charges are within the negotiated rate; and
2. not services or supplies that are excluded from coverage (as provided in the Exclusions section of this document); and
3. not services or supplies in excess of the Lifetime Maximum or Annual Maximum described in this Booklet.

You should note that the Plan might not reimburse you for all expenses that are considered Eligible Medical Expenses.

Non-Eligible Medical Expenses

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are determined to be not Medically Necessary, in excess of the Negotiated Rate, not covered by the Plan, in excess of the Lifetime Maximum and/or in excess of any applicable Annual Maximum.

In-Network and Out-of-Network Benefits

You may obtain health care services from In-Network or Out-of-Network Health Care Providers.

- **In-Network:** The MultiPlan PPO offers you a choice of participating providers. In-Network health care providers have agreements with MultiPlan under which they provide health care services and supplies for favorable negotiated discounted fees for Plan Participants. If you receive medical services or supplies from a health care Provider that has contracted with the Plan's PPO, you will be responsible for paying less money out of your pocket. Health care Providers who are under a contract with the PPO have agreed to accept the discounted amount (MultiPlan's Negotiated Rate). The Plan pays for covered services as payment in full less any co-payments for that benefit.
- **Out-of-Network (also called Non-Network):** This refers to providers who have not contracted with the PPO Network. Out-of-Network providers have no agreements with

the Plan and are generally free to set their own charges for the services or supplies that they provide. These Out-of-Network Providers **may bill you a non-discounted amount** for any balance that may be due **in addition to** the allowed amount (according to the Negotiated Rate) payable by the Plan, also called balance billing. When you choose to receive care from an Out-of-Network provider, the Plan generally reimburses Eligible Medical Expenses at 100% of the Negotiated Rate after the *Deductible* (as described below). As a result, when you use an Out-of-Network provider, you are responsible for the Deductible (as described below), AND any charges over and above the MultiPlan Negotiated Rate (In other words, the providers may bill you for the balance after payment from your insurance).

Deductible

Each calendar year, if you or an eligible Dependent uses an Out-of-Network Provider, you must first satisfy the Deductible before the Plan will pay any benefits. The individual Deductible is \$100 per person per calendar year. Once you (and your Dependents) have satisfied the Deductible, the Plan will usually reimburse Eligible Medical Expenses at 100% of the Negotiated Rate, as described above. Deductibles are applied to Eligible Medical Expenses in the order in which claims are received by the Plan on a calendar year basis. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductible and non-eligible expenses will not count towards the Deductible.

The MultiPlan PPO

The MultiPlan PPO covers physician visits, x-ray, laboratory and diagnostic tests, hospitalization and home health care, among other things. The *Explanation of Medical Benefits* below summarizes the In-Network and Out-of-Network benefits available to you through the PPO, as well as any limitations or maximums that may apply to individual benefits.

The MultiPlan network consists of more than half a million primary care practitioners and specialists throughout the New York and New Jersey region. This network of physicians covers specialists ranging from internists and other family doctors to various types of surgeons. Additionally, MultiPlan's networks include hospitals, diagnostic facilities, laboratory facilities and radiology facilities, as well as ancillary providers.

Directories of Network Providers

Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any provider is a member of MultiPlan by visiting www.MultiPlan.com or by calling 1-800-464-0292.

Maximum Plan Benefits

Annual Plan Maximum for Medical, Mental Health, Hospital and Prescription Benefits

For each covered person, the maximum amount payable for Eligible Medical Expenses under the Plan will not exceed \$150,000 per covered individual per calendar year for all hospital, medical and prescription benefits combined. The dental, optical and death benefits have separate maximums that are not counted under this annual plan maximum.

Lifetime Maximum Benefits for Medical, Mental Health, Hospital and Prescription Benefits

Through calendar year 2007, the Plan's overall Lifetime Maximum is \$250,000. Plan coverage will not exceed \$250,000 per person per lifetime for Medical, Mental Health, Hospital and Prescription Benefits.

Effective January 1, 2008, the lifetime maximum will be raised to \$500,000 per person.

These maximums apply to the entire period an individual is covered under this Plan (as a Participant and a Retiree).

Maximums That Apply to Specific Eligible Medical Expenses

In addition, benefits for certain Eligible Medical Expenses are subject to annual or lifetime maximums. Once the Plan has paid the annual or lifetime maximum for a Plan benefit, it will not pay any further benefits for those services or supplies under that provision of the Plan for the balance of the calendar year. The services or supplies that are subject to the annual or lifetime maximums are identified in the *Explanation of Medical Benefits*. Any lifetime maximums for specific benefits apply to the entire period an individual is covered under this Plan.

REVIEW OF CERTAIN PROCEDURES (Pre-certification/Pre-Authorizations)

The Fund has adopted a review procedure for all hospital and many medical services. The purpose of the review program is to help assure (though it is not a guarantee) that the care you are receiving meets or exceeds current standards, that the service requested is covered by the Plan, that services requested do not exceed your benefits without your knowledge, and that your provider and the Fund establish an understanding of what services will be required and how they will be reimbursed before they are rendered. The review coordinator will also help organize other services that you may require after surgery or hospitalization so that transition from one type of care to another is timely and cost-effective. The review program is not intended to replace or in any way interfere with the doctor- patient relationship. Rather it is intended to improve communication and better serve the member and their provider.

You should note that the fact that your Physician recommends surgery, inpatient hospitalization, or any other medical services or supplies does not mean that the recommended services or supplies will be considered Medically Necessary for determining coverage under the Medical Plan, or that it is not specifically excluded or limited under the Plan.

The Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The certification that a service is Medically Necessary does not mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan in either whole or in part.

All treatment decisions rest with you and your Physician (or other health care Provider). You should follow whatever course of treatment you and your Physician (or other health care Provider) believe to be the most appropriate, even if the Plan does not certify a proposed surgery or other proposed medical treatment as Medically Necessary or specifically excludes it. Benefits payable by the Plan may, however, be affected by the determination of the review.

With respect to the administration of this Plan, the Claims Administrator (Daniel H. Cook Associates) does not engage in the practice of medicine, and does not assume responsibility for the quality of health care services actually provided, even if they have been certified by the Claims Administrator as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified as Medically Necessary.

Pre-certification Review is a procedure, administered by the Claims Administrator (Daniel H. Cook Associates) to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a hospital or health care facility, surgery, and other health care services are Medically Necessary.

Services Recommended for Pre-certification

The following services are recommended for pre-certification review:

Any Inpatient Stay (Emergency Inpatient Admissions should be certified within 48 hours after admission occurred.)

Any Surgery, regardless of place of service (office, hospital, free standing surgical center)

Infusion therapies or injections (not including radiation or chemotherapy)

Pain Management Interventions

Diagnostic tests over \$1000 (e.g. MRI, nuclear stress test, colonoscopy, cardiac catheterization)

Durable Medical Equipment

Orthotic or Prosthetic appliances

Medical Supplies

Rehabilitation Services

Substance Abuse Treatment

Home care of any type (skilled nursing, home health aide, hospice, physical therapy)

Physical Therapy

Services where Pre-certification is not recommended

Maternity admissions and routine maternity care (Mothers or babies staying in the hospital **longer** than 48 hours for a vaginal delivery or 96 hours for a caesarean section should have pre-certification for the extended stay)

Diagnostic tests estimated to cost less than \$1000 (most ultrasounds, x-rays, laboratory tests)

Office Visits

Radiation Oncology and Chemotherapy

Please also be aware that there is no penalty for not obtaining pre-certification. This means that if the service was medically necessary and a covered benefit, the claim will be paid as if pre-certification had been obtained once the claim is reviewed. However, the administrator or its designee reserves the right to deny or hold payment for a claim if medical necessity is not obvious or requires more documentation than is on the claim submitted for payment. The member or provider must provide any requested medical records, notes, and/or a letter of medical necessity to supplement the claim in order for payment to be made.

The above rules do not apply if the patient is covered by Medicare as primary insurance. If another health plan is your primary insurer, pre-certification is recommended should there be a coverage problem with your primary insurance.

How to Request Pre-certification

You or your Physician should call the Claims Administrator at 1-877-888-AUTH (2884) Monday through Friday, between the hours of 9 AM and 5 PM. Calls for Elective services should be made at least 7 days before the expected date of service, where possible. If you call after hours, leave a message and someone will get back to you (or the Provider) the next business day.

It is recommended that your provider call the pre-certification coordinator to give all the necessary information for the authorization. You or your dependent may also call if the provider is unwilling or unable to call. Please have the pre-certification process begin as soon as you are aware that you will require it. Pre-certification may take up to 7 days to process depending on the type of service requested and necessary documentation to be reviewed.

If your admission or service is determined not to be Medically Necessary or not a covered service, you and your physician will be given notification of such. You may also pursue an appeal. See the Claims and Appeals Procedures section regarding appealing the determination.

Concurrent (Continued Stay) Review

When you are receiving medical services in a hospital or other inpatient health care facility, the Claims Administrator will monitor your stay by contacting the utilization review department within the facility or your physician to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your physician or other health care providers of various options and alternatives for your medical care available under this Plan.

If at any point your stay is found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If it is determined that your hospital stay was not Medically Necessary or if it is determined that the care provided was related to an excluded service under the Plan, no benefits will be paid on any related hospital, medical or surgical expense.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the Claims Administrator before you are admitted. If this happens, you should notify them of the hospital admission within 48 hours (or by the next business day, if later). You, your physician, the utilization review department, the hospital, a family member or

friend can make the phone call. This will enable the Plan to assist with discharge plans, determine the need for continued medical services, and/or advising your physician or other health care Providers of the various recommendations, options, and alternatives for your medical care.

Retrospective Review

All claims for medical services or supplies that have not been reviewed under the Plan's Pre-certification or Concurrent (Continued Stay) Review, may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Administrator determines that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies.** The Claims Administrator may use the advice of a medical review firm to determine if the stay was medically necessary. You have the right to appeal an adverse determination. For complete information on Claim Review and Claim Appeals, see the Claims and Appeals section of this document.

Review of New Medical Services or Supplies

New medical services, supplies, and medications are implemented frequently. If you or your Provider presents a new medical service, supply or medication (that has a temporary code assigned for the new, non-experimental, non-investigational procedures) which is not currently maintained on the Fund's Negotiated Rate schedule for reimbursement (or for pre-certification), the Claims Administrator will review the service, supply or medication to determine if the treatment is Medically Necessary, not Experimental and not otherwise excluded under the Plan. If the Claims Administrator determines it is eligible for reimbursement, they will determine a rate of reimbursement based on internal protocols, which include a review of the service, supply or medication against current medical practice and current reimbursement rates for similar types of procedures. The review and determination will be at the discretion of the Plan Administrator or its designee. You may contact Daniel H. Cook Associates for more information.

OTHER PLAN INFORMATION

Hospital Length of Stay for Childbirth

This Plan complies with federal law that prohibits restricting 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, or requiring a Physician or other health care Provider to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care Provider or Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

Reconstructive Services and Breast Reconstruction after Mastectomy

This Plan complies with the **Women's Health and Cancer Rights Act** which requires that for any Covered Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage is provided 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 physical complications for all stages of mastectomy, including lymphedemas.

Coverage for the mastectomy related service or benefits will be subject to the same Maximum Plan Benefits provisions that apply with respect to other medical or surgical benefits provided under the Plan.

Qualified Medical Child Support Order (QMCSO)

Benefits will be provided in accordance with the applicable requirements of a Qualified Medical Child Support Order. The process begins when the Plan receives a medical child support order (MCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

- (a) Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;
- (b) Requires a Participant to provide only the group health coverage available under the Plan for the Participant's Dependent children, even though the Participant no longer has custody; and
- (c) Clearly specifies:
 - 1. The Participant's name and last known mailing address and the names and addresses of each Dependent Child covered by the order,
 - 2. A reasonable description of the coverage to be provided, and
 - 3. The length of time the order applies.

The Plan will provide written notification to the Participant and each identified Dependent Child that it has received a court order requiring coverage. If the order meets the above requirements, the Plan will also provide written notification to the Participant and each Dependent Child that the order is a QMCSO and their eligibility for coverage. The foregoing is conditioned upon the order being filed on a timely basis and approved in writing by the Trustees.

The Qualified Medical Child Support Order cannot require the Plan to provide any benefit or option not otherwise provided under the Plan.

EXPLANATION OF MEDICAL BENEFITS

The list below outlines the medical services, supplies, and conditions that are considered Eligible Medical Expenses and are covered by the Plan.

Except as otherwise noted in this section or in the Exclusions section which follows, Eligible Medical Expenses are the Plan's Allowances for services listed below and that are incurred by you or an eligible Dependent - subject to the Definitions, Limitations and Exclusions and all other provisions of this document. Services and supplies must be approved by a Physician (or other health care Provider as defined in the definition section), must be Medically Necessary (as defined on in the definitions section), and not excluded by the Plan

Acute Rehabilitation (Inpatient) – Pre-certification Recommended

The Plan will cover Inpatient Rehabilitation Services only if provided in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting**. Such services must be performed under a program approved by the New York State Department of Health or similar state agency for hospitals outside New York State.

The maximum number of days covered for acute rehabilitation will not exceed **7** per calendar year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Allergy Services

The Plan will cover allergy sensitivity testing (skin patch and blood tests) and allergy shots for desensitization and hyposensitization.

The Maximum benefit for allergy testing and treatments will not exceed \$2,000.00 per year.

In-network coverage (with Multiplan): 100% of in-network rate.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Ambulance Services

The Plan will cover paramedic care and ambulance transport to the nearest appropriate facility as necessary for the treatment of a medical emergency. Expenses for ambulance services are covered only up to the level of care that is appropriate for the transport (Basic Life Support training versus Advanced Cardiac Life Support training).

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Anesthesia

The Plan will cover physician fees for anesthesia if surgery benefits are payable by the Plan.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Annual Physical (Adult Well Care)

The Plan will cover annual physical exams as well as adult immunizations that conform to the standard of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services, and that are not being given for work or for travel. The plan will also cover annual routine gynecological examinations including Pap smear.

In-network coverage (with Multiplan): \$20 co-payment per office visit.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Behavioral (Mental) Health Benefits- – (pre-certification recommended)

Inpatient

The plan will cover inpatient hospitalizations due to a Behavioral (Mental) Health Disorder as described in the definitions section of this document for up to 7 days per calendar year and no more than 14 days per lifetime.

Intensive Out-Patient or Partial Program

If an intensive out-patient program (IOP) or partial program is considered medically necessary, the Plan will cover each IOP or partial day as a half day of the 7 day inpatient allowance. For example, the fund would cover 3 in patient days and then 8 IOP days for a total of 7 inpatient days.

Therapy Visits – Out Patient

The plan will cover one hour of out-patient talk therapy with a licensed therapist and/or psychiatric medication management up to 12 visits in a calendar year.

In-network coverage (with Multiplan): \$20 co-payment per office visit. Inpatient, Intensive out-patient or partial program covered at 100% of in-network rate.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Chemotherapy and Cancer Treatments

The Plan will cover cancer chemotherapy and cancer hormone treatments and services in any medically appropriate treatment setting which have been approved by the FDA for general use in the treatment of cancer.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Corrective Appliances– (pre-certification recommended)
(Prosthetic & Orthotic Devices, other than Dental)

The Plan will cover the rental (up to the purchase price of the device), repair, adjustment or servicing of prosthetic devices such as artificial limbs and eyes, as well as prescribed custom orthotics.

Coverage for Corrective appliances in combination with DME and Nondurable supplies shall not exceed \$5,000.00 per calendar year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of what would be paid to an in-network provider (the negotiated rate or allowable amount) after the \$100 deductible has been met.

Diagnostic Studies – pre-cert recommended on tests costing above \$1000.00

The Plan will cover medically necessary diagnostic tests and procedures such as X-rays, ultrasounds, Cat Scans, MRI, nuclear medicine, angiograms, and endoscopies in any setting that is appropriate for the testing. Pre-certification is strongly recommended for diagnostic tests and procedures costing in excess of \$1000.00. Justification for the procedure or test may be requested in writing at the discretion of the claims administrator.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Durable Medical Equipment (DME) – pre-certification recommended

The Plan will cover the rental (up to the purchase price of the item), purchase, repair, adjustment or service of medically necessary durable medical equipment. Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.

Coverage for DME in combination with Non-durable supplies and Corrective appliances shall not exceed \$5,000.00 per calendar year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Emergency Room & Urgent Care Services (subject to post claim review)

The Plan will cover facility, professional, and ancillary charges (such as lab or x-rays) for a hospital emergency room (ER) or for an Urgent Care facility for a medical Emergency.

Please note that Emergency Room and Urgent Care Services should be used only for **true medical emergencies**. A true medical emergency is defined as a situation where there is a sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the member (or if pregnant, the unborn child) in serious jeopardy by serious impairment to bodily functions or serious dysfunction of any bodily organ or part. Follow-up care following a true medical emergency should be obtained and coordinated by your primary care physician, or if appropriate, physician specialist.

If after review of your claim for emergency care, it is determined that the circumstances did not constitute a medical emergency, or if the charges for the emergency room care are for follow-up care (such as wound care or removal of sutures), then a \$100 co-payment for that visit will be applied to the hospital bill.

In-network coverage (with Multiplan): 100% of in-network rate provided the care was for a true medical emergency.

Out of Network coverage: 100% of the negotiated rate or allowable amount for a true medical emergency after the \$100 deductible has been met.

Hearing Aids

The Plan will cover expenses for the examination, fitting and/or purchase of a hearing aid. The benefit will not exceed \$400.00 for each ear over a period of three consecutive years.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Home Health Care – (pre-certification recommended)

The Plan will cover:

- Part-time professional nursing visits (skilled nursing care only).
- Part-time home health aide services (up to 4 hours of care is equal to one home care visit).
- Laboratory services performed by the professional nurse.
- Home infusion services performed or taught by the professional nurse.
- Physical or Occupational therapy evaluations.
- Social work evaluations, as appropriate

Home health care should be coordinated prior to leaving the hospital or arranged by your physician's office and concurrent review should be submitted to the pre-certification department. Home health care is only payable when provided through a non-profit New York State Certified Home Health Agency or similar facility if out of state.

The Home Health Care Benefit will not exceed 50 visits a year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Hospice Benefits (pre-certification recommended)

The Plan will cover hospice services in any appropriate setting when the patient meets the criteria for Hospice care, as defined in this Booklet.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Hospital Services – (pre-certification recommended)

Inpatient – The Plan will cover room and board in a semiprivate room with general nursing services or a specialty care room, such as intensive care, if appropriate, as well as the necessary ancillary services and supplies necessary in association with the inpatient stay.

Outpatient Benefits – The Plan will cover the facility fee for ambulatory surgery or procedures performed in the outpatient department of a hospital or in a free standing surgery center.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Maternity Services

The Plan will cover routine prenatal and maternity care for an Employee or his Spouse, but not for dependent children otherwise covered under the plan. Please see the Exclusions section entitled *Maternity/Family Planning/Contraceptive Exclusions* for more information.

This Plan complies with federal law that prohibits restricting 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, or requiring a Physician or other health care Provider to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care Provider or Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

In-network coverage (with Multiplan): \$20 co-payment for initial prenatal office visit then 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Office (Physician) Visits

The plan will cover physician services for visits made in a physician's office, a clinic, an emergency room, or in an inpatient setting.

In-network coverage (with Multiplan): \$20 co-payment for out patient office visits. 100% of in-network rate for inpatient or emergency visits.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Pain Management (Pre-certification Recommended)

The Plan will cover a reasonable amount of treatment for pain management but only with documentation that other conservative treatments have been tried for a reasonable amount of time and have failed, and that continued treatments are effective and medically necessary. Injections to the spine for pain management shall not exceed one series of three per year.

In-network coverage (with Multiplan): \$20 co-payment for office visits. 100% of in-network rate for out-patient treatments.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Physical and Occupational Therapy (Out Patient)
(Physical Medicine and Rehabilitation)

The Plan will cover short term active, progressive Occupational or Physical Therapy performed by a licensed or duly qualified therapist as ordered by a Physician.

Maintenance Rehabilitation and coma stimulation services are not covered. See specific exclusions relating to Rehabilitation in the Exclusions section.

The maximum number of physical or occupational therapy visits shall not exceed 10 per year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Preadmission Testing (Outpatient)

The Plan will cover laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a covered, scheduled hospital admission or outpatient surgery in that hospital.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Radiation Therapy

The Plan will cover treatment of disease by X-Ray, radium, or radioactive isotopes, including the cost of radioactive materials supplied and billed by the provider.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Substance Abuse Benefits (pre-certification required)

Pre-certification & Benefit Administration provided by: Workforce Assistance Programs, Provider for the **Marble Industry Trust Fund Members Assistance Program**

For Pre-Certification, Treatment Referral, Intervention, Follow-up & Member Assistance Services - Please Contact Pat Mercora (914) 417-5355

The plan covers detoxification, rehabilitation, and counseling for substance abuse treatment for eligible members and dependents in both inpatient and outpatient settings. Services must be provided in an accredited (In Network) non-governmental facility. Plan exclusions apply.

Annual limitations apply and are subject to pre-certification.

Benefit is limited to \$20,000 per calendar year and \$40,000 per lifetime for all types of substance abuse treatments and services.

In network:

Inpatient: 100% coverage of approved days up to the annual benefit maximum for substance abuse treatment. (Pre-certification required).

Outpatient: 100% coverage up to 60 visits per calendar year and not to exceed the annual benefit maximum for substance abuse treatment. (Pre-certification required)

Out of network: 100% of negotiated rate (paid at the lowest rate of in-network providers) after \$100.00 deductible up to the annual benefit maximum for substance abuse treatment.

Supplies (Medical/Surgical Supplies)– (pre-certification recommended)

The Plan will cover supplies such as

- Dressings, casts, splints, trusses, braces, crutches; sterile surgical supplies used immediately after a covered surgery;
- Supplies needed to operate or to use covered Durable Medical Equipment or Corrective Appliances; and
- Supplies needed for use by skilled home health or home infusion personnel, during the course of their required services.

Supplies must be obtained through a medical supply or durable medical equipment company that will provide a detailed health insurance claim form to the administrator.

Coverage for Nondurable supplies in combination with DME and Corrective appliances shall not exceed \$5,000.00 per calendar year.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Surgery– (pre-certification recommended)

The Plan will cover physician surgical fees when performed by a Physician or Surgeon in an office, hospital, emergency room or other covered health care facility location.

If two or more surgeries are performed through the same incision, the total benefits paid for all such operations will not exceed the maximum Negotiated Rate for the operation for which the largest benefit is payable.

In-network coverage (with Multiplan): 100% of in-network rate

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

Well Child Care (Periodic Evaluations)

Children (Birth to Age 19)

The Plan will cover periodic health evaluations for newborns and infants, annual physicals for children ages 2 and up, and immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U. S. Department of Health and Human Services.

In-network coverage (with Multiplan): \$20 co-payment per office visit.

Out of Network coverage: 100% of the negotiated rate or allowable amount after the \$100 deductible has been met.

PRESCRIPTION DRUG BENEFITS

Prescription Benefit Manager

Your prescription drug benefit is provided by the Fund and administered by General Prescription Programs, Inc (GPP). The customer service number for GPP is 1 (800)341-2234.

GPP will mail you a plastic identification card within 60 days of becoming eligible for benefits. Each member of your family eligible for prescription benefits will have their own card. Call the Fund Office to request a new identification card if you do not receive one when you are first eligible for benefits or if you lose yours.

GPP will also send you their formulary (a menu of preferred drugs), a list of participating pharmacies, and information for mail service pharmacy for maintenance drugs.

Co-payments

Co-payments are the fixed dollar amount that the member is responsible for when filling a prescription. The Fund pays for the balance of the cost of the medication. Your prescription plan has a three tier co-payment program:

\$5.00 for generic drugs

\$10.00 for Brand name drugs that appear on GPP's formulary

\$25.00 for Brand name drugs that do not appear on GPP's formulary

Your out-of-pocket cost will be less if you use generic drugs. Tell your doctor that your co-payment will be less with generic drugs. Show your doctor GPP's formulary when he or she is prescribing your medication. If your doctor needs to prescribe a brand name drug for you, the formulary may help him or her choose a drug that will have the lower co-payment.

Filled Prescriptions at Non-Participating Pharmacies

If you go to a non-participating pharmacy you may still be reimbursed for prescription drugs. However, you have to pay for the prescription when it is filled.

After the claim is processed, the Fund Office will mail you a reimbursement check based on the reimbursement allowance made to participating pharmacies (which is the average wholesale price (AWP) less any applicable co-payment). In addition, if a generic equivalent is available for a brand name drug you purchased, the reimbursement will be based on what the Plan would reimburse you for the generic drug. In other words, if the cost of your prescription is more than what would be reimbursed to a participating pharmacist, you will not be reimbursed for the difference.

Drugs That Are Covered

The Fund's prescription drug benefit only covers oral and inhalation medications that, by federal law or state law, require a prescription and are prescribed by a licensed practitioner. In addition, the Plan covers syringes and needles for use in conjunction with insulin injections. Please understand that if a drug is on GPP's formulary, but if it is excluded by the Plan, it will not be covered under your medical or prescription benefits.

Items That Are Not Covered

- ◆ Allergy Serums
- ◆ Anabolic Steroids
- ◆ All Vitamins, even if they require a prescription
- ◆ Cosmetic Medications
- ◆ Diaphragms, Injectable and Oral Contraceptives
- ◆ Genetically Engineered Drugs
- ◆ Growth Hormone Therapy
- ◆ Imitrex auto injector and Imitrex vial
- ◆ Injectables Medications (except insulin and see below)
- ◆ Ostomy products
- ◆ Rhogam
- ◆ Rogaine or other medications for hair growth
- ◆ Unauthorized refills
- ◆ Medications for which you do not need a prescription (over the counter drugs)
- ◆ Weight control drugs (e.g., Meridia, Xenical),
- ◆ Devices or appliances, support garments or other non-medical substances,
- ◆ Syringes or needles (except diabetic supplies),
- ◆ Investigational or Experimental drugs,
- ◆ Infertility drugs,
- ◆ Medications that treat erectile dysfunction (Viagra, Levitra Yohimbine),
- ◆ Food supplements, including baby formulas,
- ◆ Prescriptions covered without charge under federal, state or local programs including Workers' Compensation,
- ◆ Immunization agents, biological sera, blood or plasma,
- ◆ Medication for eligible members and dependents who are confined to a rest home, nursing home, sanatorium, extended care facility, hospital, or similar institution.
- ◆ Smoking cessation aids, such as nicotine patches and gum.

Medications administered for injection may be covered when prescribed for a limited duration to treat a temporary condition (such as for correction of blood cells following chemotherapy). Chronic therapy requiring medication for injection is not covered, except for diabetes/insulin therapy.

Immunizations or vaccinations for high-risk individuals (such as anti-rabies or RSV prophylaxis), or for treatment of contagious disease (such as Hepatitis C) can be covered under the medical plan providing that prior authorization and submission of requested documentation is provided.

Retiree Benefits Regarding the Prescription Plan

Retirees may have two choices for prescription benefits, depending on whether they are eligible for Medicare Part D:

Retiree Benefit Plan through GPP up to \$2,250.00 per year per person

GPP will mail you a plastic identification card. Each member of your family eligible for prescription benefits will have their own card. GPP will also send you their formulary (a menu of preferred drugs), a list of participating pharmacies, and information for mail service pharmacy for maintenance drugs.

Retirees will be responsible for the co-payments mentioned on page 38. The Fund will pay up to \$2,250.00 in prescription benefits through GPP per year per covered individual. Should a retiree or their dependents require additional drugs, they may be eligible for a GPP discount card. This would entitle the member to discount prices on drugs, but would not entitle the member to additional coverage of prescriptions from the Fund.

Premium Reimbursement when Enrolled under Medicare Part D

For retirees who are eligible for benefits under Medicare Part D, the retiree may opt to sign up for a Prescription Drug Program as Part of the Medicare Part D program. If a member elects to enroll in a Medicare Part D program, the Fund will contribute up to \$300.00 per year per eligible participant towards the premium of such a plan. If the Member enrolls in United Healthcare's prescription drug plan for Medicare Part D, the Fund will pay the premium of up to \$300.00 directly to United Healthcare.

Please see further explanation on the next page for the rules regarding how Medicare Part D affects you and your family under this Plan.

Medicare Part D

Prescription Drug Benefits for Retirees and Dependents who are Medicare Eligible

As of January 1, 2006, Medicare will cover prescription drug benefits. If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D (Medicare's new Prescription Drug benefit effective January 1, 2006).

This Plan offers "Creditable Coverage," which means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have the Plan's prescription drug coverage in order to avoid a late penalty under Medicare. You may in the future enroll in a Medicare Prescription Drug Plan during Medicare's annual enrollment period (November 15-December 31 of each year). For more information about creditable coverage, see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of the Notice of Creditable Coverage by calling the Fund Office and asking for one.

If you, as a Medicare-eligible Retiree and your Medicare-eligible Dependents, enroll in a Medicare Prescription Drug Plan or Medicare Advantage Prescription drug Plan, your prescription drug benefits under the Plan will be terminated.

If you, as a Medicare-eligible Retiree or your Medicare-eligible Spouse enroll in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drugs, you and/or your spouse **will not** be eligible to receive any prescription drug benefit under this Plan. If you enroll in a PDP or Medicare Advantage plan while covered under this plan, your prescription drug benefits will be terminated. However, you will be able to continue your medical and hospital coverage. If you lose prescription drug coverage in the Fund, so will your Spouse and Dependents.

If you or your Medicare-eligible Dependent(s) enroll in a Medicare PDP or Medicare Advantage plan, and you later change your mind, you may not re-enroll in this Plan. **If you enroll in a Medicare Prescription Drug Plan you and your Dependents will lose your coverage in this Plan and you and your Dependents cannot re-enroll in this Plan.**

PLAN EXCLUSIONS

The following is a list of services and supplies or expenses not covered by the Medical Plan. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. General Exclusions are listed first, followed by specific medically-related plan exclusion.

GENERAL EXCLUSIONS (applicable to all services and supplies)

1. Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.
2. Costs of Reports, Bills, etc.: Expenses for preparing medical reports, bills or claim forms; medical testimony; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees and/or photocopying fees.
3. Educational Services: Expenses for educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, auditory aides, speech aids, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc., even if they are required because of an injury, illness or disability of a Covered Individual.
4. Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your employer, or if benefits are otherwise provided under this Plan or any other plan that your employer contributes to or otherwise sponsors, such as HMOs.
5. Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation, Annual Maximum, or Lifetime Maximum Plan benefits as described in the Medical Expense Coverage section of this document.
6. Expenses Exceeding the Plan's Negotiated Rate: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Negotiated Rate as defined in this document.
7. Expenses for Eye refraction, fitting of glasses except as provided under the Vision care benefit.
8. Expenses for elective services, except as explicitly provided by the Plan.
9. Expenses for which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or

other tortuous or wrongful act of that third party. See the provisions relating to Third Party Liability in the section on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.

10. Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.
11. Experimental and/or Investigational Services: Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions section of this document.
12. Failure to Comply with Medically Appropriate Treatment: Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Plan Administrator or its designee.
13. Government-Provided Services (Tricare, VA, etc.): Expenses for services when benefits for them are provided to the Covered Individual under any plan or program (including, without limitation, Tricare, and Veterans programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; or under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
14. Hospital stays: Hospital stays or any part of hospital stays that are primarily for diagnostic studies. Hospital benefits that are for services of a physician or private or special nurse or other private attendants or their board.
15. Illegal Act: Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of a felony or an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

16. Internet/Virtual Office Visit: Expenses related to an online internet consultation with a Physician or other Health Care Provider, also called a virtual office visit/consultation, physician-patient web service or physician-patient e-mail service, including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.
17. Leaving a Hospital Contrary to Medical Advice: Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician.
18. Medical Students, Interns or Residents: Expenses for the services of a medical student, intern or resident.
19. Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be Medically Necessary, as defined in the Definitions section of this document.
20. Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, electric recliners, special furniture, etc.
21. No-Cost Services: Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
22. No Physician Prescription: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Nurse Practitioner.
23. Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual.
24. Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.

25. Operation of a Vehicle Under Influence of Alcohol or Drugs: As determined by the Plan Administrator or its designee, expenses that were incurred by any covered individual for injuries caused in a motor vehicle accident if the covered individual was operating the vehicle while intoxicated (had a blood alcohol level that exceeded the legal limit of the jurisdiction in which the accident occurred or no breathalyzer exam was performed or the person refused to submit to a requested breathalyzer or blood test) or was under the influence of illegal drugs; unless the injuries arise as a result of an underlying physical or mental health condition. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the motor vehicle accident.
26. Personal Comfort Items: Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
27. Physical Examinations, Tests for Employment, School, etc.: Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party; including exams or drug testing required for employment purposes.
28. Private Room in a Hospital or Health Care Facility: The use of a private room in a Hospital or other health care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Plan Administrator or its designee.
29. Relatives Providing Services: Expenses for services provided by any Physician or other Health care Provider who is the parent, spouse, sibling (by birth or marriage) or child of the patient or covered Employee.
30. Self-Inflicted Injury or Attempted Suicide: Expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted injury or illness, including complications thereof, unless the attempt arises as a result of a physical or mental illness
31. Stand-By Physicians or Health Care Providers: Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Provider was available to on a stand-by basis.
32. Telephone Calls: Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any

- purpose whatsoever, including, without limitation: Communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Covered Individual; consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.
33. Travel Contrary to Medical Advice: Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.
34. War or Similar Event: Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

1. Alternative/Complementary Health Care Services Exclusions

- A. Expenses for acupuncture and/or acupressure
- B. Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
- C. Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
- D. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.
- E. Expenses for any service performed by a Chiropractor (D.C.)
- F. Expenses for Hypnosis, hypnotherapy or biofeedback therapy.
- G. Expenses for extracorporeal shock wave therapy (lithotripsy) for any body part except for treatment of gall bladder and kidney stones.

2. Behavioral (Mental) Health Care Exclusions

- A. Expenses for residential care services for Mental Health care, except as provided and described in the Schedule of Medical Benefits.

- B. Expenses for Behavioral Health Care services related to:
 - i. dyslexia, learning disorders, vocational disabilities;
 - ii. Autism, developmental disabilities, or mental retardation;
 - iv. court-ordered Behavioral Health Care services or custody counseling;
 - v. family planning/pregnancy/adoption counseling, transsexual/gender reassignment/sex counseling.
 - vi. tests and related expenses to determine the presence of or degree of a person's attention deficit disorder, dyslexia or learning disorder.
- 3. ***Blood Donation, Collection or Administration Exclusions***

Expenses for donation, collection, or administration of autologous blood, blood products, or biological serum.
- 4. ***Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions***
 - A. Expenses for any items that are not Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms are defined in the Definitions section of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
 - B. Expenses for replacement of lost, missing, stolen, duplicate or personalized Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
 - C. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they exceed the cost of standard models of such appliances or equipment.
 - D. Expenses for occupational therapy supplies and devices needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.
 - E. Expenses for nondurable supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

5. *Cosmetic Services Exclusions*

- A. Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, removal of excessive skin, breast augmentation, reduction mammoplasty (breast reduction surgery) or blepharoplasty (eyelift surgery) even if Medically Necessary, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan does cover Medically Necessary Reconstructive Services as required under the Women's Health and Cancer Rights Act (WHCRA) as described in the section "Other Plan Information" To determine the extent of this coverage, contact Daniel H. Cook Associates.
- B. Expenses for treatment of complications related to cosmetic surgery.
- C. Removal and/or replacement of breast implants, except as covered under the Women's Health and Cancer Rights Act (WHCRA), surgical complications of cosmetic surgery
- D. Expenses for ear piercing or tattooing

6. *Custodial Care Exclusions*

- A. Expenses for Custodial Care as defined in the Definitions section of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.
- B. Medical and nursing services performed in a custodial care setting.

7. *Dental Services Exclusions*

- A. Expenses for Dental Prosthetics or Dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body.
- B. Expenses for the diagnosis, treatment or prevention of Temporomandibular Joint (TMJ) Dysfunction or Syndrome.
- C. Expenses for Orthognathic services/surgery for treatment of Prognathism, Retrognathism and TMJ and other cosmetic reasons.
- D. Expenses for oral surgery to remove teeth, including wisdom teeth, gingivectomies, treatment of dental abscesses, root canal (endodontic) therapy.

8. *Drugs, Medicines and Nutrition Exclusions*

In addition to those benefits excluded under the Prescription drug benefit, the Plan excludes expenses for:

- A. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization.
- B. Vaccinations, immunizations, inoculations or preventative injections, except those provided under the Annual Physical benefit for children and/or adults and those required for treatment of an injury or exposure to infectious disease (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).
- C. Smoking cessation programs and prescriptions for nicotine patches and gum.
- D. Outpatient prescription drugs are only covered when received through the Prescription Drug Benefits administered by as described in this Booklet, subject to the definitions, exclusions and limitations described in that section.

9. *Durable Medical Equipment Exclusions*

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

10. *Fertility and Infertility Services Exclusions*

Expenses for the diagnosis and treatment of infertility, along with services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures unless the treatment is necessary to correct an organic disease.

11. *Foot/Hand Care Exclusions*

Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation) or hand care including manicure and skin conditioning. Routine foot

care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

12. Genetic Testing and Counseling Exclusions

- A. Genetic Testing: Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics except:

Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder but only when those tests are performed using fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women.

- B. Genetic Counseling: Expenses for genetic counseling.
- C. Paternity Testing

13. Hair Exclusions

Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

14. Home Health Care Exclusions

- A. Expenses for any Home Health Care services other than part-time, intermittent skilled nursing services and supplies.
- B. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
- C. Expenses for a homemaker, custodial care, child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage.
- D. Expenses for Home Health Care that is not arranged through an accredited agency or is not arranged prior to hospital discharge or through your physician's office.

15. *Hospice Exclusions:*

- A. Expenses for bereavement counseling, funeral arrangements, pastoral counseling, financial and legal counseling.
- B. Expenses for Homemaker or Caretaker services, and any service not solely related to the care of the member.
- C. Expenses for sitter or companion services
- D. Respite Care.

16. *Maternity/Family Planning/Contraceptive Exclusions:*

- A. Contraception: Expenses related to prevention of pregnancy, including, but not limited to drugs or medicines such as birth control pills, emergency contraceptive medication, injectables such as Depo-Provera and Lunelle, contraceptive devices such as condoms, intra-uterine device (IUD) or diaphragm or implantable birth control devices.
- B. Termination of Pregnancy: Expenses for elective induced abortion unless the attending physician certifies that the physical health of the woman would be endangered if the fetus were carried to term.
- C. Home Delivery: Expenses for pre-planned home delivery.
- D. Expenses for childbirth education, Lamaze classes, breast-feeding classes.
- E. Services of alternative birthing facilities.
- F. Circumcision: Expenses for routine circumcision of newborn males and any complications thereof.
- G. Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child or surrogate mother's pregnancy.
- H. Expenses related to obtaining and storing umbilical cord blood or other tissue or organs.
- I. Charges for vasectomy or tubal ligation and/or charges for the reversal of a vasectomy or tubal ligation.

18. *Prophylactic Surgery or Treatment Exclusions*

Expenses for all medical or surgical services or procedures, including prescription drugs and the use of Prophylactic Surgery as defined in the Definitions section of

this document, when the services, procedures, prescription of drugs, or Prophylactic Surgery is prescribed or performed for the purpose of:

- A. avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
- B. treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, except when the services or procedures are based on the results of amniocentesis, chorionic villus sampling (CVS), or alphafetoprotein (AFP) analysis.

19. *Rehabilitation Therapy Exclusions (Inpatient or Outpatient)*

- A. Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- B. Expenses for massage therapy, Rolfing and related services.
- C. Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to coma stimulation programs and services.
- D. Expenses for Maintenance Rehabilitation as defined under Rehabilitation in the Definitions section of this document.
- E. Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders.
- F. Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or result of a covered treatment.

20. *Sexual Dysfunction Services Exclusions*

- A. Treatment of Sexual Dysfunction regardless of origin: Expenses for prescription drugs (i.e. Viagra) and/or medical or surgical treatment of sexual dysfunction (i.e., penile implants) or inadequacy, and any complications thereof.
- B. Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual/gender

reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures.

21. *Snoring Exclusions*

Expenses related to the medical or surgical treatment of snoring, including diagnosis and medical equipment.

22. *Skin Exclusions*

- A. Expenses related to treatment of non-malignant skin conditions such as rosacea, hyperhidrosis, spider veins, skin tags and acne treatments.

23. *Transplant (Organ and Tissue) Exclusions*

- A. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post operative services and drugs or medicines, and all complications thereof.
- B. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
- C. Expenses for insertion and maintenance of an artificial heart or other organ or related device including complications thereof, except a ventricular assist device (VAD) when used as a bridge to a heart transplant, heart valves and kidney dialysis.
- D. Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this Plan.

24. *Vision Care Exclusions*

- A. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser in Situ Keratomileusis (LASIK).
- B. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies except as provided under the Vision benefits.
- C. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.
- D. Ocular therapy or training

25. *Weight Management and Physical Fitness Exclusions*

- A. Medical or surgical treatment for weight-related disorders, including, but not limited to, surgical interventions, dietary programs and prescription drugs.
- B. Expenses for medical or surgical treatment of obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, and any complications thereof, even if those procedures are performed to treat a co-morbid or underlying health condition.
- C. Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.
- D. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment

DISABILITY BENEFITS (Short Term Disability) LAW

The Marble Industry Trust Fund pays special assessments to the States of New York and New Jersey to provide benefits for Employees normally employed in those States who may become ill while employed. A Participant is eligible for short term disability to compensate for lost wages if he cannot work because of an accident or illness **not** connected with his job.

A Participant must be under the care of a legally qualified physician and be unable to work at his job in order to receive short term disability. The physician who is giving him regular care must certify that he is unable to work at his job, and such certification must be provided whenever requested by the Fund Office.

Short Term Disability begins on the eighth day a Participant suffers a disabling accident or a disabling illness. A Participant may receive a maximum of 26 weekly benefit payments during any one period of disability, or for all disabilities during a period of 52 consecutive calendar weeks. Successive periods of disability separated by less than two weeks (10 days) of active full time work for Contributing Employers will be considered a single period of disability, unless the subsequent disability is due to an injury or illness entirely unrelated to the causes of the previous disability and begins after the employee has returned to active work. Short Term Disability payments are subject to the applicable FICA withholding.

The provisions of the applicable Disability Benefits Law of the States of New York and New Jersey will be applied in the administration of this Benefit. Each Participant is guaranteed that he will always receive benefits for a period of disability at least equal to benefits which he would have received under the Statutory Provisions of the applicable State Laws.

Employees employed in the States of New York and New Jersey may become eligible for short term disability before becoming eligible for all benefits provided by this Fund. Any new Employee who becomes injured or ill prior to completing 960 hours of work in Covered Employment (1,280 hours for Marble Restoration Finishers) should contact the Fund Office for additional information.

Total and Permanent Disability Benefits for Covered Employees

If a Covered Employee becomes totally and permanently disabled before reaching the age of 60 while still a Covered Employee of the Fund, he will be covered for the Death Benefit as per the schedule listed under that benefit explanation, as long as he remains totally and permanently disabled, and provides proof of the disability as required by the Trustees of the Marble Industry Trust Fund. A totally and permanently disabled Covered Employee must furnish written proof to the Fund Office between the ninth and twelfth months after the beginning of the disability. Subsequent written proof of the total and permanent disability must be given to the Fund Office each year thereafter.

ADDITIONAL SECURITY BENEFIT ACCOUNT (Supplemental Benefits)

Explanation

The Additional Security Benefit Account (ASBA) was established through collective bargaining between your Union and various employers and is administered by the Trustees. This is a separate fund through which your Employer makes contributions and from which an Employee may withdraw monies for certain eligible expenses and events as outlined below. An Employee shall become eligible for disbursement of benefits provided by the ASBA upon the receipt of at least ten dollars (\$10.00) contributed on his behalf by a Contributing Employer to the Additional Security Benefit Account. The disbursements from the account may not exceed the amount in the account.

Eligible Payments from the ASBA

Unemployment and Disability

In the event that an eligible worker becomes unemployed, ill, or injured, the Trustees may authorize the payment matching the current amount payable from the state per week from the ASBA to the worker, for the same period during which the worker receives payment under a State Unemployment Insurance Law, a State Disability Benefits Law, or a State Workers' Compensation Law. Total payment may not exceed the total dollar amount of the worker's service credits, nor can payment be made for any period in excess of the period for which the worker is in receipt of benefits under the above mentioned State Laws.

Application for Supplementary Unemployment and Sickness Benefits must be made within two years of the expiration of eligibility for unemployment, disability, or sickness benefit payments under State Laws.

Original check stubs for Unemployment, State Disability or Workers' Compensation payments must be submitted for disbursement of funds from the ASBA.

Un-reimbursed Medical, Dental, Vision, and Drug Expenses

In the event that an Employee or an eligible dependent incurs expenses in excess of those benefits provided by the Marble Industry Trust Fund basic plan, the Trustees may authorize payment to the worker upon written request up to the total dollar amount of the worker's service credits, but not more than the excess medical expenses incurred. Expenses may include co-payments, coinsurance, deductibles, and excluded services under the plan. The plan administrator or designee will determine if the expense is eligible. Original receipts and additional documentation may be required before disbursement of the ASBA can be made.

Death Benefit (Liquidation of the ASBA)

In the event of the death due to any cause of an eligible worker, the Trustees may authorize the payment of the total dollar amount of the deceased worker's accumulated service credits at the time of death. Payment shall be made as a Supplementary Death Benefit to any person named as beneficiary. The beneficiary may be changed at any time

by signing a new designation of beneficiary card which can be obtained from the Fund Office.

Filing a claim for payments out of the ASBA

If you wish to file a claim for benefits, you should telephone or write the Fund Office or your Local Union Office and you will be sent the proper claim form. Application for Benefits must be made in the form and manner prescribed by the Board of Trustees.

After you have received the claim form, read the instructions carefully and complete the form, attaching all required documentary evidence. Return the completed form and attachments to the Fund Office. No claim form will be processed unless it is properly completed in accordance with the instructions. Your claim must be filed within 12 months of the event for which payment is being sought. If the Employee is continuously unemployed after such an event, the claim must be filed within 36 months.

The Trustees shall be the sole judges of the standard of proof required for the Additional Security Benefits. If a worker makes a false statement material to his claim for benefits, he may be denied any and all benefits and the Board of Trustees shall have the right to recover any payments made pursuant to such false statements.

Non-Assignability and Non-Encumbrance of Benefits

No Employee or beneficiary shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute or anticipate any benefit payment and such payments shall not in any way be subject to any legal process to levy execution upon or attachment or garnishment proceedings against the same for the payment of any claims against a marble worker.

Neither the fund nor any of its assets shall be liable for the debts of an Employee, participant or beneficiary, nor shall benefits be subject to garnishment, attachment, or execution, except that the fund may offset overpayments by the fund to an Employee, participant or beneficiary against assets specifically allocable to pay benefits, current or future, to such Employee, participant or beneficiary.

In addition to any rights or remedies which the Trust Fund (including the Additional Security Benefit Account (ASBA) may employ to obtain restitution of any benefit payment made which exceeds the amount authorized under the provisions of the ASBA ("Excess Payment") and without in any way limiting such rights and remedies, the provisions of these regulations shall apply to the obligation of the recipient of an Excess Payment to make restitution of such amounts to the ASBA. The recipient of any Excess Payment shall be obligated to the ASBA to make restitution of the Restoration Amount in such manner as the Trustees shall determine.

No further distribution of benefits shall be made from the ASBA until such time as the "Restoration Amount" is restored to the ASBA. The "Restoration Amount" shall be the amount of any Excess Payment increased or decreased by the annual rate of earnings of the ASBA from the time of distribution to the time of restoration plus any amount of

costs allocated to and charged to the Excess Payment. The Administrator, with the approval of the Trustees, shall determine the amount of earnings attributable to any Excess Payment and such determination shall be binding on the participant.

In the case of a worker who is obligated to restore a Restoration Amount to the ASBA, the ASBA shall be the death beneficiary of the Supplementary Death Benefit to the extent of the Restoration Amount without regard to whether the worker's estate or a designated individual has been named as beneficiary. The Supplementary Death Benefit provided by the ASBA shall be adjusted by such amount. The determination of the amount of any such death benefit, which is equal to a Restoration Amount, shall be determined by the ASBA Administrator.

Under such rules as the Trustees shall adopt, a worker who is obligated to repay a Restoration Amount to the ASBA because of the receipt of an Excess Payment who has incurred expenses which have not previously been submitted to the ASBA for reimbursement as a Supplementary Medical Benefit, but which if they had been submitted to the ASBA for payment in such timely manner as the Trustees may, by rule, determine would have been eligible for a benefit payment from the ASBA, may submit such expenses to the ASBA. To the extent that expenses described in the preceding sentence would have qualified for a benefit payment the Excess Payment shall be reduced and the Restoration Amount shall be correspondingly adjusted. The preceding sentence shall not apply if any of the previously incurred but not claimed expenses submitted to the ASBA for crediting against a restoration obligation is false in whole or in part (as contrasted with an actually incurred expense which does not qualify for a benefit payment; for example, cosmetic surgery).

Any costs incurred by the ASBA to effect a restoration of any Excess Payment shall, in such manner as the Trustees determine, be allocated and charged to workers who become obligated to restore amounts distributed to them by increasing the Restoration Amount by the allocable amount of such costs.

The ASBA may take any administrative action it believes will facilitate restitution of any Restoration Amount including an acknowledgement of the obligation to make restoration and written agreements as to the manner and the period in which the restitution of the Restoration Amount is to be made.

VACATION FUND

Eligibility

The Vacation Fund was established through collective bargaining between your Union and various employers and is administered by the Trustees.

You are eligible for Vacation Benefits if you are working for an employer who is required by a collective bargaining agreement to make contributions on your behalf to the Vacation Fund. (This is called "Covered Employment"). Contact the Fund Office if you want to find out if you are working in Covered Employment.

Payments

Vacation benefits are paid out of Employer Contributions made on your behalf as determined by your work hours reported to the Fund Office by your employer during the Plan year. The Plan year is January 1 through December 31. Vacation benefits are distributed twice a year during April and October.

Please note that the Vacation benefits portion of your pay is subject to withholding taxes. These are to be paid by your Employer and should be reflected on your pay stub and your W-2 form when that is issued. It is important to remember that vacation benefits received from the Plan should not be added to your income tax return since taxes have already been paid on it.

Forfeiture

The proceeds in your Vacation account will be permanently forfeited under the following circumstances:

- A. If a Vacation check remains uncashed 36 months after it has been mailed to the last known address of the Employee; or,
- B. If an Employee dies and the designated beneficiary, surviving spouse, children or parents cannot be located or if an executor or administrator has not been appointed within 36 months following the death of the Employee; or,
- C. If an Employee fails to provide the Fund Office with his personal address or his beneficiary's address and the Fund Office is unable to locate either of them, Vacation benefits will be permanently forfeited if no claim is made by the Employee or someone on his behalf, within three years after the last month in which a contribution was made for him, or within three years after his death, as the case may be.

VACATION FUND (continued)

Beneficiary

You have the right to name a beneficiary to receive the undistributed proceeds in your Vacation account in the event of your death. The designation of a beneficiary must be made in writing. Special forms are available at the Fund Office for this purpose.

If no beneficiary is named, the undistributed proceeds in the deceased employee's account will be paid according to the provisions of the Plan.

Assignment of Benefits and Repayments

Under the terms of the Vacation Plan no Employee or beneficiary is permitted to assign the undistributed proceeds in the Vacation account.

Effective October 27, 1997, notwithstanding the paragraph above, amounts credited to a participant's Vacation account shall be offset, first by any required loan repayments to the annuity portion of the Marble Industry Pension Trust Fund and second by any amounts owed to that participant's account in the Additional Security Benefit section of this Trust.

LEAVES OF ABSENCE

There are certain circumstances where you may be entitled to a leave of absence from covered employment.

Family and/or Medical Leave

You are entitled by law to up to 12 weeks of unpaid leave under the Family and Medical Leave Act (FMLA), which is for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a spouse, child or parent who is seriously ill, or for your own serious illness. The Fund will maintain your eligibility status and keep your medical coverage in effect during that leave period provided your Employer properly grants such leave, makes the required contribution on your behalf, and made the required notification to the Fund. If you do not return to work after your FMLA leave ends, you may be required to repay the contributions your Employer paid toward your coverage.

Eligibility may be continued for up to twelve (12) weeks during a twelve (12) month period, for any of the following reasons:

1. to care for your child after the birth or placement of a child for adoption or foster care; so long as such leave is completed within twelve (12) months after the birth or placement of the child;
2. to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
3. for your own serious health condition.

In the event you and your spouse are both covered as Participants, the continued coverage may not exceed a combined total of twelve (12) weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of twelve (12) weeks.

You are generally eligible for a leave under FMLA if you:

- Have worked for a covered 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 a 75 mile radius.
- Your employer continues to pay your required contributions

If, on the day your eligibility is to begin, you are already on an FMLA leave, you will be considered actively at work. Benefits for you and any Eligible Dependents (if applicable) will be in accordance with the terms of the Plan as herein set forth.

You and your Eligible Dependents (if applicable) are subject to conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

FMLA continuation ends on the earliest of:

- a) The day you return to work;
- b) The day you notify your employer that you are not returning to work;
- c) The day your coverage would otherwise end under the Plan; or
- d) The day coverage has been continued for 12 weeks.

If you do not return to Covered Employment after your leave ends, you are entitled to continue your coverage under the COBRA provision described in the section of this document entitled “Continuation of Coverage.”

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the continuation of coverage should be referred to the Fund Office.

Leave for Military Duty in the United States Armed Forces

Under the federal Uniformed Services Employment and Reemployment Rights Act (“USERRA”) of 1994, employers must grant unpaid military leave and continue to subsidize health care coverage for up to 31 days. If you go into military service you can continue your Health coverage during that period for up to 31 days. If you go into active military service for more than 31 days, you should receive military health care coverage at no cost. Your coverage under this Plan will terminate; however, you may continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage before December 10, 2004, the maximum period for this coverage is up to 18 months.
- If you elect USERRA continuation coverage on or after December 10, 2004, the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See the COBRA section of this document for details. In addition, your Dependent(s) may be eligible for health care coverage under Tricare (formerly known as CHAMPUS). This Plan will coordinate coverage with Tricare.

When you are discharged (not less than honorably) from military duty, your full eligibility will be reinstated on the day you return to work with a Participating Employer, provided you return to work within:

1. 90 days from the date of discharge if the period of service was more than 180 days; or

2. 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
3. At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by military duty, these time limits are extended for up to 2 years.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions regarding the continuation coverage during leave should be referred to the Fund Office.

Reinstatement of Coverage after Leaves of Absences

If your coverage ends while you are on an approved FMLA leave or USERRA military service, your coverage will be reinstated on the day you return to active employment (see the Military Leave section above for more details), subject to all annual and lifetime plan benefit maximums that were incurred prior to the leave of absence.

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

COBRA CONTINUATION OF COVERAGE

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you and your covered Dependents to continue health care coverage at your own expense under certain circumstances when health care coverage would otherwise end. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Under COBRA, you and your covered Dependents may continue the same coverage that you had before the COBRA-Qualifying Event, including:

- Medical coverage
- Hospital coverage
- Prescription drug coverage
- Dental coverage
- Optical coverage.

Death Benefits are not available under COBRA Continuation Coverage.

COBRA Eligibility (COBRA-Qualifying Events)

For You

COBRA coverage is available to you if coverage would otherwise end because:

- You do not work the required number of hours to maintain eligibility under the Welfare Fund.
- Your employment ends for any reason other than gross misconduct.

For Your Dependents

COBRA coverage is available for your covered Dependents if coverage would otherwise end because:

- You do not work the required number of hours to maintain eligibility under the Welfare Fund.
- You (the active participant) end employment for any reason other than gross misconduct.
- You (the active participant) die, get divorced, become legally separated, or become entitled to Medicare (and voluntarily drop Fund coverage due to Medicare entitlement).
- Your Dependent child ceases to be eligible for Fund coverage. For example, he or she marries or reaches the maximum age limit for coverage. See the definition of Dependents on page 4.

How COBRA Coverage Works

The following is the title, address, and telephone number of the person who is responsible for administering COBRA Continuation Coverage for the Fund:

Fund Office
Marble Industry Trust Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, New York 10001
(212) 505-5051

In order to protect your family's rights, you should keep the Fund office informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Fund office.

Providing Notice of Qualifying Events

Your Employer will usually notify the Fund Office of your death, termination of employment, reduction in hours, retirement, or entitlement to Medicare. However, you or your family should also notify the Fund Office promptly and in writing if any such event occurs in order to avoid confusion over the status of your or their health care in the event there is a delay or oversight in providing that notification. It is also important that you notify the Fund Office of a COBRA-Qualifying Event in your life or in the life of your spouse and/or Dependent child(ren) so that the Fund Office can provide you and/or them with a COBRA election form and a certificate of creditable coverage.

The time period in which your Employer must notify the Fund Office of your death, termination of employment, reduction in hours, retirement or Medicare entitlement will begin to run from the date of your loss of coverage and not the date of the Qualifying Event.

You and/or a family member are responsible for providing the Fund Office with timely notice of the following Qualifying Events:

- (1) The divorce or legal separation of a covered employee from his or her spouse.
- (2) A beneficiary ceases to be covered under the Plan as a Dependent child of a participant.
- (3) The occurrence of a second Qualifying Event after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include an employee's death, entitlement to Medicare, divorce or legal separation or child losing Dependent status.

In addition to these Qualifying Events, there are two other situations where you and/or a family member must provide the Fund Office with notice within the timeframe noted in this section:

- (4) When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security

Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

- (5) When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Office is notified of any of these five occurrences listed above. Failure to provide this notice in the form and within the timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

How Should Notice Be Provided?

Notice of any of the five situations listed above must be provided in writing by sending a letter to the Fund Office containing the following information: your name, a description of one of the five events listed above for which you are providing notice, the date of the event, and the date on which the participant and/or beneficiary will lose coverage.

To Whom Should the Notice Be Sent?

Notice should be sent to Daniel H. Cook Associates at the address on the prior page.

When Should the Notice Be Sent?

If you are providing notice due to a divorce or legal separation, a Dependent losing eligibility for coverage or a second qualifying event, you must send the notice no later than **60 days after the later of** (1) the date upon which coverage would be lost under the Plan as a result of the qualifying event or (2) the date of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than **60 days after the later of** (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, notice must be sent no later than **30 days from** the date of the determination by the Social Security Administration that you are no longer disabled.

These time periods to provide these notices will not begin until you have been informed of the responsibility to provide these notices and these notice procedures through the furnishing of a summary plan description or a general (initial) notice by the Plan.

Who can provide a Notice?

Notice may be provided by the covered employee, qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or

qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, his Spouse and Child are all covered by the Plan, and the child ceases to become a Dependent under the Plan, a single notice sent by the spouse would satisfy this requirement.

If notice has not been received by the Fund Office by the end of the applicable period described above, you and/or your spouse and/or your Dependent(s) will not be entitled to choose/extend COBRA Continuation Coverage.

Once you have provided notice, the Fund Office will send you information about COBRA coverage.

Where you or your Dependents have provided notice to the Fund of a divorce or legal separation, beneficiary ceasing to be covered under the plan as a Dependent, or a second qualifying event but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This notice will be provided within the same timeframe that is required to provide an election notice.

How to Elect COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the Plan, you die, or you divorce, or become legally separated, become entitled to Medicare, or when the Fund Administrator is notified that a Dependent Child lost Dependent status under the Plan, the Fund Administrator will give you and/or your covered Dependents notice of the date on which coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to apply for COBRA Continuation Coverage.**

Each qualified beneficiary with respect to a particular Qualifying Event has an independent right to elect COBRA continuation coverage. One or more covered Dependents may elect COBRA even if the employee does not. For example, both the employee and the employee's Spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for minor child(ren). In order to elect COBRA Continuation Coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event.

IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN 60 DAYS AFTER RECEIVING NOTICE, YOU AND/OR THEY WILL HAVE NO GROUP HEALTH COVERAGE FROM THIS PLAN AFTER THE DATE COVERAGE ENDS.

If you notified the Fund Office of a Qualifying Event and you are not entitled to COBRA coverage, the Fund Administrator will send you a written notice stating the reason you are no longer eligible for COBRA. The Fund will provide this notice to you within 14 days after its receipt of your notice of a Qualifying Event.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on “Paying for COBRA Continuation Coverage” that appears later in this section for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Duration of COBRA Coverage

Your COBRA coverage can continue for up to 18, 29 or 36 months, depending on the COBRA-Qualifying Event. The COBRA continuation coverage period begins on the date you and/or your covered Dependents lose coverage (rather than on the date of the Qualifying Event).

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length Of COBRA Coverage:
<i>You and Your Eligible Dependents</i>	<ul style="list-style-type: none">• Your employment ends (for example, you resign).• Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's program.	18 months (29 months if you and your eligible Dependents are Social Security-disabled*)
<i>Your Eligible Dependents Only</i>	<ul style="list-style-type: none">• You die;• You are divorced or legally separated;• You become entitled to Medicare and voluntarily drop Fund coverage);• Your child(ren) no longer qualifies as an eligible Dependent under the Plan	<ul style="list-style-type: none">• 36 months

- See “COBRA Coverage In Cases of Social Security Disability,” below for more details.

COBRA Coverage in Cases of Social Security Disability

If you, your spouse or any of your covered Dependent child(ren) are entitled to COBRA 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 an additional 11 months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage;
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration; and
- The Fund is notified by you or your eligible Dependent that the determination was received:
 - no later than 60 days after it was received; and
 - before the 18-month COBRA continuation period ended.

This extended period of COBRA coverage will end at the **earlier** of:

- 30 days after Social Security has determined that you and/or your eligible Dependent(s) are no longer disabled;
- the end of the 29-month period from the date of the loss of coverage due to the COBRA-Qualifying Event;
- the date the disabled individual becomes entitled to Medicare; or
- the day after your COBRA payment is due and not timely paid (including grace periods).

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA continuation coverage is extended because of Social Security Disability, the Fund will charge members and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren)

born to, adopted by or placed for adoption with you (the covered Employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of Social Security disability). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Termination of Employment/Reduction of Hours Following Medicare Entitlement

If you become entitled to (enrolled in) Medicare and you later have a termination of employment or reduction of hours, then your spouse and/or your Dependent child(ren) would be entitled to COBRA Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of hours or 36 months from the date you became entitled to Medicare, whichever is longer.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated employees and families (including both the Employer's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay for the COBRA Continuation Coverage after it is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. **If payments are not made by the end of this grace period, COBRA Continuation Coverage will be terminated.**

Confirmation of Coverage before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect or you, your Spouse or Dependent Child(ren) are within the COBRA

election period but have not yet elected COBRA, notice will be given to the Health Care Provider that COBRA has not yet been elected, and/or the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will be provided retroactively to the date coverage was lost if you elect COBRA continuation coverage.

Addition of Newly Acquired Dependents

If, while you (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you properly enroll them after the marriage, birth, adoption, or placement for adoption. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for five months of COBRA coverage. To enroll your new Dependent for COBRA coverage, notify the Fund Administrator within 31 days after acquiring the new Dependent. Adding a Spouse or Dependent Child may require that you switch from individual to family coverage and may cause an increase in the amount you must pay for COBRA Continuation Coverage.

If COBRA coverage ceases for you, your spouse or your Dependent child (ren) before the end of the maximum 18, 29 or 36-month COBRA period, COBRA coverage will also end for the newly added Dependent. Check with the Fund for more details on how long COBRA coverage lasts.

Loss of Other Group Health Plan Coverage

If, while you (the Employee) are enrolled for COBRA Continuation Coverage your spouse or Dependent loses coverage under another group health plan, you may enroll the spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under the pre-COBRA plan and declined, the spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may require that you switch from individual to family coverage and may cause an increase in the amount you must pay for COBRA Continuation Coverage.

When COBRA Continuation Coverage May Be Cut Short

Once COBRA Continuation Coverage has been elected, it may be cut short on the occurrence of any of the following events:

1. The date on which the Fund no longer provides group health coverage to any participants;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which you or your eligible Dependent(s) first become entitled to (enrolled in) Medicare (usually 65);
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the covered person may have;
5. The date the plan has determined that the covered person must be terminated from the plan for cause;
6. If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed to be no longer disabled.

If any covered person enrolls in Medicare, the COBRA Continuation Coverage of that person ends, but the COBRA Continuation Coverage of any covered spouse or Dependent child of that covered person will not be affected.

Notice of Termination of COBRA

If Continuation Coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the determination that Continuation Coverage will terminate. The Notice will set out why COBRA Continuation Coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Whom to Contact if You Have Questions or To Give Notice of Changes in Your Circumstances (Very Important Information)

If you have any questions about your COBRA rights, please contact the Fund Office at the address listed on page 14.

Also, remember that to avoid loss of any of your rights to obtain COBRA Continuation Coverage, you must notify the Fund Office:

1. within 60 days if you have changed marital status; or have a new Dependent child; or
2. within 60 days of the date you or a covered Dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a “Dependent child”** as that term is defined by the Plan; or
4. promptly if you or your spouse have **changed your address**.

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

FMLA and COBRA

Taking a leave under the Family and Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur **after** the FMLA period expires, **if** the person does not return to work and thus loses coverage under their group health plan. Then the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the Employee notifies the Employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

Leave of Absence (LOA) and COBRA

If an Employee is offered alternative health care coverage while on LOA, and this alternate coverage is not identical in cost (increase in premium), or benefits to the coverage in effect on the day before the LOA, then such alternate coverage does not meet the COBRA requirement, and is considered to be a loss in coverage requiring COBRA to be offered. If a qualified beneficiary rejects the COBRA coverage, the alternative plan is considered to be a different group health plan and, as such, after expiration of the LOA, no COBRA offering is required under this Plan.

Certification of Coverage when Coverage Ends

When your COBRA coverage ends, the Fund Office will provide you and/or your covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan (including if applicable, COBRA coverage). If, within 63 days after your coverage under this Plan ends, (including if applicable, COBRA coverage) you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan (including if applicable, COBRA coverage), and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after this Plan knows, or has reason know, that your (or their) coverage (including, if applicable, COBRA coverage) under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated.

In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the Fund Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to the Fund Administrator whose address is listed below.

Please make all requests for certificates of creditable coverage to:

Fund Office
Marble Industry Welfare Fund
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, New York 10003-1599
(212) 505-5051

ADDITIONAL COBRA ELECTION PERIOD & TAX CREDIT IN CASES OF ELIGIBILITY FOR BENEFITS UNDER THE TRADE ACT OF 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your Dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/. The Fund Office may also be able to assist you with your questions.

COORDINATION OF BENEFITS

HOW DUPLICATE COVERAGE OCCURS

This section describes the circumstances when you or your covered Dependents may be entitled to medical and/or dental benefits under this Plan and may also be entitled to recover all or part of your medical and/or dental expenses from some other source. In many of those cases, either this Plan or the other source (the primary plan or program) pays benefits or provides services first, and the other source (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays benefits. This can occur if you or a covered Dependent is also covered by:

1. Another group health care plan; or
2. Medicare; or
3. Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
4. Workers' compensation.

This section describes the rules that determine which plan pays first (is primary) and which pays second (is secondary), or when one of the plans is responsible for benefits and the other is not. This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source you possess (as described above), would allow you to recover more than 100% of expenses you incur. In many instances, you may recover less than 100% of those expenses from the duplicate sources of coverage or recovery. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party. Duplicate recovery of medical and/or dental expenses may also occur if a third party caused the injury or illness by a negligent or intentional wrongful act.

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits section, the word “plan” refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Covered Individual or that provides medical or dental services to the Covered Individual. A “group plan” provides its benefits or services to Employees, retirees or members of a group who are eligible for and have elected coverage.

2. Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan (or its insurer) know about all your coverages when you submit a claim.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

- A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**
- B. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

- A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a Dependent) pays first; and the plan that covers the same person as a Dependent pays second.
- B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a Dependent pays first; and the plan covering the person other than as a Dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

- A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:
 1. the parents are married;

2. the parents are not separated (whether or not they ever have been married); or
 3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.
- C. The word “Birthday” refers only to the month and day in a calendar year; not the year in which the person was born.
- D. If the specific terms of a court decree that is determined to be a Qualified Medical Child Support Order (“QMCSO”) state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable during the remainder of the plan year or policy year.
- E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:
1. The plan of the custodial parent pays first; and
 2. The plan of the spouse of the custodial parent pays second; and
 3. The plan of the non-custodial parent pays third; and
 4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

- A. The plan that covers a person either as an active Employee (that is, an Employee who is neither laid-off nor retired), or as that active Employee's Dependent, pays first; and the plan that covers the same person as a laid-off or retired Employee, or as that laid-off or retired Employee's Dependent, pays second.
- B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered as a laid-off or retired Employee under one plan and as a Dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

- A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's Dependent) pays first, and the plan providing continuation coverage to that same person pays second.

- B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- C. If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a Dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

- A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
- B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
- C. The start of a new plan does not include a change:
 - 1. in the amount or scope of a plan's benefits;
 - 2. in the entity that pays, provides or administers the plan; or
 - 3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).
- D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary:

When this Plan pays second, it will pay 100% of “**Allowable Expenses**” less whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

“**Allowable Expense**” means a health care service or expense, including deductibles, coinsurance or co-payments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Specialized Health Care Facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.

- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If the other coordinating plan determines benefits on the basis of Usual and Customary Charges, this Plan will use the Negotiated Amount as the allowable expense.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

1. To administer COB, the Plan reserves the right, in accordance with the HIPAA Privacy Rules (see page 110), to:
 - exchange information with other plans involved in paying claims;
 - require that you or your Health Care Provider furnish any necessary information;
 - reimburse any plan that made payments this Plan should have made; or
 - recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.
2. If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.
3. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
4. This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.
5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the

reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit, determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

COORDINATION WITH MEDICARE

- A. Entitlement to Medicare Coverage:** Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.
- B. Coverage under Medicare and This Plan When You Are Totally Disabled:** 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.
- C. Coverage under Medicare and This Plan When You Have End-Stage Renal Disease:** 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 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.
- D. How Much This Plan Pays When It Is Secondary to Medicare**
 - 1. When the Plan Participant Is Covered by Medicare Parts A and B:** When the plan participant is covered by Medicare Parts A and B and this plan is secondary to Medicare, this Plan pays the same benefits provided for active Employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the Health Care Provider.

Those enrolled in Medicare Part A and/or Part B or Part C may either retain or cancel coverage under this Plan. If an eligible individual under this Plan is covered by Medicare and an employee cancels coverage under this Plan, coverage of their Spouse and/or Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of the eligible employee's Dependents are covered by Medicare and the employee cancels that Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's employer will provide any consideration, incentive, or benefits to encourage cancellation of coverage under the Plan.

Those enrolled in Medicare Part D will not be eligible to receive any prescription drug benefits under this Plan.

2. ***When The Plan Participant Is Covered by Medicare Advantage (formerly called Medicare + Choice or Part C):*** This Plan provides benefits that supplement the benefits received from Medicare Parts A and B coverage. If an individual is covered by a Medicare Advantage program and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable co-payments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

However, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification, preauthorization, case management or utilization of in-network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

3. ***When Covered by Medicare Part D:*** If an eligible individual or Dependent enrolls in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Plan with prescription drugs (MA-PD) you and your Dependents will not be eligible to receive any prescription drug benefits under this Plan.
4. ***When the Plan Participant Is Not Covered by Medicare:*** If the Plan Participant is **eligible for, but is not enrolled in**, Medicare, this Plan pays what it would have paid if the Participant had been enrolled in Medicare. In general, this is the deductible and coinsurance. The participant will be required to demonstrate what the appropriate coinsurance and deductible would have been before payment can be made.
5. ***When the Plan Participant Enters Into a Medicare Private Contract:*** Under the law a Medicare participant is entitled to enter into a Medicare private contract

with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

6. **When Medicare excludes a benefit**, the Plan will not consider it for payment.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

- A. Medicaid:** If a Covered Individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.
- B. Tricare:** If a Covered Dependent is covered by both this Plan and the Tricare, the program that provides health care services to Dependents of active armed services personnel, this Plan pays first and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary and this plan is secondary.
- C. Veterans Affairs Facility Services:** If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services would otherwise be covered by the Plan.
- D. Motor Vehicle Coverage Required by Law:** If a Covered Individual is covered for medical and/or dental benefits by both this Plan and any motor vehicle coverage that is required by law, including but not limited to no-fault, uninsured motorist or underinsured motorist, the motor vehicle coverage pays first, and this Plan pays second.
- E.** If a Covered Individual is covered for **loss of earnings** by both this Plan and any motor vehicle coverage that is required by law, including no-fault, uninsured motorist or underinsured motorist, the benefits payable by this Plan on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle coverage.
- F. Other Coverage Provided by State or Federal Law:** If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

WORKERS' COMPENSATION

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the Contributing Employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent or wrongful act (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions section), but it will advance payment on account of Plan benefits (hereafter called an **“Advance”**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent if and when there is any recovery from any third party:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made;
2. even if the recovery is not sufficient to make the Employee or ill or injured person whole pursuant to state law or otherwise; and
3. without any reduction for legal or other expenses incurred by any ill or injured person in connection with the recovery against the third party or that third party's insurer; and
4. except as may be expressly agreed to by the Plan at its sole discretion.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and** any ill or injured Dependent on whose behalf the Advance is made must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **“Agreement”**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement on request by or on behalf of the Plan. If the Agreement is not executed at the Plan's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.**

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and the ill or injured Dependent each agree that they:

1. will reimburse the Plan from all amounts paid or payable to either of them by any third party or that third party's insurer for the entire amount of the Advance; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
3. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the

- injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts and keep the Plan Administrator informed of developments regarding any claims, actions, legal or administrative proceedings, or settlement discussions; and
4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and ill or injured Dependent jointly agree that the Plan will be subrogated to their right of recovery from a third party or that third party's insurer for the entire amount of the Advance. This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or ill or injured Dependent, but only to the extent of the amount of the Advance.
2. Under its subrogation rights, the Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advance and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or ill or injured Dependent, but in doing so, the Plan will **not** represent, or provide legal representation for either of them with respect to their damages that exceed any Advance; or intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. Remedies Available to the Plan

If the covered Employee or ill or injured Dependent does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of all Covered Individuals to the amount not reimbursed; or
2. obtain a judgment against the covered Employee and/or ill or injured Dependent from a court for the amount of the Advance that was not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or ill or injured Dependent.

F. Arbitration

Any dispute arising out of or relating to this "THIRD PARTY LIABILITY SECTION" or the breach thereof shall be submitted to final and binding arbitration by an arbitrator designated by the American Arbitration Association. The arbitration will be conducted in accordance with the Federal Arbitration Act.

CLAIMS AND APPEALS PROCEDURE

This section describes the procedures for filing a claim for benefits from the Marble Industry Welfare Fund (the “Plan”). It also describes the procedure to follow if your claim is denied in whole or in part, or if any adverse determination is made with respect to your claim, and you wish to appeal the decision.

How to File a Claim

In order to file a claim for benefits offered under this Plan, you must follow the procedures outlined in this section, which may include submitting a completed claim form (where required). Simple inquiries about the Plan’s provisions that are unrelated to any specific benefit claim or are exclusively about eligibility will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. In addition, the presentation of a prescription to a pharmacy which exercises no discretion on behalf of the Plan is not considered a claim. Benefits received from in-network providers are also not considered a “claim” under these procedures. However, if your request for any of these benefits is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

When and Where to File Claims

Claims must be filed within twelve months following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time.

Your claim will be considered to have been filed as soon as it is received at the address below by the appropriate organization that is responsible for determining the initial determination of the claim.

Hospital, Medical, Dental and Optical Claims

You are generally not required to file claims for hospital (including those for in-network MultiPlan facilities) or MultiPlan PPO providers in order to be reimbursed for benefits because these claims are submitted directly to Daniel H. Cook Associates, the Claims Administrator, by the Hospital and MultiPlan PPO providers.

If you use an out-of-network provider who will not submit your claim for you, you must submit a completed claim form to:

Daniel H. Cook Associates
253 West 35th Street
New York, New York 10001

Retail Prescription Claims

You do not need claim forms when visiting a participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim under these procedures. In addition, if you use a non-participating pharmacy, you need to file a claim form. Contact Daniel H. Cook Associates for a claim form and file claims at the above address.

If you need to contact the prescription plan, please see their pamphlet for contact information.

Death Benefit Claims

In order to file a claim for Death benefits offered under this Plan, your beneficiary should contact the Fund Office, c/o Daniel H. Cook Associates at the above address. Upon receipt of notification of the death of the participant, the Plan will provide the necessary forms to be completed by the beneficiary.

Additional Security Benefit Account (ASBA)

In order to file a claim for supplemental benefits from your ASBA, contact the fund office to obtain the appropriate form. Original documents demonstrating the reason for withdrawal of funds must be provided.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Claims Procedures

The claims procedures for hospital and medical, dental, prescription, vision and death claims will vary, depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Death Benefit Claim. Please read each section carefully to determine which procedure is applicable to your request for benefits.

Pre-Service and Urgent Care Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Currently, although there are pre-authorization requirements in the medical portion of the Plan, there is no penalty for failure to pre-certify. However, if the medical review is done on a post-service basis and it is found, according to the Plan provisions and limitations, that the Hospitalization or procedure was not Medically Necessary, or was otherwise excluded under the Plan, benefits could be denied. Please see “REVIEW OF CERTAIN PROCEDURES” in the Medical section for a description of the review process.

If a Pre-Service Claim is improperly filed, the Claims Administrator has to notify the patient as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless the patient (or representative) requested written notification. Notification of a procedural failure would only be provided if the claim was received and it included (i) the patient’s name, (ii) specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it would not constitute a claim.

Under the rules for Pre-Service Claims, the patient and health care provider will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Claims Administrator, and the patient is notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because additional information is needed, an extension notice needs to specify the information needed. In that case, the patient and/or physician have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim is suspended until the date of response to the request. The Claims Administrator has 15 days to make a decision and notify the patient of the determination. The patient has the right to appeal a denial of a pre-service claim.

Urgent Care Claim

An Urgent Care Claim is any Pre-Service Claim for medical or dental treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- (1) could seriously jeopardize the patient’s life or health or ability to regain maximum function, or
- (2) In the opinion of a physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is an Urgent Care Claim is determined by the healthcare organization applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of the patient's medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different. The Claims Administrator will respond to you and your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim by the Plan.

If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Claims Administrator will notify you and your doctor as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within five (5) days. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the Claims Administrator receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for three days that is reviewed at three days to determine if additional days are appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the *termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by the Claims Administrator as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon by the Claims Administrator within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Post-Service Claim

The following procedure applies to Post-Service Claims. A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

There are no claim forms to submit for MultiPlan in-network benefits, for most hospital claims and prescription drug benefits. MultiPlan Facilities and MultiPlan PPO providers will submit claims directly to the applicable payer under the terms of those contracts. Receipt of such benefits from these providers does not constitute a claim.

When you need to submit a claim, either:

- The Provider can submit a completed Universal claims form (HCFA 1500/UB 92 or dental form) directly to Cook or the Provider can submit a HIPAA-compliant electronic claim submission, **OR**
- You may obtain a claim form from Cook and complete the employee's portion of the claim form (including your name and social security number, the patient name, the patient's date of birth) and have your Physician complete the Attending Physician's Statement section of the claim form including Date of Service, CPT-4 code or ADA codes, ICD-9 (the diagnosis code), Billed Charge, Number of Units (for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, billing name and address and if treatment is due to accident, accident details. If you submit a universal claim form, make sure it is completely filled out.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all necessary documentation. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Mail any further bills or statements for services covered by the Plan to the applicable address as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service claim within *30 days* from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to *15 days* if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The applicable organization then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

Death Benefit Claims

For Death Benefits, the Plan will make a decision on the claim and notify your beneficiary within 90 days. If the Plan requires an extension of time due to matters beyond its control, it will notify your beneficiary of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Plan notifies your beneficiary of the delay. If an extension is needed because additional information is needed from your beneficiary, the extension notice will specify the information needed. Until your beneficiary supplies this additional information, the normal period for making a decision on the claim will be suspended.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or any other adverse benefit determination. This notice will state:

- The specific reason(s) for the determination,
- Reference to the specific Plan provision(s) on which the determination is based,
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary,
- A description of the appeal procedures and applicable time limits,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if any adverse benefit determination is made with respect to your claim, you may ask for a review.

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Board of Trustees:

The Marble Industry Welfare Fund
c/o Daniel H. Cook Associates
235 West 35th Street
New York, New York 10001

You must submit your appeal in writing within *180 days* after you receive notice of denial.

Your request for a review of an Urgent Claim may be made by phone by calling Daniel H. Cook, Associates at 1-877-888-AUTH (2884).

Review Process

You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the claim, without regard to whether their advice was relied upon in deciding your claim.

Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Board of Trustees (or Appeals Subcommittee)/Daniel H. Cook Associates.

- **Urgent Care Claims:** You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by the Board of Trustees (or Appeals Subcommittee)/Daniel H. Cook Associates.
- **Post-Service Claims:** Ordinarily, decisions on appeals involving all Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees of The Marble Industry Welfare Fund following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- **Death Benefit Claims:** The decision will be made within 60 days of your beneficiary's request for review. An extension of 60 days may be granted for reasons beyond the control of the Plan. Your beneficiary will be advised in writing within the 60 days after receipt of his/her request for review if an additional period of time will be necessary to reach a final decision on the Death Benefit claim.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination,
- Reference to the specific plan provision(s) on which the determination is based,
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge, and
- If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are Medically Necessary.

Behavioral (Mental) Health Disorder: A Behavioral (Mental) Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things: autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this chapter. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Calendar Year: The 12-month period beginning January 1 and ending December 31. All Deductibles and Annual Maximums will be accumulated based on a calendar year. Hospital admissions will accumulate as of the admission date.

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC)

Claims Administrator: The person or company retained by the Plan to administer the claim payment responsibilities and other administration or accounting services as specified by the Plan, Daniel H. Cook Associates.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Co-pay, Co-payment: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical or Dental Expense for certain services.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Durable Medical Equipment: Equipment that can withstand repeated use; **and** is primarily and customarily used for a medical purpose **and** is not generally useful in the absence of an injury or illness; **and** is not disposable or non-durable **and** is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Elective Hospital Admission: Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical and/or Dental Expenses: Expenses covered, in full or in part, by the Plan for medical and/or dental services or supplies, but only to the extent that they are covered in full or in part by the Plan as Medically Necessary as defined in this Section; **and** the charges for them are at the Negotiated Rate; **and** coverage for the services or supplies is not excluded; **and** the Lifetime, and/or Annual Maximum Plan benefits for those services or supplies has not been reached.

Emergency Care: Medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical or dental attention could reasonably be expected to result in any of the following:

1. The patient's life or health would be placed in serious jeopardy.
2. There would be a serious dysfunction or impairment of a bodily organ or part.
3. In the event of a Behavioral (Mental) Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming him or herself and/or other persons.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or in the consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, that there is either an absence of authoritative medical, dental or scientific literature on the subject, or a lack of such literature published in the United States; **and** by experts in the field that shows that recognized medical, dental or scientific experts classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; **and** it has not been granted at the time the service or supply is prescribed or provided; **or** a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will **not** be considered Experimental and/or Investigational if it is:

- approved by the FDA as an “investigational new drug for treatment use”; **or**
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; **or**
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was **not** approved for general use, **and** the FDA has **not** determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including, but not limited to “United States Pharmacopoeia Dispensing Information”; **and** “American Hospital Formulary Service”;
5. The published opinions of: the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program”, etc.; **or** specialty organizations recognized by the AMA; **or** the National Institutes of Health (NIH); **or** the Center for Disease Control (CDC); **or** the Office of Technology Assessment; **or** the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of “The Medicare Coverage Issues Manual.”

Extended Care Facility: See the definition of Skilled Nursing Facility.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Hospitals, Outpatient Ambulatory Surgical Facilities, Hospices, Skilled Nursing Facilities, Home Health Care Agency and Sub acute Care Facilities, as those terms are defined in this Definitions chapter.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
 - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
 - It has a full-time administrator.
 - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
 - It maintains written clinical records of services provided to all patients.
 - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
 - Its employees are bonded.
 - It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual

care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

1. It is approved by Medicare; **or** is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
2. If licensing is not required, it meets all of the following requirements:
 - It provides 24 hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified Physician.
 - It has a full-time administrator.
 - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - The main purpose of the agency is to provide Hospice services.
 - It maintains written records of services provided to the patient.
 - It maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

Any portion of a Hospital used as an Ambulatory Surgical Facility, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy of a covered employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a health care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a Physician, or other duly licensed Health care Provider who is authorized to provide or prescribe it, or a Dentist if a dental service or supply is involved; **and**
2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; **and**
3. is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
 - It is consistent with the **symptoms or diagnosis and treatment of an illness or injury**; **and**
 - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; **and**
 - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; **and**
 - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; **and**
 - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment **and is** no more likely to produce a negative outcome than any alternative service or

- supply, both with respect to the illness or injury involved and the patient's overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as **and** no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
- C. A medical or dental service or supply will be considered to be **“Cost-Efficient”** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.
- E. A Hospitalization or confinement to a Health Care Facility will **not** be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.
- F. A medical or dental service or supply that can safely and Appropriately be furnished in a Physician's or Dentist's office or other less costly facility will **not** be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.
- G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health care Provider to provide medical services will **not** result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.
- H. A medical or dental service or supply will **not** be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health care Provider or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health care Provider, Hospital or Health Care Facility.

The deeming of a medical or dental service or supply as Medically Necessary does not ensure payment of the expenses under the Plan. Coverage may be limited or excluded by the Plan by Plan design even if a service or supply is found to be Medically Necessary.

Negotiated Rate: The amount payable to In-Network Multiplan providers for eligible medical services or supplies.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical

Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Devices). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Office Visit: A direct personal contact between a Physician or other Health Care Provider and a patient in the Health Care Provider's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. Neither a telephone discussion with a Physician or other Health care Provider, internet/virtual office visit, nor a visit to a Health Care Provider's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical disability.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD), Doctor of Osteopathy (DO), or Doctor of Podiatry (DPM) or a Dentist (DDS or DMD) for dental benefits and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Plan Participant: The eligible employee or eligible dependent who has enrolled for coverage under the Plan.

Pre-Admission Testing: Laboratory tests and x-rays and other Medically Necessary tests performed on an out-patient basis prior to a scheduled hospital admission or outpatient surgery.

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Reconstructive Surgery: A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**
3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were Medically Necessary.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; **and** are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; **and** require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed **only** by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; **and**
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; **and**
3. It provides services under the supervision of Physicians; **and**

4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; **and**
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; **and**
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; **and**
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapist: A person legally licensed as a professional speech therapist (or speech pathologist) who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisp, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; **and**

2. It maintains on its premises all facilities necessary for medical care and treatment; **and**
3. It provides services under the supervision of Physicians; **and**
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; **and**
5. It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; **and**
6. It is not a hotel or motel.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Total Disability, Totally Disabled: The inability of a covered employee to perform all the duties of his or her occupation with an Employer as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Handicap.

You, Your: When used in this document, these words refer to the employee who is covered by the Plan. They do **not** refer to any Dependent of the employee.

HIPAA PRIVACY RULES

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Marble Industry Fund protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment and is available from the Plan Administrator. This statement is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan also hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Under federal law, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

This Plan maintains a Notice of Privacy Practices which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the Notice, please contact the Privacy Officer at the Fund Office. If you have questions about the privacy of your health information, please contact the Privacy Officer. If you wish to file a complaint about a privacy issue, please contact the Privacy Officer at the Fund Office.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Marble Industry Trust Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's 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 Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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 annual report.

Continue Group Health Plan Coverage

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 Plan on the rules governing your COBRA Continuation Coverage rights.

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 a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in new coverage.

Prudent Actions 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 or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report 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 Plan 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

Assistance with Your Questions

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory 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 Employee Benefits Security Administration. The toll-free telephone number is 1-800-998-7542.

IMPORTANT PLAN INFORMATION

(a) Name of Plan and Employer Identification Number:

Marble Industry Trust Fund
E.I. No. 13-6118206 Plan No. 501

(b) Name and Address of Union and Employer Associations:

B.A.C. Local 7, Tile, Marble and Terrazzo of New York and New Jersey, located at 45-34 Court Square, Long Island City, New York 11101 representing the employees, and Marble Industry of New York, Inc. c/o Petrillo Stone, 610 South Fulton Avenue, Mt. Vernon, New York 10550, representing the most significant group of employers. Participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan, and if so, the sponsor's address.

(c) Type of Plan:

Welfare

(d) Operation and Administration:

The operation and administration is the joint responsibility of the Board of Trustees consisting of:

UNION TRUSTEES

James Beecher
Saverio Demercurio
Christopher Guy
Ernesto Jimenez
Mortimer Lynch
Ronald Nicastri

EMPLOYER TRUSTEES

Patrick Barrett
Kevin Ennis
Thomas McNamara

With offices at 253 West 35th Street, 12th Floor
New York, NY 10001
Or phone the Fund Office: (212) 505-5050

The Trustees listed above are the Administrators of the Plan and the agent for service for process and notices.

(e) Collective Bargaining Agreements & Contributions:

Parties to the Collective Bargaining Agreement relating to the Plan are the B.A.C. Local 7, Tile, Marble and Terrazzo of New York and New Jersey and the contributing employers. The collective bargaining agreement contains a clause providing for the rate of contribution to the Marble Industry Trust Fund, and a copy is available for your examination upon written request to the Board of Trustees.

(f) Funding Medium:

Marble Industry Trust Fund is the funding medium used for the accumulation of assets and through which benefits are provided, and which is administered by the Board of Trustees.

(g) Listing of Trustees' and Addresses

Kevin Ennis	Thomas McNamara	Patrick Barrett
C/o Petrillo Stone Co.	C/o Continental Marble	C/o Port Morris Tile
610 South Fulton Ave.	1361 Lincoln Avenue, Suite 2	& Marble Corp
Mt. Vernon, NY 10550	Holbrook, NY 11741	1285 Oak Point Avenue
		Bronx NY 10474

and

James Beecher	Ernesto Jimenez
Saverio Demecurio	Mortimer Lynch
Christopher Guy	Ronald Nicastrì

With Offices at:
45-34 Court Square,
Long Island City, New York 11101

FUTURE OF THE PLAN AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances which may result in disqualification, ineligibility, or denial of benefits that a Plan Participant or beneficiary might otherwise reasonably expect the Plan to provide. This Summary Plan Description booklet details the eligibility rules, benefits, limitations and exclusions for coverages.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend or modify the plan is reserved by the Board of Trustees, in accordance with the Declaration of Trust. In addition, the continuance of the Plan is subject to the maintenance of collective bargaining agreements which provide for Employer Contributions to the Fund.

If it ever becomes necessary to terminate the Plan, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Plan Participants and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any Employer or to the Union. In the event of termination of the Plan, the Trust Funds are to be used exclusively to continue the payment of benefits provided to eligible Plan Participants, their Dependents, beneficiaries, or their estates, to defray reasonable administration and termination expenses, and to otherwise effectuate the purpose of the Trust Fund. Upon the necessity for termination, the Trustees would establish a plan to be applied to the balance of assets in the Trust Fund so that the assets would be applied solely for these purposes.

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