



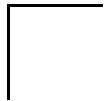
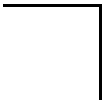
**SUMMARY PLAN DESCRIPTION**

**DENTAL BENEFIT PLAN**

of the

**ELEVATOR INDUSTRY**

**JUNE 1, 2003**



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This booklet is the Summary Plan Description of the Dental Benefit Plan of the Elevator Industry (Plan). This Summary Plan Description is presented to participants and eligible dependents to explain, in plain language, who is eligible to receive benefits under the Plan, how to apply for benefits and what your rights are under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

### GENERAL INFORMATION

<b>Name of Plan:</b>	Dental Benefit Plan of the Elevator Industry
<b>Plan Sponsor Identification No.</b>	13-0891035
<b>Plan Number:</b>	508
<b>Plan Year:</b>	June 1 through May 31
<b>Plan Administrator and Agent for Legal Process:</b>	Joint Industry Board of the Electrical Industry 158-11 Harry Van Arsdale Jr. Avenue Flushing, N.Y. 11365 (718) 591-2000
	Service may also be made upon any Trustee of the Plan.
<b>Type of Plan:</b>	Multiemployer/employee welfare benefit plan providing dental benefits to covered employees and

their eligible dependents.

**Type of Administration:** The Plan is self-administered by the Trustees whose names, and office addresses are listed below:

MICHAEL BONARDI  
Thyssen Krupp  
494 8<sup>th</sup> Avenue  
New York, NY 10001

ROBERT MARTIN  
United Elevator Corp.  
13-02 44<sup>th</sup> Ave.  
L.I.C., NY 11101

DAVID TALCOTT  
United Elevator Corp.  
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158-11 Harry Van Arsdale  
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Flushing, NY 11365

ROBERT OLENICK  
Local Union No. 3, IBEW  
158-11 Harry Van Arsdale  
Jr. Avenue  
Flushing, NY 11365



## **SOURCES OF CONTRIBUTIONS**

The Plan was established and is maintained under a Collective Bargaining Agreement between Local Union No. 3, International Brotherhood of Electrical Workers, AFL-CIO, 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365, ("Union") and the Elevator Industries Association, Inc., c/o Martin Elevator Co., 32-37 56th St., Woodside, NY 11377. Upon a written request from a participant or eligible dependent, the Plan Administrator will state in writing whether a particular Employer is obligated to contribute to the Plan and provide the Employer's principal business address. The Plan Administrator will also provide, upon a written request from a participant or eligible dependent, a copy of the Collective Bargaining Agreement. Copies of the Agreement are also available for inspection at the Fund Office during normal business hours.

## **SOURCE OF BENEFITS**

The dental benefits available under the Plan are provided by Empire Blue Cross and Blue Shield and DDS, Inc. The Plan has a contract with both administrators who will provide the benefits described herein as effective June 1, 2003. The Trustees may change these benefits or the administrators at any time, but will give participants written notice if a change is made.

## **DENTAL BENEFIT PROGRAMS**

The Dental Benefit Plan of the Elevator Industry provides three optional programs under which a participant may elect to be covered as follows:

### **1. EMPIRE BLUE CROSS AND BLUE SHIELD INDEMNITY PROGRAM**

This fee-for-service program covers a complete range of dental services performed by a duly licensed dentist anywhere in the world. A partial schedule of covered services is listed in this booklet. Under this program, you may visit the dentist of your choice. You are responsible for the payment of fees that exceed the Plan's maximum allowance per procedure, as well as for costs exceeding the calendar year limit applicable to covered prosthetic services and the lifetime limit covering orthodontic services.

### **2. EMPIRE DENTAL MANAGED NETWORK PROGRAM**

This alternative dental delivery system uses a network of dental offices throughout New York and New Jersey and is administered by Empire Blue Cross and Blue Shield. Each year you and your eligible dependents are able to choose from a list of network-affiliated dental offices. Once enrolled, you and your family must remain with the office you have selected for one year. Under this program, individuals are encouraged to obtain preventive dental care. There are no out-of-pocket expenses for covered services except for general anesthesia and the annual and lifetime limitations applicable to prosthetic and orthodontic services.

### **3. DDS INC. PROGRAM**

This alternative dental delivery system has a panel of private practice dentists in the New York/New Jersey metropolitan area who have agreed to accept assignment as payment in full for covered services. Unlike the Empire network, there is no specified time period for your selection of a particular DDS dentist. Instead, you may choose a different dentist whenever you need to

have dental work performed. Under this option, there are typically no out-of-pocket expenses, except for the annual and lifetime limitations applicable to prosthetic and orthodontic services. If you elect to enroll in the Empire Dental Managed Network Program, you are not eligible to use the DDS Inc. Panel.

## **ELIGIBILITY FOR BENEFITS**

The following eligibility rules apply to only those participants who are covered under any collective bargaining agreement that is recognized by the Plan. In order to receive the dental benefits provided by this Plan, you must be an "eligible participant," either active or retired. Initial eligibility is satisfied by having worked for a contributing employer to this Plan for at least 26 consecutive weeks on a full-time basis, during which time contributions were received on your behalf, unless such requirement is waived by the Trustees, for instance, in the case of a new group of employees. Thereafter, a participant must have been employed on a full-time basis during which time contributions were made to this Plan for at least 26 consecutive weeks immediately prior to incurring a reimbursable expense, or, if unemployed during all or any portion of such period, must have been registered as available for employment.

Eligibility for benefits terminates on the day when contributions cease to be made on behalf of the participant. However, a participant who has registered as available for employment can remain eligible under this Plan for up to 6 months after the last contribution has been made to the Plan. A participant on whose behalf contributions are no longer being made who restricts availability for employment to a specific type of job, location or time, will not be deemed to be available and will cease to be covered as of the date such restriction occurs. The participant will be responsible for expenses incurred and any benefit payments made by the Plan after the coverage terminates.

In order to be eligible, you must complete an enrollment form and submit applicable documentation. Benefits will not be paid until appropriate documentation is received. You are an eligible retired participant if you are receiving a Stan-

Standard Pension, Early Retirement Standard Pension or Disability Pension under the Pension Trust Fund of the Electrical Industry and have been covered immediately prior to the effective date of retirement. A participant who is receiving an Early Retirement Standard Pension will cease to be entitled to any dental benefits under this Plan if employed in any other capacity and will not be eligible for reinstatement.

### **DEPENDENTS' BENEFITS**

Once you satisfy the eligibility requirements, you become a participant and your eligible dependents are covered under the Plan, provided you have completed one applicable enrollment form and submitted the applicable documents. Eligible dependents are:

- 1) Your lawful spouse
- 2) Your unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending approved institutions of higher learning shall be covered up to age 25 provided the Plan receives an original letter from the registrar's office of the applicable institution as proof of current college or school attendance after each spring and fall semester commences. Dental services rendered during the months of July and August will be reimbursed after receiving the necessary documentation of a child's full-time student status for the next semester.

The term "children" shall mean natural or legally adopted children. A child may be considered an eligible dependent on the conditional basis that proof of a pending adoption proceeding is submitted to the Plan Administrator and the participant periodically furnishes the Plan Administrator with information as to the status of the proceeding.

- 3) Your surviving spouse and eligible children if you die, who will continue to be covered by the provisions of this Plan for up to 18 months following your death. Thereafter, the

surviving spouse and/or eligible children may elect to purchase coverage until the spouse's remarriage, by paying a premium rate that is established by the Plan.

- 4) If a participant dies while at work as a result of injuries suffered at work, the surviving spouse and dependent children will be entitled to the full dental benefits subject to the following:
  1. Benefits to the spouse shall continue for her life unless she remarries; upon remarriage the benefits will cease, and
  2. Benefits to the dependent children shall continue in accordance with the rules of the Plan as if the participant was still alive regardless of whether the surviving spouse remarries or dies.

### **DENTAL INDEMNITY PROGRAM**

A summary of Covered Dental Services, How To Obtain Benefits and a Partial Schedule Of Allowances, all pertaining to the Dental Indemnity Program, follows.

#### **COVERED DENTAL SERVICES**

- A) Diagnostic and Preventive Services**
  1. Clinical Oral Examinations
    - not more than twice annually
  2. Cleaning, Scaling and Polishing
    - not more than twice annually
  3. Fluoride Treatment (up to age 19)
  4. X-rays
- B) Palliative Services**

Emergency treatment for relief of pain
- C) Restorative Services**
  1. Fillings, amalgam or tooth colored
  2. Stainless steel crowns (up to age 19)
- D) Oral Surgery**
  1. Extractions
  2. Fractures

3. Other oral surgical procedures

- E) Endodontic Services**  
Root Canal treatment
- F) Space Maintainers**  
Simple (up to age 19)
- G) Periodontic Services**
  - 1. Curettage
  - 2. Gum Surgery
- H) Repair of Dentures and Bridges**
  - 1. Repair of broken full or partial dentures
  - 2. Repair of bridgework
- I) Prosthetic Services**
  - 1. Dentures, full or partial (once in 5 years)
  - 2. Crowns and inlays (once in 5 years)
  - 3. Bridges, fixed or removable  
(once in 5 years)
- J) Orthodontics**
  - 1. Diagnosis
  - 2. Active treatment
  - 3. Retention treatment

### **HOW TO OBTAIN BENEFITS UNDER THE INDEMNITY PROGRAM**

When you know that it will be necessary for you or an eligible dependent to be treated by a dentist, or in cases where emergency treatment was performed, you should get a Dental Claim Report Form from the Joint Industry Board Members• Records Department at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

You fill out the patient's portion of the form and the dentist completes the rest. The dentist should keep one copy for his records. The form should then be returned to the Joint Industry Board Members• Records Department for determining eligibility and benefit authorization.

#### **Pre-Determination of Benefits Is Required For All Prosthetic and Orthodontic Procedures.**

The pre-determination of benefits procedure requires that

your dentist fill out a claim form (Treatment Plan), **before treatment is begun.** Be sure that the dentist includes the patient's X-rays. This will reduce the processing time. The Treatment Plan and X-rays should be sent to the Members• Records Department which will forward them to the Empire Blue Cross and Blue Shield Dental Benefit Program.

The Dental Indemnity Program will process the Treatment Plan and the dentist will receive a pre-determination of benefits form showing which services are covered by our Program. Services not covered will also be indicated on the form. When treatment is completed the dentist must insert the dates the authorized services were performed and return the pre-determination of benefits form for payment.

All claim forms received are processed for payment, screened for completeness, coded, numbered, micro-filmed, checked for eligibility, reviewed for coverage and approved or rejected. Both you and, in all instances, your dentist are advised of the approval or rejection of benefits and the payment is made to the appropriate party.

**SUMMARY OF ALLOWANCES  
of  
COVERED DENTAL SERVICES**

**BASIC SERVICES**

<b>PROCEDURE</b>	<b>MAXIMUM ALLOWANCE</b>
<b>A. DIAGNOSTIC AND PREVENTIVE SERVICES</b>	
Comprehensive Oral Exam .....	\$ 44.00
Periodic Oral Exam .....	33.00
(Limit 1 exam every 6 months, not more than two exams annually)	
Cleaning, scaling and polishing (Not more than twice annually)	
Adults .....	64.00
Children .....	45.00
Fluoride treatment up to age 19 .....	31.00
X-rays-individual total not to exceed the allowance for full mouth series, Full mouth series, at least 10 films (Not more than one in three years) .....	
Bitewing	84.00
First film .....	14.00
Two Films .....	25.00

Periapical, single	
First film.....	19.00
Each additional film.....	15.00
Intraoral occlusal (edentulous jaw)	
Each.....	31.00
Facial Survey.....	85.00

**B. PALLIATIVE SERVICES**

Emergency treatment for relief of pain.....	57.00
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**C. RESTORATIVE SERVICE**

Fillings	
Silver Fillings (Permanent Tooth)	
One surface .....	65.00
Two surfaces.....	92.00
Three or more surfaces.....	118.00
Tooth color fillings (Resin)	
Per filling - 1 surface anterior .....	87.00
Stainless steel crowns, each (up to age 19).....	165.00

PROCEDURE	MAXIMUM ALLOWANCE
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**D. ORAL SURGERY -  
INCLUDING X-RAYS, ANESTHESIA AND  
POST-OPERATIVE TREATMENT**

Extractions	
Routine or simple .....	92.00
Soft tissue impaction .....	226.00
Partial bony impaction .....	321.00
Complete bony impaction .....	420.00
Complex including bone removal and sutures .....	161.00
Other oral surgical procedures:	
Alveoloplasty not in conjunction with extractions necessary extractions.....	309.00
Alveoloplasty in conjunction with extractions per quadrant .....	190.00
Apicoectomy.....	436.00
Biopsy, including report	
Hard tissue .....	234.00
Soft tissue .....	182.00
Frenulectomy.....	283.00

**E. ROOT CANAL TREATMENT - INCLUDING  
X-RAYS AND FOLLOW-UP CARE**

Anterior .....	449.00
Bicuspid .....	513.00
Molar .....	658.00

**F. SPACE MAINTAINERS, SIMPLE (UP TO AGE 19)**

Fixed, (unilateral) .....	252.00
Fixed, (bilateral).....	327.00
Removal (Unilateral) .....	209.00
Removable, (bilateral).....	293.00

**G. PERIODONTIC SERVICES (TREATMENT  
OF GUMS AND ASSOCIATED TISSUES)**

Periodontic root scaling and planing, including medications	
Per Quadrant .....	111.00
Gum or bone surgery, including post- operative visits (per quadrant)	
Gingivectomy .....	360.00
Osseous surgery .....	708.00

**H. REPAIR OF DENTURES AND BRIDGES**

Repairs to Partial Dentures	
Repair acrylic saddle or base.....	\$100.00
Repair cast framework .....	119.00
Repair or replace broken clasp.....	107.00
Replace broken teeth - per tooth .....	67.00
Add tooth to existing existing partial denture .....	94.00
Add clasp to existing partial denture .....	117.00
Relining upper or lower full or partial denture	
Full upper (chairside) .....	189.00
Partial upper (chairside) .....	177.00
Recement crowns.....	55.00
Recement inlays.....	61.00

**PROSTHETIC SERVICES**

The maximum amount payable for Covered Prosthetic Services is \$3,000 per calendar year. Each covered member of the family is entitled to a separate maximum.

<b>PROCEDURE</b>	<b>MAXIMUM ALLOWANCE</b>
<b>A. INLAYS, METALLIC</b>	
1. One surface metallic.....	\$ 413.00
2. Two surfaces metallic .....	550.00
3. Three or more surfaces metallic, maximum per tooth.....	641.00
<b>B. DENTURES, FULL (Including supplying, inserting, fitting and adjustments)</b>	
1. Upper, once in four years .....	867.00
2. Lower, once in four years .....	867.00
<b>C. DENTURES, PARTIAL</b>	
1. Bilateral acrylic or comparable base, either jaw, two or more full clasps, and rests, each .....	692.00
2. Upper bilateral, cast metal framework, two or more clasps and rests, acrylic attachment, each .....	910.00
3. Lower, bilateral, cast metal framework, two or more cast clasps and rests, acrylic	

- attachment, each .....884.00
- D. CROWN AND BRIDGEWORK**
- 1. REMOVABLE Unilateral  
(one piece casting with clasps  
and rests)  
One tooth replaced .....543.00
- 2. FIXED Partial Denture retainers - crowns  
(a) Three-quarter crown .....726.00  
(b) Full cast crown.....787.00
- 3. PONTICS  
(a) Pontic (porcelain)  
facing with cast backing).....661.00  
(b) Pontic (cast high noble metal)....770.00
- 4. CROWNS  
(a) Porcelain/Ceramic.....747.00

**ORTHODONTIC BENEFITS**

Orthodontics provides for the correction of irregularities in the positioning of teeth. Orthodontic services will be provided subject to the following:

- A. The need for Orthodontic Services must be diagnosed by a dentist and must indicate that the orthodontic condition consists of handicapping malocclusion which is abnormal and is correctable.
- B. A Detailed Treatment Plan must be submitted to Empire Blue Cross and Blue Shield and approved prior to the commencement of treatment.

The benefits provided will be:

For handicapping malocclusion

- 1. For diagnosis, including models and photographs, all necessary appliances and all adjustments  
(not to exceed 24 months).....\$ 147.00  
Per month
- 2. For retention treatment following active treatment (not to exceed 24 months) .....\$ 20.00  
Per month

3. Maximum Amount Payable.....\$ 4,000.00

The maximum number of months for which benefits will be provided for active or retention treatment will be reduced by the number of months of such treatment received before commencement of coverage.  
Exclusions and limitations:

1. If orthodontic services are terminated before completion of the approved orthodontic treatment for any reason, the responsibility of the program will cease with payment through the month of termination.
2. Any charges for the replacement and/or repair of any appliances furnished under the Treatment Plan will be excluded.

**THE EMPIRE BLUE CROSS AND  
BLUE SHIELD DENTAL MANAGED  
NETWORK PROGRAM**

**HOW TO OBTAIN BENEFITS UNDER  
THE EMPIRE BLUE CROSS AND BLUE  
SHIELD DENTAL MANAGED NETWORK  
PROGRAM**

An open enrollment is held once annually to permit participants to elect coverage under this network as well as to permit those participants already covered under the network to change their enrollment. Instead of receiving a fixed reimbursement amount for a given dental service under this network, you receive necessary covered dental care on a prepaid basis through a network of private dental offices. For as long as you are enrolled, you will receive all necessary covered dental services at the office selected by you, except for specialty care arranged for you by your network dentist or for an out-of-area emergency. No precertification or claim form is required.

## THE DDS, INC. PROGRAM

If you are not enrolled in the Empire Blue Cross and Blue Shield Dental Managed Network Program, you may enroll in the DDS, Inc. program at any time during the year by calling the Members• Records Department at the Joint Industry Board of the Electrical Industry. You will be given a number to call that will enable you to select a dentist from the DDS Panel. Once eligibility has been verified with the Members• Records Department, an appointment will be set up by DDS with the dentist you have chosen and you will receive an appointment card with a specific date. You must present the appointment card to the dentist in order for any work to be performed. No precertification or claim form is required.

## COORDINATION OF BENEFITS

Because of the growing number of group benefit plans and the increasing number of two-income families, more people are becoming covered under two group plans. There is nothing wrong with this provided the benefits payable under all plans do not exceed the expenses incurred. To control over-insurance, our benefits are subject to a coordination of benefits provision which applies to benefits from other group plans, **but not to individual policies.**

Under the coordination of benefits provision, if a participant or any eligible dependents are also covered under any other group plan, the total payment received from all such programs combined may not amount to more than 100% of the incurred expenses. A participant must report duplicate group coverage on the claim form submitted for reimbursement of dental expenses.

The order in which various plans will pay benefits is as follows:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits

before a plan which covers the person as a dependent.

3. A plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If a plan does not have this provision regarding birthdays, then the rule set forth in that plan will determine the order of benefits.
4. If 1, 2, and 3 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person whose claim is based as a retired employee or the dependent of such person shall be determined after the benefits of any other plan which covers such person as an employee who is not retired or a dependent of such person.

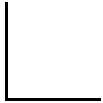
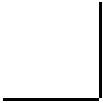
If either plan does not have a provision regarding retired employees and as a result each plan determines its benefits after the other, then the above paragraph will not apply.

### **LIMITATIONS OF BENEFITS**

**No coverage is provided under this Plan for expenses incurred with any of the following:**

- E Dental services received from a dental or medical department maintained by or on behalf of an employer, an actual benefit association, labor union, trustee or similar person or group;
- E Dental services for which the subscriber incurs no charge;
- E Dental services for which coverage is available to the subscriber, in whole or in part, under any Workers' Compensation Law or similar legislation whether or not the subscriber claims compensation or receives benefits thereunder;

- E Dental services primarily for cosmetic surgery, except essential reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;
- E Dental services furnished or available to a subscriber in whole or in part under the laws of the United States, or any state, or political subdivision thereof (except Medicaid) or for which the subscriber would have no legal obligation to pay in the absence of this or any similar coverage;
- E Dental services rendered by a dentist beyond the scope of his license;
- E Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage existed hereunder;
- E Gold foil restorations;
- E Dental services not considered within the scope of normal good dental practice or which are inconsistent with the highest ethical standards of the dental profession;
- E Dental services other than those specifically listed as Covered Dental Services;
- E Any loss, or portion thereof, for which mandatory automobile no-fault benefits are recovered or recoverable.
- E Dental services to the extent coverage is available to the subscriber under any other contract of a Participating Plan:
- E Prosthetic services where teeth are restorable by means other than crowns; services involving periodontal, provisional or temporary splints; temporary crowns, implants; bridges or dentures involving implants;



E Payment of benefits for replacement of full or partial dentures, inlays, crowns or bridges shall be limited to once in every five years;

## **PARTICIPANTS RECEIVING WORKERS' COMPENSATION BENEFITS**

An eligible participant other than a non-bargaining unit employee or an employee of the Joint Board or the Union, who is unable to work due to a work-related injury and is receiving workers' compensation benefits shall remain eligible for coverage under this Plan until the earlier of:

1. The date on which the participant ceases to be eligible for workers' compensation benefits; or
2. The date which is two years following the date on which the participant first became unable to work because of the injury, including all periods during which workers' compensation benefits were received.

A participant who ceases being eligible for workers' compensation benefits prior to receiving 24 months of benefits shall then be entitled to purchase coverage for up to 18 months, pursuant to continuation coverage provisions referred to on page 19.

Such a participant who receives more than 24 months of workers' compensation benefits shall be entitled to purchase coverage for a minimum of 18 months. If the participant is still receiving workers' compensation benefits after the 18 month period, he will be entitled to continue purchasing such coverage as long as proof of the workers' compensation payment is furnished to the Dental Committee.

## **PARTICIPANTS WHO ARE DISABLED**

An eligible participant other than a non-bargaining unit employee or an employee of the Union or the Joint Board who is unable to work and is receiving disability benefits or is disabled shall remain eligible for coverage under this Plan until the earlier of:

1. The date on which the participant ceases to be eligible for disability benefits; or
2. The date which is two years following the date on which the participant first became unable to work, including all periods during which the participant

received disability benefits and furnished evidence to the Dental Committee that he was disabled.

Such a participant who remains disabled after receiving 26 weeks of disability payments may continue to be covered under this Plan for up to a total of 104 weeks, as long as he submits proof of the disability on a monthly basis to the Dental Committee. After the 104th week of being disabled, a participant may purchase continuation coverage under the Plan for a minimum of 18 months. If such participant is still disabled after this period of time, he may continue to purchase coverage on a monthly basis for as long as he is able to furnish proof of the disability to the Dental Committee.

### **CONTINUATION COVERAGE**

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), this Plan allows for the purchase of continuation coverage upon the occurrence of certain •qualifying events. •

If you are covered under this Plan, you have a right to choose continuation coverage for yourself and your eligible dependents if you lose your coverage because of the reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of a participant covered under this Plan, you have the right to choose continuation coverage for yourself and your eligible dependents if you lose coverage for any of the following reasons:

1. The death of your spouse;
2. The termination or reduction of hours of your spouse's employment (for reasons other than gross misconduct);
3. Divorce from your spouse.

In the case of a dependent child of a participant covered under this Plan, he or she has the right to continue coverage if coverage under this Plan is lost for any of the following reasons:

1. The death of a parent;
2. The termination or reduction of hours of a parent's employment (for reasons other than gross misconduct);
3. Parent's divorce;
4. The dependent ceases to be a "dependent child" under this Plan.

Under the law, the participant or a family member has the responsibility to inform the Joint Industry Board of a divorce, or a child's losing dependent status under this Plan in a timely fashion. The Plan will not provide continuation coverage to a spouse or child unless the Joint Industry Board is notified in writing of these changes in status within 60 days after the divorce or child losing dependent status.

When the Joint Industry Board is notified that one of these qualifying events has occurred, it will, in turn, notify you and your family that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the qualifying events described above or the date of the notice of your election right, whichever is later, to inform the Joint Industry Board that you want to elect the continuation coverage.

If you do not choose continuation coverage, your dental coverage will end, unless you elect to enroll in an individual conversion plan with Empire Blue Cross and Blue Shield.

If you elect continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under this Plan to similarly situated participants or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 3 years unless you lose group health coverage because of a reduction in hours or termination of employment. In that case, the required continuation period is 18 months. If during that 18 months another qualifying event takes place that also entitles your dependents to coverage, coverage may be extended for them for up to a total of 36 months from the original qualifying event. In no case, may the total amount of continuation coverage

be more than 36 months.

However, the law also provides that continuation coverage may be cut short for any of the following reasons:

1. The Plan no longer provides coverage to any participant;
2. The premium for your continuation coverage is not paid on a timely basis;
3. You become covered for dental benefits under another group health plan that does not have a pre-existing condition exclusion. If the new plan includes a pre-existing conditions limitation or exclusion, coverage will cease under this Plan once the pre-existing conditions limitation or exclusion has been satisfied or once eligibility for continuation coverage otherwise terminates.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay the premium for your continuation coverage on a timely basis. The Plan is allowed to charge 102% of the cost to the Plan on a monthly basis.

**DISABLED INDIVIDUALS** - If an individual who is eligible to purchase continuation coverage is determined to be disabled under Title II or Title XVI of the Social Security Act at the time the qualifying event occurred, such person will be entitled to purchase coverage for up to 29 months. The Plan is allowed to charge 102% of the cost to the Plan for the first 18 months and up to 150% of the cost to the Plan for months 19 through 29.

The Plan Administrator must be notified of the determination of disability within 60 days after the date such determination is made and prior to the end of the first 18 months of continuation coverage in order to extend coverage for the additional 11 months. The Plan Administrator must also be notified within 30 days of the date of any final determination that the individual is no longer disabled. Extended continuation coverage can be terminated in the month that begins more than 30 days after the date of the final determination under

the Social Security Act that the qualified beneficiary is no longer disabled.

If you have any questions about the purchase of group continuation coverage, please communicate with the Plan Administrator at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365. Also, if you have changed your marital status or you or your spouse have changed your address, please notify the Plan Administrator at the above address.

### **CONVERSION**

Whether or not you elect to purchase continuation coverage, you may choose to convert to an individual policy with Empire Blue Cross and Blue Shield. This can be done upon your rejection of continuation coverage, or you may convert to an individual policy upon the expiration of your continuation coverage. You will be furnished with the appropriate applications and full instructions concerning this conversion policy when you request such information from the Plan Administrator.

The benefits provided upon your conversion to an individual policy with Empire Blue Cross and Blue Shield will not be the same as the coverage under this group plan. Before you decide to convert to an individual policy, you have the right to contact Empire Blue Cross and Blue Shield to review the benefits provided under their plan. Applications for conversion of coverage must be received by Empire Blue Cross and Blue Shield within 30 days after your benefits under this Plan terminate.

### **FAMILY AND MEDICAL LEAVE ACT OF 1993**

Eligible participants who properly notify their employer of their election to take up to 12 weeks of unpaid leave from employment for the specific purposes allowed under the Family and Medical Leave Act will continue to be covered under this Plan during such leave. After the employer has verified that the leave is in compliance with this Act, the employer will be responsible for providing the Plan with written notification in order to extend the participant's health coverage. Coverage under the Plan during the participant's leave shall continue at the same level it would have been if the participant had continued to be employed. Upon return to active

employment, the participant shall not be subject to any restrictions, waiting periods or pre-existing condition exemptions.

If the participant does not return to work after the leave or upon the participant's determination that he or she will not return to employment, if earlier, such date will be considered a qualifying event under COBRA and the participant will be eligible for continuation coverage as described above.



### **QUALIFIED MEDICAL CHILD SUPPORT ORDER**

Benefits may become payable directly or indirectly to a dependent of a participant if the Plan is served with a valid Qualified Medical Child Support Order (QMCSO). The purpose of furnishing the Plan with a QMCSO is to: (1) ensure that group health coverage will be made available to eligible dependent children of non-custodial parents, regardless of such parent's refusal to enroll the child; (2) allow for immediate enrollment and ongoing coverage of the child of an eligible plan participant and (3) facilitate the authority of the custodial parent as well as the financial reimbursement to such parent with respect to a child's medical care and expense. To the extent that a QMCSO provides health benefits under state domestic relations law or enforces a state medical child support law, such law will apply to this Plan's compliance with a QMCSO.

A QMCSO is qualified if it meets certain criteria indicated in Section 609 of ERISA. The Plan has written procedures relating to administering a medical child support order. They include notifying the participant and each alternate recipient as to how it is determined whether the QMCSO is valid and notifying all appropriate parties as to the determination of the Plan.

### **CLAIMS AND APPEALS PROCEDURES**

The Dental Benefit Plan of the Elevator Industry (the "Dental Plan") will apply the following procedures to all claims and appeals filed under the Dental Plan on or after January 1, 2002. If you have any questions about these procedures, please contact the Dental Plan at:



158-11 Harry Van Arsdale Jr. Avenue  
Flushing, New York 11365  
(718) 591-2000

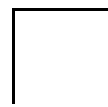
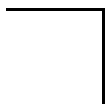
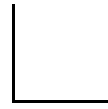
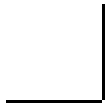
The procedures for filing claims with respect to your benefits under the Dental Plan will vary depending upon which of the three benefit programs offered by the Dental Plan you elect to participate in: the Empire Blue Cross and Blue Shield Indemnity Program, the Empire Dental Managed Network Program, or the DDS Inc. Program.

## **CLAIMS PROCEDURES FOR THE EMPIRE BLUE CROSS AND BLUE SHIELD INDEMNITY PROGRAM**

If you choose to participate in the Empire Blue Cross and Blue Shield Indemnity Program (the "Indemnity Program"), you and your dentist will need to complete a Dental Claim Report Form for all services received. You may obtain a Dental Claim Report Form by contacting the Members' Records Department at the address indicated on the previous page. You must complete the patient's portion of the Dental Claim Report Form and have your dentist complete the remainder of the form, and return the completed form to the Members' Records Department.

You are required to submit a Dental Claim Report Form to the Members' Records Department within one year of receiving dental services. Although not required, you are encouraged to contact the Dental Plan in advance of receiving dental services to verify that coverage is available, especially in the case of prosthetic and orthodontic services.

Ordinarily, you will be notified of the decision on your claim within **30 days** from the Dental Plan's receipt of your Dental Claim Report Form. The Dental Plan may extend this period one time for up to **15 days** if the extension is necessary due to matters beyond the control of the Dental Plan provided that, prior to the expiration of the initial 30-day period, the Dental Plan notifies you of the circumstances requiring the extension of time and the date by which the Dental Plan expects to render a decision. If an extension is needed because the Dental Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have **45 days** from your receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period you are given to supply additional information, the 30-day period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of (i) 45 days or (ii) the date you respond to the request (whichever is earlier). The Dental Plan then has **15 days** to decide your claim and notify you of the determination.



**CLAIMS PROCEDURES FOR THE EMPIRE  
BLUE CROSS AND BLUE SHIELD DENTAL  
MANAGED NETWORK PROGRAM**

If you choose to participate in the Empire Blue Cross and Blue Shield Dental Managed Network Program (the “Managed Network Program”), once you enroll and select a dental office, you will not need to submit any forms or obtain pre-certification for any services. Your dental office will take care of any required paperwork.

**Emergency Treatment**

In the event that you receive emergency care when you are outside of a 50 mile radius of your designated dental office, you must contact the Empire Managed Dental Care Program at 1-800-722-8879 and request a claim form. The claim form and the dentist’s original bill must then be submitted to the Empire Managed Dental Care Program, Dept. 316, Empire Blue Cross and Blue Shield, P.O. Box 791, Minneapolis, MN 55440-0791. You will be reimbursed up to a maximum of \$25 per emergency visit. The time frames for deciding emergency treatment claims under the Managed Network Program are the same as those stated above for the Indemnity Program.

**CLAIMS PROCEDURES FOR  
THE DDS, INC. PROGRAM**

If you choose to participate in the DDS, Inc. Program, once you enroll by contacting the Members’ Records Department, you will not need to submit any forms or obtain pre-certification for any services. You need only call the DDS network to schedule an appointment and you will then be sent an appointment card that can be presented to a participating dentist within 30 days; the dental office is responsible for any required paperwork.

**NOTICE OF DECISION**

You will be provided with written notice of a denial of a claim. This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Dental 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 lawsuit under ERISA 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
- If the determination was based on the absence of dental necessity, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Dental Plan to your claim, or a statement that it is available upon request at no charge

## **APPEALS PROCEDURES**

### **A. Appeals Procedure for DDS, Inc.**

#### **1. First Level Appeal to DDS, Inc.**

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the determination.

If you participate in the DDS Inc. Program, your appeal should be sent to DD Services, Inc., 1640 Hempstead Turnpike, East Meadow, New York 11554.

Your appeal must be made in writing within **180 days** after you receive notice of denial of your claim and must include your current identification number, the claim number, any pertinent information or comments you wish to make, and shall set forth the reasons why you believe the decision is incorrect. You will be sent a notice of the decision on appeal within **30 days** of receipt of the appeal by DDS, Inc.

#### **2. Second Level Appeal to the Joint Industry Board of the Electrical Industry**

If DDS, Inc. denies your appeal in whole or in part, you

may file a second appeal to the Joint Industry Board of the Electrical Industry (the "Joint Board"). Your appeal to the Joint Board must be in writing and must be made within **60 days** after you receive notice of denial of your appeal by DDS, Inc., and shall set forth the reasons why you believe the decision is incorrect. The Joint Board will notify you of the determination of your appeal within **30 days** of the Joint Board's receipt of the appeal.

**3. Optional Third Level Appeal to the Board of Trustees**

If the Joint Board denies your second level appeal in whole or in part, you have the **option** of filing a third level appeal with the Board of Trustees (the "Trustees").

If you elect to file an appeal with the Trustees, your appeal must be in writing and must be made within **30 days** after you receive notice of denial of your appeal by the Joint Board, and shall set forth the reasons why you believe the decision is incorrect. The Trustees will notify you of the determination of your appeal within **90 days** of the Trustees' receipt of the appeal. This third level appeal with the Trustees is voluntary. The Dental Plan will not assert your decision not to file a third level appeal with the Trustees as a defense if you bring a lawsuit against the Dental Plan instead of appealing a decision to the Trustees. If you do file a third level appeal, the Dental Plan agrees that any statute of limitations or other defense based on timeliness will be suspended during the time that the appeal to the Trustees is pending. The decision of whether to appeal to the Trustees will have no effect on your rights to any other benefits under the Dental Plan.

**B. Appeals Procedures For The Indemnity Program or The Managed Network Program**

**1. First Level Appeal to the Indemnity Program or the Managed Network Program**

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may appeal the determination.

If you participate in the Indemnity Plan, your appeal should be sent to Empire Blue Cross and Blue Shield Program, Dental Benefits Claims Review, P.O. Box 791, Minneapolis, MN 55440-0791. You may also appeal by calling 1-800-722-8879.

If you participate in the Managed Network Program, your appeal should be sent to Empire Managed Dental Care Program Dept. 316, Empire Blue Cross and Blue Shield, P.O. Box 791, Minneapolis, MN 55440-0791. You may also appeal by calling 1-800-722-8879.

Your appeal must be made within **180 days** after you receive notice of denial of your claim and must include your current identification number, the claim number, any pertinent information or comments you wish to make, and shall set forth the reasons why you believe the decision is incorrect. You will be sent a notice of the decision on appeal within **30 days** of receipt of the appeal by the Indemnity Program or the Managed Network Program.

**2. Second Level Appeal to the Indemnity Program or the Managed Network Program**

If your first level appeal is denied in whole or in part, you may file a second level appeal.

If you participate in the Indemnity Plan, your second level appeal should be sent to Empire Blue Cross and Blue Shield Program, Dental Benefits Claims Review, P.O. Box 791, Minneapolis, MN 55440-0791. You may also appeal by calling 1-800-722-8879.

If you participate in the Managed Network Program, your second level appeal should be sent to Empire Managed Dental Care Program Dept. 316, Empire Blue Cross and Blue Shield, P.O. Box 791, Minneapolis, MN 55440-0791. You may also appeal by calling 1-800-722-8879

Your appeal must be made within **60 days** after you receive notice of denial of your first level appeal and must include your current identification number, the claim number, any pertinent information or comments you wish to make, and shall set forth the reasons why you believe the decision is incorrect. You will be sent a notice of the decision on appeal within **30 days** of receipt of the appeal by the Indemnity Program or the Managed Network Program.

**3. Optional Third Level Appeal of *Indemnity Claims Only* to the Joint Industry Board of the Electrical Industry**

If the Indemnity Program denies your second level appeal in whole or in part, you have the **option** of filing a third level appeal with the Joint Industry Board of the Electrical Industry (the "Joint Board"). **Please note that there are NO additional levels of appeal for denials of claims for the Managed Network Program.** If you elect to file an appeal of an Indemnity Program claim with the Joint Board, your appeal must be in writing and must be made within **30 days** after you receive notice of denial of your second level appeal by the Indemnity Program, and shall set forth the reasons why you believe the decision is incorrect. The Joint Board will notify you of the determination of your appeal within **90 days** of the Joint Board's receipt of the appeal. This third level appeal with the Joint Board is voluntary. The Dental Plan will not assert your decision not to file a third level appeal with the Joint Board as a defense if you bring a lawsuit against the Dental Plan instead of appealing a decision to the Joint Board. If you do file a third level appeal, the Dental Plan agrees that any statute of limitations or other defense based on timeliness will be suspended during the time that the appeal to the Joint Board is pending. The decision of whether to appeal to the Joint Board will have no effect on your rights to any other benefits under the Dental Plan.

#### **4. Optional Fourth Level Appeal of Indemnity Claims Only to the Board of Trustees**

If the Joint Board denies your third level appeal of an Indemnity Program claim in whole or in part, you have the **option** of filing a fourth level appeal with the Board of Trustees (the "Trustees"). **As noted above, there are only two levels of appeal for denials of claims for the Managed Network Program.** If you elect to file an appeal with the Trustees, your appeal must be in writing and must be made within **30 days** after you receive notice of denial of your appeal by the Joint Board, and shall set forth the reasons why you believe the decision is incorrect. The Trustees will notify you of the determination of your appeal within **90 days** of the Trustees' receipt of the appeal. As with the third level appeal to the Joint Board, this fourth level appeal to the Trustees is voluntary. The Dental Plan will not assert your decision not to file a fourth level appeal with the Trustees as a defense if you bring a lawsuit against the Dental Plan instead of appealing a decision to the Trustees. If you do file a fourth level appeal, the Dental Plan agrees that any statute of limitations or other

defense based on timeliness will be suspended during the time that the appeal to the Trustees is pending. The decision of whether to appeal to the Trustees will have no effect on your rights to any other benefits under the Dental Plan.

**C. Right to Review Documents and to Obtain Other Information**

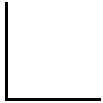
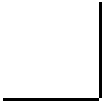
You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Dental Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Dental Plan's administrative processes for ensuring consistent decisionmaking; or it constitutes a statement of the Dental Plan's policy regarding the denied treatment or service. Upon request, you will be provided with the identification of dental experts, if any, that advised the Dental Plan concerning your claim, without regard to whether the advice was relied upon in deciding your claim.

**D. Right to Independent Review**

A different person other than the one who originally denied the claim will consider your appeal. The reviewer will not consider the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit. The Trustees will not consider the decision by the Joint Board, Indemnity Program, or DDS Inc. and the reviewing parties at the Board of Trustees will not be the same parties who made the decision at the first or second levels of review with the Indemnity Program or DDS Inc. or the third level of review at the Joint Board, nor will they be the subordinates of those parties. Similarly, the Joint Board will not consider the decision by the Indemnity Program or DDS Inc., and the reviewing parties at the Joint Board will not be the same parties who made the decision at the first or second levels of review with the Indemnity Program or DDS Inc., nor will they be the subordinates of those parties.

**E. Cases Involving a Professional Judgment**

If your claim was denied on the basis of a professional judgment (such as a determination that the treatment or



service was not necessary), a health care professional who has appropriate training and experience in a relevant field of dentistry will be consulted.

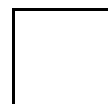
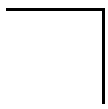
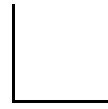
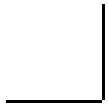
## **NOTICE OF THE DETERMINATION OF YOUR APPEAL**

The Indemnity Program's, the Managed Network Program's, or DDS, Inc.'s and/or the Joint Board's and or Trustees' decision on your appeal will be in writing and will include the following information:

- The specific reason(s) for the determination
- Reference to the specific Dental 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 lawsuit under ERISA following an adverse benefit determination on review
- If an internal rule, guideline or protocol was relied upon by the Dental Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on a professional judgment, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Dental Plan to your claim, or a statement that it is available upon request at no charge

### **DESIGNATED AUTHORIZED REPRESENTATIVES**

You may submit a claim and appeal a denial of a claim on your own behalf. Alternatively, you may designate another individual to act as your representative. If you choose to designate someone else to act on your behalf, you must do so in writing on a form provided by the Dental Plan; the designation will not be effective until it is received by the Dental Plan. You may revoke your designation of an Authorized Representative but such revocation will not be effective until received by the Plan and such revocation must be in writing in order to be effective. You may obtain a Designated Authorized Representative form by contacting the Plan. Once you have designated an Authorized Representative, all communications and notices from the Dental Plan that would otherwise be sent to you will only be sent to your Authorized Representative.



## AMENDMENT AND TERMINATION

The Dental Committee may at any time and from time to time modify this Plan in any of its terms, or terminate the same in its entirety. Neither the promulgation of this Plan nor the creation of the Trust Fund by the Trust Agreement shall be construed as giving any participant or any person whatsoever any legal or equitable right against the Union, any Employer, Employer Association, the Dental Committee and/or the Trust Fund, except such right as is specifically provided for herein, or given by action of the Dental Committee duly taken in accordance with the Plan provisions hereof. However, no such modification or termination shall:

(A) cause or permit any property held subject to the terms of the Trust Agreement to be diverted to purposes other than the exclusive benefit of participants, retired participants and their dependents and/or for the administration expenses of the Trust Fund; or,

(B) increase the duties or liabilities of the Dental Committee without their written consent.

The Plan may be terminated when there is no longer in force any Collective Bargaining Agreement requiring contribution to the Plan. The Plan and Trust may likewise be terminated by the unanimous vote of the Dental Committee with the consent of the Employers and the Union.

In the event of a termination of the Plan, the Dental Committee shall apply the Trust Fund to pay or provide for the payment of any and all obligations of the Plan and Trust and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Plan and Trust Agreement, provided, however, that no part of the corpus or income of the Trust shall be used or diverted for purposes other than the exclusive benefit of participants, retired participants and dependents of either or the reasonable administrative expenses of the Plan and Trust.

The Dental Committee shall give written notice to all participants, retired participants, Employers and the Union of all amendments to or the termination of the

Plan.

## STATEMENT OF ERISA RIGHTS

As a participant in the 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:

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.

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 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 risks.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if

you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

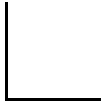

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants 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 (pension, welfare) benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

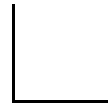
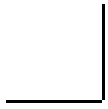
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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.

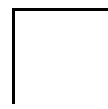
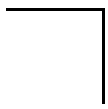
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions

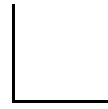
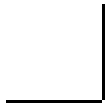


about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration,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

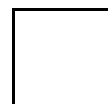
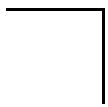


**NOTES**





**NOTES**





**DENTAL BENEFIT PLAN  
OF THE  
ELEVATOR INDUSTRY**

**158-11 Harry Van Arsdale Jr. Avenue  
Flushing, New York 11365  
718-591-2000**

**EMPLOYER REPRESENTATIVES**

**Michael Bonardi  
Robert Martin  
David Talcott**

**EMPLOYEE REPRESENTATIVES**

**Christopher Erikson  
Joseph Licato  
Robert Olenick**

