

**United Food and Commercial Workers Unions and Employers
Midwest Health Benefits Fund**

**Health Benefits Plan Document
Effective January 1, 2007**

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ARTICLE 1 — PURPOSE

This Health Benefit Plan is adopted by the Trustees of the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund under the terms of the Agreement and Declaration of Trust in order to establish provisions which determine the eligibility of Employees for the benefits provided by the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund and to prescribe the amount, extent, conditions and methods of payment under the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan.

Article V, Section 7 of the Trust Agreement authorizes the Trustees to prescribe rules and regulations as may be proper or necessary for the sound and efficient administration of the Trust, provided that the rules and regulations shall be consistent with the provisions of the Trust Agreement.

ARTICLE 2 — DEFINITIONS

Word and phrases appearing in this Plan shall have the respective meanings set forth in this Article, unless the context clearly indicates to the contrary.

Section 2.1. Actively Employed or Active Employment.

Actual attendance at the job site and performance of job duties, including vacation, holidays and regular non-working days, if actively at work on the last preceding regular work day.

Section 2.2. Ambulatory Care Facility.

A facility approved or licensed as such by an agency of the governing jurisdiction that provides medical care on an outpatient basis. There are two types of ambulatory care facilities:

- (a) Hospital affiliated facilities under the direct supervision of a Physician owned and operated by and licensed through a Hospital; or
- (b) free-standing facilities under the direct supervision of a Physician, which include surgicenters, emergency care centers and urgent care centers.

Section 2.3. Benefits Fund Office.

The office from which the Plan is administered. The office is located at 1300 Higgins Road, Suite 300, Park Ridge, Illinois.

Section 2.4. Brand-Name Drug.

A Prescription Drug which is an original drug product marketed under a trademarked name.

Section 2.5. Break in Coverage.

A period of 63 days or more between the date a person's Creditable Coverage ended and the date the person becomes enrolled under this Plan. A person's enrollment date is the earlier of the date coverage starts or a waiting period starts.

Section 2.6. Calendar Year.

The period of 12 months starting on January 1 of each year.

Section 2.7. Collective Bargaining Agreement.

A written agreement to which a Union and an employer are parties, that recognizes the Union as the exclusive bargaining agent of a bargaining unit of the employer's Employees and that provides for current or future contributions to this Fund by the employer on behalf of bargaining unit Employees.

Section 2.8. Contributing Employer.

Any employer who:

- (a) on or after the Effective Date has a Collective Bargaining Agreement with a Union requiring periodic contributions to be made to the Fund,
- (b) signs a copy of the Trust Agreement or executes a Participation Agreement or in some other written manner indicates consent to be bound by the terms of the Trust Agreement, which is then filed at the administration office of the Fund,
- (c) is accepted for participation in the Fund in accordance with the provisions of Article 3 hereof,
- (d) makes contributions to the Fund as required by the Collective Bargaining Agreement, and
- (e) has been accepted, and has not, by resolution of the Trustees, been terminated as a Contributing Employer because of failure, for a period of ninety 90 days after the due date, to make contributions to the Fund as provided for in its Collective Bargaining Agreement or Participation Agreement.

The term "Contributing Employer" shall also include the United Food and Commercial Workers Unions and Employers Midwest Pension Fund, the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, the Unions, and the Illinois Food Retailers Association, provided that each has signed a copy of the Trust Agreement as an employer becoming bound by its terms and agrees to make contributions to the Fund, pursuant to a Participation Agreement unanimously acceptable to the Trustees, upon such terms and conditions necessary to preserve an equitable relationship between the contributions made by the other Contributing Employers participating in the Plan and the benefits payable to the Employees of such other Contributing Employers.

If an Employer has more than one place of business, the term "Contributing Employer" shall only apply to the place or places of business covered by the Collective Bargaining

Agreement requiring contributions to the Fund. A business organization shall not be deemed a Contributing Employer simply because it is part of a controlled group of corporations or of a trade or business under common control, some other part of which is a Contributing Employer.

Section 2.9. Co-Pay

That portion of the Covered Expense which is required to be paid by the Participant and which is not subject to reimbursement by the Plan.

Section 2.10. Cosmetic Surgery or Treatment.

Surgery or medical treatment which is performed primarily to improve or preserve physical appearance, but not physical function, or to improve self-esteem, except as set forth in Article 12.

Section 2.11. Covered Hours.

Hours in which an Employee is Actively Employed and for which a Contributing Employer is obligated to make contributions to the Fund.

Section 2.12. Covered Expense.

The charges for Medically Necessary services and supplies for the diagnosis or care of an Eligible Employee or Eligible Dependent's Illness or Injury. A Covered Expense will not exceed the Usual and Customary charges, as determined by the Fund Administrator, within the geographical area in which the expense is incurred. An expense must also be allowable under the benefit provisions of the Plan in order to be considered a Covered Expense.

Section 2.13. Creditable Coverage.

Coverage of an individual under any of the following forms of health benefits coverage:

- (a) A group health plan;
- (b) Health insurance coverage;
- (c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- (d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under SSA §1928 (relating to childhood immunizations);
- (e) Chapter 55 of Title 10, United States Code (CHAMPUS or TRICARE);

- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A state health benefit risk pool;
- (h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Plan);
- (i) A public health plan (as defined in applicable regulations);
- (j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 USCS §2504(e)); and
- (k) A State Children's Health Insurance Program.

Section 2.14. Custodial Care.

Services or supplies; regardless of where or by whom they are provided, that:

- (a) a person without medical skills or background could provide or be trained to provide; or
- (b) are provided mainly to help the patient with daily living activities, including but not limited to, walking, getting in or out of bed, exercising or moving, bathing, using the toilet, administering enemas, dressing and assisting with hygiene needs, assistance with tube or gastrostomy feedings and stoma and ostomy maintenance, cleaning or preparation of meals, acting as a companion or sitter, or administering or supervising the administration of medication including but not limited to the administration of insulin and other injectable medications, changing of dressings, or as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, sickness, injury or functional ability.

Section 2.15. Deductible.

The amount of Covered Expenses an Eligible Employee or Eligible Dependent is responsible for paying before the Plan begins to pay benefits.

Section 2.16. Dental Services.

Any service involving teeth, tooth supporting structures, tissues of the oral cavity, and services listed in the Schedule of Dental Procedures as shown in Appendix D.

Section 2.17. Dentist.

A person who is licensed to practice dentistry or perform oral surgery and who is practicing within the scope of his or her license. A licensed dentist will also be considered a dentist while practicing within the scope of his or her license, and to the extent that benefits are provided.

Section 2.18. Earnings.

The regular pay an Eligible Employee receives. It does not include commissions, bonuses or overtime pay.

Section 2.19. Eligible Dependent.

Any or all of the following individuals:

- (a) the Eligible Employee's spouse of the opposite sex, pursuant to the marriage (i.e., legal union) of one man and one woman as husband and wife;
- (b) those children of the Eligible Employee who are unmarried and primarily dependent on the Eligible Employee for more than one-half of their financial support and maintenance and have not reached their 19th birthday. For this purpose, "children" shall include:
 - (i) natural children;
 - (ii) step-children, if both the stepchild and the stepchild's natural parent resides in the Eligible Employee's home;
 - (iii) legally adopted children or those for whom adoption proceedings have been started and the children are placed in the Eligible Employee's home by a licensed placement agency for the purpose of adoption or if the children have been living in the Eligible Employee's home as foster children for whom foster care payments are being made, and a petition for adoption has been filed; and
 - (iv) children for whom the Eligible Employee has legal responsibility as the result of a court order, if the child is a first degree relative (e.g., grandchild, nephew, niece) of the Eligible Employee;

who reside with the Eligible Employee permanently and regularly for more than one-half of the year.

- (c) those children of the Eligible Employee who have reached their 19th birthday but

are unmarried and incapable of self-sustaining employment by reason of mental retardation or physical handicap, provided:

- (i) such incapacity commenced prior to the limiting age in subsection (b) above or (d) below, and
 - (ii) such children reside with the Eligible Employee permanently and regularly for more than one-half of the year or live in a treatment center and are primarily dependent on the Eligible Employee for more than one-half of their financial support and maintenance, and
 - (iii) the Eligible Employee submits satisfactory proof of such incapacity after the upper age limit is reached. The Benefits Fund Office may require, at reasonable intervals following the date the child reaches the age limit, subsequent proof of continuing incapacity and dependency. The Trustees reserve the right to have such children examined by a Physician of their choice to determine the existence of such incapacity.
- (d) those children who have reached their 19th birthday but have not reached their 23rd birthday who reside with the Eligible Employee permanently and regularly for more than one-half of the year, are primarily dependent on the Eligible Employee for more than one-half of their financial support and who attend an accredited college, university or vocational school on a full-time basis (that is, take at least 12 undergraduate credit hours). A child's temporary absence to attend school is permissible if a child returns home when school is not in session. Proof of full-time student status must be provided to the Benefits Fund Office each semester or quarter.
- (e) If both husband and wife are Eligible Employees, their children shall be considered Eligible Dependents of both.
- (f) Any child under subsections 2.19(b)(i), (ii) or (iii), (c) and (d) of an Eligible Employee who is a non-custodial parent and who is divorced or legally separated can satisfy the support and residency conditions of these subsections if the child in question receives over half of his or her support from the Eligible Employee and the child lives with either the Eligible Employee and/or the other parent for more than half of the Calendar Year.

The Benefits Fund Office may require legal documentation to determine if a person meets these requirements.

Section 2.20. Eligible Employee.

An individual who satisfies the conditions for eligibility under Article 4.

Section 2.21. Emergency.

An unforeseen event that requires immediate medical treatment to prevent loss of life or permanent damage to the organs or systems of the body.

Section 2.22. Emergency Service(s).

Any Medically Necessary service(s) which must be provided immediately.

Section 2.23. Employee.

Any employee on whose behalf payments are required to be made to the Fund by a Contributing Employer pursuant to a Collective Bargaining Agreement with a Union; and any employee employed by the United Food and Commercial Workers Unions and Employers Midwest Pension Fund, the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, the Union, or the Illinois Food Retailers Association, on whose behalf such Employer is obligated to make contributions to the Fund pursuant to a Participation Agreement.

The term “Employee” includes a leased employee of a Contributing Employer, within the meaning of Section 414(n) of the Internal Revenue Code, who otherwise meets the conditions for participation under the Fund.

The term “Employee” does not include:

- (a) a sole proprietor or self employed person;
- (b) a partner, regardless of the size of the partnership interest; or
- (c) anyone whose inclusion would, in the opinion of the Trustees, jeopardize the tax-exempt status of the Fund or violate provisions of the Employee Retirement Income Security Act of 1974.

Section 2.24. Experimental, Investigational or Unproven Services.

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan Administrator (at the time a determination is made regarding coverage in a

particular case) to be

- (1) not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopoeia Dispensing Information, or the American Medical Association Drug Evaluations as appropriate for the proposed use; or
- (2) subject to review and approval by an Institutional Review Board for the proposed use; or
- (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the Illness or Injury for which its use is proposed.

Section 2.25. Fund.

The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund, established to receive and invest contributions of the Contributing Employers and from which benefits are paid.

Section 2.26. Fund Administrator.

An individual employed by the Trustees of the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund charged with any administrative duties of the Fund, such as recordkeeping, reporting and disclosure, processing of applications for benefits and related functions attendant to the administration of the Plan.

Section 2.27. Generic Drug.

A Prescription Drug which is a multi-source drug which has never been under patent protection.

Section 2.28. Health Care Provider.

Any of the institutions or persons listed below legally licensed and/or legally authorized to practice or provide medical care or diagnostic treatment to sick or injured persons under the laws of the state or jurisdiction in which the services are rendered:

- (a) Home Health Agency;
- (b) Ambulatory Care Facility;
- (c) licensed ambulance service;
- (d) Practitioner;
- (e) Physician;
- (f) Hospital;
- (g) laboratory;
- (h) Skilled Nursing Facility;
- (i) Hospice;
- (j) licensed clinical social worker;
- (k) licensed social worker;
- (l) licensed clinical professional counselor;
- (m) occupational, physical, respiratory or speech therapist.

Section 2.29. Home Health Care.

A program of continued medical care and treatment rendered by an approved Home Health Care Agency at home in lieu of continued Hospital Confinement.

Section 2.30. Home Health Care Agency.

A Home Health Care Agency is a public or private agency which meets all the following requirements:

- (a) is certified as a home health agency under Medicare or is licensed as a home health agency by the state or is a Hospital possessing a valid certificate to provide home health care services;
- (b) is primarily engaged in providing skilled nursing and other therapeutic services;
- (c) has its policies set by a professional group which governs the services provided;

and

- (d) maintains records for each patient.

Section 2.31. Hospice.

A health care program which provides a coordinated set of palliative and supportive health care services rendered at home or in outpatient or institutional settings for terminally ill individuals assessed to have a life expectancy of six months or less. Hospice also means a public or private entity, or part of it, which is licensed or certified as a Hospice by Medicare and by the state.

Section 2.32. Hospital.

An institution which meets all the following requirements:

- (a) is accredited by The Joint Commission;
- (b) is approved by Medicare as a Hospital;
- (c) is mainly engaged in providing inpatient medical care for diagnosis and treatment of an illness or injury, and routinely makes a charge for such care;
- (d) is supervised by a staff of Physicians on the premises;
- (e) provides on the premises 24 hour nursing services by registered graduate nurses; and
- (f) is operated with organized facilities for operative surgery on the premises, except for the following institutions:
 - (i) mental/psychiatric hospitals;
 - (ii) drug/alcohol rehabilitation hospitals; and
 - (iii) physical rehabilitation hospitals.

A hospital does not include any institution:

- (a) which is run mainly as a rest, nursing, or convalescent home;
- (b) for which any part is mainly for the care of the aged; or
- (c) which is engaged in the schooling of its patients.

Section 2.33. Hospital Confined or Hospital Confinement.

Confined in a Hospital as a registered bed-patient.

Section 2.34. Illness.

Any marked, pronounced deviation from a normal, healthy state. Illness also includes pregnancy.

Section 2.35. Injury.

Any damage to the body which is the result of an unintended and unforeseen event.

Section 2.36. In-Network.

Services and supplies provided by Health Care Providers who are members of the Plan's Preferred Provider Option (PPO).

Section 2.37. Medically Confined.

An inpatient in a medical facility due to Illness or Injury. Medically Confined includes confinement in a Hospital, Skilled Nursing Facility, alcoholism or drug abuse treatment facility, mental health treatment center, Hospice, or any other facility engaged in the treatment of Illness or Injury.

Section 2.38. Medically Necessary

- (a) A medical service, supply, treatment or confinement will be determined to be "Medically Necessary" by the Plan Sponsor if it meets all the following requirements:
 - (i) is provided by or under the direction of a Physician or other Health Care Provider who is authorized to provide or prescribe it; and
 - (ii) is determined by the Plan Sponsor or its designee to be necessary in terms of generally accepted medical standards in the U.S.; and
 - (iii) is determined by the Plan Sponsor to meet all of the following requirements:
 - (A) It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and

- (B) It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility; and
- (C) It is an “Appropriate” service or supply given the patient’s circumstances and condition; and
- (D) It is the most “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
- (E) It is safe and effective for the Illness or Injury for which it is used; and
- (F) For Hospital Confinement, it cannot be safely provided on an outpatient basis.

The fact that a Physician or other Health Care Provider orders or recommends a service, supply, treatment or confinement does not in itself make them Medically Necessary.

- (b) A medical service, supply, treatment or confinement will be considered to be “Appropriate” if:
 - (i) It is a diagnostic procedure that is called for by the health status of the patient, and is:
 - (A) as likely to result in information that could affect the course of treatment as; and
 - (B) 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.
 - (ii) It is care or treatment that is:
 - (A) as likely to produce a significant positive outcome as; and
 - (B) 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.

Section 2.39. Medicare.

The four health care programs, a hospital benefit plan (Part A), a supplementary medical benefits plan (Part B), the health care plans under the Medicare+Choice program (Part C), and the prescription drug program (Part D), as established by Title XVIII of the Social Security Act, as amended.

Section 2.40. Mental or Nervous Disorder.

A mental illness or organic or functional nervous disorder which is identified as a mental illness or nervous disorder in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Section 2.41. Month.

Any of the 12 calendar months of the year.

Section 2.42. Out-of-Area.

The term used to describe medical care received in geographical areas not served, with regard to such care, by the Plan's Preferred Provider Option.

Section 2.43. Out-of-Network.

Services and supplies provided by Health Care Providers who are not members of the Plan's Preferred Provider Option (PPO), but who are located in geographical areas served by the PPO.

Section 2.44. Participant.

An Eligible Employee who is covered under the Plan according to the eligibility rules as set forth in Article 4.

Section 2.45. Participation Agreement.

A written agreement in form or content acceptable to the Trustees pursuant to which an employer consents to be bound by the Trust Agreement and adopts the Plan.

Section 2.46. Physician.

A person who is duly licensed by the appropriate state agency of the state in which the services are performed practicing within the scope of his license as:

- (a) a Doctor of Medicine (M.D.);
- (b) a Doctor of Osteopathy (D.O.);
- (c) a Doctor of Dental Surgery (D.D.S.);
- (d) a Doctor of Podiatry (D.P.M.);
- (e) a Doctor of Chiropractic (D.C.);
- (f) a Doctor of Chiropody (D.P.M.; D.S.C);
- (g) a Doctor of Medical Dentistry (D.M.D.).

Section 2.47. Plan.

The United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan, the Plan set forth herein, as amended from time to time.

Section 2.48. Plan Sponsor.

The Trustees of the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund.

Section 2.49. Plan Classification.

Any of several plans of benefits provided by the Fund. A Participant is eligible for the plan of benefits for which his employer makes the required contributions, as determined by the Trustees from time to time.

Section 2.50. Plan Year.

The twelve-month period from December 1 through November 30.

Section 2.51. Practitioner.

A person, other than one defined above as a Physician, who:

- (a) upon referral by a Doctor of Medicine or a Doctor of Osteopathy, provides services which are covered under the Plan; and
- (b) is practicing within the scope of his license as a Health Care Provider.

Section 2.52. Preauthorization.

The approval of the Fund Administrator of a proposed treatment plan before services are provided to assure that Hospital admissions and lengths of stay, surgery and other health care services are Medically Necessary.

Section 2.53. Preferred Provider Option (PPO).

A group or network of Health Care Providers under contract with the Plan to provide health care services and supplies at agreed-upon discounted rates as payment in full and to handle the paperwork required for submission of claims.

Section 2.54. Pre-Existing Condition.

Any Illness (except pregnancy), Mental or Nervous Disorder or Injury for which a diagnosis has been made or medical care and/or treatment has been recommended or provided (including the prescription of drugs or medicines) during the 180 days (90 days for Plan DM) immediately preceding the enrollment date. The enrollment date is the earlier of the date coverage starts or a waiting period starts.

Section 2.55. Prescription Drugs.

The following are considered Prescription Drugs:

- (a) Most Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution—Federal Law prohibits dispensing without prescription" or "Rx Only".)
- (b) Drugs which require a prescription under State law but not under Federal law.
- (c) Compound drugs. (This is a drug that has more than one ingredient. At least one of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under State law.)
- (d) Injectable insulin, syringes, needles and blood glucose testing strips.
- (e) Certain approved over-the-counter (OTC) drugs when prescribed by a Physician.

Section 2.56. Prosthetics.

A durable appliance or device which replaces a lost body part or function.

Section 2.57. Skilled Nursing Facility.

A facility which is operating legally to provide room and board for sick or injured persons under the supervision of a registered nurse or a Physician, and along with the services of nurses at all hours, meets all of the following criteria:

- (a) it has available at all times the services of a Physician who is on the staff of a Hospital;
- (b) it keeps a daily medical record for each patient; and
- (c) it is not primarily a place for rest or custodial care, a place for the aged, a place for alcoholics or drug addicts, or a hotel.

Section 2.58. Sound and Natural Teeth.

Natural teeth (not dentures, bridges, pontics or artificial teeth) that:

- (a) are free of active or chronic clinical decay; and
- (b) have at least 50% bony support; and
- (c) are functional in the arch; and
- (d) have not been excessively weakened by previous dental procedures.

Section 2.59. Substance Abuse.

The use of alcohol or other drugs to the extent that the person:

- (a) loses self-control;
- (b) places in peril his social, economic, psychological and/or physical welfare; or
- (c) could be a menace to public health, morals, safety or welfare.

Section 2.60. Totally Disabled or Total Disability.

The inability of an Eligible Employee to perform all the duties of his occupation or any occupation as a result of an Illness or Injury, or the inability of an Eligible Dependent to perform the normal activities or duties of a person of the same age and sex.

To be considered Totally Disabled, a person must also be continuously under the care of a Physician for treatment consistent with the disability during the entire period of disability.

Section 2.61. Trust Agreement.

The Agreement and Declaration of Trust creating the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund dated December 1, 1960, as amended from time to time.

Section 2.62. Trustees.

The persons appointed pursuant to the provisions of the Trust Agreement and who are responsible for the operation and administration of the Plan and Fund, sometimes collectively referred to as the “Board of Trustees” or the “Board.”

Section 2.63. Union.

Any local Union affiliated with United Food and Commercial Workers International Union, AFL-CIO & CLC, which has or shall become a party to the Trust Agreement and the Plan.

Section 2.64. Usual and Customary Charge.

- (a) With respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary services or supplies will be determined by the Plan Sponsor or its designee to be the lowest of:
 - (i) The usual charge by the Health Care Provider for the same or similar service or supply; or
 - (ii) No more than 85% of the “Prevailing Charge” of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply; or
 - (iii) The Health Care Provider’s actual charge.
- (b) With respect to a PPO provider and any other provider within the geographic area served by the PPO, the Usual and Customary Charge means the charges set forth in the agreement between the PPO provider and the PPO or the Plan.
- (c) The “Prevailing Charge” of most other Health Care Providers in the same or similar geographic area for the same or similar health care service or supply shall be determined by the Fund Administrator who shall use proprietary data that is updated no less frequently than annually, and provided by a reputable company

or entity.

Notwithstanding the Prevailing Charge, if a surgical facility is a Non-PPO Provider, the allowable charge is limited to the following for each listed type of surgery (exclusive of professional fee for anesthesia):

(i)	arthroscopy.....	\$ 3,200
(ii)	cataract.....	\$ 3,000
(iii)	colonoscopy	\$ 1,100
(iv)	cystourethroscopy	\$ 1,500
(v)	elective abortion	\$ 750
(vi)	endoscopy	\$ 1,100
(vii)	epidural injections with fluoroscopy	\$ 1,300
(viii)	foot—hallux valgus	\$ 3,000
(ix)	foot—hammer toe.....	\$ 2,500
(x)	foot—other.....	\$ 2,500
(xi)	gynecological.....	\$ 3,200
(xii)	joint implant removal.....	\$ 250
(xiii)	nasal septum	\$ 3,500
(xiv)	skin disorder repair	\$ 250
(xv)	tonsillitis-related.....	\$ 2,400

- (d) With respect to durable medical equipment and Home Health Care, the Usual and Customary Charge means the charge agreed to between the Plan and providers who have agreed in writing to provide the applicable equipment or service in the geographic area.

Further, at all times, the purchase price for certain equipment will be limited as follows::

(i)	hospital bed	\$ 1,500
(ii)	custom wheelchair	\$12,000
(iii)	limb prosthesis	\$20,000
(iv)	scooter or other non-wheelchair transportation .	\$ 2,600
(v)	stander	\$ 3,000
(vi)	CPAP machine, complete.....	\$ 1,200
(vii)	CPAP replacement supplies every 6 months	\$ 200

- (e) No provision of this Plan requires the Plan to pay benefits based on the charges submitted by a proprietary provider of a medical supply or service.

Section 2.65. Work Related Illness or Injury.

Illness or Injury which arises from or is sustained in the course of work for pay, profit or gain.

ARTICLE 3 — PARTICIPATING EMPLOYERS

Section 3.1. Commencement of Participation.

An employer shall be entitled to participate in this Plan only if its participation has been approved by the Trustees. An employer who is participating in the Plan on the date this document is adopted shall continue to be a Contributing Employer.

The Trustees shall approve a business organization's participation herein only if such participation will not adversely affect the Fund, as determined by the Trustees. To enable the Trustees to make such determination, each Union seeking approval of a new Employer shall be required to furnish the name, Social Security Number, sex, date of birth and employment history of each Employee then covered by the Collective Bargaining Agreement between the Union and the new employer, as well as such other reasonable information as the Trustees shall request. Such determination may be made on an individual employer basis or, for purposes of administrative convenience and expense savings, by pooling the experience of all new employers whose contributions to the Fund commence within a period of one Calendar Year or other appropriate unit, in accordance with rules or guidelines established by the Trustees.

Any business organization accepted as an Employer may be required to sign, with the Union, a Participation Agreement approved by the Trustees which sets forth the full details of the basis for contributions to the Fund and the basis for acceptance as a Contributing Employer. When an Employer is accepted for participation, the Trustees may, in writing, impose on such acceptance any terms and conditions they consider necessary. A written notice of acceptance shall be sent by the Trustees to any new Employer who is accepted for participation herein. Participation in the Fund shall be deemed to commence on a date set forth in such written notice.

If a Contributing Employer is sold, merged or otherwise undergoes a change of corporate identify, the successor company shall participate as to the Employees theretofore covered in the Plan just as if it were the original company, provided it remains a Contributing Employer as defined in Section 2.8 of Article 2.

Section 3.2. Termination of Participation.

An Employer's participation in this Plan shall be effectively terminated upon the permanent cessation of contributions by such Employer. If an Employer no longer remains obligated under a Collective Bargaining Agreement with the Union to make contributions to the Fund, no eligibility shall be given for the period with respect to which the Employer is not

obligated to make contributions to the Fund. If an Employer fails to make contributions due for 90 days after their due date, the Trustees may, by resolution, terminate the Employer's participation in the Fund. If an Employer, other than an Employer who has entered into a "Maintenance of Benefits" contract with the Union, fails to make all contributions needed to provide sufficient revenue to fund the plan of benefits for 90 days after a contract expires, the Trustees may, by resolution, provide an alternate plan of benefits to the Eligible Employees of such Employer.

Section 3.3. Suspension of Coverage.

Coverage under the Plan for an Employer's Employees shall be suspended when the contribution for the affected individual(s) is delinquent for 120 days, provided however, that the suspension may occur at an earlier date if the Fund Administrator, in consultation with the Fund's advisors, determines that it is likely that the continuation of Plan coverage without a timely contribution will have a material financial impact on the Plan. This 120-day period may be extended by the Board of Trustees where it determines that it is likely that the contribution will be paid within a reasonable period of time and there are mitigating circumstances surrounding the delinquent contribution.

ARTICLE 4 — ELIGIBILITY

Section 4.1. General.

Employees shall become eligible for benefits if, after satisfying any waiting period requirements, they perform covered work and sufficient contributions are made to the Fund on their behalf in accordance with the following provisions of this Article. In certain instances, eligibility may be based on self-contributions as specified in this Article.

Section 4.2. Plan of Benefits.

The Trustees shall establish plans of benefits corresponding to levels of contributions required to be made by Contributing Employers for Eligible Employees and other conditions of participation. An Eligible Employee is entitled to the benefits of that plan for which the Contributing Employer is obligated to contribute on his behalf and does so contribute.

Section 4.3. Change in Benefits.

If an Eligible Employee becomes entitled to greater or lesser benefits due to a change in Plan Classification, any increase or decrease will become effective on the first day of the Month coinciding with or next following the date of change.

Section 4.4. Initial Employee Eligibility.

An Employee shall become eligible by completing any applicable waiting period and by working the Covered Hours required during a period of continuous employment. The waiting periods, required Covered Hours and periods of continuous employment vary by type of benefit and Plan Classification, as set forth in Appendix A.

In addition, Plan Classification D5 requires an Employee to elect coverage and to pay a weekly contribution via payroll deduction as set forth in Section 4.5. The weekly payroll deduction for the period December 1, 2005 through October 31, 2008 is \$5 for Single Coverage and \$15 for Family Coverage.

Coverage starts on the first day of the Month following the date the eligibility requirements are met.

Section 4.5. Election of Coverage under Plan Classification D5.

- (a) An Eligible Employee's weekly payroll deduction shall be made pursuant to an Employer-established Section 125 Plan ("Cafeteria Plan") and the payroll deduction amount shall be applied against the Employer's contribution for the

affected Eligible Employee.

To receive Single Coverage or Family Coverage, an Eligible Employee must sign an election and payroll reduction agreement pursuant to the Employer's Cafeteria Plan authorizing the Employer to reduce the Eligible Employee's weekly pay by the amount equal to the Eligible Employee's coverage election amount. Election and payroll reduction agreements are to be executed within 60 days of the effective date of the Eligible Employee's initial eligibility for coverage or on an annual date established by the Board of Trustees.

- (b) Pursuant to the provisions of the Cafeteria Plan, the Benefits Fund Office is authorized to accept a substitute election form when the following conditions are met:
 - (i) the Fund Administrator is satisfied that there is clear and convincing evidence that a clerical error has been made;
 - (ii) the Eligible Employee attests to the nature of the error;
 - (iii) there is a time limit of 45 days after the first payroll deduction should have been made for error to be corrected;
 - (iv) the Eligible Employee agrees that this is a confidential process; and
 - (v) the Eligible Employee may only correct a mistake one time.

- (c) An election and payroll reduction agreement may be executed or changed before the annual enrollment date in the event of any of the following Special Enrollment Events:
 - (i) HIPAA Special Enrollment Events. The Health Insurance Portability and Accountability Act ("HIPAA") requires that Eligible Employees be allowed to enroll themselves and their dependents in the Plan when other coverage is lost or gained (or if the employer ceases contributing towards the employee's or dependents' other coverage) and when a new dependent is acquired through marriage, birth, adoption or placement for adoption.
 - (ii) Change in Status Events. An Eligible Employee may enroll for, change existing, or drop coverage on account of and consistent with a gain or loss of eligibility (including an increase or decrease in the number of

dependents eligible for coverage) resulting from any of the following events:

- (A) Change in legal marital status, such as marriage, death of spouse, divorce, legal separation or annulment.
 - (B) Change in number of dependents, such as birth, death, adoption or placement for adoption.
 - (C) Change in employment status. Any of the following events that change the employment status of the Eligible Employee, the spouse or a child:
 - (1) a termination or commencement of employment;
 - (2) a commencement of or return from an unpaid leave of absence; or
 - (3) a change in class of employment (e.g., bargained v. non-bargained, full-time v. part-time, etc.).
 - (D) Dependent satisfies or ceases to satisfy eligibility requirements, such as attainment of age 19, gain or loss of full-time student status, etc.
- (iii) Judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for an Eligible Employee's dependent child.
 - (iv) Entitlement to Medicare or Medicaid or loss of entitlement by an Eligible Employee, spouse or child.
 - (v) Cost change that results in a significant increase or decrease in the cost of a plan.
 - (vi) Coverage change that results in the coverage of an Eligible Employee or of a dependent being significantly curtailed, with or without loss of coverage, or significantly increased.
 - (vii) Special requirements relating to the Family and Medical Leave Act. An Eligible Employee taking leave under the Family and Medical Leave Act

may revoke an existing election and make such other election for the remaining portion of the period of coverage as may be provided for under the FMLA.

- (viii) Different Enrollment Period. An Eligible Employee's spouse or dependent child has a plan with a different enrollment period.
- (d) A change in an Eligible Employee's election during the Plan Year must be filed with the Benefits Fund Office within 30 days of the Special Enrollment Event.

Section 4.6. Continuation of Employee Eligibility.

An Eligible Employee shall remain eligible for a benefit by working the Covered Hours required during a period of continuous employment. The required Covered Hours and periods of continuous employment vary by type of benefit and Plan Classification, as set forth in Appendix A.

Section 4.7. Employee Termination of Eligibility.

Employee eligibility shall terminate upon the earliest of the following dates:

- (a) the last day of the Month in which he ceases to work the Covered Hours required for coverage under the Plan;
- (b) the first day of the Month for which any self-payment is due and unpaid;
- (c) the last day of the Month in which the Employee is no longer disabled;
- (d) the last day of the Month during which the Plan receives three months advance notice from the Contributing Employer that he is withdrawing from the Plan; or
- (e) the date the Plan terminates or the Contributing Employer ceases to participate in the Plan.

Section 4.8. Extension of Coverage While Totally Disabled.

If an Eligible Employee becomes Totally Disabled while Actively Employed, he shall continue to be covered under the Plan. Coverage will continue, without Employer contributions or self-payment, for up to:

- (a) two Months if covered under Plan D5-Tier A or Plan DH for employee benefits only.

- (b) six Months if covered under Plan DM or if covered under Plan D5-Tier A or Plan DH for Dependent benefits.
- (c) two Months if covered under Plan D5-Tier B.

Only one two-month or one six-month extension will apply to the same or related condition regardless of whether or not the Eligible Employee has returned to work for any period of time.

Section 4.9. Reinstatement.

An Employee whose eligibility has been terminated who returns to work immediately after:

- (a) a leave of absence for a period of Total Disability covered under the Plan which lasted at least one Month but not more than 12 Months,
- (b) a temporary layoff of at least one Month but not more than six Months, or
- (c) a sanctioned strike

shall become reinstated on the date he returns to work, provided he had previously satisfied the eligibility requirements set forth in Section 4.4 and further provided that his Contributing Employer immediately begins to make the applicable contributions on his behalf.

An Employee whose eligibility has been terminated due to failure to work required hours shall become reinstated by again meeting the initial eligibility requirements set forth in Section 4.4.

Section 4.10. Dependent Eligibility.

Dependents shall become eligible on the later of the following dates

- (a) on the date set forth in Appendix A;
- (b) on the date the dependent becomes an Eligible Dependent, as defined in Article 2, Section 2.19.

Notwithstanding the foregoing, dependents of an Eligible Employee covered under Plan Classification D5 will become eligible only if the Eligible Employee elects Family Coverage and authorizes the weekly payroll deduction set forth in Section 4.4 and 4.5.

Section 4.11. Termination of Dependent Eligibility.

Dependent eligibility shall terminate upon the earliest of the following dates:

- (a) the last day of the Month in which the Dependent ceases to be an Eligible Dependent as defined in Section 2.19 of Article 2; or
- (b) the last day of the Month in which the Eligible Employee fails to work the hours required for Dependent coverage, except as provided below; or
- (c) the date of divorce for a covered spouse; or
- (d) the last day of the Month in which the Eligible Employee is ineligible for coverage.

In the event of an Eligible Employee's death, coverage for his Eligible Dependents will continue until the earliest of the following dates:

- (a) the last day of the third Month following the date of the Eligible Employee's death;
- (b) the last day of the Month in which the dependent ceases to be an Eligible Dependent as defined in Section 2.19 of Article 2; or
- (c) the date the Eligible Dependent becomes eligible for health coverage under a group policy or plan.

Section 4.12. Qualified Medical Child Support Orders (QMCSOs).

If a copy of a Medical Child Support Order as defined in ERISA Section 609(a) is filed with the Fund Administrator, the Fund Administrator shall promptly notify the Eligible Employee and each alternate recipient of the receipt of such order and of the Plan's procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO), as further defined in ERISA Section 609(a). The Fund Administrator shall then determine whether the order is a QMCSO pursuant to the Plan's procedures, and notify the Eligible Employee and each alternate recipient of the determination. The Plan shall provide benefits in accordance with the applicable requirements of any QMCSO. Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

Section 4.13. Continuation of Coverage During Leave of Absence (FMLA).

Eligible Employees may be able to continue medical benefits under the Family and Medical Leave Act of 1993 (FMLA).

A. Maintenance of Health Benefit

A Covered Employer must continue to make contributions for an Eligible Employee while the Eligible Employee is on FMLA leave. Notice must be made on a remittance form and the contributions must be sent to the Benefits Fund Office. For purposes of this Section 4.13, Covered Employer means an Employer who employs 50 or more Employees on each working day during each of 20 or more work weeks in the current or preceding Calendar Year.

B. Termination of the FMLA Obligation to Maintain Health Care Coverage

If a Covered Employer makes contributions under FMLA and the Eligible Employee is also eligible for an extension of coverage while disabled, the Fund shall consider the contributions and the extension of coverage to apply to the period of time which provides the longest period of continuous coverage to the Eligible Employee.

The obligation to maintain health care coverage during FMLA leave ends on the earliest of:

1. when an Eligible Employee returns to work; or
2. when 12 weeks of FMLA leave ends.

C. Interaction with COBRA

If the Eligible Employee does not return to work within 12 weeks, he will have a COBRA qualifying event as outlined in Section 4.15.

D. Disputes over Eligibility and Coverage

All disputes over an Eligible Employee's eligibility and coverage under FMLA are between the Eligible Employee and Covered Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

Section 4.14. Uniformed Services Employment and Re-Employment Rights (USERRA).

Eligible Employees may be able to continue medical benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

(a) Definitions

These definitions apply when the following terms and words are used in this Section 4.14.

- (i) **Health Coverage** means Hospital, surgical, medical or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modifications.
- (ii) **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).
- (iii) **Service in the Uniformed Services** means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.
- (iv) **Uniformed Services** means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

(b) Continuation of Group Health Coverage

- (i) For an Eligible Employee and his Eligible Dependents: If Health Coverage ends because of an Eligible Employee's Service in the Uniformed Services, an Eligible Employee may elect to continue such Health Coverage, if required by USERRA, until the earlier of:
 - (A) the end of the period during which he is eligible to apply for reemployment in accordance with USERRA; or

- (B) 24 consecutive Months after coverage ended.
- (ii) To continue coverage, an Eligible Employee or his Eligible Dependent must pay the required premium, unless service in the Uniformed Service is for fewer than 31 days, in which case an Eligible Employee must pay his share, if any, of the premium. The Benefits Fund Office will inform an Eligible Employee or his Eligible Dependent of procedures to pay premiums.
- (iii) End of Continuation. An Eligible Employee's or Eligible Dependent's continued Health Coverage will end at midnight on the earliest of:
 - (A) the day an Eligible Employee's former Contributing Employer ceases to provide any group health plan to any Employee;
 - (B) the day a premium is due and unpaid;
 - (C) the day an Eligible Employee or Eligible Dependent again becomes covered under the Plan; or
 - (D) the day Health Coverage has been continued for the period of time provided in subparagraph (i)(A) or (i)(B) above (or any longer period provided in the Plan).
- (iv) Other Continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which a premium is paid in whole or in part by a Contributing Employer, the premium an Eligible Employee is required to pay may increase for the remainder of the period provided above.

Nonetheless, it is recognized that some provisions of Section 4.15 provide more generous coverage rights than those available under Section 4.14 (e.g., Section 4.15 provides for coverage of 29 or 36 months in some circumstances) and vice versa (e.g., Section 4.14 does not allow for termination of coverage where an individual obtains other group health plan coverage after electing continuation coverage). An individual eligible for continuation coverage rights under both Section 4.14 and Section 4.15 shall be entitled to the most generous coverage provisions available under

Section 4.14 and Section 4.15.

(c) Reemployment (following Service in the Uniformed Services)

Following discharge from such Service, an Employee may be eligible to apply for reemployment with his former Contributing Employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any then existing Health Coverage provided by the Contributing Employer.

(d) Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by an Employee's Contributing Employer or former Contributing Employer, shall apply.

Section 4.15. COBRA Continuation Coverage.

Pursuant to the provisions of the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") and regulations issued thereunder, the Fund shall offer Qualified Beneficiaries the opportunity for a temporary extension of health coverage ("continuation coverage") on a self-pay basis at group rates (or slightly higher) upon the occurrence of a Qualifying Event as defined below. COBRA continuation coverage only applies to the health coverage (including dental and vision benefits) available under the Plan, and shall not include continuation of coverage for life insurance, accidental death and dismemberment insurance or income protection benefits. The following COBRA provisions shall be interpreted in accordance with the developing regulatory and case law under COBRA, since it is the intent of the Trustees, in their capacity as sponsor of this Plan, to meet the requirements of COBRA but not to exceed them, except as expressly set forth in paragraph (f)(ii)(A) below.

(a) Definition of Qualified Beneficiary

A "Qualified "Beneficiary" is any person who, as of the day before a Qualifying Event, is:

- (A) an Eligible Employee covered under the Plan as of such day,
- (B) the spouse of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day, or
- (C) a child of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day.

A dependent child born to an Eligible Employee, adopted by the Eligible Employee or placed for adoption with the Eligible Employee during a period of continuation coverage is also a Qualified Beneficiary.

(b) Qualifying Events

Any of the following shall be considered to be a Qualifying Event if it would cause the Qualified Beneficiary to lose coverage under the Plan were it not for the continuation of coverage provisions of this Section 4.15.

(i) Qualifying Events for an Eligible Employee

A Qualified Beneficiary who is an Eligible Employee shall have the right to choose continuation coverage for himself if he loses coverage under the Plan because of the termination of his employment (except by reason of gross misconduct) or a reduction in hours of employment, which includes, but is not limited to, layoff, strike, disability, medical leave of absence or retirement.

(ii) Qualifying Events for Eligible Dependents (Spouse and Children)

A Qualified Beneficiary who is the spouse of an Eligible Employee shall have the right to choose continuation coverage for himself if he loses coverage under the Plan for any of the following reasons:

- (A) The death of the Eligible Employee;
- (B) The termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;
- (C) Divorce or legal separation from the Eligible Employee; or
- (D) The Eligible Employee's becoming entitled to Medicare.

A Qualified Beneficiary who is a child of an Eligible Employee, shall have the right to choose continuation coverage if his coverage under the Plan is lost for any of the following reasons:

- (A) The death of the Eligible Employee;
- (B) The termination of the Eligible Employee's employment (for

reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;

- (C) Divorce or legal separation of the Eligible Employee;
- (D) The Eligible Employee's becoming entitled to Medicare; or
- (E) He ceases to be an Eligible Dependent as defined under this Plan.

(c) Notice and Election of Continuation Coverage

- (i) In order to qualify for continuation coverage, the Qualified Beneficiary has the responsibility to inform the Fund Administrator at the Benefits Fund Office immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "Eligible Dependent child" in the Plan. If the Qualified Beneficiary does not report such event to the Fund Administrator within 60 days after loss of coverage due to the event, continuation coverage will not be available.
- (ii) It is the responsibility of the Eligible Employee's Contributing Employer to notify the Fund Administrator within 45 days of the Eligible Employee's death, termination of employment, or reduction in hours which causes a loss of medical benefits under the Plan, or the Eligible Employee's entitlement to Medicare. However, the Eligible Employee or other family member should notify the Fund Administrator if any of these Qualifying Events occurs in order to assure timely notification of eligibility for, and processing of, an election of continuation coverage.
- (iii) Each Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time, or within 60 days, of a Qualifying Event must notify the Fund Administrator at the Benefits Fund Office of such determination within 60 days after the determination. Each Qualified Beneficiary who has been determined to have been disabled at the time of a Qualifying Event must notify the Fund Administrator at the Benefits Fund Office within 30 days of the date of any final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.
- (iv) When the Fund Administrator is notified that a Qualifying Event has occurred, the Fund Administrator will notify all Qualified Beneficiaries

within 14 days of their right to choose continuation coverage by submitting the appropriate election. Notification to a Qualified Beneficiary who is a spouse of an Eligible Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

- (v) COBRA Continuation Coverage must be elected within 60 days from the later of the date coverage terminated or will terminate under the Plan or the date of the notice advising of rights to continuation coverage. The Qualified Beneficiary does not have to show that he is insurable to choose continuation coverage. If the Qualified Beneficiary does not elect continuation coverage within the 60-day time limit, his coverage under the Plan will not be continued.

(d) Benefits Available Under Continuation Coverage

If continuation coverage is elected, the Plan shall provide coverage which, at the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Eligible Employees and their Eligible Dependents, except that a Qualified Beneficiary is not required to elect dental and vision coverage,. The Plan shall not provide continuation coverage of life insurance, accidental death and dismemberment or income protection benefits.

(e) The Cost of Continuation Coverage

Entitlement to continuation coverage shall be conditioned upon payment of monthly contributions equal to 102% of the cost of providing health benefits to individuals in the same benefits selection situation as the Qualified Beneficiary. However, the Trustees, in their discretion, may charge an amount up to, but not exceeding, 150% of the cost of providing health benefits during the 19th through the 29th Month of coverage for a Qualified Beneficiary who elects extended continuation coverage because of disability. The Benefits Fund Office will provide specific cost information to the Qualified Beneficiary along with notice of eligibility for continuation coverage.

Contributions for the period of continuation coverage through the Month in which the election is made must be received by the Benefits Fund Office within 45 days after the date of the election. Contributions for each Month subsequent to the Month in which the election was made must be received by the Benefits Fund Office by the first of that Month, except that a grace period shall be provided

through the last day of such Month.

(f) The Maximum Period of Continuation Coverage

(i) COBRA continuation coverage shall extend for the maximum periods set forth in this paragraph (i), or until the occurrence of an event described in paragraph (ii) below, if earlier.

(A) Qualified Beneficiaries who are Eligible Dependents will be afforded the opportunity to continue health coverage for 36 Months after the Qualifying Event (commencing on the date coverage would otherwise terminate), except in the case where the Qualifying Event is the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, in which case the continuation coverage period for all Qualified Beneficiaries (including the Eligible Employee) is 18 Months after the Qualifying Event. However, if a Qualified Beneficiary who is an Eligible Dependent is receiving COBRA continuation coverage for the 18 Month period and another Qualifying Event occurs, e.g., the Eligible Employee dies, the Eligible Dependent is eligible to have COBRA continuation coverage extended to a total of 36 Months from the date of the first Qualifying Event.

(B) In the case of a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of or within 60 days of the Qualifying Event involving the Eligible Employee's loss of coverage due to termination of employment or reduction in hours, the maximum period of continuation coverage is extended from 18 Months to 29 Months, provided that the Qualified Beneficiary has provided notice of such determination to the Fund as required in paragraph (c)(iii), within the original COBRA continuation period of 18 Months. In addition, other family members who had elected COBRA coverage can keep it for the extended period if they choose. In the event that the Qualified Beneficiary is finally determined under Title II or Title XVI of the Social Security Act to no longer be disabled, the period of extended continuation coverage beyond the 18 Months shall terminate at the end of the Month beginning at least 30 days after the date of the final determination that the Qualified Beneficiary no

longer is disabled.

- (C) If an Eligible Employee becomes entitled to (covered by) Medicare and subsequently terminates employment or reduces hours of employment, either of which results in loss of coverage under the Plan for a Qualified Beneficiary, the duration of continuation coverage is the greater of 36 Months from the date of Medicare entitlement or 18 Months from the Qualifying Event (commencing on the date coverage would otherwise terminate).
- (ii) Regardless of which continuation period applies, a Qualified Beneficiary's continuation coverage shall terminate upon the occurrence of any of the following events:
 - (A) The Contributing Employer ceases to provide any group health plan to any employee.
 - (B) The Qualified Beneficiary fails to make a required premium payment when due (including any grace period);
 - (C) The Qualified Beneficiary becomes covered under another group health plan obtained after the commencement of this COBRA continuation coverage, unless such health plan contains an exclusion or limitation with respect to a preexisting condition that such Qualified Beneficiary has; or
 - (D) The Qualified Beneficiary becomes entitled to Medicare after COBRA coverage was elected.

Section 4.16. Certification of Coverage.

When an Eligible Employee's coverage under this Plan ends, the Fund Administrator shall provide such Employee and his Eligible Dependents with a certificate of coverage that indicates the period of time such Employee and his Eligible Dependents were covered under the Plan and certain additional information that is required by federal law. The certificate will be sent by first class mail shortly after the person's coverage under this Plan ends. If the Eligible Employee or Eligible Dependent elects COBRA continuation coverage, another certificate will be provided shortly after the COBRA continuation coverage ends. In addition, a certificate shall be provided upon receipt of a request for such certificate if that request is received by the Benefits Fund Office within two years after the later of the date coverage under this Plan

ended or the date COBRA continuation coverage ended.

ARTICLE 5 — GENERAL PROVISIONS

Section 5.1. Funding.

All Contributing Employers shall make the contributions required under their Collective Bargaining Agreements with the Union, as well as any and all contributions otherwise required by law. All contributions made under the Plan shall be held in trust in the Fund until disbursed for payment of benefits (including payment of premiums on insurance to provide benefits) or administrative expenses.

The Trustees may, in their discretion, use assets of the Plan to purchase insurance to provide any benefit under the Plan. In addition, the Trustees may, in their discretion, use assets of the Plan to purchase “excess” or “stop loss” insurance, provided that such “excess” or “stop loss” insurance is no more than a financial device of the Plan intended to protect the Plan assets against large losses, meaning that the Trustees (or the Plan) are the named insured, and in the event of an insurable event, reimbursement under such insurance flows directly from the insurer to the Plan, and no Participant has any rights of any kind under such “excess” or “stop loss” coverage.

Except to the extent insured, all benefits under the Plan shall be paid from the assets of the Plan held in the Fund. Neither the Union nor any Contributing Employer nor any Trustee shall have any liability for payment of benefits under the Plan.

Section 5.2. Administration.

The Trustees or their designee shall have all rights, duties and powers necessary or appropriate for the administration of the Plan. In particular, the Trustees or their designee shall have and shall exercise complete discretionary authority to construe, interpret and apply all of the terms of the Plan, including all matters relating to eligibility for benefits, amount, time or form of payment, and any disputed or allegedly doubtful terms. The Trustees may employ or retain the services of one or more individuals to carry out the day-to-day administration of the Plan on behalf of the Trustees, of whom the chief executive shall be known as the “Fund Administrator.”

Section 5.3. Right to Receive and Release Necessary Information.

The Trustees have the right to obtain or provide information needed to coordinate benefit payments with other plans. This information may be obtained from or provided to any insurance company, organization, or person without notice to the Participant and without the Participant’s consent.

Section 5.4. Right to Make Payment.

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the provisions of the Plan. Those payments that are made in good faith are considered benefits paid under this Plan.

Section 5.5. Right of Recovery.

Whenever payments have been made by the Trustees with respect to charges in a total amount at any time in excess of the maximum amount of payment required under the provisions of this Plan, the Trustees shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Trustees shall determine:

- (a) any persons to or for or with respect to whom such payments were made;
- (b) any insurance companies; and
- (c) any other organizations.

Section 5.6. Offset.

In the event any payment is made by the Plan to or for an individual who is not entitled to such payment, in whole or in part, the Plan shall have the right to suspend or withhold payment of incurred claims and to reduce future payments due to such person and/or his or her family members participating in the Plan (e.g., Dependents, Eligible Employees) by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment. The Plan and Trustees may take other actions to recover the erroneous payments and other amounts including, but not limited to, commencing a restitution action under ERISA.

Section 5.7. Submission of Falsified or Fraudulent Claims.

All claims, enrollment forms and any other information submitted or provided to the Plan, directly or indirectly, shall be accurate and complete. If the Board of Trustees finds, at any time, that false or inaccurate information has been submitted or provided to the Plan, directly or indirectly, in support of a claim, such claim shall be denied and the Trustees shall offset the amount improperly paid and/or terminate future coverage for the affected individual and the affected individual's covered family members.

Section 5.8. Workers' Compensation Not Affected.

The Plan is not in lieu of and does not affect any requirements for coverage by the applicable Workers' Compensation laws of any state.

Section 5.9. Amendment and Termination.

In order that the Trustees may carry out their obligation to maintain, within the limits of the funds available to them, a sound and economical program dedicated to providing the maximum benefits for Participants, the Trustees expressly reserve the right in their sole discretion and without notice to Participants, Contributing Employers, the Union and others affected hereby, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time.

The Fund shall pay benefits only to the extent the Fund's assets allow. No benefits shall be payable at any time after the Plan has terminated and all Fund assets expended.

Section 5.10. Notice and Proof of Claim.

A claim for the Income Protection Benefit must be submitted within two weeks of the onset of the disability. Subsequent reports confirming care and treatment must be submitted every three weeks thereafter.

Written notice of Illness or Injury upon which a claim for any other benefit may be based must be given to the Benefits Fund Office within 90 days of the date on which an expense was first sustained for an Illness or Injury for which benefits may be claimed.

Failure to furnish notice or proof of expense within the time provided in the Plan will not invalidate or reduce any claim if it is shown not to have been reasonably possible to provide such notice, except that in no event will claims or medical bills incurred in connection with any claim be accepted for payment under the Plan more than 24 Months after the date the expense was incurred. It is the Participant's responsibility to see that claims and medical bills are submitted promptly and no later than the 24 Month period permitted under the Plan.

Section 5.11. Time of Payment of Claims.

All payments will be made as soon as administratively feasible after proof of claim is received; however, for any loss for which recurrent payments are provided, benefit amounts shall be paid as they accrue, but not less often than monthly.

Section 5.12. Payment of Claims.

The Trustees in their discretion, may pay benefits directly to the Health Care Provider or

to the Participant. To the extent that a Participant has filed a written assignment to have payment made directly to a provider of medical services and supplies, payments shall be made in accordance with the assignment.

The foregoing to the contrary notwithstanding, the Trustees in their discretion may authorize the Fund Administrator to reject or override an assignment and to further advise a Health Care Provider that the Plan will not honor any future assignments that the Provider has received from a Participant or Eligible Dependent. Further, the Trustees authorize the Fund Administrator to reject or override an assignment a Provider has received from a Participant or Eligible Dependent if the Provider has not made available a current Taxpayer Identification Number to be used for reporting payments to the Internal Revenue Service.

In situations where a Provider has overcharged for services in the past, the Plan Administrator is authorized to require preauthorization of a service and the costs therefore by such a Provider as a condition for coverage of the service under the Plan.

Benefits are payable for Covered Expenses upon receipt of a complete application for benefits and all information, as determined by the Trustees, sufficient to adjudicate the claim. The Fund reserves the right to obtain satisfactory evidence of the nature, extent and proof of loss, including, but not limited to, detailed hospital, doctor or other provider records of services rendered or supplies provided to determine medical appropriateness or necessity of expenses claimed.

Loss of life benefits will be paid in accordance with the provisions which apply to such benefits. Any other benefits accrued but unpaid at death may be paid to the deceased person's estate or, at the Trustees' option, to the beneficiary.

Benefits which are payable to a deceased person's estate or to a person who is a minor or who is not competent to give a valid release may instead be paid at the Trustees' option to any person who is related by blood or marriage and whom the Trustees deem to be suitable to receive them. Such payment will fully discharge the Plan to the extent of the payment.

Section 5.13. Claim Filing and Appeal Procedures.

The Benefits Fund Office shall make an initial decision regarding a claim for benefits.

(a) Time Limits on Decision of Claims.

(i) Health Claims.

(A) Urgent Care Claims. The Fund will inform the claimant of the

decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was filed. If, during the review, additional information is required from the claimant, the claimant will be so notified within 24 hours and will be provided at least 48 hours to provide the information. In such a case, the Fund will inform the claimant of the decision no later than 48 hours after the additional information is submitted.

An Urgent Care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant 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 will be determined by the Fund, deferring to the judgment of a Physician with knowledge of the claimant's condition.

- (B) Pre-Service Claims. If pre-certification has been requested for a Pre-Service claim (defined below), the Fund will issue a decision on a Pre-Service claim within 15 days of the date the claim is filed. If additional information is required resulting in a delay in determining benefits or more time is needed due to matters beyond the Fund's control, then the response to the claimant may be delayed no more than an additional 15 days. The claimant will be notified if an extension is needed and advised of the reason for and estimated date by which a decision will be made.

When additional information is requested, the claimant will have up to 45 days to provide such information to the Benefits Fund Office. When a request for additional information is made, the measurement of the time elapsed while processing the claim is frozen.

A Pre-Service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care.

- (C) Post-Service Claims. The Fund will adjudicate a Post-Service claim within 30 days of the date the claim is received at the Benefits Fund

Office. If additional time or information is required, the claimant will be notified a decision will be delayed by no more than 15 days.

If additional information is required from the claimant, the claimant will be so notified and will have up to 45 days to provide such information to the Benefits Fund Office. When a request for additional information is made, the measurement of the time elapsed while processing the claim is frozen.

- (D) **Concurrent Care Claims.** Any request by a claimant to extend the duration or number of treatments previously approved and later reduced or terminated is a Concurrent Care claim. The Plan will inform the claimant of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim, if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. The claimant may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve Urgent Care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., Pre-Service or Post-Service).

- (ii) **Income Protection Claims.** A claim for Income Protection will be adjudicated within 45 days of the date the initial claim was received. This time limit may be extended for up to two 30-day periods if the Fund Administrator determines that an extension is needed due to matters beyond the Fund's control. The claimant will be notified if an extension is needed and will be advised of the reason for the extension and the estimated date that a decision will be made.

If, during the review, additional information is required from the claimant, the claimant will be so notified, and the claimant will have 45 days to provide such information. When a request for additional information is made, the measurement of the time elapsed while processing the claim is frozen.

- (b) **Content of Denial Notice on a Claim.** If a claimant's claim is partially or wholly denied, he will receive notice from the Fund stating the specific reason(s) for the

denial including specific reference to the pertinent Plan provision on which the denial is based, describing any additional material or information required of the claimant in order to make the claimant's claim valid and explaining the procedure to be followed to have the claim denial reviewed (including a statement of the claimant's right to file suit under ERISA if an appeal is filed and denied). The notice will inform the claimant if the denial is based on a determination of Medical Necessity or experimental treatment or similar exclusion, and provide the scientific or clinical judgment for the determination or include a statement that the information will be provided upon request. The notice will also inform the claimant if an internal rule, guideline, protocol or other similar criterion was relied upon or include a statement that this information will be provided upon request. An Urgent Care claim will include a description of the expedited appeal process available. The Benefits Fund Office may first provide this orally and then subsequently provide to the claimant in writing.

- (c) Appeal of Denied Claim. If a claimant wants to have the denied claim reviewed, a written request for a review of the claim denial must be sent to the Fund Administrator no later than one year from the date of the notice of denial. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue.
- (d) Filing an Appeal of a Benefit Determination.
 - (i) Full and Fair Review. A claimant has the right to a full and fair review if a claim is denied in whole or in part by the Plan. The review will be conducted by a fiduciary of the Fund who was not involved in the initial decision (and is not a subordinate of the person who made the decision) and will not give deference to the initial decision. If the denial was based on a medical judgment, the fiduciary will consult with a medical professional who has training and experience in the appropriate medical field and who was not involved in the initial decision (and is not a subordinate of the person involved). The fiduciary will identify any medical or vocational experts who were consulted regarding the appeal.
 - (ii) How to File an Appeal. If a claimant wants to have a denied claim reviewed, an appeal must be filed in writing to the Fund Administrator within one year of the denial of the claim. To be considered an appeal, the claimant must file a written request for a review of a specific claim and

state the reason for disagreement with the benefit determination. The Fund will review all information submitted with the appeal, whether or not it was considered in the initial decision.

An appeal may be submitted by the Plan Participant or spouse; the covered Dependent (correspondence will be directed to the Participant); the provider of services if benefits are assigned to them by the patient (correspondence will be directed to the Participant with copies to the provider); or an Authorized Representative (see section 5.13(h)).

(e) Time Requirements for Appeal Response.

- (i) Pre-Service Appeals. Pre-Service Appeals are defined as appeals concerning the denial, in whole or in part, of expenses for services or supplies that have not yet been received by the claimant or billed to the Fund.

Within 15 days of receipt of the appeal, the Fund Administrative Manager will review all information submitted with the letter of appeal, as well as any additional information that may be reasonably obtained. If the Fund Administrative Manager's decision is favorable to the claimant, a letter will be sent to the claimant advising of the decision. If the Fund Administrative Manager's decision is to continue to deny the expenses for the services or supplies, in whole or in part, the appeal will be referred to the Appeal Committee of the Board of Trustees. The claimant will receive a written notice of the Appeal Committee's decision within 30 days of receipt of the pre-service appeal. The Appeal Committee's decision will be the final administrative remedy.

For Urgent Care Claims, the review may be expedited. Under an expedited review, a claimant may submit a request for review orally or in writing and all necessary information will be transmitted by telephone, facsimile or another expeditious method. A claimant will be notified as soon as possible of the decision, but no later than 72 hours after the appeal is received.

- (ii) Post-Service Claim Appeals. Post-Service Appeals are defined as appeals concerning expenses already processed and denied in whole or in part by the Fund.

All Post-Service Appeals are reviewed by the Appeal Committee of the Board of Trustees at its quarterly meeting. Prior to the quarterly meeting, the Fund Administrative Manager will issue an advisory notice to the claimant which will provide an analysis of the additional information that has been submitted with the appeal. Following the receipt of the advisory notice, the claimant may provide additional information or justification to the Fund in support of the claim. The Appeal Committee and the Fund Administrative Manager will review the information that was submitted with the letter of appeal as well as any additional information that is provided by the claimant in response to the advisory notice and any other information that may be reasonably obtained, and issue a written decision to the claimant within five days after the decision is made. The Appeal Committee's decision is the final administrative remedy.

Note that if, prior to the quarterly meeting, the Fund Administrative Manager determines that benefits should be paid on behalf of the claimant based on the additional information submitted with the appeal, a favorable decision for the claimant will be made. This favorable decision will be reported in writing to both the claimant and the Appeal Committee.

- (iii) Income Protection Claim Appeals (Weekly Disability). All Income Protection Claim Appeals are reviewed by the Appeal Committee of the Board of Trustees at its quarterly meeting. Prior to the quarterly meeting, the Fund Administrative Manager will issue an advisory notice to the claimant which will provide an analysis of the additional information that has been submitted with the appeal. Following the receipt of the advisory notice, the claimant may provide additional information or justification to the Fund in support of the claim. The Appeal Committee and the Fund Administrative Manager will review the information that was submitted with the letter of appeal as well as any additional information that is provided by the claimant in response to the advisory notice and any other information that may be reasonably obtained, and issue a written decision to the claimant within five days after the decision is made. The Appeals Committee's decision is the final administrative remedy.

Note that if, prior to the quarterly meeting, the Fund Administrative Manager determines that benefits should be paid on behalf of the claimant

based on the additional information submitted with the appeal, a favorable decision for the claimant will be made. This favorable decision will be reported in writing to both the claimant and the Appeal Committee.

- (iv) Medical Experts. Reviews will include examination of the claim material by qualified medical experts, when appropriate.
- (f) Notification of Appeal Response. The claimant will be given written notification of the decision on the appeal. If the appeal is denied, the notification will include the following information:
 - (i) the specific reason for the denial, including a reference to the specific Plan provision on which the denial is based;
 - (ii) a statement that the claimant is entitled, upon request and free of charge, to copies of all documents, records and other information relevant to the claim;
 - (iii) a statement of the claimant's right to file suit under ERISA if the appeal is denied;
 - (iv) any internal rule, guideline, protocol or other similar criterion that was used in denying the appeal, or a statement that this information is available upon request;
 - (v) an explanation of any scientific or clinical judgment for the denial decision, if it was based on a medical necessity, experimental treatment or other exclusion or limit, or a statement that this information will be provided on request.

A decision shall be made by the Appeals Committee within the period of time allowed by law. The Participant shall be advised in writing of the Committee's decision, and this decision shall be final and binding on all parties and no further appeal shall be available through either the Benefits Fund Office or the Board of Trustees.

- (g) Right to File a Lawsuit. A claimant has the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) following the denial of a claim on appeal by the Appeal Committee. A claimant must exhaust his or her administrative remedies before filing a lawsuit.

- (h) **Authorized Representative.** A participant or legal guardian may authorize another individual or entity to act on his or her behalf to submit a claim and/or an appeal. To establish that a person is an Authorized Representative, written notification must be sent to the Benefits Fund Office on a form provided by the Fund and available on request. Once established, an Authorized Representative may only be dismissed in writing by the participant.

An Authorized Representative does not need to be appointed to receive occasional verbal assistance from the Fund on matters that are not considered a claim or an appeal. An example of this is the use of a translator or a non-claimant family member to assist a participant in obtaining or understanding information. The Fund will not divulge personal employment or health information when dealing with an informal representative.

- (i) **Further Action.** In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with the claims appeal provisions set forth in this section. All decisions of the Trustees will be final and binding on the Plan, the Participant and all other interested parties.

Section 5.14. Physical Examination.

The Plan reserves the right to have the Eligible Employee and Eligible Dependent examined, at the Plan's own expense, as often as is reasonably necessary while a claim is pending.

Section 5.15. Gender.

Except as the context may specifically require otherwise, use of the masculine gender shall be understood to include both masculine and feminine genders.

Section 5.16. Maximum Amount.

For any Eligible Employee and Eligible Dependent, whether or not there has been an interruption in the continuity of his coverage, the maximum amount of benefits available at any time shall be equal to the amount by which the maximum amount exceeds the sum of the benefits previously payable on his account.

Section 5.17. Severability Clause.

If any provision of the Plan or any amendment made to the Plan is determined or judged

to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Plan.

ARTICLE 6 — SCHEDULE OF BENEFITS

With regard to In-Network services, percentage refers to percentage of Preferred Provider Option's negotiated fee schedule.

With regard to Out-of-Network and Out-of-Area services, percentage refers to percentage of Usual and Customary charges.

Section 6.1. Plan Classification D5-Tier A.

Eligible Employees and Eligible Dependents, except as indicated

Life Insurance Benefit—Employee	\$15,000
Accidental Death and Dismemberment Insurance Benefit—Employee (Principal Sum)....	\$7,500
Life Insurance Benefit—Dependent	
Spouse	\$2,500
Children 15 days but less than 1 year	\$100
Children 1 year but less than 18 years	\$2,500

The above benefits are currently insured.

Income Protection Benefit—Employee	
Maximum Amount	55% of weekly Earnings but not to exceed \$250 per week
Maximum Period	26 weeks
Date Benefits start.....	First day Accident First day Hospital confined First day Outpatient Surgery Eighth day Sickness

Comprehensive Medical Expense Benefit	
Lifetime Maximum	\$1,000,000

Calendar Year Deductible:

Per Person	\$250
Maximum Per Family (3 persons must each satisfy Deductible).....	\$750

Non-PPO Deductible (applies to each Non-PPO Hospital confinement).....	\$350
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Non-Compliance Deductible (applies to each Hospital confinement, surgery, or advanced diagnostic testing for which Pre-Authorization is not obtained).....	\$100
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Percent of Covered Expenses Payable per Calendar Year:

In-Network Hospital	85%
Out-of-Network Hospital	65%
Out-of-Area or Emergency Hospital.....	80%
Surgery for which a Second Surgical Opinion is required but not obtained	50%
All other Surgery	80%
Designated Preferred Laboratory Testing (not subject to Deductible)	100%

Most other Covered Expenses.....	80%
Out-of-Pocket Maximum per Calendar Year	\$2,000 per person
Other Limitations	
Well Child Care (Dependent Child to Age 2)	
Percent of Covered Expenses Payable per Calendar Year (not subject to Deductible).....	100%
Lifetime Maximum	\$500
Preventive Care (Employees and Dependent Spouses)	
Percent of Covered Expenses Payable per Calendar Year:	
First \$50	100% not subject to Deductible
Expenses in Excess of \$50	80% after Deductible
Mammogram	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Maximum per Procedure	\$130
Expenses in Excess of \$130	80% after Deductible
Occupational Therapy	
Maximum per Calendar Year.....	\$2,500
Physical Therapy, Chiropractic Therapy, Prolo Therapy, Acupuncture	
Chiropractic Therapy Maximum per Calendar Year	\$1,500
Combined Maximum for all Therapy, including Chiropractic Therapy, per Calendar Year.....	\$2,500
Speech Therapy	
Maximum per Calendar Year.....	\$2,500
Cardiac Rehabilitation	
Maximum per Event	\$1,000
Oxygen, Outpatient or Portable	
Maximum per Calendar Year.....	\$500
plus one-time cost of an oxygen concentrator	
Home Health Care	
Maximum per Calendar Year.....	\$10,000
plus cost of durable medical equipment	
Mental and Nervous Disorder	
Percent of Covered Expenses Payable per Calendar Year:	
Inpatient Treatment	
In-Network	85%
Out-of-Network	65%
Out-of-Area or Emergency	80%
Maximum Days per Calendar Year.....	10
Outpatient	50%;
Maximum Visits per Calendar Year	20

Section 6.2. Plan Classification D5-Tier B.

Eligible Employees

Comprehensive Medical Expense Benefit	
Lifetime Maximum	\$150,000
Calendar Year Deductible	\$250
Non-PPO Deductible (applies to each Non-PPO Hospital confinement).....	\$350
Non-Compliance Deductible (applies to each Hospital confinement, surgery, or advanced diagnostic testing for which Pre-Authorization is not obtained).....	\$100
Percent of Covered Expenses Payable per Calendar Year:	
In-Network Hospital	85%
Out-of-Network Hospital	65%
Out-of-Area or Emergency Hospital.....	80%
Surgery for which a Second Surgical Opinion is required but not obtained	50%
All other Surgery	80%
Designated Preferred Laboratory Testing (not subject to Deductible)	100%
Most other Covered Expenses.....	80%
Out-of-Pocket Maximum per Calendar Year	\$2,000
Other Limitations	
Preventive Care	
Percent of Covered Expenses Payable per Calendar Year:	
First \$50	100% not subject to Deductible
Expenses in Excess of \$50.....	80% after Deductible
Mammogram	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Maximum per Procedure	\$130
Expenses in Excess of \$130	80% after Deductible
Occupational Therapy	
Maximum per Calendar Year.....	\$2,500
Physical Therapy, Chiropractic Therapy, Prolo Therapy, Acupuncture	
Chiropractic Therapy Maximum per Calendar Year	\$1,500
Combined Maximum for all Therapy, including Chiropractic Therapy, per Calendar Year.....	\$2,500
Speech Therapy	
Maximum per Calendar Year.....	\$2,500
Cardiac Rehabilitation	
Maximum per Event	\$1,000
Oxygen, Outpatient or Portable	
Maximum per Calendar Year.....	\$500

plus one-time cost of an oxygen concentrator

Home Health Care

Maximum per Calendar Year.....\$10,000
plus cost of durable medical equipment

Mental and Nervous Disorder

Percent of Covered Expenses Payable per Calendar Year:

Inpatient Treatment

In-Network 85%

Out-of-Network 65%

Out-of-Area or Emergency 80%

Maximum Days per Calendar Year..... 10

Outpatient 50%;

Maximum Visits per Calendar Year20

Substance Abuse

Lifetime Maximum\$5,000

Transplant

Maximum per Transplant.....\$100,000

Hearing Aid

Percent of Covered Expenses Payable 80%

Maximum per 5 consecutive year period\$500

Intentionally Destructive Injury (except suicide or attempted suicide)

Percent of Covered Expenses Payable 50%

Maximum per Event\$5,000

Pre-Existing Condition

Percent of Covered Expenses Payable 50%

Maximum Amount per Condition\$5,000

Hospital Charges for Dental Surgery

Percent of Covered Expenses Payable 50%

Maximum per Event\$5,000

Treatment of Varicose Veins (except ulcerated conditions)

Lifetime Maximum\$2,500 per leg

Voice Communication Machine

Lifetime Maximum\$7,500

Prescription Drug Benefit..... 100% after applicable Co-Pay
per prescription when filled through the Prescription Drug Benefit Program
at a Participating Pharmacy; up to \$1,500 maximum per Calendar Year
30-Day Supply: Co-pay for Tier Zero Drug\$0
Co-pay for Tier One Drug.....\$4
Co-pay for Tier Two Drug.....\$10
Co-pay for Tier Three Drug ..\$25
90-Day Supply: Co-pay for Tier Zero Drug\$0
Co-pay for Tier One Drug.....\$8
Co-pay for Tier Two Drug.....\$20

Section 6.3. Plan Classification DH.

Eligible Employees and Eligible Dependents, except as indicated

Life Insurance Benefit—Employee	\$15,000
Accidental Death and Dismemberment Insurance Benefit—Employee (Principal Sum)....	\$7,500
Life Insurance Benefit—Dependent	
Spouse	\$2,500
Children 15 days but less than 1 year	\$100
Children 1 year but less than 18 years	\$2,500

The above benefits are currently insured.

Income Protection Benefit—Employee	
Maximum Amount	55% of weekly Earnings but not to exceed \$250 per week
Maximum Period	26 weeks
Date Benefits start.....	First day Accident First day Hospital confined First day Outpatient Surgery Eighth day Sickness

Comprehensive Medical Expense Benefit	
Lifetime Maximum	\$1,000,000
Calendar Year Deductible:	
Per Person.....	\$200
Maximum Per Family (3 persons must each satisfy Deductible).....	\$600
Non-PPO Deductible (applies to each Non-PPO Hospital confinement).....	\$250
Hospital Deductible (applies to each Hospital confinement for which Pre-Authorization is not obtained).....	\$100
Percent of Covered Expenses Payable per Calendar Year:	
In-Network Hospital	90%
Out-of-Network Hospital	75%
Out-of-Area or Emergency Hospital.....	80%
Surgery for which a Second Surgical Opinion is required but not obtained	50%
All other Surgery	80%
Designated Preferred Laboratory Testing (not subject to Deductible)	100%
All other Covered Expenses	80%

Out-of-Pocket Maximum per Calendar Year\$1,500 per person

Other Limitations

Well Child Care (Dependent Child to Age 2)

Percent of Covered Expenses Payable per Calendar Year (not subject to Deductible).....	100%
Lifetime Maximum	\$500
Preventive Care (Employees and Dependent Spouses)	
Percent of Covered Expenses Payable per Calendar Year:	
First \$50	100% not subject to Deductible
Expenses in excess of \$50	80% after Deductible
Mammogram	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Maximum per procedure	\$130
Expenses in excess of \$130.....	80% after Deductible
Hearing Aid	
Percent of Covered Expenses Payable	80%
Maximum per 5 consecutive year period.....	\$500
Hospital Nursery	
Percent of Covered Expenses Payable	
In-Network Hospital.....	90%
Out-of-Network Hospital.....	75%
Out-of-Area or Emergency Hospital.....	80%
Chiropractic and Physical Therapy	
Maximum per Calendar Year.....	\$2,200
Occupational Therapy	
Maximum per Calendar Year.....	\$2,200
Intentionally Destructive Injury (except suicide or attempted suicide)	
Percent of Covered Expenses Payable	50%
Maximum per Event	\$5,000
Transplant	
Maximum per Transplant.....	\$100,000
Cardiac Rehabilitation	
Maximum per Event	\$1,000
Mental and Nervous Disorder	
Percent of Covered Expenses Payable per Calendar Year:	
Inpatient Treatment	
In-Network	90%
Out-of-Network	75%
Out-of-Area or Emergency	80%
Maximum Days per Calendar Year.....	10
Outpatient Psychotherapy.....	50%;
	20 visits per Calendar Year
Substance Abuse	
Lifetime Maximum	\$5,000

Sclerotherapy Treatment of Varicose Veins	
Lifetime Maximum	\$2,200 per leg
Hospital Charges for Dental Surgery	
Per Claim Maximum	\$5,000
Percent of Covered Expenses Payable	50%
Pre-Existing Condition	
Percent of Covered Expenses Payable	50%
Maximum Amount	\$5,000

Dental Benefit

Calendar Year Deductible	
Diagnostic and Palliative Treatment	None
All other covered Dental Charges	\$35
Percent of Charges Payable	100% of Scheduled Amount
Orthodontia and non-surgical treatment of TMJ	
Maximum per lifetime	\$1,000
Percent of Charges Payable	50%

Vision Benefit

Maximum per Calendar Year	\$150
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Prescription Drug Benefit.....	100% after applicable Co-Pay
	per prescription when filled through the Prescription Drug Benefit Program
	at a Participating Pharmacy; up to \$14,000 maximum per Calendar Year
30-Day Supply:	Co-pay for Tier Zero Drug\$0
	Co-pay for Tier One Drug.....\$4
	Co-pay for Tier Two Drug.....\$10
	Co-pay for Tier Three Drug ..\$25
90-Day Supply:	Co-pay for Tier Zero Drug\$0
	Co-pay for Tier One Drug.....\$8
	Co-pay for Tier Two Drug.....\$20
	Co-pay for Tier Three Drug ..\$50

Section 6.4. Plan Classification DM.

Eligible Employees and Eligible Dependents, as indicated

Life Insurance Benefit—Employee	\$15,000
Accidental Death and Dismemberment Insurance Benefit—Employee (Principal Sum)....	\$7,500
Life Insurance Benefit—Dependent of Full-time Employee Only	
Spouse	\$2,500
Children 15 days but less than 1 year	\$100
Children 1 year but less than 18 years	\$2,500

The above benefits are currently insured.

Income Protection Benefit—Full-time Employee Only

Maximum Amount	55% of weekly Earnings but not to exceed \$250 per week
Maximum Period	26 weeks
Date Benefits start.....	First day Accident First day Hospital confined First day Outpatient Surgery Eighth day Sickness

Comprehensive Medical Expense Benefit—Employee and Dependent of Full-time Employee
 Lifetime Maximum\$1,000,000

Calendar Year Deductible:	
Per Person.....	\$200
Maximum Per Family (3 persons must each satisfy Deductible).....	\$600

Non-PPO Deductible (applies to each Non-PPO Hospital confinement).....\$250

Hospital Deductible (applies to each Hospital confinement for which Pre-Authorization is not obtained).....\$100

Percent of Covered Expenses Payable per Calendar Year:	
In-Network Hospital	90%
Out-of-Network Hospital	85%
Out-of-Area or Emergency Hospital.....	85%
Surgery for which a Second Surgical Opinion is required but not obtained	50%
All other Surgery	85%
Designated Preferred Laboratory Testing (not subject to Deductible)	100%
All other Covered Expenses	85%

Out-of-Pocket Maximum per Calendar Year\$1,259

Other Limitations

Well Child Care (Dependent Child to Age 2)	
Percent of Covered Expenses Payable per Calendar Year (not subject to Deductible).....	100%
Lifetime Maximum	\$500

Preventive Care (Employees and Dependent Spouses)	
Percent of Covered Expenses Payable per Calendar Year:	
First \$50	100% not subject to Deductible
Expenses in excess of \$50	85% after Deductible

Mammogram	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Maximum per procedure	\$130
Expenses in excess of \$130.....	85% after Deductible

Hearing Aid	
Percent of Covered Expenses Payable.....	85%
Maximum per 5 consecutive year period.....	\$500

Non-Surgical Medical Treatment for Covered Expenses incurred outside a Hospital

Percent of Covered Expenses Payable per Calendar Year	
First \$100	100% not subject to Deductible
Expenses in excess of \$100	85% after Deductible
Hospital Nursery	
Percent of Covered Expenses Payable	
In-Network Hospital	90%
Out-of-Network Hospital	85%
Out-of-Area or Emergency Hospital	85%
Chiropractic and Physical Therapy	
Maximum per Calendar Year	\$2,200
Occupational Therapy	
Maximum per Calendar Year	\$2,200
Intentionally Destructive Injury (except suicide or attempted suicide)	
Percent of Covered Expenses Payable	50%
Maximum per Event	\$5,000
Transplant	
Maximum per Transplant	\$100,000
Cardiac Rehabilitation	
Maximum per Event	\$1,000
Pre-Admission and Pre-Surgery Testing	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Diagnostic X-ray and Laboratory Testing	
Percent of Covered Expenses Payable (not subject to Deductible)	100%
Maximum per Calendar Year	\$150
Percent of Covered Expenses Payable after \$150 and Deductible	85%
Mental and Nervous Disorder	
Percent of Covered Expenses Payable per Calendar Year	
Inpatient Treatment	
In-Network	90%
Out-of-Network	85%
Out-of-Area or Emergency	85%
Maximum Days per Calendar Year	10
Outpatient Psychotherapy	50%;
	20 visits per Calendar Year
Substance Abuse	
Lifetime Maximum	\$5,000
Sclerotherapy Treatment of Varicose Veins	
Lifetime Maximum	\$2,200 per leg
Hospital Charges for Dental Surgery	
Per Claim Maximum	\$5,000
Percent of Covered Expenses Payable	50%

Pre-Existing Condition
 Percent of Covered Expenses Payable 50%
 Maximum Amount\$5,000

Dental Benefit

Calendar Year Deductible
 Diagnostic and Palliative Treatment None
 All other covered Dental charges\$35
 Percent of Charges Payable 100% of Scheduled Amount
 Orthodontia and non-surgical treatment of TMJ
 Maximum per lifetime.....\$1,000
 Percent of Charges Payable 50%

Vision Benefit

Maximum per Calendar Year\$150

Prescription Drug Benefit..... 100% after applicable Co-Pay
 per prescription when filled through the Prescription Drug Benefit Program
 at a Participating Pharmacy; up to \$14,000 maximum per Calendar Year
 30-Day Supply: Co-pay for Tier Zero Drug\$0
 Co-pay for Tier One Drug.....\$4
 Co-pay for Tier Two Drug.....\$10
 Co-pay for Tier Three Drug ..\$25
 90-Day Supply: Co-pay for Tier Zero Drug\$0
 Co-pay for Tier One Drug.....\$8
 Co-pay for Tier Two Drug.....\$20
 Co-pay for Tier Three Drug ..\$50

ARTICLE 7 — UTILIZATION MANAGEMENT

Section 7.1. Inpatient Pre-Authorization.

The Eligible Employee or Eligible Dependent must contact Health Information Services at the Benefits Fund Office prior to a non-Emergency Hospital admission, within 48 hours of an Emergency Hospital admission or when an inpatient procedure or surgery is proposed. If the Eligible Employee or Eligible Dependent fails to comply with such requirements for pre-authorization, benefits shall be reduced or modified as follows:

- (a) An additional \$100 Deductible must be satisfied if Health Information Services at the Benefits Fund Office is not contacted two weeks prior to a scheduled Hospital admission or within 48 hours of an Emergency Hospital admission; and
- (b) Physician charges shall be payable at the lower percent specified in the Schedule of Benefits if the procedure or surgery required a Second Opinion, as described below, and the Second Opinion was not obtained.

Pre-authorization is required in order for the Eligible Employee or Eligible Dependent to receive reimbursement for expenses to the full extent provided in the Plan. Pre-authorization decisions are limited to whether expenses are covered for reimbursement under the Plan and if a Second Opinion is required. Pre-authorization does not constitute medical advice to the Eligible Employee or Eligible Dependent. Regardless of whether a particular expense is covered under the Plan, the Eligible Employee or Eligible Dependent remains free to decide, in consultation with the Physician of his choice, whether to undergo such treatment, and pre-authorization is not intended to interfere (and shall not be construed as interfering) with the Physician-patient relationship.

It is recommended that an Eligible Employee or Eligible Dependent contact the Benefits Fund Office before proceeding with advanced diagnostic testing such as MRI (magnetic resonance imaging) scans, CT (computerized tomography) scans, or Thallium stress tests, to learn in advance whether expenses for a proposed diagnostic test are covered under the Plan.

Section 7.2. Second Opinion.

A second independent medical examination and Physician's opinion is required for any non-Emergency procedure or surgery listed in the Required Second Opinion Review List in Appendix C. If the second medical opinion does not agree with the recommended procedure or surgery, then a third medical examination and opinion is also necessary.

If a Second Opinion is not obtained, all covered charges associated with the procedure

or surgery shall be payable at the lower percent specified in the Schedule of Benefits. If the majority of Physicians do not agree that the procedure or surgery is Medically Necessary or if a required third examination is not submitted to, no benefits will be payable.

In addition, the Second Opinion Requirements are satisfied only if:

- (a) the second and, if necessary, the third medical examination and opinion is given by a doctor of medicine or osteopathy who, as determined by the Trustees, is board certified in the appropriate medical specialty;
- (b) the patient is personally examined by the Physician giving the opinion;
- (c) the examining Physician provides the Benefits Fund Office with an independent, timely and complete written report of the medical examination, in addition to an explanation of the Physician's medical opinion as to whether or not the proposed procedure or surgery is Medically Necessary for the patient's immediate condition, and the Physician's recommendations for alternate treatment, if any, together with copies of any related diagnostic x-ray or test results; and
- (d) neither the examining Physician, nor anyone in the Physician's office or who is otherwise financially connected with the examining Physician, performs, or assists in the proposed or any alternate procedure or surgery, or otherwise treats the patient's immediate condition.

Usual and Customary expenses for required second and, if necessary, third independent medical examinations and opinions including pre-authorized necessary and appropriate x-rays and diagnostic tests which satisfy this provision will be considered Covered Expenses. The Fund may request that medical records be made available by the patient for the second opinion Physician.

It is recommended that the Eligible Employee or Eligible Dependent arrange these examinations through the Benefits Fund Office. The Fund reserves the right to select the second opinion Physician.

For certain medical conditions, after an examination of the patient's medical records or if it is determined that it is unsafe for the patient to travel and be examined, the Second Opinion requirements may be waived in writing by the Trustees prior to the proposed procedure or surgery being performed.

ARTICLE 8 — EMPLOYEE LIFE INSURANCE BENEFIT

Section 8.1. General.

Upon receipt of written proof of the death of an Eligible Employee, the Plan shall pay benefits as specified in the Schedule of Benefits.

Section 8.2. Benefits Payable.

This benefit is currently provided through a group insurance contract. The terms of this benefit are governed by the policy attached as Appendix B.

ARTICLE 9 — EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

Section 9.1. General.

If an Eligible Employee dies or suffers Injuries which result in any losses described in Appendix B, upon presentation of a proper claim, benefits will be paid as specified in the Schedule of Benefits.

Section 9.2. Benefits Payable.

This benefit is currently provided through a group insurance contract. The terms of this benefit are governed by the policy attached as Appendix B.

ARTICLE 10 — DEPENDENT LIFE INSURANCE BENEFIT

Section 10.1. General.

Upon receipt of written proof of the death of an Eligible Dependent, the Plan shall pay benefits as specified in the Schedule of Benefits.

Section 10.2. Benefits Payable.

This benefit is currently provided through a group insurance contract. The terms of this benefit are governed by the policy attached as Appendix B.

ARTICLE 11 — INCOME PROTECTION BENEFIT

Section 11.1. General.

Upon receipt of written proof that an Eligible Employee who is Actively Employed has become Totally Disabled as a result of a non-occupational Illness or Injury and requires the regular care of a Physician, which shall be determined according to the condition for which the Eligible Employee is being treated, the Eligible Employee shall receive a weekly benefit, subject to the provisions of this Article. Telephone consultations are not considered regular care of a Physician.

Section 11.2. Benefits Payable.

The weekly benefit shall be payable in the amount set forth in the Schedule of Benefits after any waiting period set forth in the Schedule of Benefits and up to the indicated maximum period.

During partial weeks of disability, the Eligible Employee shall be paid a daily rate of one-seventh of the weekly benefit amount set forth in the Schedule of Benefits.

Section 11.3. Periods of Disability.

Successive periods of disability due to Injuries received in an accident will be considered one period of disability. A period of disability that results from both an Injury and an Illness will be considered one period of disability.

Successive periods of disability shall be considered one period of disability unless:

- (a) between the periods of disability, the Eligible Employee has returned to Active Employment for at least four consecutive weeks; or
- (b) the disabilities are due to unrelated causes and begin after the Eligible Employee has returned to Active Employment for at least one day.

In no event will benefits be paid during any number of successive periods of disability any longer than a total aggregate period of:

- (a) up to one 26 week period as a result of any one accidental bodily Injury and related re-injuries within a 12-month period following the end of the initial convalescence, or
- (b) up to two 26 week periods as a result of any Illness contributed to by the same or

related illness unless acceptable evidence of good health establishing full and complete recovery is furnished.

Section 11.4. Exclusions and Limitations.

No benefits shall be payable under this Article for any:

- (a) disability resulting from illness or injury for which an Eligible Employee is not under the regular care of a Physician;
- (b) disability arising out of or in the course of any occupation, employment or self-employment; or for which the Eligible Employee has a right to payment under any Workers' Compensation law or occupational disease law; illness or loss for which the Eligible Employee is entitled to benefits or reimbursement under any motor vehicle insurance plan, insurance settlement, or any third party settlement or agreement;
- (c) disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment;
- (d) disability incurred by owner-operators, non-Employee operators, proprietors, owner-Employees, partners, commission-only Employees or non-bargaining unit Employees or any person participating on a voluntary basis; or
- (e) periods for which the Employee receives remuneration from any employer or any source for work or services performed.

ARTICLE 12 — COMPREHENSIVE MEDICAL EXPENSE BENEFIT

Section 12.1. General.

If an Eligible Employee or Eligible Dependent incurs Covered Medical Expenses as a result of a non-occupational Illness or Injury, payment will be made for the Covered Medical Expenses incurred, up to the maximum amounts specified in the Schedule of Benefits and according to the provisions of this Article.

Section 12.2. PPO Agreement.

The Fund has entered into an agreement with a Preferred Provider Option (PPO). Eligible Employees and Eligible Dependents may choose health care services provided by Hospitals which have negotiated agreements with the PPO. The Plan pays a higher percentage of the expenses when a PPO Hospital is used. Appendix E sets forth the agreement signed between the Fund and the PPO. Such agreement may be renegotiated from time to time.

Section 12.3. Benefits Payable.

Benefits are payable at the percentage specified in the Schedule of Benefits for Covered Medical Expenses after any applicable Deductible has been satisfied.

Benefits payable under this Article shall not exceed the lifetime maximum specified in the Schedule of Benefits.

Section 12.4. Deductible Amounts.

(a) Calendar Year Deductible

The Calendar Year Deductible is the amount specified in the Schedule of Benefits of Covered Medical Expense the Eligible Employee or Eligible Dependent pays before he is entitled to certain Comprehensive Medical Benefits.

When a family has satisfied the Calendar Year Family Deductible, as specified in the Schedule of Benefits, no further Deductible will be required for Covered Medical Expenses incurred thereafter in that Calendar Year.

The Calendar Year Deductible applies only once in any Calendar Year though the Eligible Employee or Eligible Dependent may have several different Injuries or Illnesses. Any Plan DM expenses applied against the Deductible in the last three months of the 1998 Calendar Year may also be applied against the

Deductible for the 1999 Calendar Year. Thereafter, only expenses incurred in a Calendar Year may be applied against the Deductible for that Calendar Year.

(b) Hospital Deductible

The Hospital Deductible is the amount specified in the Schedule of Benefits of inpatient Hospital expense the Eligible Employee or Eligible Dependent must pay for each Hospital Confinement which is not pre-authorized.

(c) Non-PPO Hospital Deductible

The Non-PPO Hospital Deductible is the amount specified in the Schedule of Benefits of inpatient non-PPO Hospital expense the Eligible Employee or Eligible Dependent must pay for each Confinement in a non-PPO Hospital. It does not apply to Emergency Confinements.

Section 12.5. Out-of-Pocket Maximum.

Once an Eligible Employee or Eligible Dependent has incurred, during a Calendar Year, the applicable amount specified in the Schedule of Benefits of Out-of-Pocket expense (which includes satisfaction of the Calendar Year Deductible and the Participant's co-pay), the Plan shall pay, subject to all applicable limitations and provisions, 100% of all of the Covered Medical Expenses which are incurred by that Eligible Employee or Eligible Dependent for the remainder of that Calendar Year, subject to the exclusions specified in the paragraph below.

Out-of-Pocket expenses payable by an Eligible Employee or Eligible Dependent for the following shall not apply toward satisfaction of the Out-of-Pocket Maximum:

- (a) amounts paid for failure to pre-authorize a Hospital Confinement (Hospital Deductible);
- (b) amounts paid to satisfy Non-PPO Hospital Deductible; or
- (c) amounts paid for Covered Medical Expenses which are reimbursed by the Plan at 50%; or
- (d) amounts paid for expenses which are not Covered Medical Expenses.

Section 12.6. Maximum Benefit.

The overall maximum lifetime benefit payable under this Article for all Covered Medical Expenses incurred by an Eligible Employee or Eligible Dependent due to all Injuries or

Illnesses is specified in the Schedule of Benefits. Benefits for certain Covered Medical Expenses are subject to annual, per condition or lifetime limits, as specified in the Schedule of Benefits. Once the Plan has paid the annual, per condition or lifetime benefit for any of these services and supplies, no further benefits are payable, even though the overall lifetime maximum has not been reached.

Section 12.7. Pre-Existing Conditions.

- (a) Prior to December 1, 1999, Payment for Covered Medical Expenses incurred for a Pre-Existing Condition will be made at 50% up to a maximum of \$5,000, until the earliest date below:
 - (i) 180 days (90 days for Plan DM) has passed from the last date care or treatment was given to the Eligible Employee or Eligible Dependent for the Illness or Injury (including pregnancy); or
 - (ii) the date on which the Eligible Employee has been covered under this Plan for two consecutive years.

- (b) Effective December 1, 1999, payment for Covered Medical Expenses incurred for a Pre-Existing Condition will be made at 50% up to a maximum of \$5,000, until the earliest date below:
 - (i) 180 days (90 days for Plan DM) after the last time care or treatment was given for the Illness or Injury; or
 - (ii) when the Eligible Employee or Eligible Dependent has been covered under this Plan for 12 consecutive months.

This provision does not apply to a newborn or adopted child under the age of 18 years who became covered under this Plan within 30 days of birth or adoption. This provision does not apply to pregnancy.

However, any period during which benefits for a Pre-Existing Condition would otherwise be excluded or limited will be reduced by the length of the Eligible Employee or Eligible Dependent's Creditable Coverage, provided there has not been a Break-in-Coverage, and the Eligible Employee or Eligible Dependent provides a Certificate of Creditable Coverage.

In applying creditable coverage, this Plan may rely on a Certificate of Creditable Coverage produced by the prior plan, insurance company, or other provider of coverage. A covered person has the right to receive a Certificate of Creditable Coverage from the

individual's prior plan, insurance company, or other provider of coverage. If necessary, this Plan will assist the individual in obtaining a Certificate of Creditable Coverage. If, after due efforts, it becomes apparent that a Certificate of Creditable Coverage is unavailable, the Plan shall take into account relevant facts and circumstances to determine whether that individual has Creditable Coverage.

A covered person who wishes to appeal an adverse determination of his or her Creditable Coverage by the Plan may appeal the determination by following the procedures outlined in Section 5.13.

Section 12.8. Covered Medical Expenses.

Covered Medical Expenses are the Usual and Customary Charges actually incurred by an Eligible Employee or Eligible Dependent upon the recommendation or approval of the attending Physician for services and supplies which are Medically Necessary and which are required for treatment of the Eligible Employee or Eligible Dependent as a result of a non-occupational accidental bodily Illness or Injury and for which benefits are payable under this Comprehensive Medical Expense Benefit in accordance with all applicable limitations and exclusions.

Covered Medical Expenses under this Comprehensive Medical Expense Benefit include the actual Usual and Customary Charges incurred for the services and supplies listed below:

- (a) Hospital expenses as follows:
 - (i) Hospital room and board charges up to the standard daily rate for a semi-private room;
 - (ii) specialty care unit charges (e.g., intensive care unit, cardiac care unit);
 - (iii) other services and supplies furnished by a Hospital; and
 - (iv) emergency room charges.

Payment for a Hospital confinement for dental surgery will be limited as shown in the Schedule of Benefits. Payment will only be made if the confinement is pre-authorized in writing by the Benefits Fund Office.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a

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

- (b) Physician's professional medical and surgical services as follows:
 - (i) Hospital, office and home visits;
 - (ii) emergency room services;
 - (iii) services for surgical procedures.
 - (iv) reconstructive surgery for the following:
 - (A) to correct damage caused by a congenital birth defect, developmental abnormality, infection, tumor, disease or trauma.
 - (B) to remove scar tissue on the neck, face or head.
 - (C) under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstruction surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of an Eligible Employee or Eligible Dependent who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:
 - (1) reconstruction of the breast on which the mastectomy was performed;
 - (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (3) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

- (c) services of a registered nurse. Payment will be limited to the dollar amount or period of care pre-authorized in writing by the Benefits Fund Office;
- (d) medical supplies, surgical dressings, casts, splints, trusses, braces, and crutches;
- (e) up to two pairs of surgical stockings each Calendar Year;
- (f) for one wig, per lifetime, payable to a maximum of \$150;
- (g) anesthetics and their administration, blood and blood plasma and its administration, oxygen and the rental of equipment for the administration of oxygen;
- (h) x-ray and laboratory examinations and x-ray, radium and radioactive isotope therapy;
- (i) confinement in a Skilled Nursing Facility if the confinement meets the following conditions:
 - (i) is pre-authorized in writing by the Benefits Fund Office with respect to both duration of benefits and daily maximum and is determined by the Benefits Fund Office to be less costly than a Hospital Confinement,
 - (ii) is approved and monitored by a Physician, and
 - (iii) immediately follows a Hospital Confinement due to the same cause.

Payment will be limited to the expenses which are pre-authorized.

- (j) charges for Hospice care made by a Hospice only if:
 - (i) the expense is incurred by an Eligible Employee or Eligible Dependent diagnosed by a Physician as terminally ill with a prognosis of six months or less to live; and
 - (ii) the Hospice provides a plan of care which:
 - (A) is prescribed by the Physician;

- (B) is reviewed and approved by the Physician on a monthly basis, or more frequently, if requested by the Plan during inpatient confinement;
- (C) is not for any curative treatment;
- (D) states the belief of the Physician and the Hospice that the Hospice care will cost less in total than any comparable alternative to Hospice care; and
- (E) is pre-authorized by the Benefits Fund Office.

Hospice care may be provided:

- (i) in the patient's home by a Home Health Agency or Hospice agency; or
- (ii) in a Hospice inpatient facility. Charges by a Hospice inpatient facility which exceed 80% of the average Hospital semi-private room daily rate in the geographical area in which the Hospice inpatient facility is located are not covered.

Hospice care includes palliative and supportive medical and nursing services. For such Hospice care, the Plan requirement that expenses will be covered only when incurred for diagnosis or treatment of an Illness or Injury will not apply.

- (k) charges for Home Health Care made by a Home Health Care Agency, provided that the plan of care by the Home Health Care Agency:
 - (i) is prescribed by a Physician;
 - (ii) is reviewed and approved by the Physician during the entire period;

and that expenses for the Plan of Care are pre-authorized by the Benefits Fund Office based on the following requirements:

- (i) the number of days of Home Health Care does not exceed the number of days of confinement in a Hospital or Skilled Nursing Facility which would otherwise have been required.
- (ii) the Home Health Care will probably cost less per day than the daily rate for Confinement in a Hospital or Skilled Nursing Facility; and

- (iii) confinement in a Hospital or Skilled Nursing Facility would otherwise be required.

Home Health Care includes:

- (i) skilled nursing care; and
 - (ii) any other services and supplies provided in lieu of the services which would have been covered under the Plan if the Eligible Employee or Eligible Dependent was confined in a Hospital or Skilled Nursing Facility. Home Health Care does not include housekeeping, Custodial Care or home health aide services.
- (l) drugs or medicines which are administered while an inpatient or during a home health or hospice visit.
 - (m) varicose vein treatment expenses as specified in the Schedule of Benefits.
 - (n) Substance Abuse treatment expenses as specified in the Schedule of Benefits.
 - (o) Mental and Nervous Disorder treatment expenses as specified in the Schedule of Benefits;
 - (p) chiropractic care expenses for the treatment of the back, neck, spine and vertebra, for conditions due to submission strains, sprains and nerve root problems, as specified in the Schedule of Benefits.
 - (q) osteopathic manipulation, physiotherapy, acupuncture and physical medicine services ordered by a qualified Physician. Payment will be limited to the Calendar Year maximum specified in the Schedule of Benefits.
 - (r) accidental Injuries to oral/facial structures including, but not limited to, jaw and facial bone fractures and Injury to Sound and Natural Teeth;
 - (s) transplant expenses as specified in the Schedule of Benefits. No benefits are payable for donor-related expenses.
 - (t) mammogram expenses. Payment will be made as specified in the Schedule of Benefits for one test performed between age 35 and 39 and annually beginning at age 40.
 - (u) preventive care expenses for Eligible Employees and Eligible Dependent

spouses. Payment will be made as specified in the Schedule of Benefits for the following:

- (i) Physician's charges for a routine annual physical exam;
 - (ii) an annual PAP test;
 - (iii) blood tests commensurate with the patient's gender, age, and family or social history as approved by the Fund Administrator in consultation with the Fund's Medical Consultant;
 - (iv) colon cancer testing for patients age 50 or older;
 - (v) Prostatic Specific Antigen (PSA) blood test.
 - (vi) bone density scanning for patients age 45 or older
- (v) medical transportation service expenses, as follows:
- (i) ground transportation by professional ambulance to the nearest appropriate facility as Medically Necessary for the treatment of a medical Emergency, acute Illness or Injury;
 - (ii) air ambulance transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient.
 - (iii) ground transportation by professional ambulance for inter health care facility transfer or hospice transfer, including hospice at home for a terminally-ill patient, ("convenience transfers") up to \$300 per trip.
- (w) durable medical equipment. Durable medical equipment is equipment which meets all of the following:
- (i) is for repeated use and is not a consumable or disposable item.
 - (ii) is used primarily for a medical purpose.
 - (iii) is appropriate for use in the home.

Covered Expenses for rental equipment will not exceed the allowable purchase price, except for the cost of a trial period of rental, for the equipment.

Payment for replacement of obsolete durable medical equipment may be covered after five years of continuous use.

Equipment parts which wear out in less than five years may be replaced, as determined by the Trustees. No payment will be made for operating supplies, repairs, or portable oxygen in excess of one tank when an oxygen concentrator is leased or purchased.

- (x) orthotic appliances. Payment will be made for the initial appliance and, after five years, one replacement for each five years of continuous use.
- (y) prosthetic appliances. Payment will be made for the initial appliance and, after five years, one replacement for each five years of continuous use for:
 - (i) artificial limbs and eyes.
 - (ii) external breast prosthesis.
 - (iii) internal breast prosthesis (implant).
 - (iv) cataract or corneal transplants.
 - (v) penile implant, limited to one per lifetime.
- (z) speech therapy to restore speech lost or impaired due to an accidental illness or injury or to correct congenital defects in newborns covered under this Plan.
- (aa) occupational therapy. Payment will be limited to the Calendar Year maximum specified in the Schedule of Benefits.
- (bb) cardiac rehabilitative services for Eligible Employees or Eligible Dependents who have had cardiac surgery or a heart attack. Payment will be made as specified in the Schedule of Benefits for the following:
 - (i) pre-program lab and diagnostic testing
 - (ii) education and exercise classes.
- (cc) hearing aid expenses as specified in the Schedule of Benefits.
- (dd) short term, active, progressive rehabilitation services, if pre-authorized by the Benefits Fund Office, that are needed to restore physical ability that has been substantially reduced due to severe illness or injury.

(ee) well child care expenses for an Eligible Dependent child under age two years, as follows:

- (i) outpatient newborn and well child visits.
- (ii) routine childhood immunizations.

Payment will be limited to the maximum specified in the Schedule of Benefits.

(ff) voice communication machine. Payment will be limited to the lifetime maximum specified in the Schedule of Benefits.

(gg) obesity surgery if pre-authorized by the Benefits Fund Office and provided that all of the following conditions are met:

- (i) The patient has a Body Mass Index (BMI) of 50 or greater, has achieved adult height, is older than age 18, and has no medical or psychiatric contraindication to undergoing bariatric surgery.
- (ii) The patient has undergone a medically-supervised weight-loss program acceptable to the Board of Trustees. The program must include physician supervision for a period of not less than six months and concurrent evaluation and treatment by a registered dietician (R.D.). The supervising physician must not perform bariatric surgery.
- (iii) The patient has been evaluated by a mental health professional skilled in the evaluation and treatment of persons with morbid obesity, and, if appropriate, has received treatment for behavioral or psychiatric co-morbid conditions. Documentation of all evaluations and treatment must be available for review by the Benefits Fund Office.

Once the above conditions have been met, the surgery must be provided by a board-certified surgeon experienced in the treatment of bariatric surgical patients and be performed at a facility acceptable to the Board of Trustees and the Fund Administrator.

Section 12.9. Smoking Cessation Program.

An Eligible Employee or Eligible Dependent spouse who completes the Plan's Smoking Cessation Program through the American Cancer Society or other designated service provider, may have his or her Deductible waived for the next following Calendar Year. A case

management nurse at the Benefits Fund Office shall make a determination as to which individuals are candidates for such a program and may offer the waiver of the Deductible as an incentive for the individual to complete the Smoking Cessation Program.

ARTICLE 13 — PRESCRIPTION DRUG BENEFIT

Section 13.1. General.

If an Eligible Employee or Eligible Dependent incurs expenses for Prescription Drugs, the Plan shall pay benefits as specified in the Schedule of Benefits and according to the provisions of this Article.

Section 13.2. Benefits Payable.

The Fund has entered into an agreement with a pharmacy benefit manger which has agreements with certain pharmacies, called participating pharmacies, to fill prescriptions at discounted rates.

When prescriptions are filled at participating pharmacies, the Plan will pay the discounted rate for Prescription Drugs after the applicable Co-pay specified in the Schedule of Benefits has been satisfied. Payment will be limited to the Calendar Year maximum specified in the Schedule of Benefits.

The Board of Trustees has established the Co-pays shown in the Schedule of Benefits and may modify the co-pays based on the following criteria:

Tier Zero. Drugs for which significant clinical rationale and cost efficacy exist to allow availability with no co-payment when prescribed by the appropriately licensed physician according to Plan utilization and medical appropriateness guidelines.

Tier One. Most generic drugs with the exception of certain higher-cost medications which usually will have appropriate acceptable clinical alternatives for most patients.

Tier Two. Most brand-name drugs with the exception of certain higher-cost medications, many of which have acceptable Tier Zero or Tier One alternatives.

Tier Three: Medications which have either limited therapeutic applications, are higher in cost, or which generally have acceptable clinical alternatives in Tier Zero, Tier One or Tier Two.

When prescriptions are filled at non-participating pharmacies, or when the Prescription Drug Benefit Identification Card is not used at a participating pharmacy, the Plan will pay the amount it would have paid had the prescription been filled using the Identification Card at a

participating pharmacy, less the applicable Co-pay. The Eligible Employee or Eligible Dependent shall be responsible for paying any balance remaining.

Section 13.3. Covered Prescription Drug Expenses.

The following supplies, authorized by a Physician, will be considered Covered Prescription Drug Expenses:

- (a) Legend Drugs which are lawfully obtainable only from an individual licensed to dispense drugs upon the prescription of a Physician;
- (b) injectable insulin;
- (c) needles and syringes to administer injectable insulin up to a maximum of a 90-unit supply per 30 days;
- (d) needles and syringes for any other use, up to a 30-day supply;
- (e) blood glucose testing strips; and
- (f) certain approved over-the-counter drugs when prescribed by a Physician.

Section 13.4. Exclusions and Limitations.

No benefits shall be payable under this Article for expenses for:

- (a) research drugs
- (b) non-Legend or over-the-counter drugs except as otherwise specifically noted
- (c) drugs dispensed for use by the Eligible Employee or Eligible Dependent when Medically Confined
- (d) oral contraceptives or implanted drugs or devices, regardless of intended use
- (e) drugs used for smoking cessation including Nicorette and nicotine transdermal patches
- (f) drugs used as an aid to weight loss
- (g) drugs which require approval by the Benefits Fund Office prior to dispensing when such prior approval has not been obtained
- (h) drugs that are intended to promote fertility

- (i) non-drug items, including but not limited to, nutritional supplements, regardless of intended use
- (j) more than a 30-day supply of a drug, except as shown below. These drugs may be dispensed in a 90-day supply:
 - (i) anti-asthmatic drugs and Inhalers
 - (ii) anti-convulsant drugs
 - (iii) anti-gout drugs
 - (iv) anti-hypertensive drugs
 - (v) anti-lipidemic drugs
 - (vi) anti-parkinson drugs
 - (vii) cardiovascular drugs
 - (viii) estrogen supplements
 - (ix) fluoride supplements (prescription-only supplements)
 - (x) methazolamide (Neptazine)
 - (xi) hypoglycemic drugs
 - (xii) Pentoxifylline (Trental)
 - (xiii) potassium supplements (prescription-only supplements)
 - (xiv) pre-natal vitamins (prescription-only vitamins)
 - (xv) Propylthiouracil
 - (xvi) thyroid Supplements
 - (xvii) blood glucose strips
 - (xviii) other drugs determined by the Plan's pharmacy benefit manager to be primarily prescribed for maintenance of a chronic condition
- (k) any prescription or refill for which the pharmacist's usual and customary charge

- to the public is less than the deductible amount payable by an Eligible Employee or Eligible Dependent
- (l) Experimental drugs, drugs intended for Experimental treatment as determined by the Trustees, or drugs not approved by the U.S. Food and Drug Administration for the condition, dose, rate or frequency prescribed
 - (m) any drug charges which exceed the Maximum Prescription Drug Benefit as specified in the Schedule of Benefits
 - (n) any drugs for which an acceptable, Medically-Necessary reason for continued long-term drug usage has not been established; or which are not covered or are excluded because of their intended use including, but not limited to, drugs used for cosmetic purposes such as “Retin-A” or, in the opinion of the Trustees, because of their potential abuse
 - (o) drugs (except Lupron) consumed at the time and place of prescription
 - (p) drugs in excess of the quantity specified in the prescription order
 - (q) drugs which will be covered by any Workers’ Compensation law, Medicare, or similar governmental program, or any other prescription program or group plan unless prohibited by federal law
 - (r) prescription orders or refills filled outside the United States, except for Emergencies
 - (s) drugs intended for any purpose other than the manufacturer’s published use, as specifically approved by the U.S. Food and Drug Administration (FDA), or drugs prescribed in quantities in excess of the dosage recommended by the manufacturer
 - (t) drugs to promote hair growth
 - (u) vitamins, except prescription pre-natal vitamins
 - (v) the difference in cost when a generic drug is available and medically appropriate but a brand-name drug is requested by an Eligible Employee or Eligible Dependent
 - (w) appliances and devices

- (x) blood and blood plasma, immunization agents and biological sera
- (y) erectile dysfunction drugs in excess of six tablets per 30-days
- (z) lancets
- (aa) lifestyle drugs
- (bb) Aciphex
- (cc) Ambien CR
- (dd) Axid and its generic, Nizatidine
- (ee) Cipro CR
- (ff) Clarinex
- (gg) Daytrana
- (hh) Exubera
- (ii) Fluoxetine tablets
- (jj) Ketek
- (kk) Lamisil
- (ll) Omeprazole
- (mm) Paxil CR
- (nn) Prescription Prilosec
- (oo) Ranitidine capsules
- (pp) Serafam
- (qq) Singular, unless used solely for the treatment of asthma
- (rr) Wellbutrin XL
- (ss) Xanax XR
- (tt) Zegerid

(uu) Zmax

Section 13.5. Prescription Drug Benefit Identification Card.

An Eligible Employee is responsible for any erroneous payments made as a result of misuse of the Prescription Drug Benefit Identification Card and must reimburse the Fund for any overpayment of benefits. The Board of Trustees authorizes the Fund Administrator, in consultation with the Fund's Medical Consultant, to deny the use of the Identification Card to any Eligible Employee or Eligible Dependent who has abused or allowed the misuse of the benefit in any way.

ARTICLE 14 — DENTAL EXPENSE BENEFIT

Section 14.1. General.

If an Eligible Employee or Eligible Dependent incurs Covered Dental Expenses for services performed by a licensed Dentist or licensed dental hygienist which are usual and customary as determined by the standards of generally accepted dental practice, payment will be made for the Covered Dental Expenses incurred, up to the maximum amounts specified in the Schedule of Dental Procedures and the Schedule of Benefits and according to the provisions of this Article.

Section 14.2. Benefits Payable.

Benefits are payable in the amount specified in the Schedule of Dental Procedures for Covered Dental Expenses incurred for dental care or treatment after any applicable Deductible is satisfied.

The Dental Deductible is specified in the Schedule of Benefits. The Deductible does not apply to any procedure listed in the “Diagnostic and Palliative Treatment” section of the Schedule of Dental Procedures nor to orthodontic expenses.

Section 14.3. Covered Dental Expenses.

Covered Dental Expenses include only the charges for services and supplies listed in the Schedule of Dental Procedures shown in Appendix D which:

- (a) are authorized by a Dentist;
- (b) are of the usual type furnished for the purpose; and
- (c) are performed by a Dentist, orthodontist or dental hygienist.

Section 14.4. Alternate Course of Treatment.

Expenses incurred for an alternate method of treating a dental condition shall be payable at the customary rate for the service that is:

- (a) most commonly used nationwide in the treatment of that condition; and
- (b) recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.

If an expense is incurred for a more expensive alternate treatment than that indicated in

the foregoing guidelines, payment will be limited to no more than the amount that would have been paid had the procedures indicated in the guidelines been followed.

Section 14.5. Pre-Treatment Estimates.

Whenever it is anticipated that dental expenses for a course of treatment will be more than \$500, an Eligible Employee or Eligible Dependent may obtain a pretreatment estimate. A regular dental claim form, available from the Benefits Fund Office, indicating the type of work to be performed with the estimated cost should be completed. Once it is received, the Benefits Fund Office will review the form and then send a statement to the Eligible Employee or Eligible Dependent and Dentist showing what the Plan will pay. Issuance of a pretreatment estimate does not constitute an evaluation or approval of the Dentist or dental plan.

Section 14.6. Orthodontia.

Covered orthodontic expenses include only the charges for the following services and supplies:

- (a) the appliance, placement of the appliance, continuing treatment, and
- (b) any preliminary studies performed, and
- (c) cephalometric radiographs, and
- (d) diagnostic casts, and
- (e) retainers and retainer devices.

Section 14.7. Temporomandibular Joint Disorders (TMJ).

Only the following services and supplies used for treatment of TMJ will be considered as covered expenses payable under the orthodontic benefit:

- (a) cephalometric x-rays;
- (b) ct scans
- (c) diagnostic casts
- (d) facebow transfers
- (e) hinge axis mountings; and

- (f) hydrostatic appliances;
- (g) injection of xylocaine, alcohol, benadryl, saline solutions or cortisone;
- (h) magnetic resonance imaging;
- (i) occlusal equilibration;
- (j) occlusal guards;
- (k) occlusal splints;
- (l) orthopedic repositioners;
- (m) panoramic radiographs;
- (n) temporomandibular joint x-rays;
- (o) tomogram x-rays;

Section 14.8. Exclusions and Limitations.

No benefits shall be payable under this Article for the following:

- (a) the replacement of a prosthesis more often than once every five years, except for:
 - (i) replacement which is needed because of the first time placement of an opposing full denture or the extraction of natural teeth;
 - (ii) a permanent prosthesis which replaces an interim complete or partial denture or other temporary prosthesis;
 - (iii) replacement of a prosthesis which, while in the mouth, has been damaged beyond repair as a result of an accident which occurs while covered;
- (b) replacement of a lost or stolen appliance;
- (c) any expense covered under the Comprehensive Medical Expense Benefit;
- (d) consultations;
- (e) services or supplies for the treatment of temporomandibular joint disorders or to alter vertical dimension, except as provided in this benefit;

- (f) expenses for procedures which are Experimental in nature, or are not generally recognized by the dental profession for the condition being treated;
- (g) customization of dental prosthesis, including personalized, elaborate, or precision attachment dentures or bridges, or specialized techniques, unless the prosthesis cannot be made to function without the specialized technique;
- (h) procedures or surgeries which are undertaken for primarily cosmetic reasons except those orthodontic procedures specified in Section 14.6;
- (i) periodontal scaling procedures on patients not manifesting Case Type II, III or IV periodontal disease;
- (j) complete series (including bitewings) of x-rays more often than once each Calendar Year;
- (k) panoramic x-rays more often than once every two Calendar Years unless made necessary by a change in Dentists;
- (l) panoramic x-rays taken in the same Calendar Year as covered complete series x-rays are taken;
- (m) periapical x-rays (single film) taken on the same day as covered complete series x-rays are taken;
- (n) prophylaxis treatments are limited to a maximum of four per Calendar Year, as follows: up to two can be dental prophylaxis (ADA codes 1110/1120); up to four can be periodontal prophylaxis (ADA code 4910) provided that they are performed as adjunctive periodontal treatment rendered with respect to active periodontal treatment;
- (o) temporary bridgework and temporary crowns except when a temporary crown is needed due to a fractured tooth.

ARTICLE 15 — VISION BENEFIT

Section 15.1. General.

If an Eligible Employee or Eligible Dependent incurs Covered Vision Expenses, payment will be made for the Covered Vision Expenses incurred, up to the maximum amount specified in the Schedule of Benefits and according to the provisions of this Article.

Section 15.2. Benefits Payable.

Benefits are payable for Covered Vision Expenses incurred, but not to exceed the maximum specified in the Schedule of Benefits.

Section 15.3. Covered Vision Expenses.

Covered Vision Expenses include expenses for:

- (a) complete eye examination including dilation of pupil and/or relaxing of focusing muscles by drops and refraction for vision by a legally qualified ophthalmologist or optometrist; and
- (b) new or replacement frames and/or lenses (including contact lenses) prescribed by an ophthalmologist or optometrist, including fitting.

An expense is deemed to be incurred on the date on which the services which give rise to the expense is rendered. No Covered Vision Expense incurred for a service or supply listed in this Article will be payable under the Comprehensive Medical Expense Benefit as set forth in Article 12.

Section 15.4. Exclusions and Limitations.

No benefits shall be payable under this Article for:

- (a) any expense that exceeds the maximum amount during any Calendar Year;
- (b) any lenses which do not require a prescription;
- (c) radial keratotomies or other procedures for surgical correction of myopia and/or refractive errors.

ARTICLE 16 — SUBROGATION

Section 16.1. General.

The Fund shall be subrogated, to the extent of the amount of benefits paid or to be paid by the Fund, and without limitation, to any and all recovery or claim of a Participant, his or her parent(s) and dependent(s) (including minor dependent(s)) or their representatives, guardians or trustees (collectively referred to as "Claimant"), arising out of the incident or condition, giving rise to the claim for benefits. The right of subrogation applies on a priority, first dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless whether the Claimant is made whole, from any source liable for making a payment relating to the injury, illness or condition to which the claim relates.

The Fund's rights of subrogation and reimbursement shall extend to any and all sources of recovery including, but not limited to, the following:

- (a) loss or damage for which the Claimant may have a claim or cause of action against any third party or its insurer;
- (b) loss or damage covered under any Workers' Compensation or occupational disease law; or
- (c) loss or damage for which the Claimant is covered by or may have a claim against or under any other insurance policy or plan, including, but not limited to, "med-pay," "personal injury protection," "financial responsibility," "no fault," "uninsured" or "underinsured" motorist coverage.

The Fund's right of subrogation is not limited to reimbursement from proceeds covering medical expenses and specifically includes any source of recovery whatsoever by the Claimant whether by settlement, judgment, or other recovery.

Section 16.2. Right of Reimbursement.

The Claimant shall first reimburse the Fund on a priority basis for all payments the Fund made or may be obliged to pay for the claim from any recovery or recovered from any source, including partial or full recoveries and regardless of whether the Claimant is made whole. Once the Fund makes or is obliged to make payments on behalf of the Claimant, the Fund is granted, and the Claimant consents to, an equitable lien by agreement or constructive trust on the proceeds of any payment, settlement or judgment received by the Claimant from any source.

Section 16.3. Enforcement of Rights.

The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under Article 16 through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any Claimant for recovery from any source, whether settlement, judgment or otherwise. The Fund's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

Further, where the Claimant or its agent receives a recovery from any source but does not reimburse the Fund in full, the Fund shall have the right to reduce future benefits on the claims submitted by the Participant and Eligible Dependents associated with the Claimant until the Fund has recovered the full amount allowed under this Article 16. This right of offset shall not, however, limit the rights of the Fund to recover such monies in any other manner.

If the Claimant has received benefits or recovery from other sources, the Fund may demand reimbursement for the benefits paid by this Fund or may credit the benefits or recovery received from other sources against benefits that the Fund may be required to pay in the future.

Section 16.4. Rights and Obligations of Claimant.

The Claimant shall hold in trust for the Fund's benefit that portion of the total recovery from any source which is due for payments made or to be made by the Fund. The Claimant shall reimburse the Fund immediately upon recovery. The Claimant must not do anything to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Claimant will assist and cooperate with the representatives designated by the Fund. The Claimant must do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.

Upon the request of the Fund, the Claimant or the Claimant's authorized representative shall take such action as necessary or appropriate to recover any and all payments made or to be made by the Fund. If the Claimant institutes legal action against another source, the Fund is entitled to intervene or participate in that action. If the Claimant fails or refuses to institute legal action, the Fund is entitled to do so in the name of that person.

Upon the request of the Fund, either before or after payment of any benefit, the Claimant shall complete and/or execute certain documentation to assist the Fund in the enforcement of its subrogation and reimbursement rights including, but not limited to, the

"Subrogation Agreement and Assignment form" in effect at the time the payment of benefits is made. The "Subrogation Agreement and Assignment" set forth in Appendix F is hereby incorporated into and made part of the Plan. Payment of benefits may be suspended or delayed indefinitely for failure of the Claimant or his legal representative or counsel to complete and/or execute such documentation as required by the Fund, including, but not limited to, the "Subrogation Agreement and Assignment form."

Section 16.5. Attorney's Fees.

The Fund specifically disavows any claims the Claimant may make under the common fund doctrine. This means that the Fund shall not be responsible for any of the Claimant's attorneys' fees or costs incurred in seeking a recovery, whether by suit, settlement or otherwise, unless the Trustees or their representatives have agreed in writing to discount the Fund's claim under this Article 16 by an agreed upon amount of such fees or costs.

ARTICLE 17 — SELF-AUDIT PROGRAM

Section 17.1. General.

The program is designed to provide a cash incentive to Eligible Employees or Eligible Dependents who discover and arrange for recovery of overcharges made on their own inpatient Hospital bills, which in turn results in benefit dollars saved for the Fund.

Section 17.2. Amount Payable.

The cash incentive paid to an Eligible Employee or Eligible Dependent for recovering an amount that was initially overcharged on a bill for him shall be 25% of the recovered amount of the overcharge that the Hospital agrees is invalid as a result of direct negotiations between the Participant and the provider.

The maximum paid by the Fund to an Eligible Employee or Eligible Dependent under this program shall not exceed \$500. Payment for typographical errors shall be limited to \$250.

For purposes of the cash incentive, only expenses which the Plan covers shall be considered in determining the amount payable to the Eligible Employee or Eligible Dependent under this program. Claims involving coordination of benefits will be eligible only if the Plan covers the Eligible Employee or Eligible Dependent for primary coverage.

Section 17.3. Payment.

Proof of eligibility for a cash incentive must be submitted to the Benefits Fund Office in the form of a copy of the initial itemized Hospital bill with the overcharges circled, and a copy of the adjusted bill showing that the Hospital dropped the discrepancy.

The Benefits Fund Office must be notified within 45 days of any dispute over a bill. Within 30 days after receipt of proof and verification that the overcharge has been recovered, the Benefits Fund Office shall disburse to the Eligible Employee or Eligible Dependent a check in the amount of the cash incentive.

The Trustees and Benefits Fund Office staff shall not be required to resolve any differences between the Eligible Employee or Eligible Dependent and the Hospital with respect to disputed charges. The Benefits Fund Office will assist in recovery, however, if the Eligible Employee or Eligible Dependent is having difficulty resolving the overcharges.

ARTICLE 18 — GENERAL PLAN EXCLUSIONS AND LIMITATIONS

Notwithstanding any other provision of the Plan to the contrary, Covered Expenses shall not include, and no payment shall be made under the Plan, for expenses for the following:

- (a) Any bodily Illness or Injury for which the Eligible Employee or Eligible Dependent for whom claim is made is not under the regular care of a Physician.
- (b) Any Illness, Injury or dental treatment for which an Eligible Employee or Eligible Dependent has received or is entitled to receive benefits under a Workers' Compensation or occupational disease law or which arise out of or in the course of any occupation or employment.
- (c) Any supplies or services:
 - (i) for which no charge is made; or
 - (ii) for which the person is not legally required to pay.
- (d) Any expense for government provided services given to a person:
 - (i) under any plan or program 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
 - (ii) under any plan or program in which any government participates other than as an employer;

unless the governmental program provides otherwise.
- (e) Supplies and services which the person is entitled to receive from the Uniformed Services Medical Care Facilities. However, services and supplies received from a Veteran's Administration (VA) Hospital for care of a non-service related disability will be covered to the extent that the Plan would have considered such charges as Covered Expenses had the VA not been involved.
- (f) Deductible or Co-Pay amounts.
- (g) Cosmetic Surgery or Treatment or complication thereof.
- (h) Diagnosis, testing or treatment of obesity including surgical removal of fat or skin,

- including, but not limited to, liposuction, and complication thereof, except that other appropriate treatment will be covered when acceptably certified by a qualified Physician as morbid obesity due to body weight in excess of 100 pounds over ideal body weight (or 100% over ideal body weight if body weight is less than 100 pounds), as determined by the Trustees.
- (i) Diagnosis, testing or treatment of infertility.
 - (j) Hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.
 - (k) Experimental, Investigational or Unproven Services.
 - (l) Services provided by a person who normally resides in the Eligible Employee's household or who is the parent, spouse, child, brother or sister of the Eligible Employee or his Eligible Dependent.
 - (m) Donation of a heart, organ or tissue.
 - (n) Expenses incurred while coverage is not in force.
 - (o) Physical examinations or medical certificates required for employment.
 - (p) Smoking cessation programs.
 - (q) Radial keratotomies or other procedures for surgical correction of myopia and/or other refractive errors.
 - (r) Immunizations, routine examinations or check-ups and other preventive care, except as provided under the Comprehensive Medical Expense Benefit.
 - (s) Custodial Care, except when provided by a Hospice.
 - (t) Any service not listed as a Covered Expense.
 - (u) Services which are not Medically Necessary.
 - (v) Blood storage charges except for use for an anticipated covered medical condition for a period not to exceed six months.
 - (w) Blood donated by family members or others specifically for another patient's use.
 - (x) Prescription or non-prescription diet pills.

- (y) Amounts in excess of Usual and Customary Charges.
- (z) Treatment received outside the United States or Canada except for Emergency first aid limited to the extent and at the currency rate of exchange or appropriate value of services solely determined by the Trustees.
- (aa) Personal convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- (bb) Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury and as provided under the Comprehensive Medical Expense Benefit), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- (cc) Examinations or treatment ordered by a court in connection with legal proceedings or obtained for the purpose of receiving favorable consideration by a court or similar body, unless such examinations or treatment would otherwise qualify as a Covered Medical Expense.
- (dd) Routine foot care such as the cutting and trimming of toenails.
- (ee) Failure to keep a scheduled visit.
- (ff) Completion of a routine claim form or routine supplemental report.
- (gg) Services and supplies for the care and treatment of an Illness or Injury resulting from an intentionally destructive act, including self-administered overdoses, that are not attributable to a medical condition (including both physical and mental health conditions) or to an act of domestic violence and that exceed the Plan's co-payment percentage and maximum benefit specified in the Schedule of Benefits.
- (hh) Marriage counseling, or treatment for anti-social behavior which is not the result of a mental or nervous disorder.
- (ii) Treatment of a condition or related condition that is a result of the commission of a felony, or a condition or related condition that is a result of war or any act of war, whether war is declared or undeclared.
- (jj) Telephone calls between a Physician or other provider and any patient, other

- provider, or representative of the Plan for any purpose whatsoever.
- (kk) Reversal of a surgical procedure.
 - (ll) Snoring correction devices, unless sleep apnea has been diagnosed.
 - (mm) Educational services, supplies or equipment, including but not limited to, computers, software, printers, books, tutoring and visual aids even if they are required because of an Illness or Injury.
 - (nn) Foods and nutritional supplements including, but not limited to, home meals, formulas, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided through a feeding tube.
 - (oo) Expenses that a person would not have incurred or would not be required to pay if this coverage or other coverage did not exist.
 - (pp) Expenses for home blood pressure monitoring or home uterine monitoring equipment, for any reason.
 - (qq) Orthopedic shoes.
 - (rr) Vision therapy.
 - (ss) Muscle stimulators in excess of \$500.
 - (tt) Expenses for dental treatment except as provided under Article 14 of this Plan and except for removal of tumors, treatment of fractures, direct surgery on the temporomandibular joint itself or surgery to correct a malocclusion of the jaw due to a skeletal deformity.
 - (uu) Routine circumcision of newborns.
 - (vv) If an Eligible Employee is employed by more than one Contributing Employer, the benefits provided to the Eligible Employee will be no greater than if the Eligible Employee was employed by only one Contributing Employer.
 - (ww) If an Eligible Employee or an Eligible Dependent is covered under more than one Plan Classification, the benefits provided will be payable under the Plan Classification providing the largest benefit.
 - (xx) Benefits provided under any one Plan Classification will be reduced by benefits

provided under any other Plan classification and by benefits previously provided under any other category of a Plan Classification.

- (yy) No expense will be covered under more than one benefit provision of any Plan Classification.
- (zz) If an Eligible Employee changes Plan Classifications, the benefits previously paid will reduce the benefit maximums payable under the new Plan Classification by the amount paid.

In addition to the general exclusions and limitations specified above in this Article 18, no payment shall be made under Plan Classification D5 for expenses for the following:

- (aaa) Genetic testing, with the exception of governmentally-mandated neonatal testing, amniocentesis, and testing for the purpose of determining the medical necessity of adjuvant therapy for the treatment of newly diagnosed breast cancer. All genetic testing for the purposes of screening for the presence of occult disease, or for the purposes of risk stratification for the development of clinically absent or unapparent disease, or for the evaluation of possibly prophylactic surgical treatment will be excluded.
- (bbb) Breast reduction surgery except for reconstruction due to breast cancer.
- (ccc) Skin removal surgery for any reason.
- (ddd) More than one medical office visit billed on the same day by the same Provider.
- (eee) Cochlear implants or similar implantable devices designed to restore, improve or augment hearing except as provided for under the Plan's allowance for a hearing aid.

ARTICLE 19 — COORDINATION OF BENEFITS

Section 19.1. General.

The benefits payable to an Eligible Employee or Eligible Dependent under this Plan shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the benefits payable by any “Other Plan” shall not exceed the total that would be payable under the Plan.

This Plan will not cover any costs of care, treatment, services or supplies which are furnished by or are payable under any motor vehicle or automobile insurance policy or plan, or any plan or policy covering loss, liability or damage caused by a third party, including but not limited to “no fault” and uninsured or underinsured motorist coverage. Income Protection Benefits payable under this Plan will be reduced by any coverage provided under any motor vehicle or automobile insurance policy or plan or any plan, policy or settlement of a claim or cause of action against a third party. Payment of benefits may be delayed indefinitely for failure of any covered person to provide information to the Benefits Fund Office regarding coverage under any motor vehicle or property owner insurance policy or plan.

Duplicate payment for the same covered expenses is not allowed.

For persons who qualify as both an Eligible Employee and an Eligible Dependent, this Plan will be considered an “Other Plan” in determining the amount of benefits payable to such person as an Eligible Dependent under this Plan except to the extent that such person does not comply with the Inpatient Hospital Requirements, Second Opinion Requirements, or PPO Requirements, in which case benefits will be reduced accordingly. Nursery expenses will be covered when the mother qualifies as both an Eligible Employee and Eligible Dependent.

Section 19.2. Other Plan.

“Other Plan” shall mean any plan providing benefits or services for or by reason of medical, dental, vision or prescription drug care or treatment for which benefits or services are provided by:

- (a) group, blanket or franchise insurance coverage (including student accident coverage);
- (b) group Blue Cross or group Blue Shield coverage or other prepayment coverage on a group basis, including Health Maintenance Organizations (HMOs) whether or not HMO requirements are followed;

- (c) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group;
- (d) any coverage under governmental programs, and any coverage required or provided by any statute;
- (e) any no-fault automobile insurance coverage or individual policy;
- (f) other arrangements of covered or self-covered group coverage; or
- (g) plans for which any employer directly, or indirectly, has made contributions or payroll deductions.

Section 19.3. Allowable Expense.

“Allowable Expense” means any necessary, usual and customary expenses incurred by an Eligible Employee or Eligible Dependent during a Calendar Year and while eligible under this Plan, for medical care or treatment, part or all of which would be covered under any Other Plan, except as provided below.

- (a) The difference between the cost of a semi-private room in a Hospital or specialized health care facility and a private room, unless the Eligible Employee or Eligible Dependent’s confinement in a private Hospital room is Medically Necessary, is not an Allowable Expense.
- (b) If the coordinating plans determine benefits on the basis of Usual and Customary Charges, any amount in excess of the highest Usual and Customary Charge is not an Allowable Expense.
- (c) 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.
- (d) If one coordinating plan determines benefits on the basis of Usual and Customary Charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement is the Allowable Expense for all plans.
- (e) When benefits are reduced by a primary plan because a covered person 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, or did not obtain a required referral, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second. In addition, if an Eligible Employee or Eligible Dependent is covered under an HMO or clinic which provides necessary treatment without charge, and the Eligible Employee or Eligible Dependent does not obtain treatment from the HMO or clinic, no benefits will be paid by this Plan.

When any Other Plan provides services rather than cash payment, the reasonable cash value of each service will be an Allowable Expense.

Section 19.4. Order of Benefit Payment.

The following order of coordination of benefits shall be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any Other Plans:

- (a) A plan without a coordination of benefits provision shall pay its benefits before a plan which contains a coordination of benefits provision.
- (b) A plan which covers a person other than as an Eligible Dependent shall pay its benefits before a plan which covers the person as an Eligible Dependent.

If the person is covered as an Employee under this Plan and as an employee under another plan, the plan provided through the employer for whom the person worked the greatest number of average hours during the claim determination period shall pay its benefits first.

If a plan which covers a person other than as an Eligible Dependent has a provision whereby the customary coordination of benefit rules for health insurance are inapplicable and/or a reduced level of coverage is applicable under such plan because the individual in question is covered as an Eligible Dependent under this Plan, then this Plan shall coordinate on the basis as if the other plan had paid based upon the customary coordination of benefit rules for health insurance and the regular plan of benefits that would apply to a covered person under such other plan but for the reduction in benefits due to coverage under this Plan. In the event this Plan cannot disregard the other plan's provision which seeks to avoid the result under customary coordination of benefit rules for health insurance and/or which seeks to apply a reduced level of benefits because of coverage as an Eligible Dependent under this Plan, then the coverage for such Eligible Dependent under this Plan shall be limited to a maximum benefit for

claims incurred in a Calendar Year of \$1,000 per Calendar Year.

- (c) For claims on behalf of Eligible Dependent children who are covered under both parents' plans and the parents are not separated or divorced:
 - (i) the plan that covers the parent whose birthday falls earlier in the Calendar Year shall pay first,
 - (ii) if both parents have the same birthday, the plan covering the parent for the longer period of time shall pay first,
 - (iii) if one plan uses the male/female rule and the other plan coordinates using the rule based on the parents' birthdays, the plan using the male/female rule shall pay its benefits first.

- (d) For a claim on behalf of Eligible Dependent children who are covered under both parents' plans and the parents are separated or divorced:
 - (i) if there is a court decree which established financial responsibility for medical expenses, the plan covering the Eligible Dependent children of the parent who has legal responsibility shall be primary.
 - (ii) if there is no court decree and the parent with custody has not remarried, the plan which covers the parent with custody shall be primary.
 - (iii) if there is no court decree and the parent with custody has remarried, the order of benefit coordination shall be
 - (A) the plan of the parent with custody,
 - (B) the plan of the step-parent with custody,
 - (C) the plan of the parent without custody.

- (e) A plan which covers a person as an active employee shall pay its benefits before a plan which covers the person as a laid-off or retired employee.

- (f) For claims on behalf of a person who is provided COBRA continuation coverage under this Plan, this Plan shall pay its benefits secondary to any other plan which covers the person.

- (g) If none of the above establishes the primary plan, the plan which has covered the

person for the longer continuous period of time shall pay its benefits before the plan which has covered the person for a shorter period of time.

- (h) In the event of a dispute as to which plan is primary, the Trustees may, in final settlement of all benefits due under this Plan, consider for payment up to 50% of pro-rated expenses covered under this Plan.

Under no circumstances may a Participant elect this Plan as primary contrary to the rules above.

Section 19.5. Working Spouse Rule.

A working Eligible Dependent spouse who is covered under Plan Classification D5 must elect employer-sponsored health coverage if available at his or her place of employment. The Plan limits coverage for a working Eligible Dependent spouse to expenses which would have been payable had the Eligible Dependent spouse elected employer-sponsored health coverage. If a working Eligible Dependent spouse does not elect employer-sponsored health coverage and the Plan cannot accurately identify what the employer-sponsored coverage would have paid, the Plan will assume that the employer-sponsored health coverage would have paid 80% of the billed amount.

Section 19.6. Effect of Medicare.

This Plan shall coordinate benefits with Medicare as set forth in Article 20 hereof. This Plan is secondary to Medicare when allowed by law.

ARTICLE 20 — EFFECT OF MEDICARE

Section 20.1. General.

The benefits payable to a Participant shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B shall not exceed the total of such “Allowable Expense.”

Section 20.2. Definitions.

“Allowable Expenses” means the reasonable charges as determined by Medicare for expenses for medical care or treatment which are covered by Medicare and this Plan.

“Small Employer” means an employer which has 20 or fewer Employees each working day in each of 20 or more calendar weeks during the current or preceding Calendar Year.

Section 20.3. Effect on Benefits.

If a Participant is eligible for Hospital insurance under Medicare Part A, but not enrolled in Part A and Medicare would otherwise have primary responsibility for expenses incurred, the benefits provided to him under this Plan shall be paid as if the Participant has enrolled in Medicare Part A.

Section 20.4. Order of Benefit Payment.

- (a) This Plan shall pay its benefits without regard to the entitlement or potential entitlement to Medicare of an active Eligible Employee or an Eligible Dependent of an Eligible Employee provided that such Employee or Dependent has not attained age 65, is eligible for Medicare benefits because he is disabled (other than an ESRD beneficiary) and is covered by the Plan on the basis of the Eligible Employee’s current employment status with a Contributing Employer.
- (b) This Plan shall have primary responsibility for the first 30 Months for the claim of an Eligible Employee or Eligible Dependent who is eligible for Medicare benefits because of end-stage renal disease (ESRD) where Medicare has secondary responsibility.
- (c) This Plan shall pay its benefits without regard to an active Eligible Employee’s or an Eligible Dependent’s entitlement or potential entitlement to Medicare if the Eligible Employee is age 65 or older and actively employed by an Employer who is not a Small Employer and which pays all or part of the required contributions

for eligibility, or for an Eligible Dependent spouse age 65 or older of an active Eligible Employee of an Employer which is not a Small Employer which pays all or part of the required contributions for eligibility.

- (d) When subsections 20.4(a), (b) and (c) do not apply, benefits otherwise payable under this Plan for Allowable Expenses shall be reduced so that benefits payable by the Plan do not exceed the amount of Allowable Expenses reduced by the amount paid or payable by Medicare.

Medicare claims for reimbursement from the Plan, whether the Plan is primary or secondary to Medicare, shall be subject to the benefit claim and appeal procedures of the Plan, including time limits for filing and processing benefit claims. For periods on and after August 5, 1997, any Medicare request for payment must be submitted for reimbursement from the Plan within three years of the date that the expense was incurred.

APPENDIX A — ELIGIBILITY REQUIREMENTS

<u>Initial Eligibility–Employee</u>	<u>Rate-Per-Hour Contribution (Plan D5, Plan DH)</u>	<u>Flat-Rate Contribution (Plan D5, Plan DH)</u>
Waiting Period	As set forth in Collective Bargaining Agreement.	As set forth in Collective Bargaining Agreement.
Employer Contributions Required	Average of at least 12 Covered Hours per week during weeks that end in each of 2 full consecutive Months.	As set forth in Collective Bargaining Agreement, a minimum number of hours is required for Employee to qualify for either full-time or part-time contributions.
<u>Coverage Effective Date</u>		
Life Insurance Benefit, Accidental Death and Dismemberment Insurance Benefit, Comprehensive Medical Expense Benefit, Prescription Drug Benefit and Vision Care Benefit	First of the Month following 2 full consecutive Months of contributions, and Employee has worked an average of at least 12 Covered Hours per week during weeks that end in each of 2 full consecutive Months.	First day of the Month following 1 Month of contributions.
Dental Expense Benefit	First of the Month after Comprehensive Medical Expense Benefit has been in effect for 2 full Months. These 2 full Months cannot be separated by periods totaling more than 6 Months during which Employee has not Actively Worked.	First of the Month after Comprehensive Medical Expense Benefit has been in effect for 2 full Months. These 2 full Months cannot be separated by periods totaling more than 6 Months during which Employee has not Actively Worked.
Income Protection Benefit	First of the Month after Comprehensive Medical Expense Benefit has been in effect for 4 full consecutive Months, and Employee has worked an average of at least 28 Covered Hours per week during weeks that end in 3 of	First day of the Month following 1 Month of full-time contributions.

**Rate-Per-Hour Contribution
(Plan D5, Plan DH)**

**Flat-Rate Contribution
(Plan D5, Plan DH)**

the 4 preceding Months.

**Continuing Eligibility–
Employee**

Life Insurance Benefit,
Accidental Death and
Dismemberment Insurance
Benefit, Comprehensive
Medical Expense Benefit,
Prescription Drug Benefit,
Dental Expense Benefit and
Vision Care Benefit

Average of at least 12
Covered Hours per week
during weeks that end in
each of preceding 2 full
consecutive Months.

Continues to qualify for
Employer’s contribution each
Month.

Income Protection Benefit

Average of at least 12
Covered Hours per week
during weeks that end in
each of the preceding 2 full
consecutive Months, and the
Employee has worked an
average of at least 28
Covered Hours per week
during weeks that end in 3 of
the 4 preceding Months.

Continues to qualify for
Employer’s full-time
contribution each Month.

Initial Eligibility–Dependent

Dependent Life Insurance
Benefit, Comprehensive
Medical Expense Benefit,
Prescription Drug Benefit and
Vision Care Benefit

First of the Month after
Employee Comprehensive
Medical Expense Benefit has
been in effect for 2 full
consecutive Months and
Employee has worked an
average of at least 28
Covered Hours per week
during weeks that end in 3 of
the 4 preceding Months.

First day of the Month
following 1 Month of full-time
contributions

Dental Expense Benefit

First of the Month after
Employee Comprehensive
Medical Expense Benefit has
been in effect for 8 full
Months, and Employee has
worked an average of at least

First of the Month after
Employee Comprehensive
Medical Expense Benefit has
been in effect for 8 full
Months, and Employee
qualifies for Employer’s full-

**Rate-Per-Hour Contribution
(Plan D5, Plan DH)**

**Flat-Rate Contribution
(Plan D5, Plan DH)**

28 Covered Hours per week during weeks that end in 3 of the 4 preceding Months.

time contributions.

**Continuing Eligibility–
Dependent**

Dependent Life Insurance Benefit, Comprehensive Medical Expense Benefit, Prescription Drug Benefit, Vision Care Benefit and Dental Expense Benefit

Employee worked an average of at least 12 Covered Hours per week each Month and worked an average of at least 28 Covered Hours per week during weeks that end in 3 of the 4 preceding Months.

Continues to qualify for Employer’s full-time contribution each Month.

Loss of Coverage

Income Protection Benefit and Dependent Coverage

Failure to work an average of at least 28 Covered Hours per week during weeks that end in 3 of the 4 preceding Months results in loss of Income Protection and Dependent coverage until the 28-hour requirement is again met.

Failure to qualify for Employer’s full-time contribution.

All Other Coverage

Failure to work an average of at least 12 Covered Hours per week during weeks that end in 1 full Month results in loss of all coverage for 2 Months.

Failure to qualify for Employer’s contribution.

**APPENDIX B — LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT
CONTRACT**

On file at Fund Administrator's office.

APPENDIX C — REQUIRED SECOND OPINION REVIEW LIST

Artery and Vein Surgery

Coronary Artery Bypass—Correction of a damaged section of an artery by diverting the heart's blood flow away from the point of damage.

Ligation and Stripping of Varicose Veins—Enlarged, twisted veins that are tied and removed.

Vein Sclerosing Injection—Injecting a solution into the veins which causes the stagnant blood within to clot.

Back Surgery

Coccygectomy, Coccyx Reduction—Surgery of the tailbone.

Discectomy—Removal of a disc.

Laminectomy—Removal of a small portion of bone from the spine.

Spinal Fusion—To permanently stiffen a portion of the spine to prevent further displacement from occurring.

Breast Surgery

Mammoplasty, Reduction, Augmentation—The surgical reconstruction of the breasts.

Digestive System Surgery

Adenoidectomy—Removal of the adenoids.

Cholecystectomy—Removal of the gall bladder. (Second Opinion necessary if performed as an inpatient)

Hemorrhoidectomy—Removal of hemorrhoids. (Second Opinion necessary if performed as an inpatient.)

Herniorrhaphy—Repair of a hernia. (Second Opinion necessary if performed as an inpatient.)

Intestinal Surgery—Intestinal bypass, intestinal stapling and reversal of covered procedures only when certified by a Physician as morbid. **Intestinal bypass** is the removal of part of the intestine and connection of the remaining ends. **Intestinal stapling** is fastening the segments

of the intestine together by using staples. **Reversal** is unfastening the segments of the intestine.

Tonsillectomy—Removal of tonsils.

Exploratory Surgery—The examination of an organ by surgery.

Eye Surgery

Blepharoplasty—Repair of the eyelid.

Cataract Removal—Removal of the cloudy portion of the lens.

Foot Surgery—A Second Opinion is required if the surgeon's and assistant surgeon's fees total \$1,000 or more.

Genital Surgery

Cystocele—Repair of a hernia of the bladder that protrudes into the vagina.

Hysterectomy—Removal of the uterus.

Penile Implant—Prosthetic appliance inserted in the penis to facilitate normal sexual functioning.

Prostatectomy or Transurethral Resection—Removal of all or part of the prostate gland.

Rectocele—Repair of a hernia of the vagina that pushes against the rectum.

Uterine Suspension—Correction of a tilted uterus.

Joint Surgery

Arthrotomy—Repair of knee joint (lateral and/or medial meniscus). (Second Opinion necessary if performed as an inpatient.)

Joint Replacement—Replacement or plastic reconstruction of a joint.

Maxillary and Mandibular Surgery—Upper and lower jaw surgery. Temporomandibular joint reconstruction is the surgical treatment for the joint in front of each ear.

Nose Surgery

Nasal Fracture Reduction (open and closed)—These fractures can be placed into normal

alignment by manual manipulation or by inserting instruments into the nasal cavity to push out depressed bony fragments.

Septoplasty—Repair of the nose structure.

Submucous Resection of Nasal Septum—Straightening out of the septum by elevating the septum and removing the cartilage blocking a nostril.

APPENDIX D — SCHEDULE OF DENTAL PROCEDURES

Diagnostic and Palliative Treatment— No Deductible Required

Prophylaxis—Adult (maximum two treatments in any Calendar Year).....	\$ 45.00
Prophylaxis—Child (maximum two treatments in any Calendar Year).....	33.00
Oral Examination	21.00
Topical application of fluoride	20.00
Topical sealant, per tooth.....	25.00
Radiographs	
Complete series, including bitewings (once each Calendar Year).....	65.00
Periapical—single, first film.....	10.00
Periapical—each addition film.....	8.00
Bitewings—two films	19.00
Bitewings—four or more films	28.00
Panoramic x-ray (once every two Calendar years)	65.00
CT Scan or similar imaging.....	250.00
Palliative treatment (emergency)	35.00
Diagnostic casts.....	48.00

Basic Dental Benefits

Surgical Extractions (including routine post-operative visits)	
Each single uncomplicated extraction..	\$ 56.00
Surgical extraction, erupted	84.00
Removal of impacted tooth (soft tissue).	127.00
Removal of impacted tooth (partially bony)	160.00
Removal of impacted tooth (completely bony).....	190.00
Surgical placement of implant.....	633.00
Surgical Incisions and Excisions	
Frenulectomy	144.00
Alveoplasty with extractions (per quadrant).....	100.00
General anesthesia (in or out of hospital)	172.00
General analgesia.....	19.00

Restorative Dentistry

Amalgam Restorations	
One surface (permanent).....	\$ 42.00
One surface (deciduous)	37.00
Two surfaces (permanent).....	53.00
Two surfaces (deciduous).....	49.00
Three surfaces (permanent)	63.00
Three surfaces (deciduous).....	58.00
Four or more surfaces (permanent).....	73.00
Four or more surfaces (deciduous).....	65.00

Composite Resin Restorations

One surface	51.00
Two surfaces	63.00
Three surfaces.....	76.00
Four surfaces or incisal angle.....	84.00

Inlay Restorations—Non-Abutment

One surface, gold	295.00
One surface, porcelain	338.00
One surface, composite.....	317.00
Two surfaces, gold	359.00
Two surfaces, porcelain.....	380.00
Two surfaces, composite.....	338.00
Three surfaces, metallic	363.00
Three surfaces only, metallic.....	380.00
Four or more surfaces only, metallic ...	401.00
Four or more surfaces only, porcelain .	443.00
Four or more surfaces only, composite	401.00

Crowns—Non-Abutment

Plastic prefabricated	106.00
Porcelain.....	401.00
Porcelain with gold	443.00
Porcelain with nonprecious metal.....	380.00
Porcelain with semiprecious metal	422.00
Gold full cast.....	422.00
Metal full cast.....	380.00
Stainless steel crown.....	106.00
Steel post and amalgam core	118.00
Cast post and gold core.....	148.00
Recement inlays	28.00
Recementation of crown.....	30.00
Sedative filling	32.00
Crown buildup-pin retention.....	93.00

Endodontics

Pulp capping, direct	\$ 23.00
Pulp capping, indirect	20.00
Vital pulpotomy	63.00
Root Canal Therapy	
Anterior (excludes final restoration).....	253.00
Bi-cuspid (excludes final restoration)....	295.00
Molar (excludes final restoration)	401.00
Apicoectomy (separate procedure)	232.00

Periodontics

Osseous surgery (per quadrant; minimum 6 teeth).....	\$ 380.00
Gingival Curettage.....	48.00
Periodontal scaling (full-mouth debridement prior to periodontal therapy)	52.00
Periodontal scaling and root planing (per quadrant; minimum of 6 teeth)	84.00
Maintenance periodontal prophylaxis	

(following periodontal therapy)..... 52.00

Prosthetic Replacements

Fixed Bridgework

Crowns—Abutment Teeth

Porcelain, gold	\$ 288.00
Porcelain, nonprecious	264.00
Porcelain, semiprecious.....	268.00
Gold (full cast).....	251.00
Nonprecious cast	225.00
Semiprecious cast	237.00

Pontics

Cast gold (sanitary).....	251.00
Cast nonprecious metal	225.00
Cast semiprecious metal	237.00
Porcelain, gold	288.00
Porcelain, nonprecious	264.00
Porcelain, semiprecious.....	268.00
Recement bridge	44.00

Complete Denture

Upper (Maxillary)	343.00
Lower (Mandibular).....	343.00

Removable Partial Denture

Upper, resin base.....	343.00
Lower, resin base.....	343.00
Upper or lower, cast framework, resin base	396.00
Removable unilateral partial, 1 piece cast metal.....	264.00

Reline—Rebase

Office reline (chairside), full denture	58.00
Office reline (chairside), partial denture .	40.00
Laboratory reline, full denture	100.00
Laboratory reline, partial denture	79.00
Full denture rebase	100.00
Partial denture rebase.....	119.00

Space Maintainers

Fixed or removable, unilateral.....	169.00
Fixed or removable, bilateral.....	211.00
Recementation.....	24.00

APPENDIX E — PPO CONTRACT

On file at Fund Administrator's office.

APPENDIX F — SUBROGATION AGREEMENT AND ASSIGNMENT

On file at Fund Administrator's office.

ADDENDUM 1 — HIPAA PRIVACY PROVISIONS

The Plan will use and disclose Protected Health Information (“PHI”) and electronic Protected Health Information (e-PHI) in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164 (the “Privacy Regulations”). The following provisions address disclosures of PHI to the Plan’s Board of Trustees (the “Trustees”) for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

1. Disclosure of PHI to the Trustees.

- (a) **Disclosures by Plan.** The Plan may disclose PHI, but not e-PHI, to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
- (b) **Disclosures by Business Associates.** The Plan’s Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
- (c) **Disclosures by Other Covered Entities.** A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:
 - (i) the Plan’s Payment activities,
 - (ii) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and
 - (iii) all of the Plan’s Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

2. Uses and Disclosures of PHI by the Trustees.

The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or HealthCare Operations.

3. Privacy Safeguards.

The Trustees agree to:

- (a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
- (b) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;
- (c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
- (d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;
- (e) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;
- (f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
- (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- (h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- (i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
- (j) If feasible, return or destroy all PHI that the Trustees maintain in any form and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the

purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

- (k) Ensure that adequate separation between the Plan and the Trustees is established, as described below.

4. Adequate Separation.

The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.