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

Health Benefits Plan Document
Amended and Restated August 1, 2018

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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 2.01. 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. Vacation time, holiday time or terminal pay cannot be used to extend Active Employment to defer the date eligibility would otherwise terminate.

Section 2.02. 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 2.03. Benefits Fund Office

The office from which the Plan is administered. The office is located at 18861 90th Avenue, Suite A, Mokena, Illinois 60048-8467.

Section 2.04. Brand-Name Drug

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

Section 2.05. Calendar Year

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

Section 2.06. 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 2.07. Contributing Employer

Any employer that:

(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 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 2.08. Co-pay

The portion of a Covered Expense that is required to be paid by the Participant and that is not subject to reimbursement by the Plan.

Section 2.09. Cosmetic Surgery or Treatment

Surgery or medical treatment that 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 2.10. 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 2.11. Covered Expense/Covered Medical Expense

The charges for Medically Necessary and Appropriate 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 2.12. 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, Illness, Injury or functional ability.

Section 2.13. Deductible

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

Section 2.14. 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 2.15. 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 2.16. Earnings

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

Section 2.17. Eligible Dependent

Any or all of the following individuals:

(a) the Eligible Employee's lawful spouse;

(b) those children of the Eligible Employee as described below. For this purpose, "children" described in paragraphs (i), (ii) and (iii) below shall include the Eligible Employee's child through the last day of the Month in which the child attains age 26; "children" described in paragraph (iv) below shall include the Eligible Employee's child through the last day of the Month in which the child attains age 19:

(i) natural children;

(ii) step-children, if the step-child'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(ren) is a first degree relative of the Eligible Employee who was covered under the Plan on December 1, 2010.

(c) those children of the Eligible Employee who have reached their 26th 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 last day of the Month in which the child attained age 26, 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 Fund 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)) If both spouses are Eligible Employees and each are eligible for dependent coverage, their children shall be considered Eligible Dependents of both.

(e) An Eligible Dependent who becomes covered under the Plan as an Eligible Employee will no longer be considered an Eligible Dependent.

Section 2.18. Eligible Employee

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

Section 2.19. 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 2.20. Emergency Service(s)

Any Medically Necessary and Appropriate service(s) that must be provided immediately.

Section 2.21. 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 2.22. 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 Fund Administrator (at the time a determination is made regarding coverage in a particular case) to be

(a) not approved by the U.S. Food and Drug Administration (”FDA”) to be lawfully marketed for the proposed use and/or 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

(b) subject to review and approval by an Institutional Review Board for the proposed use; or

(c) 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

(d) 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 2.23. 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 2.24. Fund Administrator

An individual employed by or a third-party administrator engaged 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 2.25. Generic Drug

A Prescription Drug that is a multi-source drug that is no longer under patent protection, is designated as a generic drug by Medispan or a similar database and has been designated as a Generic Drug by the Board of Trustees.

Section 2.26. 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) Physician;

(e) Hospital;

(f) laboratory;

(g) Skilled Nursing Facility;

(h) Hospice;

(i) psychologist;

(j) licensed clinical social worker;

(k) licensed social worker;

(l) licensed clinical professional counselor;

(m) occupational, physical, respiratory or speech therapist;

(n) certified alcohol and drug counselor;

(o) licensed nurse practitioner.

Section 2.27. Home Health Care

Care provided in the home or outside of any state or federally licensed acute or chronic care facility including but not limited to all nursing, respiratory therapy, or skilled care giver of any kind providing services in the home including but not limited to services related to monitoring an acute or chronic condition or providing ancillary or supportive services including those related to providing home ventilator or respiratory care, wound care, peri-partum care, infusion services or other home therapies with the exception of therapies with limitations as stated otherwise in the Plan without regard to the venue where the service was provided.

All home therapies shall be subject to all additional relevant provisions of the Plan including but not limited to Medical Appropriateness and Necessity.

Section 2.28. Home Health Care Agency

A Home Health Care Agency is a public or private agency that 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 that governs the services provided; and

(d) maintains records for each patient.

Section 2.29. Hospice

A health care program that 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, that is licensed or certified as a Hospice by Medicare and by the state.

Section 2.30. Hospital

(a) An institution that meets all the following requirements:

(i) is accredited by The Joint Commission or other similar credentialing entity recognized by the Centers for Medicare & Medicaid Services ("Medicare") or successor entities;

(ii) is approved by Medicare as a Hospital;

(iii) 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;

(iv) is supervised by a staff of Physicians on the premises;

(v) provides on the premises 24 hour nursing services by registered graduate nurses; and

(vi) is operated with organized facilities for operative surgery on the premises, except for the following institutions:

(A) mental/psychiatric hospitals;

(B) drug/alcohol rehabilitation hospitals; and

(C) physical rehabilitation hospitals.

(b) A hospital does not include any institution:

(i) that is run mainly as a rest, nursing, or convalescent home; or

(ii) for which any part is mainly for the care of the aged; or

(iii) that is engaged in the schooling of its patients; or

(iv) that does not meet all of the requirements of Section 2.30(a).

Section 2.31. Hospital Confined or Hospital Confinement

Confined in a Hospital as a registered bed-patient.

Section 2.32. Illness

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

Section 2.33. Injury

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

Section 2.34. In-Network

Services and supplies provided by Health Care Providers who are members of the Plan's Preferred Provider Option ("PPO") or other designated network of Health Care Providers and facilities.

Section 2.35. Intentionally Destructive Act

An intentionally destructive act includes, but is not limited to, knowingly failing to comply with a prescribed course of treatment, such as

(a) failing to take prescribed medication;

(b) failing to enroll in and complete a prescribed course of treatment which has been recommended by a Physician after an appropriate evaluation, such as for chronic or acute conditions including, but not limited to, hypertension, diabetes or substance abuse;

(c) failing to complete other similar medically appropriate treatment or testing which is prescribed by a Physician, including completion of a course of treatment in an inpatient acute care facility or leaving an acute care facility against the medical advice of the treating Physician; and

(d) self-administered overdose.

Section 2.36. Medically Confined

An inpatient in a medical facility due to Illness or Injury. Medically Confined includes confinement in a Hospital, Skilled Nursing Facility, Substance Use Disorder treatment facility, Mental or Nervous Disorder treatment center, Hospice, or any other facility engaged in the treatment of Illness or Injury.

Section 2.37. Medically Necessary/Medically Necessary and Appropriate

(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 licensed and authorized to provide or prescribe it within the scope of his or her practice; 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 2.38. 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 2.39. Mental or Nervous Disorder

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

Section 2.40. Month

Any of the 12 calendar months of the year.

Section 2.41. 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 2.42. Out-of-Network

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

Section 2.43. Participant

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

Section 2.44. 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 2.45. 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.),

(f) a Doctor of Medical Dentistry (D.M.D.).

Section 2.46. 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 2.47. Plan Classification

Any of several plans of benefits provided by the Fund. A Participant is eligible for the plan of benefits for which his Contributing Employer makes the required contributions, as determined by the Trustees 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 Year

The 12-Month period from December 1 through November 30.

Section 2.50. 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 that are covered under the Plan; and

(b) is practicing within the scope of his license as a Health Care Provider.

Section 2.51. Pre-authorization/Pre-certification

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 and Appropriate. For purposes of communication with an Eligible Employee, an Eligible Dependent or a Health Care Provider, and for contracting with vendors providing support services to the Plan, the terms Pre-authorization and Pre-certification may be used interchangeably.

Section 2.52. Preferred Provider Option (PPO)/PPO Provider

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 2.53. 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 that 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 that requires a prescription under State law.)

(d) Injectable insulin, syringes, needles, lancets and blood glucose testing strips.

(e) Certain drugs specifically approved by the Board of Trustees.

Section 2.54. Prothesis/Prosthetics

A durable appliance or device which replaces a lost body part or function and that is not available without a prescription or written order from a Physician.

Section 2.55. Skilled Nursing Facility

A facility that is licensed and 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 residential care facility for the treatment of Mental or Nervous Disorders and Substance Use Disorders, or a hotel.

Section 2.56. 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 2.57. Substance Use Disorder

A disorder that is identified as a substance use disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Section 2.58. Totally Disabled or Total Disability

The inability of an Eligible Employee to perform all the duties of his employment for which a Contributing Employer's contributions are payable to the Plan 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 2.59. 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 2.60. 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 2.61. Union

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

Section 2.62. Usual and Customary Charge

(a) With respect to a provider outside of the geographic area served by the PPO, the charge for Medically Necessary and Appropriate 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.

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

Section 2.63. Work Related Illness or Injury

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

ARTICLE 3 — CONTRIBUTING EMPLOYERS

Section 3.01. 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 that 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 a Contributing 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 that 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 identity, 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 2.07 of Article 2.

Section 3.02. Termination of Participation

A Contributing Employer's participation in this Plan shall be effectively terminated upon the permanent cessation of contributions by such Contributing Employer. If a Contributing 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 Contributing Employer is not obligated to make contributions to the Fund. If a Contributing Employer fails to make contributions due for 90 days after their due date, the Trustees may, by resolution, terminate the Contributing Employer's participation in the Fund. If a Contributing Employer, other than a Contributing Employer that 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 Contributing Employer. A Contributing Employer's participation in the Plan may be terminated by action of the Trustees if the terms of the Collective Bargaining Agreement are not consistent with the terms adopted from time to time by the Trustees for participation in the Plan.

Section 3.03. 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 4.01. 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 described in this Article.

Section 4.02. 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 4.03. 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 4.04. 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 4.05. The weekly payroll deduction amount shall be established by the Trustees.

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

Section 4.05. 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 Contributing 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 period 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 Eligible Dependents in the Plan when other coverage is lost or gained, including coverage under Medicaid or the State Children's Health Insurance Program ("SCHIP") (or if the employer ceases contributing towards the employee's or dependents' other coverage), when a new dependent is acquired through marriage, birth, adoption or placement for adoption, and when an Eligible Employee or Eligible Dependent becomes eligible for assistance through Medicaid or SCHIP for coverage under the Plan.

(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.

(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 ("FMLA"). 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. Notwithstanding the foregoing, an Eligible Employee's election must be filed with the Benefits Fund Office within 60 days of the following Special Enrollment Events:

(i) Loss of coverage under Medicaid or SCHIP; and

(ii) Eligibility for assistance through Medicaid or SCHIP for coverage under the Plan.

Section 4.06. 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, as set forth in Appendix A.

Section 4.07. 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 is Actively Employed and 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 he is no longer disabled;

(d) the date the Plan terminates or the Contributing Employer ceases to participate in the Plan.

Section 4.08. 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 Contributing Employer contributions or self-payment, for up to:

(a) two Months if the Eligible Employee was covered under Plan D5–Tier A or Plan LU and was classified as part-time or was covered under Plan D5–Tier B or Plan D5–Tier C at the time of becoming Totally Disabled.

(b) six Months if the Eligible Employee was covered under Plan D5–Tier A or Plan LU and was classified as full-time at the time of becoming Totally Disabled.

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 4.09. 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 that 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 4.04 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 4.04.

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 for dependent coverage;

(b) on the date the dependent becomes an Eligible Dependent, as defined in Article 2, Section 2.17.

Notwithstanding the foregoing, dependents of an Eligible Employee covered under Plan Classification D5–Tier A will become eligible only if the Eligible Employee elects Family Coverage and authorizes the weekly payroll deduction as set forth in Sections 4.04 and 4.05.

Section 4.11. Termination of Dependent Eligibility

(a) Dependent eligibility shall terminate upon the earliest of the following dates:

(i) the last day of the Month in which the dependent ceases to be an Eligible Dependent as defined in Section 2.17 of Article 2; or

(ii) the last day of the Month in which the Eligible Employee fails to work the hours required for dependent coverage, except as provided in subparagraph (b) below; or

(iii) the last day of the Month in which the date of divorce occurs for a covered spouse; or

(iv) the last day of the Month in which the Eligible Employee is ineligible for coverage.

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

(i) the last day of the third Month following the date of the Eligible Employee's death;

(ii) the last day of the Month in which the dependent ceases to be an Eligible Dependent as defined in Section 2.17 of Article 2; or

(iii) 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 a Contributing Employer that 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 that 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:

(i) when an Eligible Employee returns to work; or

(ii) when 12 weeks, or longer if allowed by law, of FMLA leave ends.

(c) Interaction with COBRA

If the Eligible Employee does not return to work within 12 weeks or longer if allowed by law, 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"), as amended.

(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 or its successor provides group Health Coverage under any other group health plan to the class of any Employees previously covered under the Plan;

(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 Section 4.15(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:

(i) an Eligible Employee covered under the Plan as of such day,

(ii) the spouse of the Eligible Employee, who is covered as an Eligible Dependent under the Plan as of such day, or

(iii) 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, if the Eligible Employee was eligible for dependent coverage when COBRA Continuation Coverage was elected.

A spouse acquired by marriage to an Eligible Employee during a period of continuation coverage is also a Qualified Beneficiary if the Eligible Employee was eligible for dependent coverage when COBRA Continuation Coverage was elected.

(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) 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:

(1) The death of the Eligible Employee;

(2) The termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;

(3) Divorce or legal separation from the Eligible Employee; or

(4) The Eligible Employee's becoming entitled to Medicare.

(B) 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:

(1) The death of the Eligible Employee;

(2) The termination of the Eligible Employee's employment (for reasons other than gross misconduct) or reduction of the Eligible Employee's hours of employment;

(3) Divorce or legal separation from the Eligible Employee;

(4) The Eligible Employee's becoming entitled to Medicare; or

(5) 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 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 that 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 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 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 45 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 that, 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 subparagraph (i), or until the occurrence of an event described in subparagraph (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 Section 4.15(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).

(D) Any period of extended coverage provided at no cost to the Eligible Employee or Qualified Beneficiary will reduce the period allowed for self-payment of contributions for COBRA continuation coverage by a period equal to the extended coverage.

(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 or its successor provides any other group health plan coverage under any other group health plan to the class of Employees previously covered under the Plan.

(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.

ARTICLE 5 — GENERAL PROVISIONS

Section 5.01. 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 5.02. 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 5.03. 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 5.04. 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 5.05. Right of Recovery

Whenever payments have been made by the Plan 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 5.06. 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 5.07. 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 5.08. 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 5.09. 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 12 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 12 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 Fund Administrator is authorized to require Pre-authorization 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 Fund 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-authorization 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.

(i) Health Claims. If a claimant's Health 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 Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, ("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 Fund may first provide this orally and then subsequently provide to the claimant in writing.

(ii) Income Protection Claims. If a claimant's Income Protection 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 Section 502(a) of 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 judgement 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 Fund may first provide this orally and then subsequently provide to the claimant in writing.

For Income Protection Claims submitted on or after April 1, 2018, the notice will also contain:

(A) An explanation of the basis for disagreement with or not following the views of a health care professional or vocational professional who treated or evaluated the claimant, a medical or vocational expert whose advice was solicited by the Plan in connection with the claim, or a disability determination made by the Social Security Administration;

(B) Copies of any internal rule, guideline, protocol or similar criteria relied on, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(C) A statement that the claimant is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to his claim upon request, free of charge.

(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 180 days 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) An appeal may be submitted by the Plan Participant, the Eligible Dependent, or an Authorized Representative (see Section 5.13(i)).

Except for Urgent Care claims, neither coverage nor rights to medical benefits under the Plan may be assigned for any reason, including the right under this Plan of any legal or equitable right to institute any court proceeding. Moreover, direct payments from the Plan to any third-party, including any medical provider, does not make the third-party an assignee or otherwise confer any rights under the Plan or ERISA. A document signed by a Participant or Eligible Dependent to the contrary shall be null and void.

Notwithstanding the above, an appeal may be submitted by an Authorized Representative of a claimant only if accompanied by a signed statement from the claimant (or parent or legal guardian) identifying the Representative and specifically authorizing the Representative to seek benefits for the Participant or Eligible Dependent that are the subject of the claim.

(e) Review of Denied Claim.

(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 Board of Trustees or its authorized committee will review the denied claim according to the terms and conditions of 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 under Section 5.13. 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.

For Income Protection Claims submitted on or after April 1, 2018, in the course of review, the Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, the Board of Trustees or Committee, or any new or additional rationale relied upon in connection with the claim. Such new or additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the claimant a reasonable opportunity to respond.

(f) 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 Administrator will review all information submitted with the letter of appeal, as well as any additional

information that may be reasonably obtained. If the Fund Administrator's decision is favorable to the claimant, a letter will be sent to the claimant advising of the decision. If the Fund Administrator'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 be notified in writing 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.

Urgent Care Appeals. 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.

Initially, the Fund Administrator will review the appeal and provide an analysis of the additional information that has been submitted with the appeal. If the Fund Administrator, based on this review, determines that additional benefits should be paid on behalf of the claimant, a favorable or partially-favorable decision for the claimant will be made. This decision will be reported in writing to the claimant. If the claim continues to be totally or partially denied, the Appeal Committee of the Board of Trustees, at its next quarterly meeting that is at least 30 days after the appeal is received, will review the information that was submitted with the letter of appeal as well as any additional information provided by the claimant and any other information that may be reasonably obtained. The Appeal Committee will 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.

If the Fund receives an appeal less than 30 days before the next Appeal Committee of the Board of Trustees meeting, the appeal will be decided at the second meeting following the date the Fund receives the appeal. If the

Fund receives the appeal 30 or more days before the next Appeal Committee meeting, the appeal will be decided at the next meeting.

If the appeal is denied in whole or in part, the claimant has the right to bring suit under Section 502(a) of ERISA within 12 months from the date the claimant has been given written notice of the Appeal Committee's decision on appeal in an attempt to recover benefits due under the terms of the Plan, enforce rights under the terms of the Plan, or to clarify rights to future benefits under the terms of the Plan.

(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 Administrator 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 Administrator 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 Administrator 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.

(g) Notification of Appeal Response.

(i) Health Claims. 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:

(A) the specific reason for the denial, including a reference to the specific Plan provision on which the denial is based;

(B) 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;

(C) a statement of the claimant's right to file suit under ERISA if the appeal is denied;

(D) 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; and

(E) 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.

(ii) Income Protection Claim. 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:

(A) the specific reason for the denial, including a reference to the specific Plan provision on which the denial is based;

(B) 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;

(C) a statement of the claimant's right to file suit under ERISA if the appeal is denied;

(D) 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; and

(E) 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.

For Income Protection Claims submitted on or after April 1, 2018, the notice will also contain:

(A) An explanation of the basis for disagreement with or not following the views of a health care professional or vocational professional who treated or evaluated the claimant, a medical or vocational expert whose advice was solicited by the Plan, the Board of Trustees or Committee in connection with the claim, or a disability determination made by the Social Security Administration;

(B) Copies of any internal rule, guideline, protocol or similar criteria relied on by the Trustees, or a statement that no such rule, guideline, protocol or similar criteria was considered; and

(C) A statement that the claimant may receive, upon request and free of charge, an explanation of the scientific or clinical judgement for the denial, applying the terms of the Plan to the claimant's medical circumstances, if the Plan's decision is based on Medical Necessity, Experimental treatment or similar exclusion or limitation.

A decision shall be made by the Appeal 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.

(h) 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.

(i) 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.

(j) 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. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has again been denied, no lawsuit or other action against the Plan or its Trustees may be filed after 12 months from the date the Participant or beneficiary has been given written notice of the final decision under the Plan's administrative proceeding. The claimant must exhaust all remedies available under the Plan's claim and appeal procedures before bringing any action in court or any administrative proceeding for Plan benefits. All decisions of the Trustees will be final and binding on the Plan, the Participant and all other interested parties.

If the time limitation in this Section of the Plan is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law.

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, non-PPO and Out-of-Area services, percentage refers to percentage of Usual and Customary Charges.

Section 6.01. Plan Classification D5–Tier A

Eligible Employee 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
- Calendar Year Deductibles
  - Per person $325
  - Maximum per family (3 persons must each satisfy the Deductible) $975
  - Non-PPO Provider, additional Deductible per person $50
  - Non-PPO Provider, additional maximum per family (3 persons must each satisfy the additional Deductible) $150
- Non-PPO Hospital Deductible (applies to each non-Emergency non-PPO Hospital Confinement).....$450
- 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-Network Hospital—Emergency or Out-of-Area Hospital 80%
Surgery for which a Second Surgical Opinion is required but not obtained 50%
Required Second and Third Surgical Opinion fees 100%
All other surgery..... 80%
Most other Covered Expenses..... 80%

Out-of-pocket maximum per Calendar Year (including the Calendar Year $325 Deductible) .....$2,650 per person
Non-PPO Provider, additional out-of-pocket maximum .....$250 per person

Preventive care—employee and Eligible Dependent spouse
Covered Expenses payable per Calendar Year
Routine annual physical exam..... $50, not subject to the Calendar Year $325 Deductible
Expenses in excess of $50..... 80% after Deductible
Preventive care testing (as described in Section 12.07(u)(ii) ..... Payable under laboratory testing
First $30 for seasonal flu vaccination ..... 100%, not subject to the Calendar Year $325 Deductible
Bone density scan, once every four Calendar Years..... 80% after Deductible

Laboratory testing
Preferred laboratory testing ..... 100%, not subject to the Calendar Year $325 Deductible
Outpatient Hospital laboratory testing..... 50% after Deductible
except for Emergencies or tests performed in conjunction with other facility-provided services or procedures that require testing to be performed on site to insure optimal treatment outcome, such as, surgical treatment..... 85% after Deductible

Mammogram
Percent of Covered Expenses payable (not subject to the Calendar Year $325 Deductible)..... 100%
Maximum per procedure $130
Expenses in excess of $130 ..... 80% after Deductible

Well-child care (Eligible Dependent child to age 2)
Percent of Covered Expenses payable (not subject to the Calendar Year $325 Deductible)..... 100%

Cardiac and pulmonary rehabilitation (as described in Section 12.07(y))
Number of sessions per Acute Occurrence .....30 sessions

Chiropractic care (as described in Section 12.07(z))
Maximum per Calendar Year $1,500

Occupational therapy (as described in Section 12.07(aa))
Number of sessions per Acute Occurrence .....25 sessions
Additional sessions for treatment of more than one system .....25 sessions
Percent of covered additional benefits if not Pre-authorized..... 50%

Physical therapy, prolo therapy, and acupuncture (as described in Section 12.07(bb))
Number of sessions per Acute Occurrence .....25 sessions
Additional sessions for treatment of more than one system or loss of special senses function.....25 sessions
Percent of covered additional benefits if not Pre-authorized..... 50%

Speech therapy (as described in Section 12.07(dd))
Number of sessions per Acute Occurrence .....25 sessions

Pain management treatment (as described in Section 12.07(ee))
Percent of Covered Expenses payable per Calendar Year
Practitioner in the Pain Management Provider Network..... 80%
Out-of-Network pain management provider 50%

Hearing aid
Percent of Covered Expenses payable..... 80%
Maximum per 5 consecutive year period $500

Intentionally Destructive Act (except suicide or attempted suicide)
Percent of Covered Expenses payable..... 50%

Hospital expenses for dental surgery
Percent of Covered Expenses payable..... 50%

Treatment of varicose veins (except ulcerated conditions)
Lifetime maximum.....$2,500 per leg

Voice communication machine
Lifetime maximum.....$7,500

Dental Benefit
Calendar Year Deductible
Diagnostic and palliative treatment..... None
All other Covered Dental Expenses.....$50
Percent of Covered Dental Expenses payable..... 100% of Scheduled Amount
Orthodontia and non-surgical treatment of TMJ
Lifetime maximum.....$1,000
Percent of covered orthodontic expenses payable 50%

Vision Benefit
Maximum per Calendar Year $135

Prescription Drug Benefit.....100% after applicable Co-pay per prescription when filled through the Prescription Drug Benefit Program at a Participating Pharmacy
30-Day Supply:

Co-pay for Tier Zero Drug $5
Co-pay for Tier One Drug.....$12
Co-pay for Tier Two Drug.....$20
Co-pay for Tier Three Drug $33

90-Day Supply (as described in Section 13.05(j)):
Co-pay for Tier Zero Drug $5
Co-pay for Tier One Drug.....$19
Co-pay for Tier Two Drug.....$40
Co-pay for Tier Three Drug $67

Section 6.02. Plan Classification D5–Tier B

Eligible Employee

Comprehensive Medical Expense Benefit
Calendar Year Deductibles
Deductible.....$325
Non-PPO Provider, additional Deductible.....$50

Non-PPO Hospital Deductible (applies to each non-Emergency non-PPO Hospital Confinement).....$450

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-Network Hospital—Emergency or Out-of-Area Hospital 80%
Surgery for which a Second Surgical Opinion is required but not obtained 50%
Required Second and Third Surgical Opinion fees 100%
All other surgery..... 80%
Most other Covered Expenses..... 80%

Out-of-pocket maximum per Calendar Year (including the Calendar Year $250 Deductible).....$2,650
Non-PPO Provider, additional out-of-pocket maximum.....$250

Preventive care
Covered Expenses payable per Calendar Year
Routine annual physical exam..... $50, not subject to the Calendar Year $325 Deductible
Expenses in excess of $50..... 80% after Deductible
Preventive care testing (as described in Section 12.07(u)(ii)..... Payable under laboratory testing
First $30 for seasonal flu vaccination ..... 100%, not subject to the Calendar Year $325 Deductible
Bone Density Scan, once every four Calendar Years ..... 80% after Deductible

Laboratory testing
Preferred laboratory testing ..... 100%, not subject to the Calendar Year $325 Deductible
Outpatient Hospital laboratory testing..... 50% after Deductible
except for Emergencies or tests performed in conjunction with other facility-provided services or procedures that require testing to be performed on site to insure optimal treatment outcome, such as, surgical treatment..... 85% after Deductible

Mammogram
Percent of Covered Expenses payable (not subject to the Calendar Year $325 Deductible)..... 100%
Maximum per procedure.....$130
Expenses in excess of $130..... 80% after Deductible

Cardiac and pulmonary rehabilitation (as described in Section 12.07(y))
Number of sessions per Acute Occurrence .....30 sessions

Chiropractic care (as described in Section 12.07(z))
Maximum per Calendar Year.....$1,500

Occupational therapy (as described in Section 12.07(aa))
Number of sessions per Acute Occurrence .....25 sessions
Additional sessions for treatment of more than one system .....25 sessions
Percent of covered additional benefits if not Pre-authorized..... 50%

Physical therapy, prolo therapy, and acupuncture (as described in Section 12.07(bb))
Number of sessions per Acute Occurrence .....25 sessions
Additional sessions for treatment of more than one system or loss of special senses function.....25 sessions
Percent of covered additional benefits if not Pre-authorized..... 50%

Speech therapy (as described in Section 12.07(dd))
Number of sessions per Acute Occurrence .....25 sessions

Pain management treatment (as described in Section 12.07(ee))
Percent of Covered Expenses payable per Calendar Year
Practitioner in the Pain Management Provider Network..... 80%
Out-of-Network pain management provider 50%

Hearing aid
Percent of Covered Expenses payable..... 80%
Maximum per 5 consecutive year period $500

Intentionally Destructive Act (except suicide or attempted suicide)
Percent of Covered Expenses payable..... 50%

Hospital expenses for dental surgery
Percent of Covered Expenses payable..... 50%

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

30-Day Supply:
Co-pay for Tier Zero Drug $5
Co-pay for Tier One Drug.....$12
Co-pay for Tier Two Drug.....$20
Co-pay for Tier Three Drug $33

90-Day Supply (as described in Section 13.05(j)):
Co-pay for Tier Zero Drug $5
Co-pay for Tier One Drug.....$19
Co-pay for Tier Two Drug.....$40
Co-pay for Tier Three Drug $67

Section 6.03. Plan Classification D5–Tier C

Eligible Employee and Eligible Dependent Child(ren)

An Eligible Employee covered under Plan Classification D5–Tier B will become eligible for Plan Classification D5–Tier C while working at least 30 Covered Hours per week for a Contributing Employer that has 50 or more employees. To receive Plan Classification D5–Tier C coverage, the Eligible Employee must elect Tier C coverage and authorize the additional weekly payroll deduction as set forth in Sections 4.04 and 4.05.

The Schedule of Benefits for Plan Classification D5–Tier C shall be the same as for Plan Classification D5–Tier B, as specified in Section 6.02, except coverage shall include:

(a) Eligible Dependent child(ren) as set forth in Section 2.17(b) and (c); and

(b) Well-child care (Eligible Dependent child to age 2)
Percent of Covered Expenses payable (not subject to the Calendar Year $325 Deductible) 100%

Section 6.04. Plan Classification LU:

Eligible Employee 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
Calendar Year Deductible
Per person $150
Maximum per family (2 persons must each satisfy the Deductible) $300
Carryover—any Calendar Year Deductible satisfied in the last 3 months of the year will be used again toward satisfaction of the following year's Calendar Year Deductible

Common Accident Deductible $150

Non-PPO Hospital Deductible (applies to each non-Emergency 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 90%
Out-of-Network Hospital 85%
Out-of-Network Hospital—Emergency or Out-of-Area Hospital 85%
Outpatient Surgery (In-Network Hospital not required) 100%
Surgery for which a Second Surgical Opinion is required but not obtained 50%
(not required that the majority opinion be followed)
All other surgery 85%
Medical treatment (non-surgical, non-hospital) ..... $100 at 100% (no Deductible for first visit); thereafter at 85% after Deductible
Most other Covered Expenses 85%

Out-of-pocket maximum per Calendar Year (including the Calendar Year $150 Deductible) ..... $1,209 per person

Preventive care—employee and Eligible Dependent spouse
Covered Expenses payable per Calendar Year
Routine annual physical exam ..... $50, not subject to the Calendar Year $150 Deductible

Expenses in excess of $50 ..... 85% after Deductible

Preventive care testing (as described in Section 12.07(u)(ii)) ..... Payable under laboratory testing

First $30 for seasonal flu vaccination ..... 100%, not subject to the Calendar Year $150 Deductible

Bone density scan, once every four Calendar Years ..... 85% after Deductible

Diagnostic X-ray and Laboratory ..... $150 at 100%, not subject to the Calendar Year $150 Deductible

Expenses in excess of $150 ..... 85% after Deductible

Laboratory testing

Preferred laboratory testing ..... 100%, not subject to the Calendar Year $150 Deductible

Outpatient Hospital laboratory testing ..... 50% after Deductible

except for Emergencies or tests performed in conjunction with other facility-provided services or procedures that require testing to be performed on site to insure optimal treatment outcome, such as, surgical treatment ..... 85% after Deductible

Mammogram

Percent of Covered Expenses payable (not subject to the Calendar Year $325 Deductible) 100%

Maximum per procedure $130

Expenses in excess of $130 ..... 85% after Deductible

Well-child care

Percent of Covered Expenses payable (not subject to the Calendar Year $150 Deductible) 100%

Cardiac and pulmonary rehabilitation (as described in Section 12.07(y))

Number of sessions per Acute Occurrence ..... 30 sessions

Chiropractic care (as described in Section 12.07(z))

Maximum per Calendar Year $1,500

Occupational therapy (as described in Section 12.07(aa))

Number of sessions per Acute Occurrence ..... 25 sessions

Additional sessions for treatment of more than one system ..... 25 sessions

Percent of covered additional benefits if not Pre-authorized 50%

Physical therapy, prolo therapy, and acupuncture (as described in Section 12.07(bb))

Number of sessions per Acute Occurrence ..... 25 sessions

Additional sessions for treatment of more than one system or loss of special senses function ..... 25 sessions

Percent of covered additional benefits if not Pre-authorized 50%

Speech therapy (as described in Section 12.07(dd))

Number of sessions per Acute Occurrence ..... 25 sessions

Pain management treatment (as described in Section 12.07(ee))
Percent of Covered Expenses payable per Calendar Year
Practitioner in the Pain Management Provider Network 85%
Out-of-Network pain management provider 50%

Hearing aid
Percent of Covered Expenses payable..... 85%
Maximum per 5 consecutive year period $500

Intentionally Destructive Act (except suicide or attempted suicide)
Percent of Covered Expenses payable..... 50%

Hospital expenses for dental surgery
Percent of Covered Expenses payable..... 85%

Treatment of varicose veins (except ulcerated conditions)
Lifetime maximum.....$2,500 per leg

Voice communication machine
Lifetime maximum.....$7,500

Dental Benefit
Calendar Year Deductible
Diagnostic and palliative treatment ..... None
All other Covered Dental Expenses ..... None
Percent of Covered Dental Expenses payable..... 80%
Maximum per Calendar Year $3,000
Orthodontia and non-surgical treatment of TMJ
Lifetime maximum.....$4,000
Percent of covered orthodontic expenses payable 80%

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

30-Day Supply:
Co-pay for Tier Zero Drug $0
Co-pay for Tier One Drug.....$7
Co-pay for Tier Two Drug.....$10
Co-pay for Tier Three Drug $31

90-Day Supply (as described in Section 13.05(j)):
Co-pay for Tier Zero Drug $0
Co-pay for Tier One Drug.....$9
Co-pay for Tier Two Drug.....$15
Co-pay for Tier Three Drug $63

Other Provisions

Benefits and provisions set forth in the Plan apply to Eligible Employees and Eligible Dependents covered under Plan Classification LU with the following modifications:

Article 7 — Utilization Management, Section 7.02 Second Opinion. The requirement to obtain a third independent medical examination for any non-emergency procedure or surgery listed in the Required Second Opinion Review List in Appendix C does not apply. A third opinion is optional, is payable at 85%, and the requirement that the majority opinion be followed does not apply.

Article 13 — Prescription Drug Benefit, Section 13.05 Exclusion and Limitations. The exclusion set forth in paragraph (d) regarding contraceptives or implanted drugs or devices does not apply.

Article 19 — Coordination of Benefits, Section 19.05 Working Spouse Rule. This provision does not apply.

Appendix A — Eligibility Requirements. Plan Classification LU is a “Rate-Per-Hour Contribution” plan; however, the requirements specified under “Flat-Rate Contribution” shall apply.

ARTICLE 7 — UTILIZATION MANAGEMENT

Section 7.01. Pre-authorization

The Eligible Employee or Eligible Dependent must contact the Benefits Fund Office prior to a non-Emergency Hospital admission, within 48 hours of an Emergency Hospital admission, when an inpatient procedure or surgery is proposed, or when a service, supply or treatment that requires Pre-authorization/Pre-certification is proposed. If the Eligible Employee or Eligible Dependent fails to comply with such requirements for Pre-authorization, benefits shall be reduced, modified or not payable, as follows:

(a) The Non-Compliance Deductible specified in the Schedule of Benefits must be satisfied if the Benefits Fund Office is not contacted two weeks prior to a scheduled Hospital admission or inpatient or outpatient surgery or within 48 hours of an Emergency Hospital admission or prior to incurring any expense for advance diagnostic testing, or the required pre-certification or pre-authorization is not obtained for a service; and

(b) Physician charges shall be payable at the lower percent specified in the Schedule of Benefits if a procedure or surgery required a Second Opinion, as described in Section 7.02 below, and the Second Opinion was not obtained.

Inpatient Pre-authorization is not required in connection with childbirth when it is a full-term vaginal delivery or a scheduled Caesarean section.

Pre-authorization or pre-certification 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 and pre-certification decisions are limited to whether expenses are covered for reimbursement under the Plan and if a Second Opinion is required. Pre-authorization or pre-certification 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 or pre-certification is not intended to interfere (and shall not be construed as interfering) with the Physician-patient relationship.

It is required that an Eligible Employee or Eligible Dependent contact the Benefits Fund Office before proceeding with ultrasound guidance for outpatient arthrocentesis or therapeutic joint injections, IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections or procedures, and advanced diagnostic testing such as

MRI (magnetic resonance imaging) scans, CT (computerized tomography) scans, or Thallium stress tests.

Section 7.02. 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 Expenses 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 and Appropriate 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 Fund 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 and Appropriate 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 Charges for required second and, if necessary, third independent medical examinations and opinions including Pre-authorized necessary and appropriate x-rays and diagnostic tests that satisfy this provision will be considered Covered Expenses and shall be payable at the percent specified in the Schedule of Benefits. 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 8.01. 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 8.02. 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.

Section 8.03. Beneficiary Designation Following Divorce

The named beneficiary shall be the person or persons designated by the Participant on a form provided for that purpose by the Trustees that was received by the Trustees during the Participant's lifetime. Effective May 10, 2011, the designation of a spouse as a Participant's named beneficiary shall be void upon the date of the dissolution of the Participant's marriage to that spouse. In such event, unless a new designation of beneficiary form is received by the Trustees after such divorce, the Life Insurance Benefit shall be paid as if no named beneficiary had been designated. To maintain the former spouse as a named beneficiary, the Participant must re-designate the former spouse as beneficiary by completing a new designation of beneficiary form following the divorce and identifying the former spouse as the named beneficiary.

ARTICLE 9 — EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

Section 9.01. General

If an Eligible Employee dies or suffers Injuries that 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 9.02. 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 10.01. 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 10.02. 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 11.01. 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 11.02. 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 11.03. Periods of Disability

(a) 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.

(b) Successive periods of disability shall be considered one period of disability unless:

(i) between the periods of disability, the Eligible Employee has returned to Active Employment for at least four consecutive weeks; or

(ii) the disabilities are due to unrelated causes and begin after the Eligible Employee has returned to Active Employment for at least one day.

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

(i) 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

(ii) 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 11.04. 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 that 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.

(f) periods after a Contributing Employer closes all stores in the geographical area of the Plan's operation or ceases to be a Contributing Employer.

ARTICLE 12 — COMPREHENSIVE MEDICAL EXPENSE BENEFIT

Section 12.01. 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, as specified in the Schedule of Benefits and according to the provisions of this Article.

Section 12.02. 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 that 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 12.03. 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.

Section 12.04. Deductible Amounts

(a) Calendar Year Deductibles

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

The Non-PPO Provider Calendar Year Deductible is an additional amount, as specified in the Schedule of Benefits, of Covered Medical Expense the Eligible Employee or Eligible Dependent must pay before he is entitled to certain Comprehensive Medical Benefits if any non-PPO Provider is used.

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

The Calendar Year Deductible must be satisfied only once in any Calendar Year though the Eligible Employee or Eligible Dependent may have several different Injuries or Illnesses.

(b) Non-Compliance Deductible

The Non-Compliance Deductible is the amount specified in the Schedule of Benefits of inpatient Hospital expense, surgery expense, or advanced diagnostic testing expense that the Eligible Employee or Eligible Dependent must pay for each Hospital Confinement, surgery or advanced diagnostic testing that 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 12.05. 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(s), the additional non-PPO Provider out-of-pocket maximum 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 that 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, surgery or advanced diagnostic testing (Non-Compliance Deductible);

(b) amounts paid to satisfy the Non-PPO Hospital Deductible; or

(c) amounts paid for Covered Medical Expenses that are reimbursed by the Plan at 50%; or

(d) amounts paid for expenses that are not Covered Medical Expenses.

Section 12.06. Maximum Benefit

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.

Section 12.07. 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 that are Medically Necessary and Appropriate and that 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 specified 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 Caesarean 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. 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.

(D) prophylactic mastectomy as set forth in Section 12.07(l).

(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 transportation service expenses, as follows:

(i) ground transportation by professional ambulance to the nearest appropriate facility as Medically Necessary and Appropriate for the treatment of a medical Emergency, acute Illness or Injury;

(ii) air ambulance transportation only as Medically Necessary and Appropriate due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient, up to $15,000 per incident in North America and $25,000 per incident elsewhere;

(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 up to a maximum of five trips per Calendar Year.

(e) drugs or medicines that are administered while an inpatient or during a iHome Health Care or Hospice visit.

(f) 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 Fund 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 that are Pre-authorized.

(g) charges for Home Health Care made by a Home Health Care Agency as follows:

(i) the plan of care by the Home Health Care Agency:

(A) is prescribed by a Physician;

(B) is reviewed and approved by the Physician during the entire period; and

(C) that expenses for the plan of care are Pre-authorized in writing by the Benefits Fund Office based on the following requirements:

(1) the number of days of Home Health Care does not exceed the number of days of confinement in a Hospital or Skilled Nursing Facility that would otherwise have been required;

(2) the Home Health Care will probably cost less per day than the daily rate for confinement in a Hospital or Skilled Nursing Facility; and

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

(ii) Home Health Care includes:

(A) skilled nursing care; and

(B) any other services and supplies provided in lieu of the services that 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 Care aide services.

(h) 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 that:

(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 or rendered with the intent of prolonging life;

(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 in writing by the Benefits Fund Office.

(iii) Hospice care is provided:

(A) in the patient's home by a Home Health Agency or Hospice agency; or

(B) in a Hospice inpatient facility. Charges by a Hospice inpatient facility that 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.

(i) durable medical equipment expenses. Durable medical equipment is equipment that 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; and

(iv) is Medically Necessary and Appropriate and complies with all other relevant provisions of the Plan.

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

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

Equipment parts that 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.

(j) anesthetics and their administration; blood and blood plasma and its administration; and oxygen and the rental of equipment for the administration of oxygen, including the purchase of an oxygen concentrator for portable oxygen tanks.

(k) x-ray and laboratory examinations and x-ray, radium and radioactive isotope therapy.

(l) prophylactic mastectomy and BRCA testing if Pre-authorized in writing by the Benefits Fund Office and in accordance with the Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time, a copy of which is attached as Appendix G to this Plan document.

(m) transplant expenses for non-experimental human organ and tissue transplants. Donor-related and procurement expenses are not covered except under Plan Classification LU as follows:

(i) donor-related expenses as follows:

(A) reasonable and necessary medical expenses for evaluation, donation surgery and immediate follow-up care incurred by a donor who is covered under this Plan if the recipient of the transplant is covered under this Plan;

(B) reasonable and necessary medical expenses for evaluation, donation surgery and immediate follow-up care incurred by a donor who is not covered by this Plan if the recipient of the transplant is covered under this Plan but only to the extent the donor is not covered by the donor's own insurance or health care plan; and

(C) complications that arise with respect to the donor if they are directly attributable to the donation surgery and only within the 30-day time period following the donation surgery.

(ii) procurement expenses from a donor up to a maximum of $50,000 per transplant recipient per transplant. Procurement includes:

(A) expenses to find the donated organ/tissue (donor search fees);

(B) tests on the potential organ/tissue for compatibility;

(C) surgery/procedures to remove the organ/tissue; and

(D) transportation fees to deliver the organ/tissue to the recipient, but only when the organ/tissue is transported within the United States.

(n) accidental Injury to oral/facial structures including, but not limited to, jaw and facial bone fractures and Injury to Sound and Natural Teeth.

(o) varicose vein treatment expenses as specified in the Schedule of Benefits.

(p) Medically Necessary and Appropriate nutritional counseling up to four visits per Calendar Year when provided by a Registered Dietician or comparably credentialed professional (e.g., Commission on Dietetic Registration) when ordered by the Eligible Employee's or Eligible Dependent's treating Physician as part of a comprehensive plan for patients with a known history of diabetes, renal failure, hepatic insufficiency, genetic metabolic disorder requiring dietary modifications or being provided as part of a Plan-approved bariatric management program.

(q) Medically Necessary and Appropriate non-surgical bariatric treatment and management (up to six visits per Calendar Year) when provided by the Eligible Employee's or Eligible Dependent's treating Physician (M.D. or D.O.) as part of a comprehensive treatment plan for patients with a history of obesity (body mass index greater than or equal to 30) when provided as part of a Plan-approved bariatric management program.

(r) bariatric surgery if Pre-authorized in writing by the Benefits Fund Office in accordance with the Bariatric Surgery Policy adopted by the Board of Trustees, as amended from time to time, a copy of which is attached as Appendix F to this Plan document.

(s) Mental or Nervous Disorder treatment expenses as follows:

(i) eligibility for all inpatient and outpatient therapy will be subject to all Plan provisions including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate; and

(ii) expenses for treatment by a residential care center must be Pre-authorized in writing by the Benefits Fund Office; and

(iii) the residential care center must

(A) be accredited by The Joint Commission or other similar credentialing entity acceptable to the Plan; and

(B) comply with all federal, state and local requirements including required licensing; and

(C) be an In-Network Provider unless an In-Network facility is unavailable, in which case the alternative facility must be Pre-authorized in writing by the Benefits Fund Office.

(t) Substance Use Disorder treatment expenses as follows:

(i) eligibility for all inpatient and outpatient therapy will be subject to all Plan provisions including, but not limited to, a determination that the therapy is Medically Necessary and Appropriate; and

(ii) expenses for treatment by a residential care center must be Pre-authorized in writing by the Benefits Fund Office; and

(iii) the residential care center must

(A) be accredited by The Joint Commission or other similar credentialing entity acceptable to the Plan; and

(B) comply with all federal, state and local requirements including required licensing; and

(C) be an In-Network Provider unless an In-Network facility is unavailable, in which case the alternative facility must be Pre-authorized in writing by the Benefits Fund Office.

(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) laboratory and other medical 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;

(iii) bone density scanning for patients age 45 or older once every four Calendar Years;

(iv) annual seasonal flu vaccination; amount payable set by the Trustees, from time to time.

(v) 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.

(w) laboratory testing. Payment will be made as specified in the Schedule of Benefits for:

(i) Preferred laboratory testing for covered tests performed at a stand-alone outpatient laboratory or by an In-Network Physician who processes the tests in his or her office.

(ii) Outpatient laboratory testing performed at a Hospital or outpatient facility affiliated with a Hospital.

(x) 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.

(y) cardiac and pulmonary rehabilitative therapy subject to all applicable terms of the Plan up to a maximum of 30 sessions per Acute Occurrence.

(i) For purposes of this subsection (y), an Acute Occurrence is an event be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require treatment to restore normal Cardiovascular or Respiratory system function or prevent additional loss of function.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six months.

(ii) For purposes of this subsection (y), a session is Medically Necessary and Appropriate supervised rehabilitation services of no more than one hour per calendar day and inclusive of no more than one low level stress test per Acute Occurrence.

(z) chiropractic care expenses for the treatment of the back, neck, spine and vertebra, for conditions due to subluxations, strains, sprains and nerve root problems up to the Calendar Year limit set forth in the Schedule of Benefits.

For purposes of this subsection (z), chiropractic care is care provided by a licensed chiropractor or a credentialed provider under the direction of or in association with a chiropractor or a credentialed provider under the direction of or in association with a chiropractor inclusive of evaluation and management as well as manipulation or adjustment of up to two areas of the body and including no more than administration of two medically appropriate modalities.

Covered treatment shall not include services or supplies, regardless of where or by whom they are provided, that

(i) a person without medical skills or background could provide or be trained to provide; or

(ii) are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(aa) Medically Necessary and Appropriate occupational therapy up to a total of 25 sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (aa), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require occupational therapy treatment to restore normal organ system function or prevent additional loss of function to any of the following systems: Musculoskeletal, Genitourinary, Skin and Related Structures,

Neurological, or loss of function of any one of the Special Senses Functions as more specifically defined in The Blue Book.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six months.

(ii) For purposes of this subsection (aa), a session is all evaluation and treatment provided on a single calendar day, the aggregate of which shall not exceed one hour per day.

(iii) No more than two times the Acute Occurrence Limit will be payable for any single event that results in impairment to two or more systems as noted above.

(iv) Medically Necessary and Appropriate sessions in excess of 25 per Acute Occurrence will require Pre-authorization in writing through the Benefits Fund Office. Failure to obtain Pre-authorization will result in payment of 50% of the Usual and Customary Charges for the Covered Expense.

(v) Covered treatment for an Acute Occurrence shall not include 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 as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(bb) Medically Necessary and Appropriate physiotherapy, acupuncture, prolo therapy, and physical medicine services ordered by a qualified Physician up to a total of 25 sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (bb), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, congenital or related to an injury suffered at birth, or due to causes unknown that causes a loss of function or structure sufficient to require physical therapy treatment to achieve or restore normal organ system function or prevent additional loss of function to any of the following systems: Musculoskeletal, Digestive, Genitourinary, Skin and Related Structures, Neurological, or loss of

function of any one of the Special Senses Functions as more specifically defined in The Blue Book.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected organ system without ongoing treatment or therapy for a period of not less than six months, or in the case of a condition related to a congenital deficit or birth injury identified and/or treated within the first year of life, an Acute Occurrence will be considered to have ended coincident with the ending of the Plan Year thereafter until the person has either been considered to have reached maximum medical improvement or has been treatment-free for 12 months at which time the condition will be subject to the Acute Occurrence Limit then applicable for all non-congenital and birth-related events. The person will be limited to 25 treatments annually for the treatment of all congenital or birth-related Injuries. The diagnosis of developmental delay in the absence of a specifically-identified congenital condition or birth injury will not be considered a congenital defect or birth-related Illness or Injury.

(ii) For purposes of this subsection (bb), a session is all care including evaluation and management and of no more than three additional modalities, procedures, or supervised services taking place for up to one hour on any single calendar day.

(iii) No more than two times the Acute Occurrence Limit will be payable for any single event that results in impairment to two or more systems as noted above.

(iv) Medically Necessary and Appropriate sessions in excess of 25 per Acute Occurrence will require Pre-authorization in writing through the Benefits Fund Office. Failure to obtain Pre-authorization will result in payment of 50% of the Usual and Customary Charges for the Covered Expense.

(v) Covered treatment for an Acute Occurrence shall not include 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 as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(cc) short term, active, progressive rehabilitation services, if Pre-authorized in writing by the Benefits Fund Office, that are needed to restore physical ability that has been substantially reduced due to severe Illness or Injury.

(dd) Medically Necessary and Appropriate speech therapy up to a total of 25 sessions per Acute Occurrence (the "Acute Occurrence Limit").

(i) For purposes of this subsection (dd), an Acute Occurrence is an acute Illness or Injury be it traumatic, infectious, ischemic, or due to causes unknown that causes a loss of function or structure sufficient to require speech therapy treatment to restore normal organ system function or prevent additional loss of function to any of the following systems: Musculoskeletal, Digestive, Neurological, or loss of function of any one of the Special Senses Functions as more specifically defined in The Blue Book.

An Acute Occurrence will be considered to have ended upon restoration of normal function or structure of the affected system without ongoing treatment or therapy for a period of not less than six months.

(ii) For purposes of this subsection (dd), a session is all evaluation and treatment provided on a single calendar day, the aggregate of which shall not exceed one hour per day.

(iii) No more than one times the Acute Occurrence Limit will be payable for any single event that results in impairment to one or more systems as noted above.

(iv) Covered treatment for an Acute Occurrence shall not include 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 as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury, or functional ability.

(ee) pain management treatment for chronic pain as specified in the Schedule of Benefits; a higher percentage of Covered Expenses is payable when treatment is provided by a Practitioner in the Pain vManagement Provider Network established by the Plan.

(ff) medical supplies, surgical dressings, casts, splints, trusses, braces, and crutches.

(gg) up to four pairs of surgical stockings each Calendar Year.

(hh) up to two bras for breast Prosthesis each Calendar Year.

(ii) one wig each Calendar Year, payable to a maximum of $150.

(jj) orthotic appliances. Payment will be made for the initial appliance and, after five years, one replacement for each five years of continuous use.

(kk) 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 transplant basic lenses;

(v) penile implant, limited to one per lifetime.

(ll) hearing aid expenses as specified in the Schedule of Benefits.

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

Section 12.08. 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 Calendar Year 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 Calendar Year Deductible as an incentive for the individual to complete the Smoking Cessation Program.

ARTICLE 13 — PRESCRIPTION DRUG BENEFIT

Section 13.01. 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 13.02. Benefits Payable

The Fund has entered into an agreement with a pharmacy benefit manager 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.

The Board of Trustees has established the Co-pays specified 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 a low 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 that have either limited therapeutic applications, are higher in cost, or that generally have acceptable clinical alternatives in Tier Zero, Tier One or Tier Two.

The Board of Trustees shall, from time to time, assign and modify the Co-pay terms, Tier levels and any coverage limitations (including exclusion from Plan coverage) for any Prescription Drug based on the advice and recommendation of the Plan's medical consultant.

A record of the Prescription Drugs and their Tier assignments shall be maintained by the Plan's administrative office.

Prescriptions or refills that are payable under a governmental program or a pharmaceutical industry co-pay assistance program are not covered under this Plan unless payments under such programs are coordinated with the Plan under specific provisions or policies adopted by the Board of Trustees.

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 13.03. Covered Prescription Drug Expenses

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

(a) Legend Drugs that 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;

(d) needles and syringes for any other use, up to a 30-day supply;

(e) blood glucose testing strips;

(f) certain drugs when specifically approved by the Board of Trustees; and

(g) lancets.

Section 13.04. Hepatitis C Virus Pharmaceutical Coverage Policy

Coverage of drugs related to treatment of the Hepatitis C Virus shall be determined by the Fund's medical consultant who will apply the current guidelines of the American Association for the Study of Liver Diseases.

Section 13.05. 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) contraceptives or implanted drugs or devices, regardless of intended use

(e) drugs or products used for smoking cessation, including Nicorette and nicotine transdermal patches

(f) drugs used as an aid to weight loss

(g) drugs that 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 for a 90-day supply of a drug as determined from time to time by the Trustees or as determined by the Plan's pharmacy benefit manager to be primarily prescribed for maintenance of a chronic condition

(k) any prescription order or refill for which the pharmacist's usual and customary charge to the public is less than the Co-pay 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 drugs for which an acceptable, Medically-Necessary and Appropriate reason for continued long-term drug usage has not been established; or that 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

(n) drugs (except Lupron) consumed at the time and place of prescription

(o) drugs in excess of the quantity specified in the prescription order

(p) drugs that 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

(q) drugs that will be payable under a governmental program or a pharmaceutical industry co-pay assistance program unless payments under such programs are coordinated with the Plan under specific provisions or policies adopted by the Board of Trustees

(r) any prescription order or refill 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, 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 between a Brand-Name Drug and a Generic Drug when a Generic Drug is available and medically appropriate but a Brand-Name Drug is requested, except when medical exigency is present as determined by the Trustees

(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) lifestyle drugs

(aa) specialty drugs when dispensed by a retail pharmacy instead of by mail through US Specialty Care or other program that has been approved by the Trustees

The listing of Prescription Drugs that are covered, excluded, or limited by the Plan may be modified at any time or from time to time by the Trustees. A list of such modifications shall be maintained by the Fund Administrator's office.

Section 13.06. 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 14.01. General

If an Eligible Employee or Eligible Dependent incurs Covered Dental Expenses for services performed by a licensed Dentist or licensed dental hygienist that 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 14.02. Benefits Payable

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

The Schedule of Dental Procedures will be reviewed by the Trustees from time to time to ensure that the benefits in the Schedule cover 100% of the median charge for Dental Services provided to an Eligible Employee or Eligible Dependent under 19 years of age.

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 14.03. 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 that:

(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 14.04. 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 14.05. 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 pre-treatment 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 Fund 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 pre-treatment estimate does not constitute an evaluation or approval of the Dentist or dental plan.

Section 14.06. 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 14.07. 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, diphenhydramine, 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 14.08. 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 that is needed because of the first time placement of an opposing full denture or the extraction of natural teeth;

(ii) a permanent Prosthesis that replaces an interim complete or partial denture or other temporary Prosthesis;

(iii) replacement of a Prosthesis that, while in the mouth, has been damaged beyond repair as a result of an accident that 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 that 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 that are undertaken for primarily cosmetic reasons, except those orthodontic procedures specified in Section 14.06;

(i) periodontal scaling procedures on patients not manifesting Case Type II, III or IV periodontal disease;

(j) complete series (including bite wings) of x-rays more than once each Calendar Year provided that this limitation shall not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;

(k) panoramic x-rays more than once each Calendar Year provided that this limitation shall not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;

(l) periapical x-rays (single film) taken on the same day as covered complete series x-rays are taken;

(m) prophylaxis treatments are limited to a maximum of four per Calendar Year, as follows: up to two for dental prophylaxis (ADA Codes 1110/1120); up to four for periodontal prophylaxis (ADA Code 4910) provided that they are performed as adjunctive periodontal treatment rendered with respect to active periodontal treatment provided that this limitation shall not apply to Medically Necessary treatment for an Eligible Employee or Eligible Dependent who is under 19 years of age;

(n) temporary bridgework and temporary crowns, except when a temporary crown is needed due to a fractured tooth.

ARTICLE 15 — VISION BENEFIT

Section 15.01. 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 15.02. Benefits Payable

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

Section 15.03. 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 that give rise to the expense are 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 15.04. 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 that do not require a prescription.

ARTICLE 16 — SUBROGATION

Section 16.01. Subrogation and Reimbursement

(a) Fund's Rights to Subrogation and Reimbursement. The Fund shall be entitled to subrogation or to seek reimbursement with regard to all rights of recovery of an Individual or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Individual (collectively, for purposes of this Section 16.01, "Individual"), to the extent of any amounts that the Fund has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the Illness, Injury, sickness, accident or condition to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverages and any employer of an Eligible Employee or Eligible Dependent under the provisions of a Workers' Compensation or Occupational Disease Law, or any individual policy of insurance that is maintained by an Individual. The Fund shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgement or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply 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 of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. Once the Fund makes or is obligated to make payments on behalf of an Individual on account of the claim, the Fund is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgement received by the Individual from any Source.

(b) Action Required of Individual. If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Fund from any Source and shall hold that portion of the total recovery from any Source—that is due for payments made or to be made in trust

for the benefit of the Fund—to be paid to the Fund immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this Section 16.01. The Individual shall assist and cooperate with representatives designated by the Fund to recover payments made by the Fund and shall do everything that may be necessary to enable the Fund to exercise its subrogation and reimbursement rights described herein.

The Trustees may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement") in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. The Fund has the right to suspend all benefit payments if the Agreement is not executed by the Individual(s) or if the Agreement is modified in any way by the Individual without the consent of the Fund. However, in its sole discretion, if the Fund advances claims payments in the absence of an Agreement, or if the Fund advances claims payments in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Eligible Employee (in the case of a minor Eligible Dependent), the Eligible Employee's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Fund. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Fund. In this regard, the Individual agrees that the amount the Fund has advanced or is obligated to advance in benefits received from any Source will be immediately deposited into a trust for the Fund's benefit and the Fund shall have an equitable lien by agreement that shall be enforceable under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Fund's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

(c) Enforcement of Rights. The Fund has the right to recover amounts representing the Fund's subrogation and reimbursement interests under this Section 16.01 through any appropriate legal or equitable remedy, including, but not limited to, the initiation of a recognized cause of action under ERISA Section 502(a)(2) or 502(a)(3), including injunctive action to ensure the claim payment amounts that the Fund has advanced are preserved and not disbursed, or any other applicable federal or state law, including the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered

from any Source, whether through settlement, judgement 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.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual. Enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Amounts recovered by an Individual from any Source are considered Plan assets and the Individual is therefore considered a fiduciary of the Fund with respect to those recovered amounts and shall not dissipate those monies without first satisfying the Fund's subrogation and reimbursement interests.

Further, in the event an Individual receives monies as the result of an Illness, Injury, sickness, accident or condition and the Fund is entitled to such monies in accordance with this Section 16.01 and is not reimbursed the amount it has paid for such Injury, Illness, sickness, accident or condition, the Fund shall have the right to reduce future payments due to such Individual, his or her parent(s) and dependent(s) (including minor dependents) or their representatives, guardians or trustees, by the amount of benefits paid by the Fund. The right of offset shall not, however, limit the rights of the Fund to recover such monies in any other manner described in this Section 16.01.

(d) Individual's Attorneys' Fees. The Fund's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Illness, Injury, sickness, accident or condition, and the Fund's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Fund's claim by an agreed upon amount of such fees or expenses.

(e) Disavowal of Common Law Defenses. The Fund specifically disavows any claims that an Individual may make under any federal or state common law defense, including, but not limited to, the common fund doctrine, the double-recovery rule, the make-whole doctrine or any similar doctrine or theory, including the

contractual defense of unjust enrichment. This means that the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to all legal fees and expenses. It also means that the Individual grants a priority, first-dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Illness, Injury, sickness, accident or condition.

Section 16.02. Offset

In the event any payment is made by the Fund to or on behalf of an Individual who is not entitled to such payment or who had an obligation to reimburse an amount to the Fund, the Fund shall have the right to reduce future payments due to such Individual or the Eligible Employee of whom such Individual is an Eligible Dependent or any other Eligible Dependent of such Eligible Employee by the amount of any such erroneous payment or unreimbursed amount. This right of offset shall not, however, limit the rights of the Fund to recover such overpayment or unreimbursed amount in any other manner.

ARTICLE 17 — SELF-AUDIT PROGRAM

Section 17.01. 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 that in turn results in benefit dollars saved for the Fund.

Section 17.02. 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 that 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 17.03. 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) Services or supplies that are not Medically Necessary and Appropriate.

(c) Any Illness, Injury or Dental Service that arises out of or in the course of any occupation or employment, or for which an Eligible Employee or Eligible Dependent has received or is entitled to receive benefits under a Workers' Compensation or occupational disease law.

(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) Services and supplies that the person is entitled to receive from the Uniformed Services medical care facilities or under any program of the Veterans Administration ("VA") when allowed by law. However, services and supplies received from a Veterans Administration 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) 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.

(g) Cosmetic Surgery or Treatment or complication thereof.

(h) Services or supplies for weight reduction by diet control, behavior modification, with or without drugs, or surgery, except for treatment covered under Sections

12.07(p) nutritional counseling, 12.07(q) non-surgical bariatric treatment, or 12.07(r) bariatric surgery.

(i) Skin or fat removal surgery for any reason.

(j) Diagnosis, testing or treatment of infertility.

(k) Hormone therapy, artificial insemination or any other direct attempt to induce or facilitate fertility or conception.

(l) Gender reassignment surgery or any associated pharmacotherapy, except as specified in Appendix H.

(m) Breast reduction surgery, except for reconstruction due to breast cancer.

(n) Prophylactic mastectomy and BRCA testing expenses that have not been Pre-authorized in writing by the Benefits Fund Office and in accordance with the Fund's Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time (a copy of which is attached as Appendix G to this Plan document).

(o) Covered Expenses for services and supplies for the care and treatment of an Illness or Injury resulting from an Intentionally Destructive Act by an Eligible Employee or Eligible Dependent who is not of diminished capacity due to a physical or mental impairment that would preclude reasonable compliance with treatment ordered by a Physician, will be payable at the percentage specified in the Schedule of Benefits.

Except in the situation where the Eligible Employee or the Eligible Dependent leaves an acute care facility against the medical advice of the treating Physician, the limitation on benefits specified in the Schedule of Benefits will not be imposed by the Plan until the Eligible Employee or Eligible Dependent has been advised in writing of the requirements necessary to maintain compliance with treatment and receive unreduced benefits.

(p) Treatment of a condition or related condition that is a result of the commission of a felony, a result of war or any act of war, whether war is declared or undeclared, or a result of participating in a riot.

(q) Snoring cessation and snoring correction devices for any reason.

(r) Vision therapy.

(s) Procedures for surgical correction of myopia and/or refractive errors.

(t) Marriage counseling, or treatment for anti-social behavior that is not the result of a Mental or Nervous Disorder or of a Substance Use Disorder.

(u) Physical examinations or medical certificates required for employment.

(v) 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 Expense.

(w) Immunizations, routine examinations or screenings and other preventive care, except as specifically provided under the Comprehensive Medical Expense Benefit.

(x) Personal hygiene, convenience or comfort items including, but not limited to, such items as televisions, telephones, first aid kits, physical fitness equipment, air conditioners, humidifiers, saunas and hot tubs.

(y) Home blood pressure monitoring or home uterine monitoring equipment for any reason.

(z) 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.

(aa) Routine foot care such as the cutting and trimming of toenails.

(bb) Routine circumcision of newborns.

(cc) Educational services, supplies or equipment (except for nutritional counseling under Section 12.07(p)), including but not limited to, computers, software, printers, books, tutoring and visual aids even if they are required because of an Illness or Injury.

(dd) 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 as sole nutrition.

(ee) Over-the-counter supplies, drugs and medicines, except as otherwise specifically noted.

(ff) Naturopathic or homeopathic services and substances.

(gg) Completion of a routine claim form or routine supplemental report.

(hh) Experimental, Investigational or Unproven Services.

(ii) Blood storage expenses, except for use for an anticipated covered medical condition for a period not to exceed six months.

(jj) Blood donated by family members or others specifically for another patient's use.

(kk) Expenses related to donation of an organ or tissue, except as provided under Section 12.07(m) for Plan Classification LU.

(ll) Expenses related to procurement from a donor of a human organ or tissue for transplant except, as specified in Section 12.07(m) for Plan Classification LU.

(mm) Expenses for ultrasound guidance for outpatient arthrocentesis or therapeutic joint injections, IV sedation utilized in conjunction with outpatient epidural or other pain management interventional injections or procedures that have not been Pre-authorized in writing by the Benefits Fund Office.

(nn) Expenses related to a surrogate pregnancy.

(oo) Reversal of a surgical procedure.

(pp) Repair of, or operating supplies for, durable medical equipment, including portable oxygen in excess of one tank when an oxygen concentrator is leased or purchased.

(qq) Shoes for any reason.

(rr) Muscle stimulators in excess of $500.

(ss) 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.

(tt) Custodial Care, except when provided by a Hospice.

(uu) Covered Expenses for Home Health Care shall not include services or supplies, regardless of where or by whom they are provided, that:

(i) a person without medical skills or background could provide or be trained to provide, provided that this shall not preclude coverage by the Plan for training for such person to provide the Home Health Care at the sole discretion of the Trustees; or

(ii) are provided as part of a maintenance treatment plan not reasonably expected to improve the patient's condition, Illness, Injury or functional ability.

(vv) All genetic testing for the purposes of screening for the presence of occult disease, or for risk stratification for the development of clinically absent or unapparent disease, or for the evaluation of possible prophylactic surgical treatment, will be excluded with the exception of the following:

(i) Governmentally-mandated neonatal testing and testing performed in association with amniocentesis and other covered related or equivalent procedures.

(ii) Testing where a definitive diagnosis of breast cancer or other hematologic or oncologic diagnosis has been made to determine the medical appropriateness of therapy subject to all Medical Necessity, Experimental/Investigational, and all other relevant provisions of the Plan.

(iii) Testing of individuals with a high probability of possessing a BRCA mutation (as defined in the Prophylactic Mastectomy and BRCA Testing Policy adopted by the Board of Trustees, as amended from time to time, a copy of which is attached as Appendix G to this Plan document) and who have undergone appropriate pre-testing evaluation and counseling, and where it has been determined that the results of testing will definitively determine future treatment or modify ongoing surveillance and treatment of the Eligible Employee or Eligible Dependent.

(ww) Infection control and medical waste disposal.

(xx) Dental Services, 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.

(yy) Prescription or non-prescription weight loss agents.

(zz) Smoking cessation programs not sponsored by the Fund.

(aaa) Expenses for and related to travel for an Eligible Employee, an Eligible Dependent or a Physician.

(bbb) 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.

(ccc) Telephone calls between a Physician or other provider and any patient, other provider, or representative of the Plan for any purpose whatsoever.

(ddd) Any services or supplies:

(i) for which no charge is made; or

(ii) for which the person is not legally required to pay.

(eee) Deductible or Co-pay amounts.

(fff) Amounts in excess of Usual and Customary Charges.

(ggg) Expenses incurred while coverage is not in force.

(hhh) Any service not listed as a Covered Expense.

(iii) Expenses that a person would not have incurred or would not be required to pay if this coverage or other coverage did not exist.

(jjj) More than one medical office visit, hospital room, or wound-care facility charge billed on the same day by the same Provider.

(kkk) Failure to keep a scheduled visit.

(lll) No expense will be covered under more than one benefit provision of any Plan Classification.

(mmm) Expenses for which complete documentation of the claim, including reports and records if needed, has not been received by the Fund.

(nnn) 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.

(ooo) 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.

(ppp) 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.

(qqq) 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.

(rrr) Expenses incurred by a Medicare Eligible Employee or Medicare Eligible Dependent for which the Centers for Medicare and Medicaid Services ("CMS") deny payment to a hospital because of CMS' "never events" policy, as amended from time to time, and for whom Medicare would pay primary to the Plan under the Plan's coordination of benefits order.

ARTICLE 19 — COORDINATION OF BENEFITS

Section 19.01. 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 that 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 19.02. 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 trusteed 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 19.03. 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 and Appropriate, 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 that 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 19.04. 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 that contains a coordination of benefits provision.

(b) A plan that covers a person other than as an Eligible Dependent shall pay its benefits before a plan that 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 another group plan that is sponsored, maintained, or contributed to by an eligible person's employer, contains a provision that: (1) excludes the eligible person from eligibility under the other group plan due to coverage under another plan; (2) has the effect of either shifting coverage liability to this Plan in a manner designed to avoid any liability under the other group plan or avoiding the customary operation of this Plan's coordination of benefit rules; or (3) modifies, limits or reduces benefits for the eligible person due to coverage under another plan, this Plan will consider such provision to have no force or effect. This Plan will coordinate benefits payable under this Plan with benefits that would have been payable under the other group plan if such provision had not existed. If the other group plan does not provide the information needed by this Plan to determine its benefits within 60 days after it is requested to do so, this Plan shall assume that the benefits of the other group plan are identical to its own and shall

pay its benefits accordingly. However, this Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the other group plan.

(c) There is one exception to the rule in Section 19.04(b) above. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

(i) secondary to the plan covering the person as a dependent; and

(ii) primary to a plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);

then the order of benefit payment is reversed, so that the plan covering the person as a dependent pays first and the plan covering the person as other than a dependent (that is, as a retired employee) pays second.

(d) 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.

(e) 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 that 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 that 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.

(iv) if the parents have joint custody and the divorce decree does not specify that one parent has responsibility for coverage or if the parents were never married, the plan that covers the parent whose birthday falls earlier in the Calendar Year shall pay first.

(v) If there was a court decree that no longer applies due to the age of the Eligible Dependent(s), the Fund will determine benefits as if the court decree was still in force.

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

(g) 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 that covers the person.

(h) If none of the above establishes the primary plan, the plan that has covered the person for the longer continuous period of time shall pay its benefits before the plan that has covered the person for a shorter period of time.

(i) 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 19.05. Working Spouse Rule

A working Eligible Dependent spouse who is covered under Plan Classification D5–Tier A must elect and maintain employer-sponsored health coverage if available at his or her place of employment. Pursuant to Plan Section 19.04(b), the Plan pays secondary to this employer-

sponsored health coverage. If the working Eligible Dependent spouse does not elect and maintain such coverage, then the Plan limits coverage to 50% of Covered Expenses.

Section 19.06. 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 20.01. 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 20.02. Definitions

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

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

Section 20.03. Effect on Benefits

If a Participant or an Eligible Dependent is eligible but not enrolled for coverage under Medicare Part A and Medicare would provide its benefits on a primary basis to the Plan for expenses incurred by such person for which Medicare Part A coverage is provided, the Plan shall pay its benefits to and on behalf of such individual on a secondary basis as if the Participant or Eligible Dependent had enrolled in Medicare Part A and Medicare had provided its benefits.

Section 20.04. 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 a Contributing Employer that is not a Small Employer and that 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 a Contributing Employer that is not a Small Employer and that pays all or part of the required contributions for eligibility.

(d) When Sections 20.04(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.

Section 20.05. Medicare “Never Events”

If an Eligible Employee or Eligible Dependent for whom Medicare pays primary to the Plan is denied payment for expenses by a hospital because of CMS' "never events" policy, as amended from time to time, the Plan shall exclude coverage as provided for under Article 18, paragraph (rrr). However, in the event the affected Eligible Employee or Eligible Dependent can be held responsible to the provider for payment of expenses in connection with the Medicare "never event," the Plan shall extend coverage for such expenses and pursue subrogation and reimbursement.

APPENDIX A — ELIGIBILITY REQUIREMENTS

	Rate-Per-Hour Contribution	Flat-Rate Contribution
Initial Eligibility		
Waiting Period	As set forth in Collective Bargaining Agreement.	As set forth in Collective Bargaining Agreement.
Employer Contributions Required	Employee has worked an 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.
Coverage Effective Dates		
Life Insurance Benefit, Accidental Death and Dismemberment Insurance Benefit, Comprehensive Medical Expense Benefit, Prescription Drug Benefit, Dental Expense 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 the 2 full consecutive Months.	First day of the Month following 1 Month of contributions.
Income Protection Benefit and Dependent Coverage	First of the Month following at least 2 full consecutive Months of contributions and after Employee has worked an average of at least 12 Covered Hours per week each Month and an average of at least 28 Covered Hours per week during weeks that end in 2 of the 3 preceding Months.	First day of the Month following 1 Month of full-time contributions.
Continuing Eligibility		
Life Insurance Benefit, Accidental Death and Dismemberment Insurance Benefit, Comprehensive	Employee has worked an average of at least 12 Covered Hours per week during weeks that end in	Employee continues to qualify for Contributing Employer's contribution each Month.

	Rate-Per-Hour Contribution	Flat-Rate Contribution
Medical Expense Benefit, Prescription Drug Benefit, Dental Expense Benefit and Vision Care Benefit	each of the preceding 2 full consecutive Months.	
Income Protection Benefit and Dependent Coverage	Employee has worked an average of at least 12 Covered Hours per week during weeks that end in each of the preceding 2 full consecutive Months and an average of at least 28 Covered Hours per week during weeks that end in 2 of the 3 preceding Months.	Employee continues to qualify for Contributing 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 2 of the 3 preceding Months results in loss of Income Protection and Dependent coverage until the 28-hour requirement is again met.	Failure to qualify for Contributing Employer's full-time contribution.
All 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 full Months.	Failure to qualify for Contributing Employer's contribution.

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

On file at the Benefits Fund 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—Permanently stiffen a portion of the spine to prevent further displacement from occurring.

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 $2,000 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.

Intestinal Surgery—Intestinal bypass, intestinal stapling and reversal of covered procedures only when certified by a Physician as morbid. I**ntestinal 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.

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 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)	$ 83.00
Prophylaxis—Child	65.00
Oral examination	43.00
Topical application of fluoride	31.00
Topical sealant, per tooth	50.00
Radiographs	
Complete series, including bitewings (once each Calendar Year)	113.00
Periapical—single, first film	25.00
Periapical—each addition film	20.00
Bitewings—two films	38.00
Bitewings—four or more films	55.00
Panoramic x-ray (once each Calendar Year)	105.00
Palliative treatment (Emergency)	83.00
Diagnostic casts	80.00

Basic Dental Benefits

Surgical Extractions (including routine post-operative visits)	
Each single uncomplicated extraction	$ 73.00
Surgical extraction, erupted	128.00
Removal of impacted tooth (soft tissue)	162.00
Removal of impacted tooth (partially bony)	195.00
Removal of impacted tooth (completely bony)	225.00
Surgical placement of implant	677.00
Surgical Incisions and Excisions	
Alveoplasty with extractions (per quadrant)	107.00
General anesthesia (in or out of hospital)	249.00
General analgesia	24.00

Restorative Dentistry

Amalgam Restorations	
One surface	$ 57.00
Two surfaces	62.00
Three surfaces	83.00
Four or more surfaces	88.00
Composite Resin Restorations	
One surface	69.00
Two surfaces	83.00
Three surfaces	93.00
Four surfaces or incisal angle	130.00
Inlay Restorations—Non-Abutment	
One surface, gold	$ 316.00
One surface, porcelain	362.00
One surface, composite	339.00
Two surfaces, gold	384.00
Two surfaces, porcelain	407.00
Two surfaces, composite	362.00
Three surfaces, metallic	388.00
Three surfaces onlay, metallic	407.00
Four or more surfaces onlay, metallic	429.00
Four or more surfaces onlay, porcelain	474.00
Four or more surfaces onlay, composite	429.00
Crowns—Non-Abutment	
Plastic prefabricated	125.00
Porcelain	483.00
Porcelain with gold	483.00
Porcelain with nonprecious metal	425.00
Porcelain with semiprecious metal	468.00
Gold full cast	468.00
Metal full cast	488.00
Stainless steel crown	170.00
Steel post and amalgam core	138.00
Cast post and gold core	170.00
Recement inlays	30.00
Recementation of crown	44.00
Sedative filling	48.00
Crown buildup-pin retention	123.00

Endodontics

Pulp capping, direct	$ 33.00
Pulp capping, indirect	23.00
Vital pulpotomy	88.00
Root Canal Therapy	
Anterior (excludes final restoration)	327.00
Bi-cuspid (excludes final restoration)	388.00
Molar (excludes final restoration)	459.00
Apicoectomy (separate procedure)	338.00

Periodontics

Osseous surgery (per quadrant; minimum 4 teeth)	$ 407.00
Periodontal scaling (full-mouth debridement prior to periodontal therapy)	74.00
Periodontal scaling and root planing (per quadrant; minimum of 4 teeth)	100.00
Maintenance periodontal prophylaxis (following periodontal therapy)	60.00

Prosthetic Replacements

Fixed Bridgework	
Crowns—Abutment Teeth	
Porcelain, gold	$ 308.00
Porcelain, nonprecious	282.00
Porcelain, semiprecious	287.00
Gold (full cast)	269.00
Nonprecious cast	241.00
Semiprecious cast	254.00
Pontics	
Cast gold (sanitary)	269.00
Cast nonprecious metal	241.00
Cast semiprecious metal	254.00
Porcelain, gold	308.00
Porcelain, nonprecious	282.00
Porcelain, semiprecious	287.00
Recement bridge	47.00
Complete Denture	
Upper (Maxillary)	367.00
Lower (Mandibular)	367.00
Removable Partial Denture	
Upper, resin base	367.00
Lower, resin base	367.00
Upper or lower, cast framework, resin base	424.00
Removable unilateral partial, 1 piece cast metal	282.00
Reline—Rebase	
Office reline (chairside), full denture	62.00
Office reline (chairside), partial denture	43.00
Laboratory reline, full denture	107.00
Laboratory reline, partial denture	85.00
Full denture rebase	107.00
Partial denture rebase	127.00
Space Maintainers	
Fixed or removable, unilateral	181.00
Fixed or removable, bilateral	275.00
Recementation	40.00

APPENDIX E — PPO CONTRACT

On file at the Benefits Fund Office.

APPENDIX F — BARIATRIC SURGERY POLICY

All procedures must be Pre-authorized in writing by the Benefits Fund Office and performed at a Fund-approved Bariatric Surgery Center of Excellence.

To be eligible for consideration for this benefit, the Employee must have been employed for at least 12 Months with a Contributing Employer and the Eligible Employee or Eligible Dependent entering the program must meet all medical appropriateness and eligibility criteria as required by the Fund, and must agree to enroll in case management through the Plan's case management program prior to being enrolled in a pre-surgical bariatric management program.

1. Approved Types of Bariatric Surgery

The Plan considers open or laparoscopic Roux-en-Y gastric bypass (RYGB) or laparoscopic gastric banding (LASGB or Lap-Band), Medically Necessary and Appropriate when the Eligible Employee or Eligible Dependent has met the criteria listed below:

(a) severe obesity that has existed for at least five years as defined by having a body mass index of 40 or above; and

(b) is 21 years of age with documentation that full bone growth has been met; and

(c) has attempted weight loss and life style modification in the past without successful long-term weight reduction; and

(d) the Eligible Employee or Eligible Dependent has enrolled in, and as determined by the Fund, successfully completed a Fund-approved multidisciplinary Physician-supervised nutrition and exercise program of at least six months duration. An approved program must be Pre-authorized in writing by the Benefits Fund Office and contain each of the following:

(i) Consultation with a licensed/registered dietician or nutritionist; and

(ii) Reduced-calorie diet program supervised by licensed/registered dietician or nutritionist; and

(iii) Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery and demonstrate the ability to maintain appropriate supportive lifestyle modifications, supervised by an exercise therapist or other qualified professional; and

(iv) Behavior modification program supervised by a qualified professional; and

(v) Psychological evaluation by a licensed psychologist or psychiatrist experienced in the evaluation and management of bariatric patients certifying the Participant's fitness for surgery including the ability to comply with required lifestyle modifications and treatment programs; and

(vi) Documentation in the medical record of the individual's satisfactory completion of the approved program. (A Physician's summary letter, without evidence of contemporaneous oversight, is not sufficient documentation. Documentation should include medical records of the Physician's initial assessment of the individual, and the Physician's assessment of the individual's progress at the completion of the multidisciplinary surgical preparatory regimen, and successful participation in exercise, behavior modification, meal planning and lifestyle modification programs.)

2. Repeat Bariatric Surgery

The Plan may consider surgery to correct complications from bariatric surgery, such as obstruction, slippage of band, port replacement or stricture when Medically Necessary and Appropriate.

The Plan considers repeat bariatric surgery Medically Necessary and Appropriate for Eligible Employees and Eligible Dependents whose initial bariatric surgery was Medically Necessary and Appropriate (i.e., who met all medical necessity and pre-operative criteria for their initial bariatric surgery), and who meet either of the following medical necessity criteria:

(a) Conversion to a RYGB may be considered Medically Necessary and Appropriate for Eligible Employees or Eligible Dependents who have not had adequate success (defined as loss of more than 50 percent of excess body weight) three years following the primary bariatric surgery procedure and the Eligible Employee or Eligible Dependent has been compliant with a prescribed nutrition and exercise program following the procedure; or

(b) Revision of a primary bariatric surgery procedure that has failed if the primary procedure was successful in inducing weight loss, and the Eligible Employee or Eligible Dependent has been compliant with a prescribed nutrition, exercise, and lifestyle modification program following the initial procedure.

APPENDIX G — PROPHYLACTIC MASTECTOMY AND BRCA TESTING POLICY

1. The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women's Health and Cancer Rights Act and in women deemed by the Trustees to be at extraordinarily high risk of developing difficult to treat breast cancer. Women with the following conditions only will be considered by the Trustees as having extraordinarily high risk and may be eligible for benefits for prophylactic mastectomy upon submitting appropriate documentation for Pre-authorization to the Benefits Fund Office:

(a) women who possess the BRCA1 or BRCA2 mutations confirmed by appropriate testing;

(b) women with a documented past history of radiation therapy treatments to the chest for Hodgkin's or other similar diseases between the ages of 10 and 30 years;

(c) women who have documented evidence of genetic mutations in the TP53 or PTEN genes;

(d) women with two or more first degree relatives on the same side of the family with a history of breast cancer or a combination of breast and ovarian cancer without regard to genetic testing results;

(e) women with a documented family history of one BRCA negative first degree relative with multiple primary or bilateral breast cancers;

(f) women diagnosed with breast cancer at 45 years of age and younger; or

(g) women with multiple primary or bilateral breast cancers.

2. BRCA testing is covered in women who have a personal history of:

(a) breast cancer with an onset on or before the age of 45 or a personal history of breast cancer after the age of 45 with additional risk factors for developing a second primary breast cancer or ovarian cancer;

(b) ovarian cancer; or

(c) a family history that would markedly increase the risk of developing breast and/or ovarian cancer and has received appropriate pre-test counseling to determine that the test results will influence ongoing screening and/or treatment.

APPENDIX H — GENDER DYSPHORIA COVERAGE POLICY

Treatment of Gender Dysphoria will be considered a Covered Expense effective for Medically Necessary services rendered on or after September 30, 2016, provided that the following criteria and all other relevant terms and provisions of the Plan are met.

Unless otherwise defined herein, all terms shall have the meanings set for in the Plan document.

1. The Eligible Employee or Eligible Dependent has undergone evaluation by a Qualified Mental Health Professional ("QMHP") experienced in the evaluation and treatment of patients with a variety of mental health issues and has requisite skill and experience in evaluation of patients with Gender Dysphoria and all relevant comorbid mental health conditions including familiarity in the application of Diagnostic and Statistical Manual of Mental Disorders (DSM V) or the then current version of the DSM. A practitioner will be considered a QMHP if he or she is a board certified psychiatrist, psychologist, or an In-Network master's level provider with a degree in a clinical behavioral science field from a nationally accredited credentialing board and appropriately licensed in the jurisdiction in which he or she practices and is qualified to evaluate and treat Eligible Employees and Eligible Dependents as noted above. For the treatment of Gender Dysphoria to be considered a Covered Expense, the Eligible Employee or the Eligible Dependent must satisfy all criteria in the current version of the DSM and have no confounding comorbid mental health conditions that would be contraindications to treatment, and treatment must have been recommended by a qualified practitioner with appropriate training and credentials acceptable to the Fund. The approval of the practitioner is to be administered so it does not constitute a prohibited non-quantitative treatment limitation ("NQTL") under the Mental Health Parity and Addiction Equity Act ("MHPAEA") and the Plan imposes corresponding approval requirements for medical/surgical benefits.

2. Covered Expenses may include supportive mental health counseling and treatment of any additional comorbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, or genital reconstructive surgery when those interventions and treatments comply with all other provisions of the Plan. Any limitations on mental health counseling shall be consistent with corresponding limitations on medical/surgical benefits under MHPAEA. For the following services to be considered Covered Expenses, the Eligible Employee or the Eligible Dependent must agree to coordination of care through the Plan's behavioral health case management program and comply with the following:

(a) hormone therapy

(i) completion of evaluations as outlined above and have a diagnosis of Gender Dysphoria with no contraindications to treatment;

(ii) treatment must be ordered and supervised by a practitioner experienced in the treatment of individuals with Gender Dysphoria; and

(iii) obtain Pre-authorization in writing prior to beginning therapy.

(b) orchiectomy, oophorectomy/hysterectomy, genital reconstructive surgery

(i) well-documented and persistent Gender Dysphoria;

(ii) age 18 or over;

(iii) two referral letters from QMHPs as described above, one of which must be the Eligible Employee's or the Eligible Dependent's treating mental health professional and the second from an additional qualified mental health professional acceptable to the Fund who has performed an appropriate evaluation of the Eligible Employee or the Eligible Dependent.

(iv) documented control of any comorbid medical or mental health conditions that would render the Eligible Employee or the Eligible Dependent incapable of making a fully-informed decision or interfere with the diagnosis of Gender Dysphoria and substantially diminish the likelihood of a reasonable treatment outcome;

(v) in the absence of a medical contraindication, complete 12 months of continuous hormone therapy appropriate to the Eligible Employee's or Eligible Dependent's gender goals and complete 12 months of living in a congruent gender role; and

(v) obtain treatment from a Fund-approved In-Network practitioner and facility with appropriate experience in the provision of the requested services.

(c) Mastectomy for an Eligible Employee or an Eligible Dependent with Gender Dysphoria seeking female to male reassignment can be considered Covered Expenses provided that all requirements under subparagraph (b) above have been satisfied.

Covered Expenses will not include any service considered to be Cosmetic Surgery or Treatment or not Medically Necessary, including, but not limited to, hair replacement or

removal, voice therapy or lessons, liposuction, rhinoplasty, breast augmentation, laryngeal or thyroid cartilage shaving or contouring, abdominoplasty, chest wall contouring, facial contouring, collagen injections and any other cosmetic procedure or service otherwise excluded under the Plan. Appropriate screening services covered under the Plan will continue to be Covered Expenses subject to all other terms and provisions of the Plan regardless of gender assignment, including, but not limited to, mammograms.

ADDENDUM 1 — HIPAA PRIVACY PROVISIONS

The Plan will use and disclose Protected Health Information ("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, 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 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 Health Care Operations or as otherwise permitted or required by the Privacy Regulations.

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.