

NATIONAL EMPLOYEES HEALTH PLAN

PLAN DOCUMENT

Effective November 1, 2008

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PREAMBLE

WHEREAS, the Agreement and Declaration of Trust of the National Employees Health Plan (hereinafter the “Fund”) invests upon the Board of Trustees of the Fund (hereinafter the “Board of Trustees”), the authority to establish and maintain a plan for the provision of health and welfare benefits to eligible Covered Employees and beneficiaries of the Trust Fund, and

WHEREAS, the Board of Trustees deems it necessary to amend and restate the Plan Document, effective November 1, 2008;

NOW THEREFORE, be it resolved that pursuant to the authority of the Agreement and Declaration of Trust, the following shall constitute the amended and restated Plan Document of the National Employees Health Plan, setting forth the governing rules and regulations thereof, and providing hereby that the Plan shall be maintained for the exclusive benefit of the Covered Employees and beneficiaries of the Plan, and shall be legally enforceable.

ARTICLE 1
GENERAL DEFINITIONS

Section 1-1 Adopted Child – The term "Adopted Child" means any person with respect to whom the Covered Employee is deemed, by the process of adoption, to be the parent, including any person who has been placed for adoption, regardless of whether the adoption has at the time of placement become final. The terms "placement" and "being placed for adoption" mean the assumption and retention by a Covered Employee of a legal obligation for total or partial support of a child in anticipation of the adoption of such child. The child's placement with the Covered Employee ceases upon the termination of such legal obligation.

Section 1-2 Board of Trustees - The term "Board of Trustees" means the Board of Trustees of the National Employees Health Plan.

Section 1-3 Collective Bargaining Agreement – The term “Collective Bargaining Agreement” means an agreement between an Employer and a Union under which the Employer has agreed to make contributions to the Trust Fund on behalf of its Employees.

Section 1-4 Covered Employee - The terms "Covered Employee" or "eligible employee" mean an Employee who is eligible for benefits under this Plan in accordance with Articles 2 through 4.

Section 1-5 Covered Person - The term “Covered Person” means a Covered Employee, a covered Retiree, or a covered Dependent.

Section 1-6 Dependent - The term “Dependent” means:

- (a) The wife or husband of an Employee, while not divorced or legally separated from the Employee.
- (b) Each child, while the child is unmarried, is not employed on a regular and full-time basis and is wholly dependent on an Employee for support and maintenance, until the end of the calendar year in which the child attains age 19, or as described in this subparagraph below.

A child who (i) otherwise qualifies as a Dependent, (ii) would lose eligibility because of age, and (iii) is a full-time student in an educational institution, is a Dependent until the end of the calendar year in which the child attains age 25. A child eligible for coverage beyond age 19 on the basis of full time student status is not required to maintain eligibility continuously after age 19, but is only eligible for coverage during times when the child satisfies all requirements.

A child who (i) otherwise qualifies as a Dependent, (ii) would lose eligibility because of age, and (iii) is incapable of self-sustaining

employment by reason of mental or physical handicap, is a Dependent during the continuation of such incapacity, subject to the right of the Plan Administrator to require proof of incapacity when the claim is first made, and proof once each year thereafter of the continuation of said incapacity. A child eligible for coverage on the basis of incapacity must have become incapacitated while covered as a Dependent and is eligible for coverage only during the continuation of such incapacity.

- (c) Stepchildren who reside with an Employee (or who are full-time students as described above), children under court appointed guardianship, children placed for adoption, and legally adopted children are eligible for coverage as Dependents to the same extent as the Employee's natural children.

A Dependent also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by an Employee.

- (d) With respect to Retirees, the term Dependent means only the spouse of the Retiree from whom the Retiree is not legally separated.

Section 1-7 Employee - The term "Employee" means each person who is employed by an Employer, and on whose behalf the Employer is required to make contributions to the Trust Fund. Employee shall also mean such other person who is eligible for coverage as agreed to by the Trustees and as set forth in a Participation Agreement.

Section 1-8 Employer - The term "Employer" means:

- (a) An employer who is bound by a Collective Bargaining Agreement with a Union or by a Participation Agreement with the Fund, to make contributions to the Trust Fund with respect to Employees covered by said Collective Bargaining Agreement or Participation Agreement.
- (b) A Union required to contribute to the Trust Fund on behalf of its employees, as agreed to by the Trustees and as set forth in a Participation Agreement.
- (c) The Trustees of the Trust Fund who contribute on behalf of Trust Fund employees, as set forth in a Participation Agreement.
- (d) The trustees of any other trust fund established pursuant to a collective bargaining agreement who contribute on behalf of trust fund employees or trust fund participants, as agreed to by the Trustees and as set forth in a Participation Agreement.

Section 1-9 Participant - The term “Participant” means a Covered Employee and/or a Dependent. The term “Participant” includes Retirees unless indicated otherwise.

Section 1-10 Participation Agreement – The term “Participation Agreement” means an agreement between an Employer, a Union or the trustees of a trust fund, and the Board of Trustees, under which the Employer, Union or the trustees of a trust fund have agreed to make contributions to the Trust Fund on behalf of non-bargaining unit employees.

Section 1-11 Plan - The term "Plan" means this National Employees Health Plan, including all amendments hereto.

Section 1-12 Plan Administrator – The term “Plan Administrator” means the person designated by the Board of Trustees to act as administrator for the Plan.

Section 1-13 Plan Year - The term "Plan Year" means the twelve (12) month period beginning on November 1 and ending October 31, of each calendar year.

Section 1-14 Retiree - The term “Retiree” means a person who meets the eligibility criterion for coverage under this Plan, as set forth in Article 5.

Section 1-15 Schedule of Benefits – The term “Schedule of Benefits” means the Schedule that sets forth the levels of benefits and payment requirements, including Co-Payments, Co-Insurance, Deductible amounts and maximum benefit and payment limitations, for a group of Employees on whose behalf an Employer is making contributions to the Trust Fund. The Schedule of Benefits is identified in the Trust Acceptance.

Section 1-16 Trust Acceptance – The term “Trust Acceptance” means an agreement signed by each Employer who is required to make contributions to the Trust Fund on behalf of its Employees under which the Employer agrees to be bound by the Agreement and Declaration of Trust of the Trust Fund and designates the Schedule of Benefits offered to its Employees.

Section 1-17 Trust Fund or Fund - The term “Trust Fund” or "Fund" means the entire trust estate of the National Employees Health Plan, as it may from time to time be constituted, including but not limited to, all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), earnings and profits therefrom, and any and all other property or funds received and held by the Trustees by reason of their acceptance of this Plan.

Section 1-18 Union – The term “Union” means a labor union local affiliated with the International Brotherhood of Teamsters.

Additional Definitions can be found in Articles and Schedules herein.

ARTICLE 2
ELIGIBILITY RULES
(HOURLY MODE)

Section 2-1 General Provision

The following eligibility rules apply to Covered Employees with respect to whom the applicable Collective Bargaining Agreement provides for eligibility on an hourly basis.

Eligibility is based on the number of hours credited to each Covered Employee's reserve account. Contributions made by an Employer on behalf of a Covered Employee are credited to each Covered Employee's reserve account based on the number of hours worked. One hour is credited to each Covered Employee's reserve account for each hour worked for a participating Employer, subject to a maximum accumulation of 780 hours in the preceding 12 consecutive months.

Section 2-2 Initial Eligibility

A Covered Employee's initial eligibility is effective when the Covered Employee's reserve account is credited with 260 hours. Initial coverage begins on the first day of the month following the month in which the Covered Employee's reserve account is credited with 260 hours.

Section 2-3 Continued Eligibility

Continued eligibility is based on the number of hours credited to a Covered Employee's reserve account. A Covered Employee with at least 130 hours credited to his reserve account at the end of a month is eligible for coverage for the following month. 130 hours will be deducted from a Covered Employee's reserve account for each month's coverage, beginning with the initial month of coverage.

Section 2-4 Termination of Coverage

A Covered Employee's eligibility for benefits terminates on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of the month following a month in which the Covered Employee had fewer than 130 hours credited to his reserve account at the end of that month.

Section 2-5 Reinstatement

A Covered Employee whose coverage terminated because the Covered Employee had less than 130 hours credited to his reserve account at the end of a month is eligible for coverage again in the month following the month in which the Covered Employee has at least 130 hours credited to his reserve account.

A Covered Employee who has less than 130 hours credited to his reserve account for a period of 12 consecutive months, however, is not eligible for reinstatement until the first day of the month following the month in which he has at least 260 hours credited to his reserve account.

Section 2-6 Re-Employment

A Covered Employee who is eligible for coverage, who terminates his employment with a participating Employer, and who is re-employed with a participating Employer within a 12 month period, is eligible for coverage on the first day of the month following the month in which the Covered Employee is re-employed and has at least 130 hours credited to his reserve account.

ARTICLE 3
ELIGIBILITY RULES
(WEEKLY MODE)

Section 3-1 General Provision

The following eligibility rules apply to Covered Employees with respect to whom the applicable Collective Bargaining Agreement provides for eligibility on a weekly basis.

Section 3-2 Initial Eligibility

A Covered Employee's initial eligibility is effective on the Sunday following the week in which the Plan receives eight (8) straight weeks of contributions paid by a participating Employer on behalf of the Covered Employee, unless immediate coverage is provided under the terms of a Collective Bargaining Agreement.

Section 3-3 Continued Eligibility

After initial eligibility is established, a Covered Employee's eligibility continues on a weekly basis for each week for which a participating Employer timely pays required contributions to the Plan on behalf of the Covered Employee.

Contributions paid by a participating Employer on behalf of a Covered Employee for the eight weeks prior to the Covered Employee's eligibility are held in a reserve bank for use by the Covered Employee upon termination of employment or coverage.

Section 3-4 Termination of Coverage

A Covered Employee's eligibility for benefits terminates on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of the last week for which a participating Employer made required contributions to the Plan on behalf of the Covered Employee, including the last day of the week after the week in which contributions held in the Covered Employee's bank are depleted.

Section 3-5 Re-Employment

A Covered Employee who is eligible for coverage, who terminates his employment with a participating Employer, and who is re-employed with any participating Employer within 26 weeks after his previous coverage ended, is eligible for coverage without re-establishing initial eligibility.

A Covered Employee who terminates his employment with a participating Employer and is not re-employed by a participating Employer within 26 weeks after such termination, however, must satisfy the requirements of initial eligibility in order to reinstate his coverage.

ARTICLE 4
ELIGIBILITY RULES
(MONTHLY MODE)

Section 4-1 General Provision

The following eligibility rules apply to Covered Employees with respect to whom the applicable Collective Bargaining Agreement provides for eligibility on a monthly basis.

Section 4-2 Initial Eligibility

A Covered Employee's initial eligibility begins on the first day of the month for which a participating Employer pays required contributions to the Plan on behalf of the Covered Employee.

Section 4-3 Continued Eligibility

A Covered Employee's eligibility continues on a monthly basis for each month for which a participating Employer timely pays required contributions to the Plan on behalf of the Covered Employee pursuant to the terms of the applicable Collective Bargaining Agreement.

Section 4-4 Termination of Coverage

A Covered Employee's eligibility for benefits terminates on the earliest of: (i) the date of termination of the Plan; or (ii) the last day of the last month for which a participating Employer made required contributions to the Plan on behalf of the Covered Employee.

ARTICLE 5
ELIGIBILITY RULES FOR RETIREES AND THEIR DEPENDENTS

Section 5-1 General Provision

The following eligibility rules apply to Covered Employees with respect to whom retiree coverage has been made available under the Plan.

Section 5-2 Initial Eligibility

An individual shall become eligible for coverage as a Retiree if all of the following requirements are satisfied:

- (a) The individual has at least 10 years of continuous service with a National Employee Health Plan participating Employer(s); and
- (b) The individual is eligible for a Teamster pension benefit, or an Employer sponsored pension plan as of the date of retirement; and
- (c) The individual is at least 55 years of age on the date of retiring from employment and is a Covered Employee whose Employer is making or has made the required contributions for retiree coverage; and
- (d) The individual has not reached age 65 on the date of retirement, and is not eligible for Medicare, unless the individual's Employer has negotiated supplemental medical coverage; and
- (e) The contributing Employer has made contributions to the Plan for at least five (5) consecutive years immediately preceding the individual's retirement; and
- (f) The individual is not also eligible to be covered as an Employee or as a Dependent of a Covered Employee on the date of retirement.

Section 5-3 Dependent Eligibility

A Retiree's spouse who is legally married to the Retiree on the date the Retiree is eligible for retiree benefits is considered to be an eligible Dependent under the Plan and shall also be eligible for retiree benefits. No other persons, including any children of the Retiree, are entitled to retiree benefits under the Plan.

Section 5-4 Continued Eligibility

In order to maintain retiree coverage for himself and/or his Dependent a Retiree must make required contributions to the Fund in a timely manner, in an amount determined by the Trustees, and in compliance with any procedures determined by the Trustees.

A Retiree's eligibility to maintain retiree coverage for himself and/or his Dependent is conditioned on his former Employer's continued participation in the Plan.

Section 5-5 Termination of Retiree Coverage

A Retiree's coverage shall end on the earliest of the following:

- (a) the date of termination of the plan;
- (b) the first day of the month in which the Retiree reaches age 65;
- (c) the first day of the first month in which the Retiree becomes eligible for Medicare, (d) unless the Employer has negotiated supplemental medical coverage);
- (e) the date of the Retiree's death;
- (f) the date that the Retiree's former Employer ceases to be a participating Employer in the Plan; or
- (g) the last day of the last month for which a Retiree made required contributions to the Plan in a timely manner.

Section 5-6 Continuation Coverage for Dependent

In the event of the Retiree's death, coverage under Medicare, or attaining age 65, a Retiree's spouse may continue retiree coverage until the earliest of: (i) the date -on which the spouse reaches age 65, (ii) the date on which the spouse becomes eligible for Medicare, or (iii) five years after the Retiree's death, coverage under Medicare, or attaining age 65.

Section 5-7 Continuation Coverage upon Employer's Cessation of Business

In the event that a Retiree's former Employer ceases to be a participating Employer in the Plan because the Employer has ceased to operate as a business, a Retiree and his Dependent may continue retiree coverage by paying 102% of the applicable group premium. Retirees and their Dependents who continue retiree coverage under these limited circumstances are eligible for retiree coverage until retiree coverage or continuation coverage is terminated as set forth in Section 5-6 and Section 5-7 above.

ARTICLE 6
ELIGIBILITY RULES FOR DEPENDENT COVERAGE

Section 6-1 Eligibility for Coverage - A Dependent's eligibility is effective on the first day upon which the Covered Employee/Retiree to whom an individual is dependent becomes eligible for benefits, or upon the first day upon which an individual becomes a Dependent of a Covered Employee/Retiree.

An individual who is eligible to be covered under the Plan as a Covered Employee is not eligible for coverage as a Dependent.

Section 6-2 Termination of Coverage – Except as provided in Article 5 relating to continuation coverage for Retirees and their Dependents, a Dependent's eligibility for benefits hereunder shall terminate on the date upon which the Covered Employee/Retiree to whom an individual is dependent is no longer eligible for benefits, or on the last day of the month during which the Dependent ceases to be a Dependent of the Covered Employee/Retiree, whichever is earlier.

ARTICLE 7
CONTINUATION COVERAGE UNDER COBRA

Section 7-1 Generally

Covered Employees and their Dependents may be entitled to elect continuation coverage as set forth in this Article. Retirees and their Dependents are not eligible for continuation coverage, except as specifically described herein in connection with a bankruptcy. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which sets forth the applicable legal framework described below.

Section 7-2 Benefits Provided

The benefits to be provided to any person electing COBRA continuation coverage shall be the same benefits that the person was eligible to receive on the day before the occurrence of any Qualifying Event.

Any amendment to the Plan of Benefits adopted by the Board of Trustees applicable to active employees modifying coverage shall also apply to any person eligible for benefits under continuation coverage.

Section 7-3 Notice of Continuation Coverage

Each Covered Employee and each Covered Employee's spouse shall receive notice, as required under 29 C.F.R. §2590.606-1, of the right to COBRA continuation coverage provided under the Plan.

Section 7-4 Qualified Beneficiaries

A person must be a Qualified Beneficiary in order to be eligible to elect continuation coverage pursuant to COBRA.

- (a) Employee - A Covered Employee is a Qualified Beneficiary eligible to elect continuation coverage if the Employee's coverage is terminated due to a Qualifying Event as described below and the Employee was covered by the Plan on the day before the Qualifying Event occurred.

- (b) Dependents - A Dependent of a Covered Employee is a Qualified Beneficiary eligible to elect continuation coverage if the Dependent's coverage is terminated due to a Qualifying Event as described below and the Dependent was covered by the Plan on the day before the Qualifying Event occurred.

A child who is born to or placed for adoption with a Covered Employee during a period of continuation coverage is considered to be a Qualified Beneficiary.

A Dependent who is a Qualified Beneficiary is eligible to elect continuation coverage even if the Covered Employee fails to elect continuation coverage.

- (c) Special Rules in Chapter 11 Bankruptcy Proceedings – The term Qualified Beneficiary may also include plan participants who are retirees, dependents of retirees or former dependents of retirees in the event of an employer’s Chapter 11 bankruptcy, as provided in ERISA §607(3)(C), 29 U.S.C. §1167(3)(C).

Section 7-5 Qualifying Events

A Qualified Beneficiary is eligible to elect continuation coverage pursuant to COBRA after the occurrence of a Qualifying Event. The following described events which result in a loss of coverage under the Plan are Qualifying Events for purposes of this Article:

(a) For an Employee:

- The Covered Employee’s hours of employment are reduced, and the Covered Employee is not credited with the minimum number of hours required to maintain coverage, or
- The Covered Employee’s employment ends for any reason other than gross misconduct.

(b) For a Spouse:

- The Covered Employee’s hours of employment are reduced, and the Covered Employee is not credited with the minimum number of hours required to maintain coverage;
- The Covered Employee’s employment ends for any reason other than gross misconduct;
- The Covered Employee dies;
- The Covered Employee and the spouse are divorced or legally separated; or
- The Covered Employee becomes entitled to Medicare.

(c) For a Dependent Child:

- The Covered Employee's hours of employment are reduced, and the Covered Employee is not credited with the minimum number of hours required to maintain coverage;
- The Covered Employee's employment ends for any reason other than gross misconduct;
- The Covered Employee dies;
- The Covered Employee and the spouse are divorced or legally separated;
- The Covered Employee becomes entitled to Medicare; or
- The Dependent Child stops being eligible for benefits under the Plan as a Dependent.

(d) Chapter 11 Bankruptcy of an Employer

In certain circumstances a Chapter 11 bankruptcy proceeding can be a Qualifying Event for retirees or their current or former dependents, as provided in ERISA §603(6), 29 U.S.C. §1163(6).

Section 7-6 Notice of Qualifying Events

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

- (a) Notice From Employers - The Employer of a Covered Employee must notify the Plan Administrator in writing of the following Qualifying Events by filing a report with the Plan Administrator setting forth the affected Employee's name, the type of Qualifying Event and the date of the Qualifying Event within thirty (30) days after the date of the Qualifying Event:

- (1) Reduction of hours of employment of the Covered Employee;
- (2) Termination of employment of the Covered Employee;
- (3) Death of the Covered Employee;
- (4) Covered Employee's eligibility for Medicare; or

(5) Bankruptcy of the Employer, if the Employer's former Employees receive retiree coverage under the Plan.

(b) Notice From Employees and Dependents - Covered Employees and/or covered Dependents, must notify the Plan Administrator in writing of the following Qualifying Events following procedures adopted by the Board of Trustees.

(1) Events affecting Dependent Status and Events Constituting a Second Qualifying Event

Covered Employees and/or Dependents must provide notice to the Plan Administrator of the following events, including the names of the Employees and/or Dependents affected, the type of Qualifying Event and the date of the Qualifying Event:

(i) Divorce or legal separation of a Covered Employee from a spouse;

(ii) A dependent child ceasing to be a covered dependent under the Plan; or

(iii) The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

Notice of these Qualifying Events must be provided no later than sixty (60) days after the later of:

(i) the date of the Qualifying Event;

(ii) the date upon which the Qualified Beneficiary loses or would lose coverage under the Plan because of the Qualifying Event; or

(iii) the date on which the Qualified Beneficiary receives a COBRA general notice describing the responsibility for and procedures for providing notice.

(2) Social Security Administration Decisions

- (i) A Covered Employee or Dependent may notify the Plan Administrator that a Qualified Beneficiary entitled to 18 months of continuation coverage has been determined by the Social Security Administration to be disabled at the time of eligibility for continuation coverage or at any time during the first 60 days of continuation coverage.

This notice must be provided no later than sixty (60) days after the latest of:

- (A) the date of the disability determination by the Social Security Administration;
- (B) the date on which a Qualifying Event occurs;
- (C) the date on which the Qualified Beneficiary loses or would lose coverage; or
- (D) the date on which the Qualified Beneficiary receives a COBRA general notice describing the responsibility for and procedures for providing notice.

- (ii) A Covered Employee or Dependent must notify the Plan Administrator that a Qualified Beneficiary who was entitled to a disability extension of continuation coverage has been determined by the Social Security Administration to no longer be disabled.

This notice must be provided within 30 days of the later of:

- (A) the date of the SSA determination that the person is no longer disabled; or
- (B) the date on which the Qualified Beneficiary receives a COBRA general notice describing the responsibility for and procedures for providing notice.

- (c) **Financial Responsibility For Failure To Give Notice:** If a Covered Employee, covered Dependent or Employer fails to give notice as provided above and, as a result, the Plan pays a claim for a person who was terminated due to a Qualifying Event, then the Employee, Dependent or Employer shall be obligated to reimburse the Plan for any claims which should not have been paid. If a Covered Employee or Dependent fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of such Covered Employee and/or such person's Dependents.

Section 7-7 Notice and Election of Continuation Coverage

(a) Notice to Qualified Beneficiaries

Within fourteen (14) days of the date of receipt of a notice of a Qualifying Event, as provided above, the Plan Administrator shall provide, in accordance with 29 C.F.R. §2590.606-4, notice to each Qualified Beneficiary of the right to elect continuation coverage.

In the event that the Plan Administrator receives notice from an Employee or Dependent as described above, and the Plan Administrator determines that coverage is not available for a person included in the notice, the Plan Administrator will notify the person that continuation coverage is not available, within fourteen (14) days of the date of receipt of notice, with an explanation as to why the person is not entitled to continuation coverage, in accordance with 29 C.F.R. §2590.606-4(c).

(b) Written Election

A person who is eligible for and chooses to elect continuation coverage must do so in writing on a form provided by the Plan Administrator.

(c) Time for Election

A written election form must be received by the Plan Administrator no later than sixty (60) days after a person's eligibility for coverage is terminated, or, if later, sixty (60) days after the date the person was notified of the right to elect continuation coverage.

(d) Separate Election Allowed

Each Qualified Beneficiary shall be entitled to separately elect continuation coverage in the event that another Qualified Beneficiary declines to elect continuation coverage.

(e) Effect of Election on other Beneficiaries

Election of continuation coverage by a Qualified Beneficiary who is the spouse or dependent child of a Covered Employee shall be deemed to include an election of continuation coverage on behalf of any other Qualified Beneficiary who would lose coverage under the Plan by reason of the Qualifying Event.

(f) Temporary Extension of Election Period for Certain Individuals

As required by ERISA §605(b), 29 U.S.C. §1165(b), individuals who are certified to be eligible for Trade Adjustment Assistance (“TAA”) may be entitled to an extended election period.

Section 7-8 Premium Requirements

Persons receiving continuation coverage must pay a premium in order to maintain coverage.

- (a) Cost of Continuation Coverage: The cost of continuation coverage shall be no more than 102% of the applicable premium for a similarly situated beneficiary, except that a higher premium may be charged to a person who qualifies for a disability extension of continuation coverage. The cost of continuation coverage for a disabled person during a disability extension shall be no more than 150% of the applicable premium during months of coverage 19 through 29.
- (b) Determination of Applicable Premium: The applicable premium shall be established using the standards set forth at ERISA §604, 29 U.S.C. §1164, based on the cost of providing coverage. The applicable premium shall be calculated based on a 12 month determination period, and shall be established and communicated before the period begins, under the standards set forth at ERISA §604, 11 U.S.C. §604, Treas. Reg. § 54.4980B-8, 26 CFR § 54.4980B-8.
- (c) First Payment: The payment for the first insurance period must be received by the Plan Administrator no later than 45 days after receipt of the completed election form. If the person elects to pay premiums in monthly installments, then all installment payments due by the first insurance period payment date must also be paid with the first installment payment.
- (d) Installment Payments: The premium for continuation coverage may be paid in monthly installments at the option of the payor.
- (e) Payment Due Date: Except for the first insurance period of continuation coverage, payment is due to be received by the Plan Administrator on the first day of each insurance period. If the person elects to pay the premium in monthly installments, each month’s installment is due to be received by the Plan Administrator on the first day of each month.

Section 7-9 Length of Continuation Coverage

The length of time for which a Qualified Beneficiary can receive continuation coverage under the Plan depends on the type of initial Qualifying Event and whether certain events happen after the date of such Qualifying Event.

The period of continuation coverage begins on the date of the initial Qualifying Event and ends as provided below.

- (a) Termination or Reduction in Hours: 18 Month Coverage: A Qualified Beneficiary who loses coverage because the Covered Employee's hours of employment were reduced or because the Covered Employee was terminated from employment (other than for reason of the Employee's gross misconduct) may elect continuation coverage for up to eighteen (18) months.
- (b) Other Than Termination, Reduction in Hours or Bankruptcy: 36 Month Coverage: A Qualified Beneficiary who loses coverage as a result of a Qualifying Event other than because the Covered Employee's hours of employment were reduced; because the Covered Employee was terminated from employment (other than for reason of the Employee's gross misconduct); or because of a retiree's former employer filing for bankruptcy; may elect continuation coverage for up to thirty-six (36) months.
- (c) Second Qualifying Event Within Initial Continuation Period: Up to 36 Month Coverage: A Qualified Beneficiary entitled to less than 36 months of continuation coverage because the Covered Employee's hours of employment were reduced or because the Covered Employee was terminated from employment (other than for reason of the Employee's gross misconduct); and who experiences a second Qualifying Event during the period following the initial Qualifying Event (other than the termination of employment of the Covered Employee following a reduction in hours or the bankruptcy of a retiree's former employer); may elect to continue coverage for the balance of the thirty-six (36) month period from the date of the initial Qualifying Event.
- (d) Disability Determination Within Initial 60 days of 18 Month Period: Up to 29 Month Coverage: If a Qualified Beneficiary is entitled to continuation coverage because the Covered Employee's hours of employment were reduced or because the Covered Employee was terminated from employment (other than for reason of the Employee's gross misconduct), and a Qualified Beneficiary is determined to be disabled under the Social Security Act at the time of eligibility for continuation coverage or within the first 60 days of continuation coverage, all affected Qualified Beneficiaries may elect continuation coverage for up to 29 months instead

of 18 months, provided that the Qualified Beneficiary provides written notice to the Plan Administrator of the Social Security disability determination as described above. The 29 month period may be extended to 36 months in the event of a second Qualifying Event as described above.

- (e) Medicare Eligibility Followed by Reduction or Termination of Employment: Up to 36 Month Coverage: If a Covered Employee is terminated from employment or suffers a sufficient reduction in hours of employment to lose coverage under the Plan, and the termination or reduction in hours occurred less than 18 months after the Covered Employee became eligible for Medicare, the Covered Employee's Dependents may elect continuation coverage for up to 36 months from the date the Covered Employee became entitled to Medicare.
- (f) Bankruptcy Proceedings and Retirees: In the case of a Qualifying Event as a result of a Chapter 11 bankruptcy proceeding, affected retirees may be entitled to continuation coverage until their death, and affected dependents of retirees may be entitled to continuation coverage for up to 36 months after the death of a covered retiree, as provided in ERISA §602(2)(iii), 29 U.S.C. §1162(2)(iii).

Upon expiration of a Qualified Beneficiary's period of continuation coverage, the Plan will provide the Qualified Beneficiary the option of enrollment under a conversion health plan if it is otherwise generally available under the Plan, as required by ERISA §602(5), 29 U.S.C. §1162(5).

Section 7-10 Early Termination of Continuation Coverage

Continuation coverage may be terminated before the end of the periods described above upon the occurrence of the following events, as indicated:

- (a) Failure to Pay Premiums: Coverage is terminated on the date on which coverage under the plan ceases because of a failure to make timely payment of the premium required with respect to a qualified beneficiary. Payments are timely if made within 30 days after the due date.
- (b) End of Plan: Coverage is terminated on the date the Plan stops providing any group health benefits to any employee.
- (c) Group Health Plan Coverage or Medicare Entitlement: Coverage is terminated on the date, after a qualified beneficiary has elected continuation coverage, that a qualified beneficiary becomes covered under another group health plan, or on the date that a qualified beneficiary

becomes entitled to Medicare benefits, as described in ERISA §602(2)(D), 29 U.S.C. §1162(2)(D).

- (d) Termination of Disability: Extended continuation coverage based on a disability is terminated after a determination by the Social Security Administration that a qualified beneficiary is no longer disabled, as described in ERISA §602(2)(E), 29 U.S.C. §1162(2)(E).

The Plan shall notify the Qualified Beneficiary of the cause of the early termination of continuation coverage, as provided in 29 CFR §2590.606-4.

ARTICLE 8
SELF-FUNDED MEDICAL BENEFITS

Section 8-1 Generally

The Board of Trustees may contract from time to time with one or more Preferred Provider Organization(s) (PPO) or other managed care network providers in order to facilitate the delivery of the benefits provided hereunder. The different PPO and network providers may in turn offer several benefit options that may be selected as set forth in the Trust Acceptance establishing participation in the Plan.

Section 8-2 Benefits Payable

Benefits are payable under this Article in accordance with the Schedule of Benefits identified in the Trust Acceptance establishing participation in the Plan.

Section 8-3 Deductible Provisions, Co-Insurance, Co-Pays and Maximum Benefits or Payments

Any applicable Co-Insurance, Co-Pays, Deductible amounts, and maximum benefit and payment limitations are set forth in the applicable Schedule of Benefits.

Section 8-4 Covered Expenses

The Plan shall pay, subject to any limitations set forth in the applicable Schedule of Benefits, the Approved Amount established by the applicable PPO or network provider as a Covered Expense for Medical Benefits. In instances in which the applicable PPO or network provider has not established an Approved Amount for a Covered Expense, the Plan shall pay, subject to any limitations set forth in the applicable Schedule of Benefits, the Reasonable and Customary Charges for such Covered Medical Expense.

Section 8-5 Medical Benefits

Medical Benefits, Exclusions and applicable Definitions are listed in Schedule A attached hereto, as provided by the applicable PPO or network provider.

Section 8-6 Date Incurred

Covered Expenses are considered to be incurred on the date a Covered Person receives the services or supplies for which the charge is made.

ARTICLE 9
INSURED MEDICAL AND PRESCRIPTION DRUG BENEFITS

Section 9-1 Generally

The Board of Trustees may contract from time to time with one or more Health Maintenance Organization(s) (HMO) or other managed care network providers to provide Plan benefits under an insurance contract. The different HMO and network providers may in turn offer benefit options that may be selected as set forth in the Trust Acceptance establishing participation in the Plan.

Section 9-2 Contracts Incorporated by Reference

Any and all insurance contracts providing group medical benefits and/or group prescription drug benefits under this Plan are incorporated herein by reference and described in Schedule B attached hereto. In the event of any discrepancy between the provisions of any such insurance contract, and specific provisions of this Plan Document, the Plan Document shall govern.

Section 9-3 Enrollment

Any insurer, including an HMO, providing medical and/or prescription drug benefits under this Plan shall provide to eligible Employees an open enrollment period of not less than 30 days duration. In the event the insurer requires Employees to file an application or other written documentation in order to establish coverage, no medical coverage shall otherwise be provided by this Plan if the Employee fails to provide the insurer with the required written documentation.

Section 9-4 Benefits under Insured Plan

The insurer shall provide the following information to all Covered Employees:

- (a) A description or summary of the benefits.
- (b) A description of any cost-sharing provisions, including deductibles, Co-Insurance, and co-payment amounts for which you will be responsible.
- (c) Any annual or lifetime caps or other limits on benefits.
- (d) The extent to which preventive services are covered.
- (e) Whether, and under what circumstances, existing and new drugs are covered.
- (f) Whether, and under what circumstances, coverage is provided for medical tests, devices and procedures.
- (g) Provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services.

- (h) Any conditions or limits on the selection of primary care providers or providers of specialty medical care.
- (i) Any conditions or limits applicable to obtaining emergency medical care.
- (j) Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service.
- (k) The listing of providers that are part of the provider network.

ARTICLE 10
SELF-FUNDED PRESCRIPTION DRUG BENEFITS

Section 10-1 Generally

The Board of Trustees may contract from time to time with a prescription drug program vendor or pharmacy benefit manager in order to facilitate the delivery of the prescription drug benefits provided under the Plan. The prescription drug program vendor or pharmacy benefit manager will administer the benefits provided and will be listed on the Covered Person's prescription drug identification card. Prescription drug benefits may be selected as set forth in the Trust Acceptance establishing participation in the Plan.

Section 10-2 Benefits Payable

Benefits are payable under this Article in accordance with the Schedule of Benefits identified in the Trust Acceptance establishing participation in the Plan.

Section 10-3 Deductible Provisions, Co-Insurance, Co-Pays and Maximum Benefits or Payments

Any applicable Co-Insurance, Co-Pays, Deductible amounts, and maximum benefit and payment limitations shall be set forth in the applicable Schedule of Benefits.

Section 10-4 Covered Expenses

The Plan shall pay, subject to any limitations set forth in the applicable Schedule of Benefits, the Approved Amount for a Covered Expense for Prescription Drug Benefits established by the applicable prescription drug program vendor or pharmacy benefit manager.

Section 10-5 Prescription Drug Benefits

Prescription Drug Benefits, Exclusions and applicable Definitions are listed in Schedule C attached hereto, as provided by the prescription drug program vendor or pharmacy benefit manager.

ARTICLE 11
VISION BENEFITS

Section 11-1 Generally

The Board of Trustees may contract from time to time with one or more managed care network providers in order to facilitate the delivery of the vision benefits provided hereunder. Covered Employees are eligible for vision benefits if vision benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Retirees may select vision benefits by paying an additional contribution to the Fund in a timely manner, in an amount determined by the Trustees, and in compliance with any procedures determined by the Trustees.

Section 11-2 Benefits Payable

Benefits are payable under this Article in accordance with the Schedule of Benefits identified in the Trust Acceptance establishing participation in the Plan. Benefits shall be payable subject to limitations imposed by the managed care network provider contracted to facilitate the delivery of benefits. Benefits may be offered as a discount from retail prices or as an allowance towards the retail cost of services or supplies.

Section 11-3 Deductible Provisions, Co-Insurance, Co-Pays and Maximum Benefits or Payments

Any applicable Co-Insurance, Co-Pays, Deductible amounts, and maximum benefit and payment limitations shall be set forth in the applicable Schedule of Benefits.

Section 11-4 Covered Expenses

The Plan shall pay, subject to any limitations set forth in the applicable Schedule of Benefits, the usual charges, as established by the managed care network provider contracted to facilitate the delivery of benefits, of an optician, optometrist or ophthalmologist for services and supplies which are necessary for treatment of a visual condition, but only to the extent that those charges are for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of vision practice.

Section 11-5 Vision Benefits

Vision Benefits, Limitations and Exclusions are listed in Schedule D attached hereto, as provided by the applicable PPO or network provider.

ARTICLE 12
DENTAL BENEFITS

Section 12-1 Generally

The Board of Trustees may contract from time to time with one or more managed care network providers in order to facilitate the delivery of the dental benefits provided hereunder. Covered Employees are eligible for dental benefits if dental benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Retirees may select dental benefits by paying an additional contribution to the Fund in a timely manner, in an amount determined by the Trustees, and in compliance with any procedures determined by the Trustees.

Section 12-2 Benefits Payable

Benefits are payable under this Article in accordance with the Schedule of Benefits identified in the Trust Acceptance establishing participation in the Plan. Benefits shall be payable subject to limitations imposed by the managed care network provider contracted to facilitate the delivery of benefits. Benefits may be offered as a discount from retail prices or as an allowance towards the retail cost of services or supplies.

Benefits for Orthodontic services are only available if listed on the applicable Schedule of Benefits.

Section 12-3 Deductible Provisions, Co-Insurance, Co-Pays and Maximum Benefits or Payments

Any applicable Co-Insurance, Co-Pays, Deductible amounts, and maximum benefit and payment limitations shall be set forth in the applicable Schedule of Benefits.

Section 12-4 Covered Expenses

The Plan shall pay, subject to any limitations set forth in the applicable Schedule of Benefits, the usual charges, as established by the managed care network provider contracted to facilitate the delivery of benefits, of a Dentist for services and supplies which are necessary for treatment of a dental condition, but only to the extent that those charges are for services and supplies customarily employed for treatment of that condition, and only if rendered in accordance with accepted standards of dental practice.

Section 12-5 Dental Benefits

Dental Benefits, Exclusions and applicable Definitions are listed in Schedule E attached hereto.

Section 12-6 Date Incurred

Except as provided herein, dental expenses shall not be covered unless they are incurred while the individual is a Covered Person.

An expense is deemed to be incurred on the date the service or treatment is rendered, except in the following cases, in which the incurred date shall be that indicated below:

- (a) With respect to crowns, bridges, inlays, onlays, the date the tooth or teeth were prepped.
- (b) With respect to dentures, date the final impression is taken.
- (c) With respect to Endodontic Services, the date the pulp chamber is opened and drained.

Section 12-7 Extension of Dental Benefits

Benefits related to expenses for the following procedures shall continue after termination of the individual's coverage under the Plan, if the procedures were commenced while the individual was a Covered Person under the Plan:

- (a) Full or partial dentures, if the patient was covered on the date the final impression is taken.
- (b) Fixed bridgework, gold restorations and crowns, if the patient was covered on the date the tooth or teeth were prepped.
- (c) Endodontic Services, if the patient was covered on the date that the pulp chamber was opened and drained.

The services must be fully completed within one year from the date the service was started to be covered.

Section 12-8 Predetermination of Dental Benefits

The Trustees may require that a request for Predetermination of Dental Benefits be filed with the Plan Administrator prior to any treatment that is expected to exceed \$200 in cost.

ARTICLE 13

DEFINITIONS AND EXCLUSIONS APPLICABLE TO ALL SELF-FUNDED BENEFITS

Section 13-1 Definitions

The following terms shall have the meaning indicated with respect to all self-funded benefits under the Plan, including benefits provided by any Preferred Provider Organization(s) (PPO) or other managed care network providers:

“Approved Amount” shall mean the maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles, Co-payments, and Co-Insurance are deducted from the Approved Amount.

“Benefit” shall mean coverage for health care services available in accordance with the terms of the Plan.

“Co-pay” or “Co-payment” shall mean a service specific amount payable by a Covered Person for covered services, often payable at the place and time services are rendered.

“Co-Insurance” shall mean the sharing of the cost of covered services between the Plan and the Covered Person. Co-Insurance can be expressed as a percentage of the allowable charge.

“Covered Expenses” shall mean the costs incurred with respect to the services, supplies, and charges for benefits provided under the Plan. .

“Deductible” shall mean the amount of Covered Expenses that a Participant must pay during each benefit period before being eligible for certain benefits to be payable by the Plan. The deductible requirement is re-established each January 1st. However, charges incurred in October, November or December of the immediately preceding year and applied to a covered person’s deductible will be applied toward that person’s deductible for the following year.

“Hospital” shall mean a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

“Illness” shall mean only sickness or disease, including mental infirmity, which requires treatment by a Physician. For purposes of determining benefits payable, "Illness" shall include pregnancy, childbirth, or miscarriage, and complications thereof. All related Illnesses shall be considered one Illness. Concurrent Illnesses shall also be considered one Illness unless such Illnesses are clearly unrelated.

"Injury" shall mean only bodily Injury sustained accidentally by external means, including such illness as results from an accident. All Injuries sustained by a Covered Person in connection with any accident shall be considered one Injury.

"Medical Emergency" shall mean a condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

"Medicare" shall mean any coverage under the federal Social Security Act as now in effect or later amended.

"Network" shall refer to those Physicians and facilities which have contracted to participate in a preferred provider organization or other managed care network chosen by the Board of Trustees to facilitate providing benefits under the Plan. . In-Network shall refer to services received through a Network, while Out-of-Network shall refer to services received through non-participating providers.

"Non-Occupational" shall mean an Injury or Illness not related to a person's employment, including an Injury which does not arise out of or in the course of any employment for wage or profit, and an Illness for which a person is not entitled to any benefits under any Workers' Compensation law or similar legislation.

"Physician" shall mean a medical doctor, doctor of osteopathy, doctor of podiatric medicine, doctor of dental surgery or doctor of medical dentistry who is legally licensed to practice.

"Reasonable and Customary Charge" shall mean the maximum allowable expense that the Plan will pay for a treatment, supply or service in a general area, based on charges made by persons or other entities regularly furnishing the type of treatment, services, or supplies in that area. The term "area" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services, or supplies for which the charge was made.

"Totally Disabled" - shall mean that a Covered Employee is prevented, solely because of a non-occupational Injury or non-occupational Illness, from engaging in his regular or customary occupation and who is performing no work of any kind for compensation or profit.

"Workers' Compensation" refers to any state law mandated program or fund that provides health care and related benefits to Employees in the event of Occupational Injuries or Illnesses.

Section 13-2 Exclusions

No payment will be made under any section of the Plan for any expenses or services in connection with:

- (a) Treatment or services that a Covered Person received at a veteran's administration hospital, public health service hospital or any facility contracted or operated by any governmental unit, unless the Covered Person is legally required to pay for them; or
- (b) Treatment or services for an Illness or Injury received outside of the United States, its protectorates, Canada or Mexico except if the treatment is for a medical emergency or is related to an incident of domestic violence; or
- (c) Treatment or services which are covered or provided by the Social Security Act; or
- (d) Treatment or services for an Illness or Injury which is job-related or covered under workers' compensation; or
- (e) Care received in the armed services of any country; or
- (f) Treatment for Illness or Injury that is received while engaged in the commission of a violation of a state or federal statute; or
- (g) Treatment or services which arise out of a war, whether declared or undeclared, or civil disturbance, including riots, demonstrations or marches; or
- (h) Charges which are in excess of the Reasonable and Customary Charges; or
- (i) State taxes or surcharges, or charges for completing claim forms; or
- (j) Charges for services or supplies which are not medically necessary for the treatment of a diagnosed Illness or Injury; or
- (k) Charges which are for experimental procedures or for the sole purpose of weight reduction.

ARTICLE 14
SHORT TERM DISABILITY BENEFITS

Covered Employees are eligible for short term disability benefits if short term disability benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Retirees and Dependents are not eligible for short term disability benefits.

When an Employee, while covered under this Plan, has become Totally Disabled due to a covered Illness or Injury, the Plan will pay the weekly income benefits stated in the applicable Schedule of Benefits. Benefits will commence as stated in the applicable Schedule of Benefits. To continue to receive short term disability benefits, the Covered Employee will be required to furnish proof of continued disability from his Physician, at least once per month or more often if the Plan Administrator deems it necessary.

An Employee shall be considered Totally Disabled when that person is prevented, solely because of a non-occupational Illness or Injury, from engaging in his regular or customary occupation, and who is performing no work of any kind for compensation or profit.

If an Employee becomes disabled as a result of an Injury requiring medical attention, short-term disability benefits will begin on the date the Employee first receives medical treatment for the Injury. This date will be determined by his Physician. If an Employee becomes disabled as a result of Illness requiring medical attention, short term disability benefits will begin eight (8) days after the date the Employee first receives medical treatment for the Illness. This date will be determined by his Physician. Short-term disability benefits for partial weeks will be computed on the basis of one seventh (1/7) of the weekly benefit per day.

In no event will any short-term disability benefits be paid for longer than the applicable maximum period as stated in the applicable Schedule of Benefits for any continuous period of disability, whether due to one or more causes or for all successive periods of disability due to the same or related cause or causes, unless separated by thirty (30) days of continuous regularly scheduled active work. If an eligible Employee returns to active work for a continuous period of at least thirty (30) days, any subsequent disability shall be deemed a new disability. A clearly unrelated Illness or Injury shall be considered a new disability provided such eligible Employee has returned to work for at least one (1) day.

ARTICLE 15

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

DEATH BENEFIT FOR RETIREES

DEPENDENT LIFE BENEFITS

Section 15-1 Life, Accidental Death and Dismemberment Benefits for Covered Employees

Covered Employees are eligible for life, accidental death and dismemberment benefits if such benefits are selected for a group as set forth in the Trust Acceptance establishing participation in the Plan. Benefits are provided in accordance with the applicable Schedule of Benefits.

Section 15-2 Contracts Incorporated by Reference

All life, accidental death and dismemberment benefits are offered through one or more insurance contracts and are governed by the terms and conditions in the applicable insurance contract. All insurance contracts providing life, accidental death and dismemberment benefits under this Plan are incorporated herein by reference and described in Schedule B attached hereto. The Plan Document shall govern in the event of any discrepancy between the provisions of any such insurance contract and specific provisions of this Plan Document.

Section 15-3 Life Benefits

In the event of a Covered Employee's death (other than death caused by an accident), benefits shall be payable on the life of the deceased Employee, in accordance with the applicable Schedule of Benefits.

Section 15-4 Accidental Death and Dismemberment Benefits

In the event of a Covered Employee's death that is caused by an accident, both life benefits and accidental death benefits shall be payable on the life of the deceased Employee, in accordance with the applicable Schedule of Benefits.

In the event of the accidental loss of a Covered Employee's hands, feet or eyesight, accidental dismemberment benefits shall be payable to the eligible Employee, in accordance with the applicable Schedule of Benefits.

Section 15-5 Death Benefit for Retirees

Retirees are not eligible for life, accidental death or dismemberment benefits. A Retiree who is eligible for and receives medical benefits under the Plan is eligible for a death benefit. In

the event of an eligible Retiree's death, a death benefit of \$1,000 shall be payable by the Plan to the eligible Retiree's beneficiary on the life of the deceased eligible Retiree.

Section 15-6 Dependent Life Benefits

Dependent life benefits are provided under the Plan to certain Covered Employees, in accordance with the applicable Schedule of Benefits. Dependents are not eligible for accidental death or dismemberment benefits.

In the event of the death of a covered Dependent who is entitled to Dependent life benefits, such benefits shall be paid to the Employee on the life of each deceased eligible Dependent, in accordance with the applicable Schedule of Benefits.

In the event of the death of a covered Dependent who is entitled to Dependent life insurance benefits and who is a Dependent to more than one eligible Employee, benefits are payable to only one eligible Employee, in accordance with the applicable Schedule of Benefits.

No Dependent life benefit shall be payable:

- (a) on the death of an eligible dependent child occurring on or after the child attains 19 years of age, or
- (b) on the death of an eligible Employee.

Section 15-7 Continuation of Life Insurance after Termination/Retirement

A Covered Employee may maintain, at his own cost, his life insurance on an individual basis upon termination of coverage under the Plan or upon retirement. The Employee must make a request for a conversion with the Insurer no later than 31 days following the termination of his coverage under this Plan, or his retirement, whichever is applicable.

ARTICLE 16
FRAUD AND MISREPRESENTATION

The Plan shall have the right to recover whatever benefits are paid on behalf of any person when the basis of such claim is misrepresented or fraudulently presented to the Plan, whether by a Participant or by any medical service provider(s). If fraud or misrepresentation is established the Plan shall have the right to recover all benefits paid by either: (1) a direct recovery from the Participant and/or the medical service provider(s) responsible for the fraud or misrepresentation; or (2) by reducing or off-setting all subsequent benefits for such Participant and members of the Participant's family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts. Such recovery may also include medical investigation charges, auditors' fees and attorney fees, as necessary.

In the event that the Plan obtains a civil judgment against any health care providers, suppliers, or practitioners related to the delivery of a health care item or service, the Plan will report it, as required by 45 CFR §61.9, to the Healthcare Integrity and Protection Data Bank (HIPDB), the national database of final adverse actions taken against health care providers, suppliers or practitioners implemented by the Secretary of Health and Human Services to collect health care fraud and abuse data.

ARTICLE 17
COORDINATION OF BENEFITS

If a Covered Person has health care coverage under another group health plan, insurance program or government program, benefits shall be coordinated between the Plan and any such source of benefit payments.

If this Plan is the primary plan it will pay full benefits, without regard to any other available coverage. If this Plan is the secondary plan it will provide payments toward the balance of the cost of covered services, up to the total allowed amount. Coordination of Benefits (“COB”) ensures that the combined payments of all coverage will not exceed the actual cost approved for the medical services provided.

The Preferred Provider Organization(s) (PPO), Health Maintenance Organization (HMO) or other managed care network provider through which the medical benefits were provided shall be responsible for COB and shall determine whether this Plan is the primary plan or secondary plan, following procedures established by such provider.

ARTICLE 18
RIGHTS UNDER HIPAA

This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, the following rules apply with respect to medical benefits provided under this Plan.

Section 18-1 **Special Enrollment Rights:**

If an Employee declines enrollment in the Plan for himself or his Dependents at the time of initial eligibility because of coverage under any other group health plan or health insurance program, and the Employee or Dependent of the Employee loses eligibility for such coverage, or if the employer sponsoring the other coverage stops contributing towards such other coverage, said Employee shall be able to enroll himself and/or his Dependents in this Plan, provided that the Employee and Dependents are otherwise eligible to enroll, enrollment is requested within 30 days after the other coverage ends, and any other applicable requirements described in 29 CFR §2590.701-6 are met.

If an Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he shall be entitled to enroll himself and his Dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

If an Employee adds coverage under these instances, the maximum length of any preexisting condition exclusion under this Plan is 12 months. However, any preexisting condition exclusion does not apply to the pregnancy of either the Employee, or the spouse of the Employee, or to any newborn or adopted child who is added to the coverage within 30 days of the birth or adoption.

Employees who enroll in the Plan under these special circumstances will be offered the same benefit packages and payment options as those offered to similarly situated employees who enroll when first eligible.

Section 18-2 **Preexisting Condition Exclusions:**

This Plan does not impose preexisting condition exclusion. In the event that preexisting condition exclusion is adopted in the future, the Plan will comply with all legal requirements under HIPAA relating to the imposition of preexisting condition exclusion.

Section 18-3 **Right to Receive a Certificate of Creditable Coverage:**

If an Employee's coverage under the Plan stops, the Employee and his covered Dependents shall receive a certificate that shows the period of time when the Employee and his Dependents had coverage under the Plan. The Employee may need to furnish the certificate if he becomes eligible under another group health plan if it excludes coverage for certain medical conditions that the Employee has before enrolling in the new plan. The Employee may also need the

certificate to buy, for himself or his family, an individual insurance policy that does not exclude coverage for medical conditions that are present before enrollment.

The Employee and his Dependents may also request a certificate within 24 months of losing coverage under this Plan, under procedures established by the Board of Trustees or by the Plan Administrator.

ARTICLE 19
HIPAA PRIVACY AND SECURITY REQUIREMENTS

Section 19-1 General

This Plan is subject to the Privacy Rule, as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule sets forth standards to ensure that personal health information is kept private.

This Article describes the conditions under which the Plan may disclose Protected Health Information (“PHI”) to the Plan Sponsor, which is the Board of Trustees, and the permitted and required use of such information by the Trustees. It also describes the Board of Trustees’ responsibilities relating to electronic protected health information.

The regulations set forth at 45 CFR §160 and §164 are incorporated herein by reference. In the event of a conflict between this Plan and the regulations, the regulations shall control.

The Plan shall disclose Protected Health Information to the Trustees upon receipt of a certification that the Plan Document is amended as set forth herein.

Section 19-2 Definitions of Terms used in this Article

- (a) Health Information means any information, whether oral or recorded in any form or medium, that:(1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and(2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual .
- (b) Individually Identifiable Health Information is information that is a subset of Health Information, including demographic information collected from an individual, and:(1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or(ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- (c) Protected Health Information means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information maintained in

certain education records, certain student health records, and employment records held by a covered entity in its capacity as an employer.

- (d) Summary Health Information means information that may be Individually Identifiable Health Information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which Individually Identifiable Health Information has been deleted except that geographic information may be expressed in a five-digit zip code.
- (e) Plan Administration Functions means administration functions performed by the Board of Trustees on behalf of the Plan and excludes functions performed by the Board of Trustees in connection with any other benefit or benefit plan sponsored by the Board of Trustees.

Section 19-3 Disclosure of Protected Health Information to the Board of Trustees

(a) Permitted Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Board of Trustees if the Board of Trustees requests it for the following purposes:

- (i) To obtain premium bids from insurance or HMO carriers for providing health insurance coverage under the Plan; or
- (ii) To modify, amend or terminate the Plan.

(b) Permitted Disclosure of Individual Participation Status

The Plan may disclose to the Board of Trustees information on whether an individual is participating in the Plan and an individual's enrollment status in insurance programs offered by the Plan.

(c) Permitted Disclosure of Protected Health Information

- (1) The Plan may disclose Protected Health Information to the Board of Trustees to carry out Plan Administration Functions that the Board of Trustees performs, as described herein.
- (2) The Plan may not permit a health insurance issuer or HMO providing health care services under the Plan to disclose PHI to the Board of Trustees except as described herein.
- (3) The Plan may not disclose, and may not permit a health insurance issuer or HMO providing health care services under the Plan to disclose, PHI to the Board of Trustees in the absence of a statement in the Notice of Privacy Rights provided to Plan participants that PHI may be disclosed to the Board of Trustees.

- (4) The Plan may not disclose Protected Health Information to the Board of Trustees for the purpose of employment-related actions and decision or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

(d) Conditions of Disclosure to the Board of Trustees

The Board of Trustees agrees to the following provisions regarding the use of PHI disclosed to the Trustees by the Plan. The Board of Trustees agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan, or as required by law.
- (2) Ensure that any agents, including independent contractors and subcontractors, to whom it provides PHI, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information.
- (3) Not use or disclose the Protected Health Information for employment related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.
- (4) Report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures permitted by the Plan, of which the Trustees may become aware.
- (5) Make available, to individual Plan participants who request access, the Plan participant's PHI, such information as may be requested, to the extent provided by 45 CFR §164.524.
- (6) Make available, to individual Plan participants who request an amendment, the participant's PHI, and incorporate any amendments to the participant's Protected Health Information, to the extent required and/or permitted by 45 CFR §164.526.
- (7) Make available, to individual Plan participants who request an accounting of disclosures of the participant's Protected Health Information, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- (8) Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).
- (9) If feasible, return or destroy all PHI received from the Plan that the Board of Trustees maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- (10) Ensure that the adequate separation between the Plan and the Board of Trustees, as required by 45 CFR §164.504(f)(2)(iii), is satisfied.

(e) Adequate Separation between the Plan and the Board of Trustees

As required under 45 CFR§164.504(f)(2)(iii), only persons described herein may be given access to PHI disclosed by the Plan to the Board of Trustees.

The Plan Administrator is designated as the authorized person to receive and use PHI disclosed by the Plan to the Board of Trustees. Access to and use of PHI is allowed only for any Plan Administration Functions that the Board of Trustees performs for the Plan.

Any person 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 Administrator's privacy disciplinary procedure.

Section 19-4 Security of Electronic Private Health Information by the Board of Trustees

(a) General

This Section describes the Board of Trustees' responsibilities to reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Board of Trustees on behalf of the Plan.

(b) Requirements

With respect to any electronic Protected Health Information created, received, maintained or transmitted to the Board of Trustees by or on behalf of the Plan, the Board of Trustees will:

- (1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI created, received, maintained or transmitted on behalf of the Plan; and
- (2) Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures; and
- (3) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (4) Report appropriately any security incident of which it becomes aware.

ARTICLE 20
QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Section 20-1 Generally

This Plan is required, under ERISA §609, 29 U.S.C. §1169, to provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (“QMCSO”). This Article sets forth procedures and requirements relating to QMCSOs.

Section 20-2 Definitions

- (a) The term “Medical Child Support Order” means any judgment, decree or order which (i) provides for child support with respect to a child of a Covered Employee in the Plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law, and relates to benefits under the Plan, or (ii) is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act with respect to the Plan and is issued by either a court of competent jurisdiction or through an administrative process established under state law, as described in ERISA §609(a)(1)(B)(ii), 29 U.S.C. §1169(a)(1)(B)(ii).
- (b) The term “Alternate Recipient” means any child of a Covered Employee who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such Covered Employee.
- (c) The term “Qualified Medical Child Support Order” (“QMCSO”) means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or beneficiary is eligible under the Plan, as long as certain requirements, described below, are met.

Section 20-3 QMCSO Requirements

A Medical Child Support Order meets the requirements for a QMCSO only if:

- (a) the order clearly specifies the name and mailing address of the Covered Employee and each Alternate Recipient covered by the order, as described in ERISA §609(a)(3), 29 U.S.C. §1169(a)(3); specifies a reasonable description of the type of coverage to be provided to each Alternate Recipient or the manner in which such type of coverage is to be determined; and specifies the period to which such order applies; and
- (b) the order does not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan, except as required under §1908 of

the Social Security Act, as described in ERISA §609(a)(4), 29 U.S.C. §1169(a)(4).

Section 20-4 Filing and Notice of Receipt of Medical Child Support Order

All requests for enrollment and/or claims for benefits pursuant to a Medical Child Support Order shall be submitted, in writing, to the Plan Administrator along with a copy of the Medical Child Support Order.

Upon receipt of a Medical Child Support Order the Plan Administrator shall notify the Covered Employee and each Alternate Recipient named in the Order:

- (a) of the receipt of the Medical Child Support Order, and
- (b) of the procedures for determining whether the Order is a Qualified Medical Child Support Order, by providing a written copy of the procedures.

Notices shall be sent to the addresses shown in the Medical Child Support Order.

Section 20-5 Designation of Representative

Alternate Recipients may designate an attorney or other representative to receive copies of notices and communications sent to them relating to a Medical Child Support Order by submitting a written and signed authorization to the Plan Administrator.

Section 20-6 Procedures for Determining Whether Order is a QMCSO

The Board of Trustees will determine whether a Medical Child Support Order is qualified using the following procedures:

- (a) Review by Legal Counsel: All Medical Child Support Orders submitted to the Plan Administrator shall be immediately submitted to legal counsel for the Plan. A legal opinion as to whether the Order is a Qualified Medical Child Support Order within the meaning of ERISA shall be provided to the Board of Trustees no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of the Medical Child Support Order, unless it is submitted within 30 days preceding the date of such meeting. If a Medical Child Support Order is submitted less than 30 days before the next meeting, legal counsel will submit a legal opinion no later than the date of the second meeting following the Plan's receipt of the Order. If special circumstances require a further extension of time, a legal opinion shall be provided to the Board of Trustees not later than the date of the third meeting following the Plan's receipt of the Order. .
- (b) Trustees' Decision: The Board of Trustees shall determine whether an Order is a Qualified Medical Child Support Order no later than the date of the Board of

Trustees' meeting that immediately follows the Plan's receipt of the Medical Child Support Order, unless it is submitted within 30 days preceding the date of such meeting. If a Medical Child Support Order is submitted less than 30 days before the next meeting, the Board of Trustees shall determine whether an Order is a QMCSO no later than the date of the second meeting following the Plan's receipt of the Order. If special circumstances require a further extension of time, the Board of Trustees shall make the determination not later than the date of the third meeting following the Plan's receipt of the Order.

- (c) Notice of the Trustees' Decision: Notice of the Trustees' decision shall be provided to the Covered Employee and to each Alternate Recipient as soon as possible, but not later than 5 days after the determination is made. The Trustees will notify the Covered Employee and each Alternate Recipient of a denial of benefits based on a determination that a Medical Child Support Order is not qualified following the procedures established under this Plan for notification of benefit claim denials, as set forth in Article 27.
- (d) Appeal of the Trustees' Decision: A Covered Employee or Alternate Recipient may file an appeal of the Trustees' decision by filing a notice of appeal within sixty (60) days after receipt of the Trustees' decision, following the procedures set forth in Article 27.

Section 20-7 National Medical Support Notices

If the Plan Administrator receives an appropriately completed National Medical Support Notice, relating to a child of a noncustodial parent who is a Covered Employee, promulgated pursuant to §401(b) of the Child Support Performance and Incentive Act of 1998, that meets the requirements for a QMCSO set forth above, the Notice shall be deemed to be a QMCSO, as described in ERISA §609(a)(5)(C), 29 U.S.C. §1169(a)(5)(C).

Where a National Medical Support Notice is deemed to be a QMCSO as set forth above, the Plan Administrator, within 40 business days after the date of the Notice, shall notify the state agency that issued the notice regarding the availability of coverage for the child under the Plan, and provide the child's custodial parent a description of coverage available, as described in ERISA §609(a)(5)(C)(ii).

Section 20-8 Payment of Benefits Pending Trustees' Decision

Pending a decision by the Board of Trustees as to whether a Medical Child Support Order is a QMCSO any amount which would be payable for benefits on behalf of such Alternate Recipient may be withheld.

Section 20-9 Treatment of Alternate Recipients

An Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan for any purposes other than reporting and disclosure requirements, and a participant under the Plan for purposes of reporting and disclosure requirements.

Section 20-10 Reimbursements to Alternate Recipient

Any payment for benefits made pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient or 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.

Payment of benefits to an official of a state or political subdivision may be treated as payment of benefits to an Alternate Recipient, as described in ERISA §609(a)(9), 29 U.S.C. §1169(a)(9).

Section 20-11 Trustee Responsibility

If the Trustees act in accordance with these procedures and ERISA in treating a Medical Child Support Order as being (or not being) a qualified medical child support order, then the Plan's obligation to the Covered Employee and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the Trustees.

ARTICLE 21
FAMILY MEDICAL LEAVE ACT

Section 21-1 Generally

Employees receiving benefits under this Plan may be eligible to take Authorized Leave under the Family and Medical Leave Act (“FMLA”). The provisions in this Article apply to the extent an Employee is granted Authorized Leave under FMLA by his Employer.

An Employer has all responsibilities and obligations under FMLA to determine whether and when an Employee is eligible for Authorized Leave under FMLA. The Plan has no responsibilities or obligations relating to such determination, except to the extent that the Plan is the Employer of any Employees receiving benefits.

An Employer who grants Authorized Leave under FMLA to an Employee is required to notify the Plan Administrator at the time the Authorized Leave period begins and provide all relevant information regarding the Employee’s Authorized Leave.

Section 21-2 FMLA Authorized Leave

Pursuant to FMLA, Authorized Leave may be granted to an Employee by an Employer for a period of up to 12 workweeks during a 12 month period, or, in the case of Authorized Leave to care for a servicemember, up to 26 workweeks during a 12 month period.

Pursuant to FMLA, Authorized Leave means leave from employment granted for the following specified reasons:

- (a) For the birth of an Employee’s child, and to care for such child;
- (b) For the placement with the Employee of a child for adoption or foster care;
- (c) To care for the Employee’s spouse, child or parent with a serious health condition;
- (d) Because of a serious health condition that makes the Employee unable to perform the function of the Employee’s job;
- (e) Because of a qualifying exigency arising out of the fact that an Employee’s spouse, child or parent is on active duty in the Armed Forces in support of a contingency operation; or
- (f) To care for the Employee’s spouse, child, parent or next of kin who is a covered service member, as defined in the Family and Medical Leave Act.

Section 21-3 Employer Obligations during FMLA Authorized Leave

Pursuant to FMLA, an Employer who grants FMLA Authorized Leave to an Employee is required to maintain group health insurance coverage for the Employee during the period of Authorized Leave on the same conditions as if the Employee had been continuously employed. An Employer must therefore continue to make contributions to the Plan in the amount and manner as would otherwise be required if the Employee was not on Authorized Leave.

An Employer is required to maintain group coverage for an Employee on Authorized FMLA Leave until:

- (a) the Employee's FMLA Leave entitlement is exhausted;
- (b) the Employer can show that the Employee would have been laid off and the employment relationship terminated; or
- (c) the Employer provides unequivocal notice of intent not to return to work.

Section 21-4 Employee Obligations during FMLA Authorized Leave

An Employee may not be required to use any hours in his reserve account during a period of FMLA Authorized Leave, and may not be required to pay a greater premium than the Employee would have been required to pay if the Employee had been continuously employed.

An Employee remains obligated to make payment of any co-payments or other financial obligations which are due to be paid by the Employee in order to maintain continuing coverage during the period of Authorized Leave.

Section 21-5 Failure by Employee to Make Required Contributions

The Plan will not terminate an Employee's eligibility for failure to make required contributions during a period of FMLA leave until and unless the Plan receives certification from the Employer that notice was properly given to the Employee that coverage would be terminated if payment was not received, as required under 29 CFR §825.212(a)(1). Nothing in this section shall be construed to prohibit an Employer from making payment of any contributions on behalf of an Employee.

If an Employee's eligibility for coverage during Authorized FMLA Leave is terminated due to the Employee's failure to make required contributions, then the Employer's contribution obligation under this Article may be suspended for the duration of the Employee's Authorized Leave.

Section 21-6 Reinstatement after FMLA Authorized Leave

If an Employee's coverage during FMLA Authorized Leave lapses for failure to make required contributions, and the Employee returns to employment after FMLA Authorized Leave, the Employee's eligibility for coverage shall be restored upon re-employment under the same conditions as if the Employee had been continuously employed, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

If an Employee on Authorized FMLA Leave chooses not to retain coverage under the Plan during the period of leave, and returns to employment after FMLA Authorized Leave, the Employee is entitled to be reinstated upon re-employment on the same terms as prior to taking the leave, and without being required to meet any qualification requirements, including pre-existing condition waiting periods.

Section 21-7 FMLA Authorized Leave and COBRA Continuation Coverage

Authorized Leave granted to an Employee by an Employer pursuant to FMLA is not a Qualifying Event as described in Article 7 Eligibility for Continuation Coverage. If an Employee fails to return to work at the end of a period of Authorized Leave, however, such failure to return to work terminates an Employer's obligation to continue coverage, and may constitute a Qualifying Event as that term is defined in Article 7 Eligibility for Continuation Coverage.

ARTICLE 22
NEWBORNS' AND MOTHERS' HEALTH
PROTECTION ACT OF 1996

This Plan is subject to the Newborn's and Mothers' Health Protection Act of 1996 (NMHPA). Accordingly, benefits for a hospital stay in connection with childbirth (for the mother and the newborn) may not be restricted below certain minimums provided by the NMHPA. Specifically, in cases of a vaginal delivery, the mother and newborn child may have a hospital stay of at least 48 hours; and in cases of a cesarean delivery, the mother and newborn may have a hospital stay of at least 96 hours. If, however, the mother and her attending provider agree that a shorter length of stay is sufficient, the mother and newborn child may leave the hospital prior to the standard 48 hours or 96 hours prescribed by the NMHPA. The hospital length of stay begins at the time of delivery of the newborn if delivery occurs in the hospital or at the time of admission to the hospital if delivery occurs outside a hospital. No provider shall be required to obtain prior authorization for prescribing a maternity hospital stay unless it exceeds the 48 or 96 hours required by NMHPA.

ARTICLE 23
WOMEN'S HEALTH AND CANCER RIGHTS
PROTECTION ACT OF 1998

This Plan is subject to the Women's Health and Cancer Rights Act of 1998 (WHCRA). Accordingly, coverage shall be provided, as required by WHCRA, to any Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, for:

- (a) All stages of reconstruction of the breast on which the mastectomy was performed;
- (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (c) Prostheses; and
- (d) Treatment of physical complications of mastectomy, including lymphedema.

Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and Co-Insurance provisions as set forth herein, and as are consistent with those established for other benefits provided hereunder.

Notice shall be sent annually to all Participants hereunder regarding rights protected under the Women's Health and Cancer Rights Act of 1998.

ARTICLE 24
MENTAL HEALTH PARITY ACT OF 1996

This Plan is subject to the Mental Health Parity Act of 1996, as subsequently extended. Accordingly, no lifetime or annual limit shall apply, in accordance with MHPA, to mental health benefits if no such lifetime or annual limit applies to substantially all medical and surgical benefits provided hereunder. To the extent that any lifetime or annual limitation applies to substantially all medical and surgical benefits provided hereunder, no distinction shall be made, if such limitation is to apply to mental health benefits, in the application of such limitation to the relevant medical and surgical benefits and to mental health benefits provided hereunder. Alternatively, no lifetime or annual limitation shall apply to mental health benefits provided hereunder that is less than that which applies to substantially all medical and surgical benefits.

ARTICLE 25
UNIFORMED SERVICES EMPLOYMENT AND
RE-EMPLOYMENT RIGHTS ACT OF 1994

Section 25-1 Generally

This Plan is subject to the Uniformed Services Employment and Re-employment Rights Act of 1994 (“USERRA”). USERRA provides certain rights in connection with health plan coverage for persons leaving employment to perform military service, and for persons returning to employment after performing military service.

An Employer who receives notice that an Employee will be leaving employment to perform military service must promptly notify the Plan Administrator and provide all relevant information regarding the Employee’s military service.

Section 25-2 Right to Continuation Coverage Upon Entering Military Service

A Covered Employee who leaves covered employment to perform services in the uniformed services may elect to continue coverage under the Plan for himself and his dependents up to a maximum period of time that is the lesser of:

- (a) the 24-month period beginning on the date on which the Covered Employee’s absence for the purpose of performing military service begins; or
- (b) the period beginning on the date upon which the Covered Employee’s absence for the purpose of performing military service begins, and ending on the day after the date on which the Covered Employee fails to apply for or return to a position of employment, as defined in USERRA.

Section 25-3 Contributions for USERRA Continuation Coverage

(a) Service Lasting Less than 31 Days

A Covered Employee who performs service in the uniformed services for fewer than 31 days is not required to pay more than any regular employee share for continuing health plan coverage.

Liability for contributions to the Plan on behalf of a Covered Employee performing military service for less than 31 days is to be allocated either:

- (1) In a manner determined by the Board of Trustees;
- (2) If the Board of Trustees does not so provide, to the Covered Employee’s last Employer prior to the Covered Employee’s military service; or

- (3) If the Board of Trustees does not so provide and the Covered Employee's last Employer is no longer functional, liability for continuing coverage is allocated to the Plan.

(b) Service Lasting Longer than 31 Days

A Covered Employee who enters military service for 31 or more days and elects continuation coverage may be required to pay no more than 102 percent of the full premium under the Plan, representing the employer's share plus the employee's share plus 2% for administrative costs.

(c) Specific Considerations for Employees with Eligibility Based on Hours or Weeks Worked

A Covered Employee who enters military service lasting more than 31 days, elects continuation coverage, and has a positive balance in his reserve account at the time he leaves employment, may either:

- (1) expend his reserve account balance instead of paying for continuation coverage, with the opportunity to continue coverage by paying no more than 102% of the full premium under the Plan if his reserve account balance is depleted; or
- (2) pay for continuation coverage as provided above in order to maintain his reserve account balance intact as of the beginning date of his military service.

Section 25-4 Election of and Payment for USERRA Continuation Coverage

Reasonable methods for election of and payment for continuation coverage shall be established by the Board of Trustees or by the Plan Administrator.

Section 25-5 Failure to Elect USERRA Continuation Coverage

If a Covered Employee leaves employment for military service without giving advance notice of such service to his Employer, then the Covered Employee's coverage under the Plan may be terminated under the terms of the Plan, unless the Covered Employee is excused from providing notice as provided in USERRA.

If a Covered Employee leaves employment for military service for a period lasting more than 30 days after giving advance notice of service but without electing continuation coverage, then the Covered Employee's coverage under the Plan may be terminated under the terms of the Plan, subject to retroactive reinstatement of uninterrupted coverage if the Covered Employee elects continuation coverage and pays all amounts due either within the time period established under the Plan for election of USERRA continuation coverage, or, if no such methods have been established, within the time period allowed for continuation coverage pursuant to USERRA, as set forth in Article 25-2.

If a Covered Employee elects continuation coverage upon entering military service and fails to make timely payment of required contributions, then the Covered Employee's coverage may be terminated pursuant to the terms of the Plan and under reasonable rules adopted allowing cancellation of USERRA continuation coverage if timely payment is not made.

Section 25-6 Rights Upon Re-Employment After Military Service

(a) Eligibility upon Re-Employment

An Employee whose coverage was terminated by reason of service in the uniformed services must have coverage under the Plan re-instated immediately upon re-employment after military service.

(b) Exclusions and Waiting Periods

The Employee's eligibility for coverage is not subject to any exclusions or waiting periods if exclusions or waiting periods would not have been imposed if the Employee's coverage had not been terminated as a result of military service.

The Plan may, however, impose an exclusion or waiting period in connection with any illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

(c) Specific Considerations for Employees with Eligibility Based on Hours or Weeks Worked

All Employees who are re-employed after military service will have coverage under the Plan re-instated immediately upon re-employment, including Employees whose eligibility for coverage is based on maintaining required numbers of hours or weeks in a reserve account. If an Employee's coverage is re-instated and his reserve account does not have sufficient hours or weeks to establish coverage, then the Plan may require that the Employee pay the cost of coverage until the time the Employee's reserve account contains sufficient hours or weeks to sustain coverage.

Section 25-7 Definitions

(a) For the purposes of this Article, the terms "service in the uniformed services" and "military service" mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority including 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 Covered Employee is absent for examination used to determine fitness for duty.

(b) For the purposes of this Article, the term "uniformed services" means the 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 of America in time of war or emergency.

ARTICLE 26
REIMBURSEMENT AND SUBROGATION

Section 26-1 Reimbursement and Subrogation

As a condition precedent to the right to receipt of benefits under this Plan, if a Participant is entitled to receive benefits under the Plan for injuries or illness caused by a third party, the Participant agrees that the Plan has the right of subrogation against any third party tortfeasor or any insurance carrier, and the separate and independent right of reimbursement from the Participant, to the extent of the benefits paid under this Plan.

As a further condition precedent to the receipt of benefits, the Participant agrees to execute a Reimbursement and Subrogation Agreement and any other required documents, as provided by the Plan Administrator, relating to the reimbursement and subrogation rights under this Plan. The Participant further agrees to notify the Plan Administrator of any claim or legal action asserted against any party or insurance carrier for such injuries or illness and to promptly provide the name and address of such party and any insurance carrier. The Participant shall take no action inconsistent with the requirements of this section, nor settle any claim without prior consent of the Trustees.

In order to protect the rights of the Plan as described in this section, the Participant agrees that the Plan has a lien on any amounts recovered by or on behalf of the Participant who received benefits, whether or not designated as payment for medical expenses, including any recovery, settlement, or judgment obtained from or against any party at fault, or from any other source, relating to injuries or illness caused by a third party. The lien shall remain in effect until the Plan is repaid for all benefits paid under the Plan. The lien applies to any such amounts recovered, whether in the possession of the Participant or a third party, such as a trustee, guardian or conservator.

The Plan's reimbursement and subrogation rights shall not be subject to equitable distribution or to any reduction for costs or attorneys' fees incurred by the Participant in pursuit of his claim against the third party or against any insurance carrier. In addition, the Plan shall be entitled to reimbursement from the first dollars paid to the Participant by any party or insurance carrier and shall have the right to full recovery, which shall not be subject to reduction regardless of whether the Participant recovers the full value of his claim against the third party and/or any insurance carrier.

In the event that the Participant fails to execute a Reimbursement and Subrogation Agreement, or otherwise fails to comply with the terms of this section, then such shall be considered a breach of this Plan and benefits may be denied by the Trustees.

ARTICLE 27
CLAIMS PROCEDURES

Section 27-1 Generally

The following procedures apply for the filing and processing of benefit claims; the notification of benefit determinations; and the appeal of adverse benefit determinations.

Section 27-2 Filing and Processing of Benefit Claims

(a) Medical Benefits

All claims for Medical benefits shall be initially submitted to the Preferred Provider Organization(s) (PPO), Health Maintenance Organization (HMO) or other managed care network provider through which the medical benefits were provided, following procedures established by such provider for submitting claims. Such PPO, HMO or other managed care provider shall serve as the Claims Administrator and will make initial claims determinations.

(b) Prescription Drug Benefits

All claims for Prescription Drug benefits shall be initially submitted to the prescription drug program vendor or pharmacy benefit manager ("PBM") through which the Prescription Drug benefits were provided, following procedures established by such provider for submitting claims. Such prescription drug program vendor or pharmacy benefit manager shall serve as the Claims Administrator and will make initial claims determinations.

(c) Vision Benefits

All claims for Vision benefits shall be initially submitted to the managed care network provider through which the Vision benefits were provided, following procedures established by such provider for submitting claims. Such managed care network provider shall serve as the Claims Administrator and will make initial claims determinations.

(d) Dental Benefits

All claims for Dental benefits shall be initially submitted to the Plan Administrator, following procedures established by the Plan Administrator for submitting claims. The Plan Administrator shall serve as the Claims Administrator and will make initial claims determinations.

(e) Short Term Disability Benefits

All claims for Short Term Disability benefits shall be initially submitted to the Plan Administrator, following procedures established by the Plan Administrator for submitting claims. The Plan Administrator will serve as the Claims Administrator and will make initial claims determination.

(f) Life, Accidental Death or Dismemberment Benefits

All claims for Life, Accidental Death or Dismemberment benefits shall be initially submitted to the Plan's life insurance carrier, following procedures established by such carrier for submitting claims. Such carrier shall serve as the Claims Administrator and will make initial claims determinations.

(g) Death Benefits

All claims for Death benefits shall be initially submitted to the Plan Administrator, following procedures established by the Plan Administrator for submitting claims. The Plan Administrator will serve as the Claims Administrator and will make initial claims determination.

Section 27-3 Time for Filing Claims

Claims for benefits may be made by a medical care service provider on behalf of a Participant at or near the time services were provided if allowed under the procedures established by the PPO, HMO, PBM or other managed care network provider through which benefits were provided.

Participants may also submit claims for benefits to the Claims Administrator designated above for each type of benefit, following procedures established by the Claims Administrator.

All claims for benefits must be made within one year of the date the claim was incurred.

Section 27-4 Claims Determination Procedures

(a) Generally

All benefit claim determinations will be made in accordance with governing plan documents and will be applied consistently with respect to similarly situated claimants.

All benefit claim determinations will be made within the time periods specified herein.

The applicable time period begins at the time a claim is filed under the procedures provided, without regard to whether all the information necessary to make a benefit determination accompanies the filing. If a claimant fails to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for

making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(b) Medical, Prescription Drug, Vision and Dental Claims

Upon submission of a claim for Medical, Prescription Drug, Vision or Dental benefits the Claims Administrator will process the claim and notify the Participant of the benefit determination. Claims will be processed and notification provided based on the type of claim, as follows:

(1) Urgent Care Claims

The Claims Administrator will notify a Participant who submits an Urgent Care Claim of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If a Participant fails to provide sufficient information, the Claims Administrator shall notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Participant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Following such notification the Claims Administrator will notify the Participant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after (i) the Plan receives the specified information, or (ii) the end of the period afforded to provide the specified additional information, whichever is earlier.

Notification of any adverse benefit determinations made relating to Urgent Care Claims will be made as provided herein.

(2) Concurrent Care Claims

Concurrent Care Claims refer to an approved ongoing course of treatment to be provided over a period of time or number of treatments.

Any reduction or termination of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claims Administrator shall notify an affected Participant of such adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

A request to extend an approved ongoing course of treatment beyond the approved time period or number of treatments that is also an Urgent Care Claim shall be decided as soon as possible, taking into account the medical exigencies, and, if such claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the Claims Administrator shall notify the Participant of the benefit determination within 24 hours after receipt of the claim.

Notification of any adverse benefit determinations made relating to Continuing Care Claims will be made as provided herein.

(3) Pre-Service Claims

Some benefits under the Plan are conditioned on pre-approval of the benefit before it is provided and thus Participants must submit Pre-Service Claims.

The Claims Administrator will notify a Participant who submits a Pre-Service Claim of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because the Participant failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Notification of any adverse benefit determinations made relating to Pre-Service Claims will be made as provided herein.

If a Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a Pre-Service Claim, the Participant or authorized representative shall be notified of the failure and of the proper procedures to be followed, provided that the failure to follow procedures is a communication as described in 29 C.F.R. §2560.503-1(c) (1)(ii). This notification shall be made as soon as possible, but no later than 24 hours following a failure to properly file a Pre-Service Claim involving Urgent Care, or 5 days following a failure to properly file any other type of Pre-Service Claim. Notification may be oral, unless written notification is requested by the Participant or authorized representative.

(4) Post-Service Claims

Participants may also file claims for benefits after services have been provided. The Claims Administrator shall notify a Participant who has filed a Post-Service Claim of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

This period may be extended one time by the Claims Administrator, for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claims Administrator determines that an extension of time is necessary because the Participant failed to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(c) Disability Claims

Upon submission of a claim for Disability benefits the Claims Administrator will process the claim and notify the Participant of an adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

This period may be extended by the Claims Administrator, for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the Participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision.

In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Notification of any adverse benefit determinations made relating to Disability Claims will be made as provided herein.

Section 27-5 Notification of Adverse Benefit Determinations

(a) Generally

Except as otherwise provided herein, if a claim is wholly or partially denied, the Claims Administrator shall notify the Participant of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Claims Administrator, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial 90 day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the benefit determination.

(b) Manner and Content of Notification of Adverse Benefit Determinations

Except as otherwise provided herein, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv).

In the case of an adverse benefit determination on a claim regarding urgent care, notification pursuant to this provision, including the information described below, may be given orally within the time frame prescribed above, provided that a written or electronic notification is furnished not later than 3 days following the date of oral notification.

The notification of an adverse benefit determination relating to any benefits offered under this Plan shall set forth, in a manner calculated to be understood by the claimant, the following information:

- (1) The specific reason or reasons for the adverse determination;
- (2) Reference to the specific plan provisions on which the determination based;
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

- (4) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;
- (5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- (6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (7) If the adverse benefit determination relates to a claim involving urgent care, a description of the expedited review process applicable to such claims.

Section 27-6 Appeals of Adverse Benefit Determinations

(a) Generally

Participants shall have an opportunity to appeal an adverse benefit determination relating to all claims for benefits under this Plan to an appropriate named fiduciary of the Plan for a full and fair review of the claim and the adverse benefit determination. Unless otherwise provided herein, participants will have at least 60 days following receipt of an adverse benefit determination to appeal the determination. Appeals of adverse benefit determinations must be brought by a Participant in the Plan or an authorized representative of a Participant in the Plan.

Participants shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Plan Administrator will provide, free of charge and upon request, reasonable access to, and copies of, all documents, records and other information relevant to a Participant's claim for benefits.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Additional Procedures for Appeals of Claims for Medical, Prescription Drug, Vision, Dental and Disability Benefits

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, Vision, Dental and Disability benefits must be submitted in writing within 180 days of a Participant's receipt of an adverse benefit determination.

The Board of Trustees will consider and decide all appeals of adverse benefit determinations for claims for Medical, Prescription Drug, Vision, Dental and Disability benefits taking into account all comments, documents, records and other information submitted by the claimant relating to the claims, without regard to whether such information was submitted or considered in the initial benefit determination. The Board will not afford deference to the initial adverse benefit determination, and the review will be conducted by a fiduciary who did not make the initial adverse benefit determination and who is not a subordinate of the person who did.

If an adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The professional so consulted will not be a person who was consulted in connection with the adverse benefit determination that is the subject of the appeal, and will not be a subordinate of any expert consulted in connection with the adverse determination under appeal.

If medical or vocational experts were consulted on behalf of the Plan in connection with an adverse benefit determination, such experts will be identified, whether or not the advice obtained was relied upon in making the benefit determination.

Appeals of adverse benefit determinations of claims for Medical, Prescription Drug, Vision or Dental benefits involving urgent care will include an expedited review process. Under the expedited review process a request for an expedited appeal may be submitted orally or in writing by the claimant, and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(c) Time for Determination and Notification of Decision after Appeal

(1) Generally

All appeals of adverse benefit claim determinations will be made within the time periods specified herein. The applicable time period begins at the time a request for an appeal is received by the Plan in accordance with the procedures for filing appeals, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a claimant fails to submit information necessary to decide a claim, and an applicable time period is extended as permitted herein, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Except as otherwise provided herein for certain types of health care claims, the Board of Trustees shall make a benefit determination no later than the date of the Board of Trustees' meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If a request for review is filed less than 30 days before the next meeting, the Board shall make a determination no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the date of the third meeting following the Plan's receipt of the request for review.

If an extension of time for review is required because of special circumstances, the Plan Administrator shall provide written notice of the extension, prior to the commencement of the extension, describing the special circumstances and the date as of which the benefit determination will be made.

The Plan Administrator shall notify a claimant of a benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Determination and Notification of Decision after Appeal of Certain Types of Health Care Claims

(i) Urgent Care Claims

A claimant who has filed a claim involving urgent care shall be notified of the Plan's determination after review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination.

(ii) Pre-Service Claims

A claimant who has filed a Pre-Service Claim shall be notified of the Plan's determination after review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claimant's request for review of an adverse benefit determination.

(d) Manner and Content of Notification of Decision after Appeal

The Plan Administrator shall provide written or electronic notification to the claimant of the Board's decision on a claim after appeal and review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv).

In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant, the following information—

- (1) The specific reason or reasons for the adverse determination;
- (2) Reference to the specific plan provisions on which the benefit determination is based;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- (4) A statement of the claimant's right to bring an action under section 502(a) of ERISA;
- (5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- (6) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (7) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find

out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Section 27-7 Definitions Used in This Article

For the purposes of this Article, the following terms shall have the meaning set forth at 29 C.F.R. §2560.503-1(m), as summarized below:

(a) The terms “a claim involving urgent care” and “Urgent Care Claim” mean any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—(A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim is a “claim involving urgent care” is to be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any claim that a physician with knowledge of the claimant's medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care” for purposes of this section.

(b) The term “Pre-Service Claim” means any claim for a benefit with respect to which the receipt of the benefit, in whole or in part, is conditioned upon the approval of the benefit in advance of obtaining medical care.

(c) The term “Post-Service Claim” means any claim for a benefit that is not a pre-service claim.

(d) The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant’s eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(e) The term “notice” or “notification” means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to the individual.

(f) The term “health care professional” means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(g) A document, record, or other information shall be considered “relevant” to a Covered Employee’s or Dependent’s claim if such document, record, or other information, (i) was relied upon in making the benefit determination, (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination, (iii) demonstrates compliance with the administrative processes and safeguards required pursuant to this section in making the benefit determination, or (iv) in the case of disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

ARTICLE 28
MISCELLANEOUS

Section 28-1 Applicable Law

This Plan is created and accepted in the State of Michigan. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Michigan except as to matters governed by federal law.

Section 28-2 Savings Clause

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.

Section 28-3 Right to Recovery

Whenever payments have been made by the Plan in excess of the maximum amount of payment allowed under the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator shall determine:

- (a) any persons to whom, for whom or with respect to whom such payments were made or
- (b) any insurance companies, service plans or any other organizations to whom such payments were made.

Section 28-4 Power and Authority of the Board of Trustees

Subject to the stated purposes of the Trust Fund and the provisions of this Plan Document, the Board of Trustees shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits, and all other related matters. The Board of Trustees shall be the sole judge of the standards of proof required in connection with any proceedings relating to the application and interpretation of this Plan. The Board of Trustees shall have the full and exclusive power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan Document and all other written documents relating to the Plan. Any decisions of the Board of Trustees shall be final and binding on all parties, including Employees, Dependents, Retirees, beneficiaries, Employers, unions, and all other persons involved or affected. If a decision of the Trustees, or of those acting for the Trustees, is challenged in court, such decision is to be upheld unless it is determined to be arbitrary and capricious.

Section 28-5 Assignment

Benefits which are not based on expenses incurred may not be assigned. Benefits payable for expenses incurred in connection with a specified period of disability, hospital care or surgical or medical treatment resulting from one injury or illness may be assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable.

The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payments and the Plan will not be required to see to the application of the payment.

Section 28-6 Physician Review

A physician designated by the Plan shall have the right and opportunity to examine any person whose illness or injury is the basis of any claim when and as often as reasonably required and, in the event of such person's death, to make an autopsy unless prohibited by law.

Section 28-7 Limitation of Actions

Exhaustion of administrative remedies is required before an action may be brought under ERISA in court. Any action brought in court must be initiated within two years of the date that a claim was denied.

Section 28-8 No Reliance on Oral Representation

All decisions relating to eligibility, coverage and benefits will be made in writing. No oral representation, confirmation, description or explanation of coverage and/or benefits is binding upon the Plan.

ARTICLE 29
AMENDMENT AND TERMINATION

Section 29-1 Generally

In order for the Board of Trustees of the Plan to carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Covered Persons, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time

- (a) to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already been incurred;
- (b) to alter or postpone the method of payment of any benefit; and
- (c) to amend or rescind any other provisions of the rules and regulations contained herein.

Circumstances under which the Plan may be terminated include, but are not limited to:

- (a) When there are no longer sufficient assets to continue the benefits of the Plan.
- (b) When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement; or
- (c) When the last surviving Covered Person entitled to receive benefits has died.

In the event of termination of the Plan, the Board of Trustees shall, within the limits of the Fund's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining assets of the Fund be used in a manner which best carries out the basic purpose for which the Fund was established.

Section 29-2 Plan Amendments

This Plan may be amended by the Trustees, in their discretion, upon majority vote of the Trustees in attendance and voting at that time. All amendments shall be in writing and signed by the Trustees.

IN WITNESS WHEREOF, the Board of Trustees have caused this Plan Document of the National Employees Health Plan to be adopted this ____ day of _____, 2009.

UNION TRUSTEES

EMPLOYER TRUSTEES

Witnessed By: _____

Schedule A
Self-Funded Medical Benefits
November 1, 2008

This Schedule sets forth the Covered Medical Expenses provided and paid under the Plan as Self-Funded Medical Benefits, as described in Article 8. It also sets forth Exclusions to the Plan’s Self-Funded Medical Benefits and applicable Definitions.

The benefits listed below are for the Plan Year commencing on November 1, 2008 as provided through a Preferred Provider Organization network product administered through Blue Cross Blue Shield of Michigan (“BCBSM”).

Schedule B
Insured Medical and Prescription Drug Benefits
Insured Life, Accidental Death and Dismemberment Benefits
Insured Dependent Life Benefits
November 1, 2008

This Schedule lists the Health Maintenance Organization(s) or other managed care network providers contracted to provide Plan benefits under an insurance contract, as described in Article 9.

This Schedule lists any insurance companies contracted to provide Plan benefits under an insurance contract, as described in Article 15.

The providers listed below are for the Plan Year commencing on November 1, 2008.

Health Alliance Plan of Michigan

Vista Healthplan, Inc.

Blue Care Network of Michigan

Fort Dearborn Life Insurance Co.

Schedule C
Self-Funded Prescription Drug Benefits
November 1, 2008

This Schedule sets forth the Self-Funded Prescription Drug Benefits provided and paid under the Plan, as described in Article 10. It also sets forth Exclusions to the Plan's Self-Funded Prescription Drug Benefits and applicable Definitions.

The benefits listed below are for the Plan Year commencing on November 1, 2008 administered through Blue Cross Blue Shield of Michigan ("BCBSM").

Schedule D
Vision Benefits
November 1, 2008

This Schedule sets forth the Covered Vision Benefits provided under the Plan, and applicable Limitations and Exclusions, as described in Article 11.

The benefits listed below are for the Plan Year commencing on November 1, 2008 as provided through Eye Med Vision, the provider contracted to facilitate the provision of vision benefits under the Plan.

Benefits are provided subject to any applicable Co-Insurance, Co-pays, Deductible amounts and maximum benefit and payment limitations.

I. The following are Covered Vision Benefits:

- (a) Complete eye examination with dilation, including contact lens fitting and follow-up;
- (b) Eyeglass Frames;
- (c) Standard Plastic Prescription Lenses, including single, bifocal, trifocal, standard progressive or premium progressive;
- (d) Contact Lenses.

II. The following Limitations apply to Covered Vision Benefits:

- (a) Eye examinations are limited to once every twelve (12) months.
- (b) Benefits for frames are limited to once every twenty-four (24) months.
- (c) Benefits for lenses or contact lenses are limited to once every twenty-four (24) months.

III. The following Exclusions apply to Covered Vision Benefits:

No benefits are payable for any loss or expense related to, caused by, incurred for, or resulting from:

- (a) Vision care services or supplies furnished by or at the direction of the United States government or any governmental agency; or
- (b) Vision care performed by a person other than an optician, optometrist, or ophthalmologist; or

- (c) Medical or Surgical treatment of the eye; or
- (d) Sunglasses, plain or prescription; or
- (e) Safety glasses; or
- (f) Vision training; or
- (g) Orthoptics; or
- (h) Treatment of aniseikonia; or
- (i) Replacement of glasses due to loss or theft unless the time limitation placed on the service has elapsed; or
- (j) Routine examinations required by an employer connection with the occupation of a Covered Person; or
- (k) Vision services or supplies received from a medical department maintained by an employer, a mutual benefit association, a labor union, trustee, or similar group.

Schedule E
Dental Benefits
November 1, 2008

This Schedule sets forth the Covered Dental Benefits paid under the Plan, and applicable Limitations, Exclusions and Definitions, as described in Article 12.

The benefits listed below are for the Plan Year commencing on November 1, 2008 as provided through a dental services network.

Benefits are provided subject to any applicable Co-Insurance, Co-pays, Deductible amounts and maximum benefit and payment limitations.

I. The following services are included as Covered Dental Benefits:

A. Class I (Preventive & Diagnostic) Services:

- (a) Routine Oral Examinations, but not more than once every six (6) months.
- (b) Prophylaxis (cleaning and scaling of teeth), but not more than once every six (6) months.
- (c) Fluoride treatment for Dependent children under 19 years of age but not more than once every six (6) months.
- (d) Space maintainers for Dependent children under 19 years of age.
- (e) Diagnostic x-rays including:
 - (1) Full mouth or panorex x-rays but not more than once every year.
 - (2) Bitewing x-rays but not more than once every six (6) months.
 - (3) Intra-oral (periapical) x-rays when required in connection with the diagnosis of a specific condition requiring treatment.
- (f) Pit and fissure sealants.

B. Class II (Restorative) Services:

- (g) Restorative services (fillings).
- (h) Oral surgery procedures including extractions.
- (i) Endodontics.
- (j) Periodontics.
- (k) IV Sedation when provided in conjunction with an oral surgical procedure.
- (l) Periodontic scaling by a dentist but not more than once per year.

C. Class III (Major) Services:

- (m) Repairing and/or re-cementing of inlays, crowns, bridgework and dentures.
- (n) Relining or rebasing partial or full dentures.
- (o) Full or partial dentures.
- (p) Fixed bridgework, crowns, inlays and onlays.

II. The following Limitations apply to Covered Dental Benefits:

Orthodontic benefits to the extent and in the amount indicated in the applicable Schedule of Benefits, and only for Dependent children.

Crowns, inlays, and onlays shall be limited to no more than once every three years. This only applies if the denture that is being replaced was covered by the Plan.

In the event that a Covered Person selected a more expensive service than is customarily provided, the Plan will limit its payment to that which is payable for the customary treatment provided to restore the tooth to its contour and function.

If dental expenses are expected to exceed \$200, a Predetermination of Dental Benefits should be filed with the Plan Administrator prior to treatment. This Predetermination shall inform the covered person and the attending Dentist in advance of the amounts payable under the Plan. Payment for dental services may be limited if a Predetermination of Dental Benefits is not filed prior to services being performed, or if the Dentist alters the course of treatment after submitting a Predetermination of Dental Benefits. Treatment must begin within 90 days of the receipt of a Predetermination of Dental Benefits.

III. The following Exclusions apply to Covered Dental Benefits:

No payment will be made for the following dental expenses:

- (a) Treatment by someone other than a dentist or doctor except for cleaning and scaling of teeth and application of fluoride by a licensed dental hygienist, when such services are rendered under the supervision and guidance of a dentist.
- (b) Services and supplies which are not necessary according to broadly accepted standards of dental practices, including services or supplies which are experimental in nature.
- (c) Services or supplies for cosmetic purposes.
- (d) Orthodontic services for Participants and spouses. Orthodontic benefits in the amount indicated in the Schedule of Benefits are included for Dependent children.
- (e) Services and supplies for which the Covered Person is not legally required to pay.
- (f) Educational programs, such as plaque control, oral hygiene instruction or nutritional counseling.
- (g) Sealants. (Except pit and fissure light cure sealants).
- (h) Failure to keep scheduled appointments or charges for completion of claim forms.
- (i) Local anesthesia.
- (j) Prescriptions written by dentists.
- (k) Fluoride application for eligible Employee or eligible Dependent age 19 or older.
- (l) In connection with restorative dentistry, temporary restorations, bases or sedative fillings.
- (m) Charges for replacement of an existing denture which is satisfactory or which can be made satisfactory.
- (n) Dental expenses incurred prior to the date the Covered Person became eligible under the Plan.
- (o) Expenses for any crown, other than a stainless steel crown, for children less than 14 years of age.

- (p) Expenses incurred for services provided for temporomandibular joint (TMJ) dysfunctions.
- (q) Charges for supplies normally used at home, including but not limited to, toothpaste, toothbrushes, waterpiks and mouthwashes.
- (r) Charges for stayplates to replace extracted anterior teeth after three (3) months following such extractions.
- (s) Charges for special, non-standard, techniques in denture construction to the extent the cost exceeds the cost of standard techniques.
- (t) Charges for replacing lost or stolen appliances or repairing damaged appliances.
- (u) Dental expenses incurred as a result of a work related condition.
- (v) In the event an Employee or eligible Dependent transfers from the care of one Dentist to another Dentist during the course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan shall be liable for not more than the amount it would have been liable for had one Dentist rendered the service.
- (w) For crowns, bridgework, dentures or prosthetic devices, expenses for duplication or replacements less than three (3) years after procedure (insertion, duplication or replacement) was previously covered by the Plan.
- (x) Expenses for relines made less than six months after insertion of denture.
- (y) Full mouth or panoramic x-rays more than once each year.
- (z) Bitewing x-rays, fluoride application, oral examination or prophylaxis (cleaning) more than once in any six month period.
- (aa) Precision attachments, specialized techniques, and personalization of dentures.
- (bb) Procedures, restorations and appliances to increase vertical dimension the distance between the nose and chin, or to alter, maintain, or restore occlusion, or for the purpose of splinting.
- (cc) Facings or veneers on molar crowns or molar pontics.
- (dd) Implantology (except for staple implants to support dentures).

- (ee) No more than two consecutive abutments on any fixed bridgework (crowns splinted and extended beyond this will be payable as individual crowns).
- (ff) Periodontic scaling more than once per year.

IV. The following are definitions of terms used in this Schedule.

"Dentist" shall mean a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

"Dental Hygienist" shall mean a person who has passed a course in dental hygiene under a recognized dental facility, has received a diploma as a qualified dental hygienist, and works under the direct supervision of a Dentist.

"Endodontic Services" shall mean procedures for the treatment of a non-vital tooth.