

**Health & Welfare Trust Fund of the International Union of
Operating Engineers
(Local 877)**

**MEDICAL AND DENTAL PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION**

**Effective: November 1, 1990
Restated As Of: January 1, 2009**

Group No: 001AB9

**Administered by:
Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581**

RECEIPT OF PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

I, the undersigned, acknowledge receipt of the Plan Document/Summary Plan Description booklet which outlines the group medical, dental and prescription drug benefits for myself and all of my Eligible Dependents (if any), who meet the eligibility requirements stated in this Plan Document/Summary Plan Description.

I further understand that my rights under the Consolidated Omnibus Budget Reconciliation Act '85 (COBRA) for continuation of coverage and eligibility under the Special Enrollment Periods and Elections are outlined within the pages of this Plan Document/ Summary Plan Description. By my following signature, I acknowledge receipt of the Plan Document/ Summary Plan Description and I am aware of my rights under COBRA and the Special Enrollment Periods and Elections.

Pre-existing Conditions: Benefits may not be payable for pre-existing conditions. Please refer to the Pre-existing Conditions Article XI.

Member's Name

Member's Signature

Operating Engineers (Local 877)

Date

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I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT, established by the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 (hereinafter the "Trust Fund") on this ___ day of _____, 2008, restates the International Union of Operating Engineers Trust Fund (Local 877) Medical and Dental Plan effective as of January 1, 2009.

A. Establishment of Plan. The Trust Fund restates its group health plan known as the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 Plan (the "Plan"). The Plan is written for the sole and exclusive purpose of providing to the Eligible Members and their Eligible Dependents Member welfare benefits as described herein.

The purpose of this Plan is to provide welfare benefits for Eligible Members of the International Union of Operating Engineers Local 877 and their Eligible Dependents as described herein. These benefits have been established by the Trust Fund and are provided on a self-funded basis. As such, the benefits are directly funded through and provided by the Trust Fund, and the Trust Fund has the sole responsibility and liability for payment of benefits under this Plan. Health Plans, Inc. is not the issuer, insurer, or provider of your benefits.

B. Effective Date. The Plan was originally effective as of November 1, 1990, and is hereby restated as of January 1, 2009.

The Plan is subject to all of the conditions and provisions set forth in this document and subsequent amendments which are made a part of this Plan.

II. GENERAL INFORMATION

Plan Name: Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 Plan

Type of Plan: Welfare plan providing medical, dental and prescription drug benefits on a self-funded basis

Effective Date: November 1, 1990 and restated as of January 1, 2009

Plan Administrator and Plan Sponsor: Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877
89 Access Road
Unit 4
Norwood, MA 02062-5233
(781)769-5789

Trustees of the Plan: Allen R. McWade

Anthony D. Pisano

Trust Fund Identification Number: 04-2624972

Plan Number: 501

Group Number: 001AB9

Claim Administrator: Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
(800) 343-7674
www.healthplansinc.com

Employee Assistance Program: Modern Assistance Programs
1458 Hancock Street 3rd Floor
Quincy, MA 02169
(800) 878-2004

Precertification Services for Mental Health, Alcohol & Substance Abuse and other specified services: Modern Assistance Programs
1458 Hancock Street 3rd Floor
Quincy, MA 02169
(800) 878-2004

Prescription Benefit Manager: **Retail Card Program and Mail Order Program -**
Express Scripts
1400 Riverport Drive
Maryland Heights, MO 63043
(800) 524-4491
Mail Order Program (for diabetic supplies only) -
New England Mail Order Pharmacy
2 Maple Street
Middlebury, VT 05753
(888) 778-8667

Case Management Services: Care Management Services
P.O. Box 663
Westborough, MA 01581
(866) 325-1550

COBRA Administrator: Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
(800) 343-7674

Agent for Service of Legal Process: Health & Welfare Trust Fund of the International Union
of Operating Engineers Local 877
89 Access Road
Unit 4
Norwood, MA 02062-5233
(781)769-5789

Source of Contributions: Payments made to the Trust by individual Employers
under the provisions of collective bargaining or
participation agreements, Member contributions, and any
income earned from investment of Employer and Member
contributions. Participants and beneficiaries may receive
from the Plan Administrator, upon written request,
information as to whether a particular Employer or
Member organization contributes to the Fund, and if so,
the Employer or Member organization's address.
Members may also receive, upon written request, a
complete list of Employers and Member organizations
who contribute to the Fund, and a copy of any applicable
collective bargaining or participation agreement(s). All
monies are used exclusively for providing benefits to the
eligible Member/Members and their dependents, and for
paying all expenses incurred with respect to operating the
Plan.

Plan Year Ends:

October 31st

Loss of Benefits:

The Trust Fund may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by the Trust. Your consent is not required to terminate or change the Plan.

Your coverage ends on the earlier of the last day of the month following the day in which you terminate employment, or on the last day of the period in which you fail to make any required contributions. Contact the Trust Fund to discuss what benefit extensions may apply or what arrangements may be made to continue coverage.

III. DEFINITIONS

The following words and phrases will have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

Accident - means a sudden or unforeseen event which: causes Injury to the physical structure of the body; results from an external agent of trauma; and is definite as to time and place. An Accident can happen involuntarily, can result from a voluntary act which entails unforeseen consequences, or can result from an intentional self-inflicted Injury even if the consequences could have been foreseen. An Accident does not include harm resulting from a disease or sickness and will be determined by the Claim Administrator.

Actively at Work - the term “Actively at Work” means the active expenditure of time and energy in the service of the Employer. A Member will be deemed Actively at Work on each day of a regular paid earned time off day and on a regular non-working day on which he or she is not totally disabled, if he or she was Actively at Work on the last preceding regular working day.

Alcoholism - means an alcohol induced disorder which produces a state of psychological and/or physical dependence.

Ambulatory Surgical Center – means a specialized facility which:

1. where coverage of such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
2. where coverage of such facility is not mandated by law, meets all of the following requirements;
 - a. it is established, equipped and operated in accordance with the applicable laws in jurisdiction in which it is located primarily for the purpose of performing surgical procedures;
 - b. it is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital (as defined) in the area;
 - c. it requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;
 - d. it provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic X-ray and laboratory examinations; and has available to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, a defibrillator, a tracheotomy set, and a blood bank or other blood supply;

- e. it provides the full-time services of one or more registered nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room;
- f. it maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require post-confinement;
- g. it maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Birthing Center - means operated primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a Birthing Center and registered as a Birthing Center with the existing state. The Birthing Center must also be licensed, if required by law.

Certificate of Coverage - means a written certification provided by any source that offers medical coverage, including this Plan, for purposes of confirming the duration and type of a Member's Creditable Coverage.

Cosmetic Surgery – means plastic, reconstructive and cosmetic surgery operations performed in order to repair or restore body parts to look normal, or to change a body part to look better.

Coverage Period - means the period during which benefits provided under this Plan are available to a Covered Person.

Covered Medical Expense - a reasonable charge incurred by a Covered Person for a necessary service or supply which appears on the Schedule of Medical Benefits.

Covered Person - means a Member and Dependent eligible for benefits and enrolled under this Plan.

Custodial Care - services designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be custodial care whenever and wherever furnished, without respect to the practitioner or provided by whom or by which they are prescribed, recommended or performed.

Creditable Coverage - means coverage a Member had under any of the following sources: A group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their Eligible Dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical

condition, a health plan offered under the Federal Members Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Day Treatment – means mental health or substance abuse care on an individual or group basis for more than two (2) hours but less than 24 hours per day in either a licensed hospital, rural health center, community mental health center or substance abuse treatment facility. This type of care is also referred to as partial hospitalization.

Educational Institution – means currently accredited institutions of higher education, including vocational technical schools, which may include but are not limited to, photography schools or beautician schools.

Effective Treatment of Alcoholism/Substance Abuse - is a program of alcoholism/substance abuse therapy that meets all of the following:

1. It is prescribed and supervised by a Physician.
2. The Physician certifies that a follow-up program has been established which includes therapy by a Physician, or group therapy under a Physician's direction at least once per month.
3. It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of alcoholism/substance abuse.

Treatment solely for detoxification or primarily for maintenance care is not considered Effective Treatment. Detoxification is care aimed primarily at overcoming the after-effects of a specific drinking episode or substance abuse episode. Maintenance care consists of the providing of an environment without access to alcohol.

Eligible Dependent – means:

- (1) A person of the opposite gender who is the husband or wife of the Member as recognized under the Federal Defense of Marriage Act ("DOMA"). Such person may also be referred to as "spouse" under the terms of the Plan. The definition of a "spouse" does not include a legally separated or divorced spouse.
- (2) A child of the Member who as of the close of the calendar year in which the taxable year of the Member begins is either:
 - (i) unmarried from birth to age 19 (i.e. through age 18), has the same principal place of residence as the Member for more than 1/2 of the taxable year of the Member, and has not provided over 1/2 of his or her own support in that year; or
 - (ii) unmarried from age 19 to age 24 (i.e. through age 23), and who is a full-time student enrolled in and attending an accredited college or university, has the same principal place of residence as the Member

for more than 1/2 of the taxable year of the Member, and has not provided over 1/2 of his or her own support in that year; or

- (iii) unmarried from age 24 to age 25 (i.e. through age 24), and who is a full-time student enrolled in and attending an Educational Institution, and who has over 1/2 of his or her support for the calendar year provided by the Member.

If a Member's unmarried child age nineteen (19) or over has had a break in coverage under the Plan as a full-time student at an Educational Institution, he/she may reenroll for coverage provided the break is no longer than one (1) year and he reenrolls within the thirty (30) day period of his/her return to full time student status. This re-enrollment will be allowed once.

Note: The Member must provide a Student verification Form to the Plan Administrator, signed by the registrar of the accredited college or university, prior to the beginning of each semester that evidences that the student is maintaining full-time attendance, in accordance with the school attended. In addition, coverage for full time students and graduate students is extended during school vacations, including summer breaks. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage terminates upon the date of graduation or withdrawal from classes. Upon termination of eligibility under the Plan, such Covered Persons may be eligible for Continuation of Coverage under the COBRA provisions of the Plan.

For purposes of determining eligibility for Eligible Dependent coverage, the term "child" includes (1) a natural child; (2) a stepchild by legal marriage; (3) a child who has been legally adopted by the Member or placed with the Member for adoption by a court of competent jurisdiction; and (4) a child for whom legal guardianship has been awarded, provided that to be eligible for coverage, the child must legally reside with the Member in a parent-child relationship for more than 1/2 of the taxable year, and must not have provided more than 1/2 of his or her own support in that year or be the subject of a Qualified Medical Child Support Order (as described in Article X, subsection D).

In addition to the foregoing, an unmarried child who is permanently and totally disabled (as defined in Internal Revenue Code Section 22(e)(B)), at any time during the calendar year in which the taxable year of the Member begins, shall be deemed to have met the age requirements described in (2) above. The Plan Administrator may require, at reasonable intervals during the two years following the child's 19th birthday, subsequent proof of the child's incapacity and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator has the right to have such child examined by a Physician of the Plan Administrator's choice to determine the existence of such incapacity.

Emergency Care - means treatment of an Illness or Injury in a hospital, clinic, or doctor's office for any Injury or Illness that requires immediate medical intervention to prevent death or serious impairment of health. Examples of Emergency Care situations include: symptoms of heart attack and stroke; poisoning; loss of consciousness; loss of breath; shock; severe bleeding; or convulsions. Emergency Care does not include ambulance service. In addition, see

PRECERTIFICATION INFORMATION PERTAINING TO EMERGENCY ADMISSIONS in the Section titled “Preadmission/Precertification Requirement for Hospitalization” under Article VI, Subsection B.

Employer – means any Employer (including any corporation, partnership or sole proprietorship, or any subdivision or other unit) or Union obligated to contribute to the Fund by reason of a collective bargaining agreement or participation agreement.

ERISA - The term “ERISA” refers to the Employee Retirement Income Security Act of 1974 as amended from time to time.

Expenses Incurred - for the purpose of this Plan an expense will be considered to be incurred at the time the service or supply to which it relates is provided.

Experimental/Investigational - means a drug, device, medical treatment, new technology, procedure or supply which is not recognized as eligible for coverage as defined below. A drug device, medical treatment, new technology, procedure or supply will be considered experimental or investigative if:

- (1) The drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, new technology, procedure or supply is furnished.
- (2) The drug, device, medical treatment, new technology, procedure or supply, or the patient’s informed consent document utilized with the drug, device, treatment, new technology, procedure or supply, was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval.
- (3) Reliable evidence shows that the drug, device, medical treatment, new technology, procedure or supply is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- (4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply.

FMLA - means the Family and Medical Leave Act of 1993, as amended from time to time.

FMLA Leave - means a leave of absence that the Employer is required to extend to a Member under the provisions of the FMLA.

Freestanding Health Clinic - means a private facility other than a private office of a Physician, which is operated primarily for the purpose of providing the treatment of Illness or minor Injuries of patients who are treated with or without an appointment for which it is duly licensed.

Home Health/Hospice Agency - means an agency or organization which fully meets each of the following requirements:

- (1) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
- (2) It has policies established by a professional group associated with the agency or organization, the professional group must include at least one Physician and at least one Registered graduate Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or required licensed or Registered Nurse.
- (3) It maintains a complete medical record on each patient.
- (4) It has an administrator.

Hospice Plan of Care - means a prearranged, written outline of care that will be provided for the palliation and management of a person's terminal sickness.

Hospital - means any institution which meets in full all of the following:

- (1) It must furnish day and night lodging.
- (2) It must be primarily engaged in providing, for compensation from its patients on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of doctors who are legally licensed to practice medicine.
- (3) It must regularly and continuously provide day and night nursing service by or under the supervision of a Physician.
- (4) It must not be, other than incidentally, a place for the aged or a nursing or convalescent home.
- (5) It must be operated in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as Hospitals.

The term “Hospital” will include an institution specializing in the care and treatment for rehabilitation and mental or emotional Illness, disorder or disturbance, which would qualify under this definition as a Hospital. The term “Hospital” will include a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.

The term “Hospital” will also include a rehabilitation facility/hospital which is licensed by the State; accredited by the Joint Commission on Accreditation of Health Care Organizations; and accredited by the Commission of Accreditation of Rehabilitation Facilities.

Illness - means a sickness or bodily disorder or disease, or mental or nervous disease or disorder. An Illness due to causes which are the same or related to causes of a prior Illness, from which there has not been complete recovery will be considered a continuation of such prior Illness. The term “Illness” as used in this Plan will include pregnancy, childbirth, abortion (elective or life-threatening), miscarriage and any complications of pregnancy and related medical conditions.

Incurred Date - means the date the service was performed or the supply (or supplies) were provided.

Incurred Expense - means an expense is deemed to be incurred on the date a service is rendered or supply is furnished.

Infertility - means the condition of a presumably healthy Covered Person who is unable to conceive or produce conception during a one year period.

Injury - means an accidental bodily Injury which results independently of Illness and will include all Injuries resulting from an Accident and all complications arising from such Injuries or Accident.

In-Network Provider - means a panel of Physicians and/or group of participating health care institutions which provide medical services to contracted groups of Covered Persons.

Inpatient Hospice Facility - means an establishment which may or may not be part of a Hospital and which meets all of these requirements:

- (1) It complies with licensing and other legal requirements in the jurisdiction where it is located.
- (2) It is mainly engaged in providing inpatient palliative care for the terminally ill on a 24-hour basis under the supervision of a Physician or a Registered Nurse, if the care is not supervised by a Physician available on a prearranged basis.
- (3) It provides pre-death and bereavement counseling.
- (4) It maintains clinical records on all terminally ill persons.
- (5) It is not mainly a place for the aged or a nursing or convalescent home.

Inpatient Hospice Facility also will include a hospice facility approved for a payment of Medicare hospice benefits.

Intensive Care Unit - means an accommodation of part of a Hospital, other than a postoperative recovery room, which, in addition to providing room and board:

- (1) Is established by the Hospital for a formal intensive care program.
- (2) Is exclusively reserved for critically ill patients requiring constant audio-visual observation prescribed by a Physician and performed by a Physician or by a specially trained registered graduate nurse.
- (3) Provides all necessary life-saving equipment, drugs and supplies in the immediate vicinity on a standby basis.

Late Enrollee - means a Member or Dependent who is enrolled for coverage after the initial eligibility date. Note, however, a Special Enrollee will not be considered a Late Enrollee.

Licensed Occupational, Speech and Physical Therapists - means therapists who are licensed by the state where services are rendered.

Medically Necessary - means a service or supply that meets all of the requirements listed below:

- (1) It must be legal.
- (2) It must be ordered by a Physician.
- (3) It must be safe and effective in treating the condition for which it is ordered.
- (4) It must be part of a course of treatment which is generally accepted by the American medical community. That community includes all of the branches, professional societies and governmental agencies therein.
- (5) It must be of the proper quantity, frequency and duration for treatment of the condition for which it is ordered.
- (6) It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered.
- (7) It must not be Experimental or Investigational.
- (8) Its purpose must be to restore health and extend life.

This determination may include the consideration of the findings and assessments of the following entities:

- (1) The Office of Medical Application of Research of the National Institute of Health, the Office of Technology Assessment of the United States Congress or any similar entities.

- (2) The National Medical Association, Societies and Organizations.
- (3) The Federal Drug Administration.
- (4) The Plan Administrator's own medical and legal counsel and advisors.

Medicare - means Title XVIII of the Social Security Act of 1965, as amended. Part A - means Medicare's hospital plan and Part B - means the supplementary medical plan.

Medicare Entitlement – means Title XVIII of the Social Security Act of 1965.

Member– means any Member who is considered to be in an employer-Member relationship with an Employer for purposes of federal withholding taxes and who meets the eligibility requirements described in Article X.

Mental or Nervous Disorder - means manic depression, neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity – means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Nurse - means a professional nurse who has the right to use the title Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) and a Registered Nurse Midwife (R.N.M.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

Out-Of-Network Provider - means a licensed Physician and/or health care institutions which are not affiliated with a Preferred Provider Organization (PPO).

Physician - means any licensed doctor of medicine, M.D., osteopathic Physician, D.O., dentist, D.D.S/D.M.D, podiatrist, Pod.D./D.S.C./D.P.M., doctor of chiropractic medicine, D.C., naturopath, N.D., optometrist, O.D., or psychologist, Ph.D./Ed.D./Psy.D. Physician will also include a certified nurse midwife or a licensed independent social worker.

Policy Year -means a period of time commencing with the effective date of this Plan or the Plan anniversary, and terminating on the date of the next succeeding Policy Year.

Preadmission Testing - means tests performed in a Hospital prior to confinement as a resident inpatient provided:

- (1) Such tests are related to the performance of scheduled surgery or a scheduled admission.
- (2) Such tests have been ordered by a duly qualified Physician after a condition requiring such surgery or treatment has been diagnosed and Hospital admission for such surgery or treatment has been requested by the Physician and confirmed by the Hospital.

- (3) The patient is subsequently admitted to the Hospital or the confinement is canceled or postponed because there is a change in the condition which precludes the surgery or the treatment.

Psychotherapist - means a person fully licensed to practice medicine who devotes a substantial portion of time to the practice of psychiatry.

Reasonable and Customary Charge - means the following:

- (1) Reasonable - the amount which is determined reasonable based on the complexity of treatment of a particular case and the prevailing fee for such treatment. In unusual circumstances or cases with medical complications requiring additional time, skill and experience in connection with a particular service or procedure, reasonable variations may be permitted from the prevailing fee.
- (2) Customary - the amount which falls within the range of usual charges for a given service charged by most providers with similar training and experience in a geographic area as determined by the Plan Administrator.

Routine Nursery Care - means routine room and board or nursery charges, Physician's or surgeon's charges, and any other related charges (including charges for circumcision) incurred while a patient in a Hospital, but not beyond the date the newborn child is first discharged from the Hospital.

Service in the Uniformed Services - means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Significant Break in Coverage - means a period of 63 consecutive days during all of which a Member did not have any Creditable Coverage but does not include waiting periods or affiliation periods.

Skilled Nursing Facility - means an institution or part thereof constituted and operated pursuant to law which:

- (1) Provides, for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered graduate Nurse. Full-time supervision means a Physician or Registered graduate Nurse is regularly on the premises at least 40 hours per week.
- (2) Maintains a daily medical record for each patient.
- (3) Has a written agreement of arrangement with a Physician to provide emergency care for its patients.
- (4) Qualifies as an "extended care facility" under Medicare, as amended.

- (5) Has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and convalescent nursing facility.

In no event, however, will a convalescent nursing facility be deemed to include an institution which is, other than incidentally, a place for rest, a place for the aged, a place for alcoholics, drug addicts, the blind or deaf, mentally ill or retarded.

Special Enrollee – means a Member and his or her Eligible Dependents who satisfy the requirements of Section X(I) for special enrollment under the Plan.

Spouse – means a person of the opposite gender who is the husband or wife of the Member as recognized under the Federal Defense of Marriage Act (“DOMA”). The definition of a “spouse” does not include a legally separated or divorced spouse.

Substance Addiction/Abuse - means a substance induced disorder which produces a state of psychological and/or physical dependence.

Total Disability or Totally Disabled - means the status of a covered Member who, during any period when, as a result of Injury or Illness, is completely unable to perform the duties of any occupation for which he or she is reasonably fitted by training, education, or experience. A covered Eligible Dependent will be considered Totally Disabled during any period when, as a result of an Injury or Illness, he or she is unable to engage in the normal activities of a person of same age and sex.

Transplant Benefit Period - means the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

Trust Agreement – means the written agreement between the Union and each Employer establishing and providing for the maintenance of the Health & Welfare Trust Fund of the International Union of Operating Engineers Local No. 877.

Uniformed Service - 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 in the time of war or emergency.

Waiting Period - means the period of time a Member must be employed prior to becoming eligible for coverage under the Plan.

Well Child Care – means treatment that is in accordance with the standards and frequencies endorsed by the American Academy of Pediatrics. Coverage includes, but is not limited to; physical examinations, history, sensory screening, developmental screening and appropriate immunizations.

DENTAL DEFINITIONS

The following words and phrases are not intended to imply that coverage for them is provided under the Plan.

Abutment - means a tooth or root that retains or supports a fixed or a removable Prosthesis.

Acid-etch - means in restorative dentistry, a method of etching the tooth enamel with an acid to provide adhesion of composite Filling material to a tooth surface.

Adjustment - means an alteration or modification which may be required on a Denture or the teeth in a Denture after it has been placed in the mouth.

Alveoplasty & Alveolectomy - means surgical excision or revision of the alveolar process to restore A normal contour. May range from simple Alveolectomy in conjunction with extractions or reconstruction of the ridge in preparation for Dentures.

Amalgam - means an alloy of mercury, silver and other metals used as a restorative material and in making dies.

Anterior - means the front, incisor or cuspid teeth.

Apex - means the anatomic end of a tooth root.

Apicoectomy - means surgical removal of the apical portion of a tooth root.

Appliance - means a device used to replace missing parts or restore function, such as a Denture, Splint or obturator.

Bicuspid - means the two teeth in each quadrant that are posterior to the cuspids and anterior to the molars. Also called premolars.

Bite Guard - means an appliance that covers the Occlusal and Incisal surfaces of the teeth. It is used to stabilize the teeth and/or provide a flat surface for unobstructed movement of the mandible.

Bitewings - means dental X-rays showing approximately the coronal halves of the maxillary and mandibular teeth on the same film.

Bridge - means a permanently cemented Appliance which includes at least one (1) Pontic (to replace a missing tooth) and at least on (1) Abutment. Removable only by a Dentist.

Bruxism - means a clenching or grinding of the teeth, associated with a forceful jaw movement, usually during sleep.

Buccal – see Surfaces.

Caries - means a progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

Cavity - means a carious lesion in a tooth.

Clasp - means a metal attachment on Partial Dentures or other removable Appliances to hold them in place.

Complete Denture - means an Appliance which replaces all of the teeth in an arch.

Composite - means a plastic restorative material made of resin and quartz crystals blended with a catalyst. (i.e., Blendant, Adaptic, Nuvafil, EpoxyLite, Compodent, Concise, Smile, Enamelite and Restodent.)

Covered Expense - means a reasonable charge incurred by a Covered Person for a necessary service or supply which appears in the Summary of Dental Benefits.

Covered Person - means a Member and any Eligible Dependents eligible for benefits and enrolled under this Plan.

Crown - means the portion of the tooth above the cemento-enamel junction. Anatomic Crown - the portion of a tooth exposed beyond the crest of the gingiva. Complete Crown - a crown that covers the entire clinical crown. Dowel Crown - a complete (full) crown that replaces the entire coronal portion of the natural tooth which is retained by a post extending into the Root Canal. Face Crown - a metal crown with a tooth-colored material on the labial or buccal surface. Jacket Crown - generally a complete veneer crown that is made entirely of porcelain or acrylic resin. Partial Crown - a crown that covers only a portion of a tooth, e.g., one half or three-quarters of its circumference. Shell Crown - a metal cap designed to fit the prepared tooth. Usually performed to reproduce the natural crown. Telescope Crown - a preparation placed over remnants of a natural tooth to give strength to the restoration. Three-Quarter Crown - see Partial Crown. Veneer Crown - full coverage crown made by acrylic, porcelain, metal or combinations of metal with acrylic or porcelain.

Curettage - means scraping or removal of diseased tissue with a curette. Apical Curettage - curettage of diseased tissue in the periapical area and on the apical portion of a tooth, without removal of the root tip. Gingival Curettage - debridement of diseased gingival tissue. Infrabony Pocket Curettage - removal of soft tissue inflammation located within and around an infrabony defect; debridement and planing of the root surface of the pocket. Root Curettage - removal of accretions on the root surface by debridement and planing. Subgingival Curettage - debridement of the entire pocket and epithelial subjacent connective tissues.

Dental Hygienist - means a person who is duly licensed to practice the art of dental Prophylaxis.

Dentist - means a duly licensed Dentist, practicing within the scope of his or her profession, and any other Physician furnishing any dental services which he or she is licensed to perform, excluding a member of the Covered Person's family or household.

Denture - means any artificial substitute for missing natural teeth and adjacent tissue' including full and Partial Dentures, and fixed or removable Bridges.

Denturist – means a person duly licensed and registered to practice the profession of denturism and whose license is in good standing with the appropriate licensing or governing body, a foreign country or other similar jurisdiction excluding a member of the Covered Person's family or household.

Distal – see Surfaces.

Dowel Post & Pins - means pins or posts placed in a tooth to provide retention for a Crown.

Edentulous - means without teeth (in an area, an arch or an entire mouth).

Enamel - means the white, hard substance that covers the coronal portion of teeth and protects the dentin.

Endodontic Treatment - means treatment of diseases of the dental Pulp.

Equilibration - means the study and achievement of equalized pressure; the balancing of opposing forces such as the maxilla with the mandible. Extensive Equilibration - a diagnostic study involving the use of study models, articulator and registrations to determine need for any type of occlusal correction. Occlusal Equilibration - the correction of Occlusion by selective grinding to equalize Occlusal stress or for harmonizing cuspal relations by removing high spots and areas of interference.

Eruption - means the process of erupting; the appearance of a tooth breaking through the gingival tissue; cutting of a tooth. Surgical Eruption - surgical removal of overlying tissue, bone, cyst or tumor to permit eruption.

Expenses Incurred - for the purpose of this Plan an expense will be considered to be incurred at the time the service or supply to which it relates is provided.

Extraction - means removing a tooth from the oral cavity. Serial Extraction - extraction of selected teeth over a period of time. Simple Extractions - uncomplicated removal of a tooth. Surgical Extraction - removal by means of surgical methods, usually involving the turning of a flap or removal of bone.

Filling - for the purpose of this Plan means restoration. By common usage filling refers to restorations which do not require castings, but is more accurately a temporary restoration. Treatment Filling - a sedative filling, temporarily placed, for treatment of sensitive dentin in preparation for a final restoration. Used when the extent of disease cannot be determined until the demineralized dentin is hardened to permit removal without Pulp exposure.

Fixed Appliance - shall mean an Appliance that is permanently cemented or attached with adhesive materials.

Fixed Bridge - shall mean a Prosthesis that replaces one (1) or more teeth and is cemented into place. It consists of one (1) or more pontics held in place by one (1) or more retainers or Abutment teeth.

Fluoride - means a solution of fluorine, which is applied to the teeth for the purpose of preventing dental Caries.

FMLA - means the Family and Medical Leave Act of 1993.

Gingivectomy - means excision of diseased or unsupported gingival tissue.

Gingivitis - means inflammation of the gingival tissue.

Impacted Tooth - means one that is positioned or wedged against another tooth, or covered by bone or soft tissue, so that it cannot erupt.

Implants - for the purpose of this Plan, shall mean dental implants made of metal or other foreign material and placed into or on the alveolar bone to provide support. Endosseous Implants - may be a single metal post inserted into the alveolar bone to support artificial Crown that replaces a missing natural tooth. May also be a metal blade to support one or more artificial Crowns or a Crown serving as an Abutment for a Fixed Bridge. Subperiosteal Implant - used for support of Dentures where there is sufficient resorption of the alveolar ridge.

Incisal - means pertaining to the cutting edge of the Anterior teeth.

Incurred Date - with respect to dentures means the date the impression was made; with respect to a Crown or gold restoration, the date the tooth was prepared; with respect to Endodontic Treatment the date the Pulp chamber was opened.

Injury - means a physical condition which is the result of an accident caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

Inlay - means a cast restoration made to fit a prepared tooth cavity and then cemented into place.

Late Enrollee – means a Covered Person who is enrolled for coverage after the initial eligibility date.

Lingual – see Surfaces.

Malocclusion - means an abnormality in the positioning and relationship of teeth.

Maxilla - means the bone forming one-half of the upper jaw. The upper jaw consists of two maxillae; however, it is commonly referred to as the maxilla.

Maxillofacial - means pertaining to the jaws and the face.

Mesial – see Surfaces.

Occlusal – see Surfaces.

Occlusal Guard - means a removable dental appliance, usually constructed of acrylic resin, that covers one or both dental arches to protect the teeth from the damaging effects of Bruxism and other Occlusal habits.

Occlusion - means the contact of the teeth of both jaws when they are closed.

Odontectomy - shall mean surgical Extraction of a tooth.

Onlay - shall mean a cast restoration that covers the entire Incisal or Occlusal surface of a tooth.

Orthodontic Treatment - means dental treatment, which has as its objective the correction of Malocclusion of the teeth.

Osseous Surgery - means surgery performed to eliminate osseous deformities; to remove diseased and defective bone tissue.

Overlay - means an Inlay or a splint that fits over the biting or grinding surface of a tooth.

Palliative - means affording temporary relief, but not a cure.

Partial Denture - means a Prosthesis which replaces one or more, but not all, natural teeth and associated structures; may be removable or fixed, unilateral or bilateral.

Periodontic Treatment - means treatment of the tissues and bones supporting the teeth including surgery, Splinting, and Occlusal Equilibration.

Periodontitis - means inflammation of the tissue surrounding a tooth.

Permanent Teeth - shall mean the thirty-two (32) adult teeth.

Plate - means the roof of the mouth.

Pontic - means the part of a Fixed Bridge that is suspended between Abutments and that replaces a missing tooth; an artificial tooth in a removable Denture.

Post - means in Partial Denture work, the minor connector that attaches the Clasp body to the framework or an upright metal device that extends into a tube tooth to retain it. In restorative

dentistry, a metal projecting in Crowns for strength which may extend into the root of a pulpless tooth or through the root into the alveolar bone.

Post & Core - shall mean a single cast unit that is placed into a tooth, followed by permanent exterior restoration, usually a Crown.

Precision Attachment - means a specially designed attachment used in fixed and removable prosthetics, for attachment to the abutting teeth. Usually consists of a tongue and groove, or male-female design.

Prophylaxis - means the cleaning of teeth by a Dentist or Dental Hygienist to remove calculus and stains.

Prosthesis - shall mean an artificial replacement for one (1) or more natural teeth and/or associated structures.

Pulp - means the connective tissue that fills the pulp chamber and Root Canals of teeth.

Pulpectomy - means complete removal of either vital or inflamed Pulp from the Pulp chamber and Root Canals.

Pulpotomy - means removal of dental Pulp from the coronal portion of a tooth.

Quadrant - shall mean one-fourth of the two (2) dental arches; one-half of each arch.

Radicular - for the purpose of this Plan shall mean pertaining to a tooth root.

Rebase - shall mean the repair or alteration of the base of an artificial Denture.

Reline - shall mean the resurfacing of the tissue-borne areas of a Denture with new material.

Replantation - means the reinsertion of a natural tooth that has been dislodged or removed.

Restoration - means Fillings, Inlays, Crowns, Bridges, Partial and Complete Dentures.

Retainer - shall mean an Abutment tooth in a fixed bridge that may be an Inlay or a Partial or full Crown. In removable prosthetics, a Clasp, attachment or device used for fixation or stabilization. In orthodontics, an Appliance used to maintain the altered positions of the teeth and jaws until they stabilize.

Root Canal - shall mean the space within the root of a tooth that contains nerves and blood vessels.

Root Canal Therapy - means treatment of a tooth having a diseased or damaged Pulp, normally performed by completely removing the Pulp, sterilizing the Pulp chamber and Root Canals, and filling those spaces with a sealing material.

Scale - means the removal of calculus (tartar) and stains from teeth with a scaler.

Sealant - shall mean a resin (plastic) material placed on the Occlusal surfaces of permanent Bicuspid and molars to prevent decay.

Space Maintainer - means a fixed or removable appliance placed to maintain space created by premature loss of one or more teeth. May also be used to create space by moving teeth apart.

Splint - for the purpose of this Plan, shall mean an Appliance designed to retain teeth in position.

Splinting - shall mean stabilizing or immobilizing periodontally involved teeth. May be accomplished with acrylic resin Bite Guards, orthodontic band Splints, wire ligation, provisional Splints and fixed Prostheses.

Surfaces - shall mean tooth surfaces. Buccal - adjacent to the cheek. Distal - away from the median plane of the face, following the curvature of the dental arch. Facial - next to the face. Incisal - cutting surface of anterior teeth. Labial - same as facial, but towards the mouth and lips. Lingual - adjacent to the tongue. Mesial - toward the center or median line of the dental arch. Occlusal - the mastication or grinding surface of molars and Bicuspid. Proximal - the surface nearest to the adjacent tooth.

Treatment Plan - means a Plan of dental treatment including X-rays showing the patient's dental needs, a written description of the proposed treatment necessary in the professional judgment of the Dentist, and the cost of the proposed treatment.

IV. SCHEDULE OF MEDICAL BENEFITS

This Section contains a summary of the benefits made available under the Plan.

If you have any questions about any of your coverage, please contact your Claim Administrator: Health Plans, Inc. at 1-800-343-7674. By working together, we can help contain medical expenses. Some of the ways we can do this are:

- The use of Preferred Provider Networks. The chosen Preferred Provider Network is a group of Physicians, hospitals and other health care providers who have agreed to accept a negotiated fee for covered services and supplies. Preferred Provider Networks may be used by participants to provide most of the covered medical services described in the Plan. As a participant in the Plan, you maintain the freedom to choose participating or non-participating providers. Please visit www.healthplansinc.com for a listing of participating providers.

When you choose a participating Physician, hospital or other health care provider, this Plan contains many advantages:

- ◆ You usually pay less money out of your pocket for health care services.
 - ◆ You may change your Physician and/or hospital at any time, because you are not required to designate a primary care Physician.
 - ◆ Your participating Physician and/or hospital will file claims directly, so you do not have to wait for claim reimbursement.
 - ◆ You are not responsible for charges over the negotiated fees allowed by the applicable network for covered services, but you are responsible for the applicable deductible, co-payment and coinsurance amounts.
- The use of outpatient surgery. Consider having surgery performed in the outpatient department of the hospital, a surgical care center or a Physician's office. This will eliminate the hospital room and board charges as well as overnight stays.
 - The use of generic drugs. A generic drug means a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. Whenever possible request your Physician prescribe a generic drug.

The following medical and prescription drug benefits are provided under the Plan in the event of a non-occupational Accident or Illness.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Expense & Mail Order Option

Retail Card Program – You Pay

(up to a 34 day supply)
 \$5 co-payment per generic drug;
 \$10 co-payment per brand name drug.

Mail Order Pharmacy – You Pay

(34 -90 day supply)
 \$0 co-payment per generic drug;
 \$10 co-payment per preferred brand name drug.

(Diabetic supplies can be obtained through the New England Mail Order Program.)

DEDUCTIBLES/COINSURANCE

IN-NETWORK PROVIDERS

OUT-OF-NETWORK PROVIDERS

Calendar Year Deductible*

None per person
 None per family

\$200 per person
 \$500 per family

Reimbursement Percentage (“co-insurance”)

100% of the fee schedule amount (unless otherwise stated)

85% reasonable & customary (after deductible; unless otherwise stated) for the first \$6,333 per person and \$8,333 per family, then 100% thereafter for the balance of the calendar year (unless otherwise stated)

Out-of-Pocket Maximums*

None per person
 None per family

\$1,150 per person (including deductible)
 \$1,750 per family (including deductible)

***Note:** The family deductible amount and family out-of-pocket maximum are satisfied by a combination of all family members.

The following expenses are excluded from the Out-of-Pocket Maximum:

- Office visit co-payments
- Prescription drug co-payments
- Inpatient/Outpatient Hospital Admission co-payments
- Precertification penalties
- Inpatient and Outpatient treatment of Alcohol & Substance Abuse

The Covered Person is also responsible to pay any amount above the reasonable and customary allowance when services are rendered by an Out-of-Network Provider.

Preadmission/Precertification for Inpatient Hospitalizations Required

If a Covered Person is scheduled to be admitted to a hospital on a non-emergency basis, he or she must have the hospitalization authorized by Care Management Services (CMS) prior to the date of admission. Failure to obtain the prior authorization will result in a reduction in benefits in the amount of 15% per admission. See Section titled “Preadmission/Precertification Requirement for Hospitalization” under Article V. Subsection B. for a more complete explanation.

CMS Review and/or Authorization

Certain services require CMS review for medical necessity and/or authorization regardless of whether the service is rendered Inpatient, Outpatient or in an Office Setting. The Plan is not obligated to pay claims for Covered Persons who fail to obtain prior review/authorization when required or meet eligibility criteria, or who receive care that is determined not to be medically necessary. Please call Health Plans, Inc. at 877-888-1616 to verify benefits.

Pre-Authorization for Other Specific Treatments Required

In addition, treatment for Mental & Nervous Conditions and Alcohol & Substance Abuse, Alternative/Complementary Care, Early Intervention Services, and Chiropractic Treatment must be authorized by Modern Assistance Program. The Modern Assistance Program can be reached by calling (800) 878-2004. Failure to obtain the prior authorization will result in a reduction of benefits in the amount of 50% per admission. See Section titled “Preadmission/Precertification Requirement for Hospitalization” under Article V. Subsection B. for a more complete explanation.

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Family Planning - (Including, but not limited to: diagnostic tests, pregnancy tests, IUDs, diaphragms, levonorgestrel implant system and insertion, and injection of birth control drugs when supplied by Provider at time of visit) (Excluding Genetic Counseling)	100%	85% reasonable & customary (after deductible)
Routine Annual Mammogram	100%, limited to one* exam per person, per calendar year, age 40 and over	85% reasonable & customary (after deductible) limited to one* exam per person, per calendar year, age 40 and over
Baseline Mammogram	100%, limited to one* baseline exam between ages 35 and 39	85% reasonable & customary (after deductible) limited to one* baseline exam between ages 35 and 39
Routine Colonoscopy	100%	85% reasonable & customary (after deductible)
Routine Gynecological Exam	100%, up to a maximum of one* exam per person, per calendar year	85% reasonable & customary (after deductible) up to a maximum of one* exam per person, per calendar year
Routine Hearing Exam	100%, up to a maximum of one* exam per person, every 24 consecutive months. Services must be rendered by a HearUSA, Inc. Provider.	100% reasonable & customary (deductible waived) up to a maximum of one* exam per person, every 24 consecutive months. Services must be rendered by a HearUSA, Inc. Provider.
Routine Adult Immunizations (If not billed with an office visit; including flu shots & travel immunizations)	100%	85% reasonable & customary (after deductible)
Routine Lab, X-rays, and Clinical Tests	100%	85% reasonable & customary (after deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Pap Smears	100%	85% reasonable & customary (after deductible)
Routine Physical Exams – Adult (Includes all charges billed at time of visit)	\$10 co-payment per visit, then 100%, age 20 and over.	85% reasonable & customary (after deductible), age 20 and over.
Routine Prostate Exam and PSA (prostate-specific antigen) Screening	100%	85% reasonable & customary (after deductible)
Routine Well Child Care - (Includes immunizations, blood lead screening and all charges billed at time of visit)	\$10 co-payment per visit, then 100%, under the age of 20	85% reasonable & customary (after deductible), under the age of 20
VISION CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Vision Exam (Includes Contact Lenses Fitting)	100% up to a maximum of one* exam and \$300* per person, per calendar year	100% reasonable & customary (deductible waived) up to a maximum of one* exam and \$300* per person, per calendar year
Lenses/Frames/Contact Lenses	100% included in the \$300* per person, per calendar year maximum above	100% reasonable & customary (after deductible) included in the \$300* per person, per calendar year maximum above
DOCTOR SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Allergy Testing	100%	85% reasonable & customary (after deductible)
Allergy Treatment	100%	85% reasonable & customary (after deductible)
Anesthesia (In/Outpatient)	100%	85% reasonable & customary (after deductible)
Chiropractic Services (Excludes X-Rays)	100% up to a maximum of 30* visits per person, per calendar year. Services must be pre-authorized by MAP.	Paid as In-Network. Must be pre-authorized by MAP.

***These maximums are combined In-Network and Out-of-Network maximums.**

DOCTOR SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Maternity – (Includes Delivery, Pre-Natal and Post-Natal Care)	100%	85% reasonable & customary (after deductible)
Physician Hospital Visits	100%	85% reasonable & customary (after deductible)
Physician Office Visits - (Includes all related charges billed at time of visit)	\$10 co-payment per visit, then 100%	85% reasonable & customary (after deductible)
Second Surgical Opinion	100%	85% reasonable & customary (after deductible)
Surgery (Inpatient)	100%	85% reasonable & customary (after deductible)
Surgery (Outpatient)	100%	85% reasonable & customary (after deductible)
Surgery (In a Physician’s office)	100%	85% reasonable & customary (after deductible)
HOSPITAL SERVICES – IN PATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Birthing Center	100%	85% reasonable & customary (after deductible)
Hospital Room & Board	100% of the hospital’s semi-private room rate & special care unit	85% reasonable & customary (after deductible) of the hospital’s semi-private room rate & special care unit
Intensive Care Unit	100%	85% reasonable & customary (after deductible)
Maternity Services	100%	85% reasonable & customary (after deductible)
Miscellaneous Hospital Charges	100%	85% reasonable & customary (after deductible)
Newborn Care - (Including Physician Visits & Circumcision)	100%	85% reasonable & customary (after deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

HOSPITAL SERVICES – INPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Organ Transplants (Limitations Apply)	100%	85% reasonable & customary (after deductible)
Surgical Facility & Supplies	100%	85% reasonable & customary (after deductible)
HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Clinic Services (At a Hospital)	\$10 co-payment per visit, then 100%	85% reasonable & customary (after deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician Services)	\$25 co-payment per visit, then 100% (co-payment is waived if admitted on an In-patient basis of a hospital), co-payment doesn't apply to life-threatening ER expenses	\$25 co-payment per visit, then 80% reasonable & customary (after deductible; co-payment is waived if admitted on an In-patient basis of a hospital) co-payment doesn't apply to life-threatening ER expenses
Outpatient Department	100%	85% reasonable & customary (after deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	100%	85% reasonable & customary (after deductible)
Preadmission Testing	100%	85% reasonable & customary (after deductible)
Urgent Care Facility/ Walk-In Clinic	\$10 co-payment per visit, then 100%	85% reasonable & customary (after deductible)

***These maximums are combined In-Network and Out-of-Network maximums.**

MENTAL & NERVOUS DISORDERS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
BENEFITS MUST BE PRE-AUTHORIZED BY MAP***		
(Exception: Mental & Nervous Treatment. However, if Out-of-Network Out-Patient Mental & Nervous Treatment services <i>are</i> pre-authorized by MAP, they are payable at the In-Network level.)		
Day Treatment/Inpatient Mental & Nervous Treatment** (Includes Physician's visits)	100% up to a maximum of 15* days per person, per calendar year; and is further limited to 30* days per person, per lifetime	Paid as In-Network. Must be Pre-Authorized by MAP.
Outpatient Mental & Nervous Treatment**	100% up to a maximum of 24* visits per person, per calendar year	85% reasonable & customary (after deductible) up to a maximum of 24* visits per person, per calendar year

ALCOHOLISM & SUBSTANCE ABUSE		
BENEFITS MUST BE PRE-AUTHORIZED BY MAP***		
<i>Alcoholism & Substance Abuse have a combined In- and Out-patient maximum of \$10,000 per person, per lifetime.</i>		
Day Treatment/Inpatient Alcoholism & Substance Abuse Treatment** (Includes Physician's visits)	100% up to a maximum of \$3,000* per person, per calendar year combined with Outpatient	Paid as In-Network. Must be Pre-Authorized by MAP.
Outpatient Alcoholism & Substance Abuse**	100% up to a maximum of \$3,000* per person, per calendar year combine with Inpatient	Paid as In-Network. Must be Pre-Authorized by MAP.

***These maximums are combined In-Network and Out-of-Network maximums.**

**** Every day of inpatient treatment will reduce the number of remaining day treatment days by two days. Conversely, every two days of day treatment will reduce the number of remaining inpatient treatment days by one day.**

***** If benefits are not pre-authorized by MAP, benefits are reduced to 50%.**

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture	See Alternative/Complementary Care Benefit	See Alternative/Complementary Care Benefit
Alternative/Complementary Care Benefit (Includes, but is not limited to, Acupressure, Acupuncture, Homeopathy, Naturopathy, Nutritional Counseling for Weight Loss, Smoking Cessation, Massage Therapy)	100% up to a maximum of \$1,000* per person, per calendar year for all services combined. Services must be Pre-Authorized by MAP.	Paid as In-Network. Must be Pre-Authorized by MAP
Ambulance Services – (Medically Necessary & Emergency Transport Only)	100%	100% reasonable & customary (deductible waived)
Cardiac Rehabilitation (Phase 1 and 2 Only; Limits Apply)	100%	85% reasonable & customary (after deductible)
Chemotherapy & Radiation Therapy	100%	85% reasonable & customary (after deductible)
Dental Surgery (Limitations Apply) (Includes excision of impacted wisdom teeth)	100%	85% reasonable & customary (after deductible)
Diabetes Self-Management Training and Education	100%	85% reasonable & customary (after deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan)	100%	85% reasonable & customary (after deductible)
Diagnostic X-ray and Laboratory (Regardless of Where Services are Rendered)	100%	85% reasonable & customary (after deductible)
Durable Medical Equipment (Prior Authorization by CMS is required for Equipment in excess of \$500)	100%	85% reasonable & customary (after deductible)

*These maximums are combined In-Network and Out-of-Network maximums.

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Early Intervention Services (Limitations Apply)	100%, Services must be pre-authorized by MAP	85% reasonable & customary (after deductible) Services must be pre-authorized by MAP
Elective Termination of Pregnancy	100%	85% reasonable & customary (after deductible)
Hearing Aids (Cochlear Implants)	100%, up to a maximum of \$1,000* per ear, per person every five years. Services must be rendered by a HearUSA, Inc. Provider for coverage.	85% reasonable & customary (after deductible) up to a maximum of \$1,000* per ear, per person every five years. Services must be rendered by a HearUSA, Inc. Provider for coverage.
Hemodialysis	100%	85% reasonable & customary (after deductible)
Home Health Care <i>(Services of a Medical Social Worker or Home Health Aide require prior authorization by CMS; however, prior authorization is recommended for other services)</i>	100% up to a maximum of 100* visits or 200* hours (whichever occurs first) per person, per calendar year	85% reasonable & customary (after deductible) up to a maximum of 100* visits or 200* hours (whichever occurs first) per person, per calendar year
Hospice Care (Limitations Apply) <i>(Prior authorization by CMS is recommended)</i>	100%	85% reasonable & customary (after deductible)
Infertility/Impotence Diagnosis	100%	85% reasonable & customary (after deductible)
Injectables	100%	85% reasonable & customary (after deductible)
Mastectomy & Reconstructive Surgery	100%	85% reasonable & customary (after deductible)
Metabolic Formula and Special Modified Low Protein Food Products - (For inborn errors in metabolism; limitations apply)	100%, must be deemed Medically Necessary	85% reasonable & customary (after deductible), must be deemed Medically Necessary

***These maximums are combined In-Network and Out-of-Network maximums.**

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Occupational Therapy (For Treatment Due to Illness or Injury)	100% (Developmental Delay is not covered)	85% reasonable & customary (after deductible) (Developmental Delay is not covered)
Nicotine Replacement Therapy	See Alternative/Complementary Care Benefit	See Alternative/Complementary Care Benefit
Nutritional Counseling	100% (initial consultation only) covered only when related to medical conditions – see also Alternative/Complementary Care Benefit	85% reasonable & customary (after deductible) (initial consultation only) covered only when related to medical conditions – see also Alternative/Complementary Care Benefit
Orthotics	100%, up to a maximum of one* per person, per calendar year	85% reasonable & customary (after deductible), up to a maximum of one* per person, per calendar year
Physical Therapy (For treatment due to Illness or Injury)	100%	85% reasonable & customary (after deductible)
Podiatry Care	100%	85% reasonable & customary (after deductible)
Private Duty Nursing (Prior authorization by CMS is required)	100%	85% reasonable & customary (after deductible)
Prosthetics	100%	85% reasonable & customary (after deductible)
Respiratory Therapy	100%	85% reasonable & customary (after deductible)
Skilled Nursing Facility/ Extended Care Facility/ Rehabilitation Hospital (Limitations Apply) (Prior authorization by CMS is required)	100% up to a maximum of 90* days per person, per calendar year	85% reasonable & customary (after deductible) up to a maximum of 90* days per person, per calendar year

***These maximums are combined In-Network and Out-of-Network maximums.**

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Sleep Disorders (Including Testing & Supplies)	100%, must be deemed Medically Necessary	85% reasonable & customary (after deductible), must be deemed Medically Necessary
Speech Therapy (For Treatment Due to Illness or Injury)	100% (Developmental Delay is not covered)	85% reasonable & customary (after deductible) (Developmental Delay is not covered)
Temporomandibular Joint Disorders (TMJ)	100% up to a maximum of \$750* per person, per lifetime	85% reasonable & customary (after deductible) up to a maximum of \$750* per person, per lifetime
Voluntary Sterilization	100%	85% reasonable & customary (after deductible)
Wigs (When Hair Loss is Due to Cancer or Medical Condition)	100% up to a maximum of one wig every 5 consecutive years*	85% reasonable & customary (after deductible) up to a maximum of one wig every 5 consecutive years*

WELLNESS BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Health Club Membership	100% (deductible waived) up to a maximum of \$200* per person and \$400* per family, per calendar year. A paid receipt of the program must be submitted to the Claims Administrator for processing under the provisions of this Plan.	

***These maximums are combined In-Network and Out-of-Network maximums.**

LIFETIME MAXIMUMS: \$2,000,000 per person, (except for In and Outpatient treatment for Alcoholism & Substance Abuse which is \$3,000 per person, per lifetime; Inpatient treatment for Mental & Nervous Disorders which is 30 days per person, per lifetime; and treatment of Temporomandibular Joint Disorder (TMJ) which is \$750 per person, per lifetime).

Notes: Expenses incurred by a Covered Person who resides or is traveling outside of the network geographic area shall be paid at the In-Network level of benefits (provided the Covered Person does not travel outside of the area for the purpose of receiving services).

An Out-of-Network Provider will be paid as an In-Network provider when medical services are rendered to a Covered Person on an inpatient or outpatient basis in an In-Network hospital or facility.

Charges by a non-participating Physician referred to the Covered Person by a participating Physician during the absence of an In-Network Physician shall be paid at the In-Network level of benefits.

Out-of-Network providers shall be paid as In-network for services that require MAP approval when those services are pre-authorized by Modern Assistance Program (MAP) (except Early Intervention Services).

V. MEDICAL BENEFITS

A. Covered Expenses. Covered Expense as used herein refers to the fee schedule amount for network providers or, if not in the network, the Reasonable and Customary Charge which is prescribed by a Physician and incurred for medical treatment of an Illness or Injury. Covered Expenses may be subject to the calendar year deductible, coinsurance and/or co-payments as described in the section titled “Schedule of Medical Benefits” for the following services:

- (1) Hospital charges for room and board and other professional services on an in/outpatient basis:
 - (a) Charges made for preadmission tests on an outpatient basis for a scheduled hospital admission or surgery provided the tests are done within seven (7) days of the planned admission and the surgery and the tests are accepted by the hospital in place of the same postadmission tests;
 - (b) Charges made by a hospital for room and board for a semiprivate room, intensive care unit, cardiac care unit or burn care unit, but excluding charges for a private room (unless Medically Necessary) which are in excess of the hospital's semiprivate room rate. Charges made by a hospital having only private rooms will be considered at 80% of the private room rate (i.e., 20% of the charge for private room will be excluded before benefits are determined);
 - (c) Charges made for routine nursery care (including circumcision and Physician's visits) while confined even though no sickness or injury exists;
 - (d) Charges made by a hospital for necessary medical supplies and services including X-ray and laboratory charges and charges for anesthetics and administration thereof;
 - (e) Charges made by a hospital for drugs and medicines obtained through written prescription by a Physician;
 - (f) Outpatient surgical services performed at a doctor's office, ambulatory surgical center, the outpatient department of a hospital, birthing center or freestanding health clinic;
 - (g) Charges made by a birthing center or freestanding health clinic. Payment will be limited to the amount that would have been paid if that person were in a hospital;
 - (h) Charges for radiation, chemotherapy or hemodialysis (renal therapy) at a Medicare-approved dialysis center;

- (i) Charges for administration of infusions and transfusions. This includes the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered;
- (j) Charges for inpatient respiratory, physical, occupational, inhalation, speech and cardiac rehabilitation therapy;
- (k) Emergency room charges; and
- (l) Outpatient department charges.

Day Treatment/ Inpatient confinement for the treatment of a mental illness in a licensed general hospital, in a mental hospital under the direction and supervision of the Department of Mental Health, or in a private mental hospital licensed by the Department of Mental Health is covered as described in the Schedule of Medical Benefits up to a maximum of fifteen (15) days per person, per calendar year and is further limited to a lifetime maximum of thirty (30) days per person. Treatment must be pre-authorized by Modern Assistance Program (MAP) as described in Article V(B).

Day Treatment/ Inpatient confinement in a public or private alcohol/substance abuse facility for the treatment of alcoholism and substance abuse is payable as described in the Schedule of Medical Benefits up to a maximum of a combined in and out-patient maximum of \$3,000 per person, per calendar year. Treatment must be pre-authorized by Modern Assistance Program (MAP) as described in Article V(B).

Every day of inpatient treatment will reduce the number of remaining day treatment days by two days. Conversely, every two days of day treatment will reduce the number of remaining inpatient treatment days by one day.

Note: In and Outpatient treatment of Alcoholism and Substance Abuse have a combined lifetime maximum of \$10,000 per person.

Inpatient confinement in a skilled nursing/extended care facility and/or in a rehabilitation facility/hospital is provided up to a maximum of ninety (90) days per person, per calendar year and is provided if:

- (a) Charges are incurred within fourteen (14) days following a hospital confinement which lasted three (3) days; and
 - (b) The attending Physician certifies that twenty-four (24) hour nursing care is medically necessary for recuperation from the Illness or Injury which required the hospital confinement.
- (2) Ambulance services must be:
- (a) To the nearest hospital or medical facility which is equipped to provide the service required;

- (b) When medically necessary, from a hospital; and
- (c) For an air ambulance or rail transportation when:
 - (i) Required because the life of the patient would be endangered through the use of any other form of transportation; and
 - (ii) Used to transport the patient to the nearest medical facility equipped to provide care.
- (3) Charges made for X-ray, microscopic tests, laboratory tests, including allergy testing and allergy injections, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
- (4) Charges incurred at an emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a hospital).
- (5) Charges made by a doctor or legally licensed Physician for medical care and/or treatment including office visits, home visits, hospital inpatient care, hospital outpatient visits/exams and clinic care.
- (6) Charges for routine adult physical examinations (over the age of 20) including all related charges billed at the time of visit are payable as described in the Schedule of Medical Benefits.
- (7) Charges for routine adult immunizations/vaccinations are payable as described in the Schedule of Medical Benefits.
- (8) Charges for a routine OB-GYN exam are payable as described in the Schedule of Medical Benefits up to a maximum of one exam per person, per calendar year.
- (9) Charges for routine Well Child Care (up to age 20) in accordance with the standards and frequencies endorsed by the American Academy of Pediatrics are payable as described in the Schedule of Medical Benefits. Coverage includes, but is not limited to; physical examinations, history, sensory screening and neuropsychiatric evaluation and appropriate immunizations.
- (10) Charges for Early Intervention Services benefits are payable for the following charges incurred by a dependent child to age three (3), including, but not limited to, learning disabilities, or development delays when received with or without a medical diagnosis, Attention Deficit Disorder, Attention Deficit Hyperactivity Disorders. Charges must be made for preventive and primary services for children. Covered services include: physical therapy, nursing care, and psychological counseling. Treatment must be pre-authorized by Modern Assistance Program (MAP) as described in Article V(B).

- (11) Charges for a routine baseline mammogram for women between the ages of 35 and 40, one (1) routine mammogram per calendar year for women 40 years of age and older are payable as described in the Schedule of Medical Benefits.
- (12) Charges for routine cytological screenings (pap smear) and routine PSA testing payable as described in the Schedule of Medical Benefits.
- (13) Charges for a routine colonoscopy performed to rule out cancer because of family history; following the guidelines published by the American Cancer Society.
- (14) Charges for one (1) routine hearing exam every twenty-four (24) months payable as described in the Schedule of Medical Benefits. Services must be rendered by a HearUSA, Inc. provider to be considered an eligible charge.
- (15) Charges for services in connection with hearing aids or such similar devices, or for the fitting of hearing aids, up to a maximum of \$1,000 per ear, per person every five (5) years. Services must be rendered by a HearUSA, Inc. provider to be considered an eligible charge.
- (16) Charge by an ophthalmologist or optometrist for a routine eye exam are payable as described in the Schedule of Medical Benefits up to a maximum of one exam and \$300 per person, per calendar year.
- (17) Charges for eye exams for the treatment of any muscle disorders of the eye (e.g. esotropia and strabismus), limited to one office or clinic visit per person, per calendar year unless surgery to correct the condition is scheduled. Expenses for muscle training, orthoptics and refractions are not an eligible expense under the provisions of this Plan.
- (18) Expenses for a second surgical opinion and in some instances a third opinion as follows:
 - (a) Fees of a legally qualified Physician for a second surgical consultation when non-emergency or elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the medical necessity of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery; and
 - (b) Fees of a legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the consulting Physician or with the Physician who will be performing the actual surgery.

- (19) Charges by a Physician or surgeon incurred for a surgical operation and for the administration of anesthesia.

If two or more Surgical Procedures are performed at one time through the same incision or in the same operative field, the maximum amount considered for surgery will be the fee scheduled amount or the Reasonable and Customary expense for the major procedure and 50% for the secondary or lesser procedure, 25% of the fee schedule amount or the Reasonable and Customary expense for the third, 10% of the fee schedule amount or the Reasonable and Customary expense for the fourth, and 5% of the fee schedule amount or the Reasonable and Customary expense for each additional procedure performed. No additional benefit will be paid under this Plan for incidental surgery done at the same time and under the same anesthetic as another surgery.

The Plan will also pay for a surgical assistant (limited to 20% of the surgeon's fee) when the nature of the procedure is such that the services of an assistant Physician are Medically Necessary.

The following dental procedures including related hospital expenses, (when deemed to be Medically Necessary) will be covered the same as any other Illness:

- (a) Treatment of an injury to a sound natural tooth, other than from eating or chewing, or treatment of an injury to the jaw due to an accident. Surgery needed to correct accidental injuries to the jaw, cheek, lips, tongue, floor and roof of the mouth;
- (b) Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia;
- (c) Biopsies of the oral cavity and related anesthesia;
- (d) Removal of bony impacted teeth, and related anesthesia;
- (e) Extractions of seven (7) or more permanent teeth performed on the same day; and

Note: If a Covered Person has a serious medical condition that requires hospitalization or treatment in an Ambulatory Surgical Center for dental services other than those listed above, Plan benefits are payable only for the Hospital or Ambulatory Surgical Center charges and not for the dentist's or anesthesiologist's charges.

Charges for cosmetic purposes or for cosmetic surgery are covered if:

- (a) Due solely to an accidental bodily injury, providing that coverage is in effect at the time treatment occurs;
- (b) Due solely to a birth defect of a Covered Person, provided coverage is in effect at the time treatment occurs; or

- (c) Due solely to surgical removal of diseased tissue as a result of an illness. Covered Persons electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy. The reconstruction procedure will be performed in a manner determined between the Physician and patient.

Surgical procedures include circumcision, abortion, vasectomies and tubal ligations, but not reverse sterilization. Amniocentesis is included if deemed medically necessary. No benefits will be payable if amniocentesis is performed only to determine the sex of an infant before birth and for women under age thirty-five (35) unless certified as medically necessary by a Physician.

- (20) Charges for the treatment of mental and nervous disorders on an outpatient basis are payable as described in the Schedule of Medical Benefits up to a maximum of twenty-four (24) visits per person, per calendar year.
- (21) Charges for the treatment of alcoholism and substance abuse on an outpatient basis are payable as described in the Schedule of Medical Benefits up to a combined in and outpatient maximum of \$3,000 per person, per calendar year. Treatment must be pre-authorized by Modern Assistance Program (MAP) as described in Article V(B).

Services must be furnished by:

- (a) A comprehensive health service organization;
- (b) A licensed or accredited hospital;
- (c) A community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;
- (d) A licensed detoxification facility;
- (e) A licensed social worker; or
- (f) A psychiatrist.

Note: Alcoholism and Substance Abuse are subject to a combined in and outpatient maximum of \$10,000 per person, per lifetime.

- (22) Charges made by a licensed chiropractor are payable as described in the Schedule of Medical Benefits up to a maximum of 30 visits per person, per calendar year. In order for treatment to be an eligible expense under the

provisions of this Plan, treatment must be pre-authorized by Modern Assistance Program (MAP) as described in Article V. Subsection B.

- (23) Services by a private duty nurse are an eligible expense (twenty-four (24) private duty nursing care is not a covered expense) when furnished by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.), for necessary nursing care as evidenced by a written statement by the attending Physician providing that the nurse is not an immediate member of the Member's family and does not reside in the Member's home. Charges billed by a Visiting Nurse Association for such services are included.
- (24) Charges for the initial diagnosis and initial testing for infertility;
- (25) Charges for ambulatory diabetic education, blood sugar kits, insulin and insulin infusion pumps, diabetic supplies for testing blood and urine specimens at home, syringes, monitors, test strips lancets, approved self-management education training as well as professional instructions, excluding printed material;
- (26) Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan, are payable as described in the Schedule of Medical Benefits up to a maximum of one hundred (100) visits or two hundred (200) hours, whichever occurs first, per person, per calendar year. Such expenses include:
 - (a) Part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);
 - (b) Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;
 - (c) Home health aides; and
 - (d) Medical supplies, drugs, and medications prescribed by a Physician and laboratory services by or on behalf of a hospital to the extent such items would have been considered by this Plan had the Covered Person remained in the hospital.

Home health care means a visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one (1) visit.

No benefits will be provided for services and supplies not included in the Home Health Care Plan, services of any social worker, transportation services, custodial care and housekeeping, or for services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

- (27) Charges for outpatient rehabilitative therapy services are payable as described in the Schedule of Medical Benefits. Such expenses include:

- (a) Charges for the treatment or services rendered by a physical therapist under direct supervision of a physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a freestanding duly licensed outpatient therapy facility;
 - (b) Charges for inhalation therapy under the direct supervision of a physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a freestanding duly licensed outpatient therapy facility;
 - (c) Charges for the treatment and services rendered by a registered occupational therapist under the direct supervision of a physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a freestanding duly licensed outpatient therapy facility;
 - (d) Expenses for the services of a legally qualified speech therapist under the direct supervision of a physician for restorative or rehabilitative speech therapy for speech loss or impairment, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy; and
 - (e) Expenses for cardiac rehabilitation program (limited to Phase I and Phase II only) provided such treatment is recommended by the attending physician. Phase I consists of acute Inpatient hospitalization, whether for heart attack or heart surgery. Highly supervised with a tailored exercise program with continuous monitoring during exercise, and Phase II consists of Outpatient with Supervision treatment for Covered Person's who have left the hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual need. Benefits are not payable for Phase III which consists of Outpatient Services without Supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.
- (28) Expenses relating to pregnancy and birthing are covered according to the following schedule:
- (a) Prenatal care of the mother and/or fetus is treated as any other Illness or Injury covered under the Plan;
 - (b) Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the

mother's or newborn's attending health care provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable); and

- (c) No authorization from the Plan need be sought by the attending provider for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as the case may be). In any case, the 48- or 96-hour limit may be exceeded with authorization of the Claim Administrator in cases of medical necessity.

(29) If the Covered Person has had or is going to have a mastectomy, the Covered Person may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, 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 the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

(30) Other medical services and supplies:

- (a) Charges for expendable supplies including, but not limited to: prescription drugs, medicines, insulin, oral contraceptives, contraceptive devices and Depo Provera injections, surgical bandages, syringes, dressings, surgical supports, head halters, colostomy bags, catheters, crutches, splints, casts, trusses, traction apparatus and cervical collars;
- (b) Charges for oxygen and other gasses and their administration;
- (c) Charges for the rental or the purchase (whichever is less) of prosthetic appliances to aid impaired functions, including but not limited to: wheelchairs, standard hospital-type bed, mechanical respirator, iron lung, bed rail, equipment for the administration of oxygen, hospital-type equipment for hemodialysis, kidney or renal dialysis (including training of a person to operate and maintain equipment), and other durable medical or surgical equipment;

- (d) Appliances and orthopedic braces such as artificial arms and legs including accessories; leg braces including attached shoes; arm, back and neck braces; surgical supports; head halters; larynx, eye(s) prosthesis, breast prosthesis (made necessary due to medically necessary breast removal), and surgical brassieres (limited to two (2) per person, per calendar year) when purchased following a mastectomy. Excludes replacement, repair or adjustment, unless the replacement, repair or adjustment is necessary because of physiological changes or the prosthesis or brace that is being replaced is at least five (5) years old and no longer serviceable. Orthotics are limited to one (1) per person, per calendar year;
- (e) Charges for Medically Necessary specially molded orthopedic shoes, limited to one (1) pair per person, per calendar year;
- (f) Charges for chemotherapy (antineoplastic) when drugs are taken by infusion, perfusion, intracavity or parenteral means;
- (g) Charges including, but not limited to, acupuncture, homeopathy, naturopathy, nutritional counseling for weight loss, smoking cessation and massage therapy when pre-authorized by Modern Assistance Program (MAP);
- (h) Charges for Health Club Memberships are payable as described in the Schedule of Medical Benefits up to a maximum of \$200 per person and \$400 per family, per calendar year. A paid receipt for the program must be submitted to the Claims Administrator for processing under the provisions of this Plan.
- (i) Expenses for growth hormones when prescribed by a board certified pediatric endocrinologist and a written treatment plan is submitted for approval to Care Management Services (CMS). The Covered Person must be seen by the attending Physician every six (6) months and response to the treatment must be verified by the Physician. The medication will be covered for a thirty (30) day supply at a time;
- (j) Wigs for hair loss resulting from the treatment of cancer, or other medical conditions limited to one (1) per person every five (5) consecutive years;
- (k) Treatment of temporomandibular joint disorders (TMJ) up to a maximum of \$750 per person, per lifetime;
- (l) Allergy testing and treatment, including preparation of serum and injections;
- (m) State surcharges, to the extent required by law; and
- (n) Other medically necessary services and supplies as prescribed by the attending physician and determined medically necessary by the Claim Administrator.

B. Preadmission/Precertification Requirement For Hospitalization.

Administered by Care Management Services and Modern Assistance Programs

For any period of hospital confinement (other than for the treatment of Mental and Nervous and Alcoholism and Substance Abuse) commencing on or after February 1, 2006, all benefits available to a Covered Person for inpatient care will be subject to a reduction in benefits in the amount of 15% per confinement, unless such period of confinement has been authorized by Care Management Services. For any period of treatment related to Mental and Nervous Disorders, Alcoholism and Substance Abuse, Chiropractic Services, Early Intervention Services, and Alternative Services commencing on or after February 1, 2006, all benefits to a Covered Person for in and outpatient care will be subject to a reduction in the benefits in the amount of 50% unless the treatment has been authorized by Modern Assistance Program. The reduction in charges not covered cannot be used to satisfy co-payments, deductibles and out-of-pocket maximums described elsewhere herein.

The preadmission/precertification service will also authorize the number of days of hospitalization required based upon the information provided. In the event the number of days of hospitalization exceed the number of precertified days, the additional days will also be subject to a reduction in benefits, unless certified as medically necessary care by the preadmission/precertification service.

In the event of an emergency or if the Covered Person is confined to the hospital's "observation" area for more than 24 hours, it is necessary that the Covered Person contact the preadmission/precertification service within 48 hours after an admission or on the first business day following admission. If authorization is not obtained, the reduction in benefits described above applies.

The preadmission/precertification requirement applies to maternity admissions as well, however the penalty for failure to precertify a hospital stay will be waived if an admission is no longer than 48 hours for a vaginal delivery, or no longer than 96 hours for a cesarean delivery.

C. Case Management Provision For Alternate Treatment Plan Under Case Management. In cases where a Covered Person's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high cost claim for a high risk or long term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the Covered Person, family and attending Physician(s).

In the event a Member case is identified as a candidate for case management, then upon approval of the attending Physician(s), the Covered Person, and the case management agency, a treatment plan is developed and implemented. If either the attending Physician and/or the Covered Person does not wish to follow the treatment plan as developed, then treatment and coverage of the patient's medical condition will continue uninterrupted and benefits will be paid as stated in the Plan.

While large case management treatment usually contains treatment options covered under the terms of the Plan, in some cases, the most appropriate and cost-effective care will be rendered in a setting or manner not normally covered under the terms of the Plan. In such cases, all Medically Necessary aspects of the approved treatment will be covered under the terms of the Plan. Any, alternative care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

D. How the Plan Works. The Period: This means a period of one calendar year starting with January 1, or, if later, the effective date of coverage, and ending on December 31st.

E. Benefit Level. In-Network Providers - this term designates an organization of physicians, hospitals and other health care providers that have agreed to provide medical care to Covered Persons and covered Eligible Dependents under the Plan. The level of coverage for benefits within the Network is generally greater than the level of coverage for benefits outside the Network.

Traveling Benefit - if a Covered Person is traveling out of state or out of country and requires medical treatment, benefits shall be payable at In-Network levels.

In-Network Providers - If a Covered Person has incurred covered medical expenses due to an Accident or Illness, and services are rendered by an In-Network Provider, the Plan will pay (subject to any co-payments stated in the Schedule of Medical Benefits year) 100% of the fee schedule amount (unless otherwise stated).

Out-of-Network Providers - Emergency Care provided by an Out-of-Network Provider when outside of the network area will be paid as an In-Network Provider (see section titled "Definitions" for the definition of Emergency Care).

An Out-of-Network Provider will be paid as an In-Network provider when medical services are rendered to a Covered Person on an inpatient or outpatient basis in an In-Network hospital or facility. In addition, Out-of-Network Providers shall be paid as In-Network when services are pre-authorized by Modern Assistance Program (MAP).

Charges by a non-participating Physician referred to the Covered Person by a participating Physician during the absence of an In-Network Physician shall be paid at the In-Network level of benefits.

If a Covered Person has incurred covered medical expenses due to an Accident or Illness, and services are rendered by an Out-of-Network Provider, the Plan will pay (after satisfaction of the calendar year deductible) 85% of the reasonable and customary charge (unless otherwise stated).

Deductible Amount - No deductible applies to In-Network services. The deductible for services rendered by an Out-of-Network Provider in each calendar year shall be \$200 per person up to a maximum of \$500 per family. Any number of family members may help to

meet the family deductible amount, but no more than the per person deductible amount apply to any one family member's expenses.

Single Accident Deductible - If two or more Covered Persons in the same family are injured in a common Accident, the deductible applicable in the calendar year of the common Accident shall be limited to a single per person deductible amount for that calendar year for covered expenses, related to that Accident, which are incurred by all family members.

Out-of-Pocket Maximum - the out-of-pocket maximum for Out-of-Network services is \$1,150 per person and \$1,750 per family, including the calendar year deductible. The out-of-pocket maximum amount excludes charges in excess of the reasonable and customary amounts, charges for the treatment of Alcoholism and Substance Abuse, any co-payments and any penalties for failure to follow Preadmission/Precertification Requirements.

LIFETIME MAXIMUMS: \$2,000,000 per person, (except for the in- and out-patient treatment of Alcoholism and Substance Abuse which is \$10,000 per person, In-Patient Treatment for Mental & Nervous Disorders which is 30 days per person and the treatment of Temporomandibular Joint Disorders (TMJ) which is \$750 per person).

F. Prescription Drug Expense.

Administered By Express Scripts

Retail Card Program - Expenses for covered prescription drugs and medicines, including insulin and oral contraceptives will be covered at 100% after a \$5 co-payment per generic prescription and a \$10 co-payment per single or multi-source brand name prescription.

Mail Order Program - Co-payments are \$0 co-payment per generic prescription and diabetic supplies and a \$10 co-payment per single or multi-source brand name prescription, then 100% if the prescription is filled through Express Script's mail order plan.

Smoking cessation products by prescription only are covered up to a maximum benefit of \$750 per person, per lifetime.

Diabetic supplies are available through New England Mail Order Program.

The benefits are payable for necessary prescription drugs ordered in writing by a Physician for treatment of a Covered Person as a result of an accidental injury or sickness or as a result of pregnancy, childbirth or related medical conditions up to a 34 day supply for each prescription or refill (34- 90 day supply for each prescription or refill through the mail order plan), unless customarily dispensed in 100 unit dose quantities.

Charges not covered:

- (a) Drugs dispensed by a Member not licensed to dispense drugs;
- (b) Administration of drugs;
- (c) Drugs labeled "Caution Limited by Federal Law for Investigational Use";

- (d) Drugs administered and consumed at the time and place of the prescription issue;
- (e) Non-legend drugs other than insulin;
- (f) Therapeutic devices or appliances, support garments and other non-medical substances;
- (g) Investigational or experimental drugs; including compounded medications for non-FDA-approved use;
- (h) Prescriptions which an eligible person is entitled to receive without charge from any Worker's Compensation laws, or any municipal, state or federal program;
- (i) Retin A, Age 26 and over;
- (j) Rogaine; and
- (k) Infertility medication and/or drugs.

G. Hospice Care Benefits. Hospice Care benefits are provided to a terminally ill Covered Person with a life expectancy of less than six (6) months; or to members of his or her immediate family and are payable as described in the Schedule of Medical Benefits. Benefits and are limited to:

- (a) Room and Board for a confinement in a hospice;
- (b) Ancillary charges furnished by the hospice while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness;
- (c) Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
- (d) Physician services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.);
- (e) Home health aide service;
- (f) Home care charges for home care furnished by a hospital or home health care agency, under the direction of a hospice, including custodial care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a home health aide;
- (g) Medical social services by licensed or trained social workers, psychologists, or counselors;
- (h) Nutrition services provided by a licensed dietitian;
- (i) Respite care (limited to five (5) days per person); and

- (j) Bereavement Counseling. Bereavement counseling is a support service provided by the Hospice Team to Covered Persons in the deceased's immediate family after the death of such terminally ill person. Such visits are to assist the Covered Persons in adjusting to the death. Benefits will be payable provided:
- (i) On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Covered Person under the Plan; and
 - (ii) Charges for such services are incurred by the Covered Persons within six (6) months of the terminally ill person's death.

The term immediate family means - parent, spouse and children of the terminally ill Covered Person.

H. Organ Transplant Benefits. Expenses for an organ and/or tissue transplant will be payable as described in the Schedule of Medical Benefits and subject to the following:

Organ and tissue transplants are subject to a mandatory second surgical opinion. Written documentation of the second surgical opinion must be submitted to Care Management Services (CMS) for review prior to any transplant procedure. In the event a mandatory second surgical opinion is not obtained, there will be no coverage available under the provisions of this Plan.

Organ and tissue transplants are covered under the Plan for the following procedures:

- Human Heart Transplant
- Bone Marrow Transplant
- Heart and Lung Transplant
- Lung Transplant
- Kidney Transplant
- Cornea Transplant
- Liver Transplant
- Pancreas Transplant

No other organ and tissue transplants are covered under this Plan.

Organ and tissue transplants are further subject to the following guidelines:

Pre-authorization Requirement for Organ Transplants: Inpatient hospital expenses incurred in connection with any organ or tissue transplant will be subject to Preadmission/Precertification Requirement for Hospitalization as described in the section titled "Preadmission/Precertification Requirement for Hospitalization" in Article V(B). All

potential transplant cases will be assessed for their appropriateness for Large Case Management. In addition, failure to obtain pre-approval will result in a denial of all transplant related expenses.

Transplant Benefit Period: Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Medical Benefits.

Covered Transplant Expenses: Covered Expenses with respect to transplants, refers to the fee schedule amount of network providers, or if not in the network, the reasonable and customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant. Such Covered Expenses include:

- (a) Charges incurred in the evaluation, screening, and candidacy determination process;
- (b) Charges incurred for organ transplantation; and
- (c) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
 - (i) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
 - (ii) Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care; and
 - (iii) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. The harvesting of the marrow need not be performed within the Transplant Benefit Period.
- (d) Charges incurred for follow-up care, including immuno-suppressant therapy; and
- (e) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other Individual, or in the event that the recipient or the donor is a minor, two (2) other Individuals. In addition, all reasonable and necessary lodging and

meal expenses incurred during the Transplant Benefit Period will be covered.

Re-transplantation: Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period and a new maximum benefit.

Accumulation of Expenses: Expenses incurred during any one Transplant Benefit Period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per person Maximum Lifetime Benefit.

Donor Expenses:

- 1) If both the donor and recipient are covered under the Plan, eligible charges incurred by both patients will be covered.
- 2) If the recipient is covered under the Plan, but the donor is not, the Plan will provide coverage to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources. Donor expenses are limited to \$500 per Transplant Period.
- 3) If the recipient is not covered under the Plan, but the donor is, neither the donor nor the recipient is eligible for coverage.

Pre-existing Condition Limitation: Transplant charges will be subject to this Plan's Pre-existing Condition Limitation as described in Article XI.

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

The following are excluded from Covered Expenses and no benefits shall be paid with respect thereto:

- (1) Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
- (2) Charges which are considered above and beyond the fee schedule amount of network providers, or if not in the network, the reasonable and customary range.
- (3) Charges for a service or supply which are not considered medically necessary as defined in the Article titled "Definitions", whether or not prescribed and recommended by a Physician or covered provider.
- (4) Except for benefits specifically stated as covered under the Plan, medical expenses incurred for treatment which is not the result of an Injury or Illness.
- (5) Except for benefits specifically stated as covered under the Plan, charges for dentures, dentistry, oral surgery, treatment of teeth and gum tissues or dental X-rays.
- (6) Except for benefits specifically stated as covered under the Plan, charges for cosmetic or reconstructive surgery.
- (7) Charges for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge.
- (8) Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or similar legislation, with the exception of when a Covered Person is not covered by Worker's Compensation Law and lawfully chose not to be.
- (9) Charges resulting from or occurring during the commission of a crime by the Covered Person or while engaged in an illegal act, illegal occupation or felonious act, or aggravated assault for which they are convicted of a felony charge.
- (10) Charges for services, supplies or treatment not recognized by the American Medical Association as generally accepted and medically necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

- (11) A drug, device, medical treatment or procedure which is Experimental or Investigational as defined in the Article titled “Definitions.”
- (12) Charges for Physician’s fees for any treatment which is not rendered by or in the physical presence of a Physician except as described herein.
- (13) Charges for fluoride, vitamins, food supplements, and any “over-the-counter drug” which can be purchased without a prescription or when no injury or illness is involved shall not be considered Covered Expenses.
- (14) Charges for any service, care, procedure or program, for weight or appetite control, weight loss, weight management, nutritional or dietary counseling (except as described under the Alternative/Complementary Benefit and Nutritional Consultation Benefit), or for control of obesity even if the weight or obesity aggravates another condition, including but not limited to: gastric bypass, gastric stapling or balloon catheterization and liposuction or reconstructive surgery unless due to the diagnosis of Morbid Obesity as defined herein.
- (15) Medical expenses incurred on account of Injury or sickness resulting from war or any act of war, whether declared or undeclared, or expenses resulting from active duty in the Uniformed Services of any international armed conflict or conflict involving armed forces of any international authority.
- (16) Except for benefits specifically stated as covered under the Plan, expenses for communication, transportation, time spent traveling, or for expenses connected to traveling that may be incurred by a Physician, Covered Person, or covered provider, in the course of rendering services.
- (17) Except for benefits specifically stated as covered under the Plan, charges for personal comfort, hygiene or convenience items such as televisions, telephones, radios, air conditioners, humidifiers, dehumidifiers, physical fitness equipment, whirlpool baths, education, or educational aids or training whether or not recommended by a Physician.
- (18) Except for benefits specifically stated as covered under the Plan, expenses for services and supplies related to sexual dysfunctions or inadequacies regardless of the cause, sex therapy, or for transsexual surgery and related preoperative and postoperative procedures or complications, which, as their objective, change the person’s sex.
- (19) Custodial care which is designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be custodial care whenever and wherever furnished, without respect to the practitioner or provided by whom or by which they are prescribed,

recommended or performed. This exclusion does not apply to custodial care described under benefits titled "Hospice Care."

- (20) Expenses for treatment, services or supplies provided by a Member, who ordinarily resides with the Covered Person, or is the Covered Person, including but not limited to, his or her spouse, child, brother, sister, or parent.
- (21) Expenses for in-vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, artificial insemination or other assisted reproductive technology services designed primarily for the purpose of conception.
- (22) Charges for Physician's services for the routine care of bunions, corns, calluses, toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints related to the feet unless corrected by a major surgical procedure.
- (23) Charges for services or treatment of behavioral problems, learning disabilities, or developmental delays when received without a medical diagnosis, including but not limited to Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and Early Intervention Services unless approved by Modern Assistance Program (MAP).
- (24) Charges for any treatment, service, or supply for nicotine use or nicotine addiction except when approved by Modern Assistance Program (MAP). However, smoking cessation products by prescription only are available under the Prescription Drug Program.
- (25) Charges for marriage counseling except when approved by Modern Assistance Program (MAP).
- (26) Charges for Friday, Saturday and Sunday admissions, unless for an Emergency as defined herein. A Sunday admission will be allowed as long as a Covered Person is admitted less than twenty-four (24) hours prior to the Covered Person's surgery.
- (27) Any surgical procedure for the correction of a visual refraction problem, including radial keratotomy.
- (28) Charges for orthoptics and visual therapy for the correction of vision.
- (29) Charges for services in connection with hearing aids or such similar devices, or for the fitting of hearing aids, except when rendered by a HearUSA, Inc. provider.
- (30) Charges for court-ordered treatment or any treatment not initiated by a Physician or covered provider of any kind.
- (31) Expenses for pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational

therapy, stress management or other supportive therapies unless approved by Modern Assistance Program (MAP).

- (32) Expenses for hypnosis unless approved by Modern Assistance Program (MAP).
- (33) Expenses for genetic counseling, testing, or related services.
- (34) Expenses for growth hormones, unless pre-authorized by Care Management Services (CMS).
- (35) Charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining medical services, drugs or medical supplies.

VII. SCHEDULE OF DENTAL BENEFITS

If, as a result of dental disease, defect or injury, a Covered Person has incurred covered dental expenses for treatment by a dentist, the Plan will pay an amount equal to the applicable reimbursement percentages and maximum shown for each class of service.

CALENDAR YEAR DEDUCTIBLE

Class I, II, III and IV	None
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COINSURANCE AMOUNTS

Class I - Preventive & Diagnostic Services	100% reasonable & customary
Class II –Basic & Restorative Services	75% reasonable & customary
Class III – Major Services	75% reasonable & customary
Class IV – Orthodontic Services (Limited for Dependent Children ages 6 to 19)	50% reasonable & customary

MAXIMUM BENEFIT

Class I, II, & III (Combined)	\$2,000* per person, per calendar year
Class IV – Orthodontic Services	\$1,500 per person, per lifetime

*Excludes dental cleanings, preventive exams and X-rays.

Pre-treatment Estimate of Benefits for Major Procedures

When the total cost associated with the proposed dental work is expected to exceed \$400, the Claim Administrator recommends that a treatment plan be filed for benefit determination prior to the date the treatment is rendered. This process identifies coverage and Plan limitations, such as deductibles, coinsurance and benefit maximums. The filing of a treatment plan avoids any misunderstanding as to the extent of coverage and gives the patient and dentist an opportunity to review the proposed treatment and the extent of the Plan coverage before any work is started. The treatment plan must include:

- A list of the services to be performed, using American Dental Association nomenclature and codes; and
- Itemized cost of each service; and
- Estimated length of treatment.

Dental X-rays, study models and whatever else is needed to evaluate the treatment must be sent to the Claims Administrator.

The Claims Administrator will review the treatment plan and estimate what will be paid. The estimate will be sent to the Covered Person's dentist. If the Claims Administrator does not agree with the treatment plan, or if one is not sent in, the Claims Administrator has the right to base payments on treatment suited to the Covered Person's condition by accepted standards of dental practice.

VIII. DENTAL BENEFITS

Class I – Preventive and Diagnostic Services - Payable at 100% subject to reasonable & customary guidelines.

1. Prophylaxis and Fluoride Applications

- (a) Prophylaxis for Covered Persons age 14 or over, including scaling and polishing, limited to two each Calendar Year, excluding Periodontal cleanings.
- (b) Prophylaxis for Covered Persons under age 14, limited to two each Calendar Year.
- (c) Topical application of Fluoride, for Covered Persons under 19 years of age and limited to two treatments during each Calendar Year.

2. Diagnostic oral examination, limited to two exams each Calendar Year.

3. X-rays

- (a) Bitewing X-rays, limited to one every six (6) consecutive months.
- (b) Periapical X-rays (single tooth), as needed.
- (c) Additional films, up to 12 each year.
- (d) Intraoral, Occlusal view, maxillary or mandibular, each.
- (e) Superior or inferior maxillary, extraoral, one (1) film.
- (f) One series of full mouth X-rays or one panoramic survey (single film), limited to once every three (3) calendar years.

Class II – Basic & Restorative Services- Payable at 75% subject to reasonable & customary guidelines.

1. Space Maintainers and their fitting for missing Primary Teeth for Covered Dependents under age 19 only.

2. Non-Routine Visits

- (a) Sedative Fillings where no other dental services except X-rays are performed.
- (b) Emergency Palliative treatment, per visit.
- (c) Consultation with a Dentist other than the Dentist providing treatment.
- (d) Office visit during regular office hours for observation and treatment of Injuries to teeth and supporting structure (other than for routine operative procedures).
- (e) Professional visit after hours; benefits will be based on the charges for the services rendered or for the after-hours visit, whichever are greater.

3. Pathology

Except for Injuries, benefits will be based on the charges for examination and diagnosis only.

- (a) Diagnostic Casts.
- (b) Biopsy of oral tissue.
- (c) Examination of oral tissue.

4. Topical application of Sealants for Covered Dependents under age 14 only, limited to once per tooth in any 36 consecutive months.

5. Extractions

- (a) Uncomplicated (single).
- (b) Surgical removal of an erupted or unerupted tooth involving tissue flap and bone removal.
- (c) Postoperative visit for suture removal or complications after multiple Extractions of impactions.

6. Removal of Impacted Teeth

- (a) Soft tissue impaction.
- (b) Partial bony impaction.
- (c) Complete bony impaction.

7. Oral Surgery

The following procedures are covered by the Plan:

- (a) Alveolectomy, only when teeth are removed, per Quadrant.
- (b) Alveolectomy (Edentulous) per Quadrant, tuberosity reduction (unilateral).
- (c) Stomatoplasty with ridge extension, per arch.
- (d) Excision of pericoronal gingiva, per tooth.
- (e) Removal of palatal torus.
- (f) Removal of mandibular tori, per Quadrant.
- (g) Incision of hyperplastic tissue, per arch.
- (h) Removal of cyst or tumor.
- (i) Incision and drainage of abscess.
- (j) Replantation of tooth or tooth bud.
- (k) Crown exposure for orthodontia.

8. Injectable antibiotics only

9. General anesthesia when required in connection with Dental Surgery.

10. Periodontics

If more than one service is performed per Quadrant, the benefit for all services will be based on the largest covered charge.

- (a) Gingivectomy, gingivoplasty.
 - (b) Gingivectomy, treatment per tooth (fewer than six (6) teeth).
 - (c) Subgingival Curettage, maximum of four (4) treatments within 12 consecutive months.
 - (d) Osseous Surgery including gingival flaps.
 - (e) Mucogingival surgery such as pedical soft tissue graft and sliding horizontal flap.
 - (f) Occlusal adjustment, only if performed in conjunction with Periodontal surgery, maximum of four (4) full mouth adjustments within 12 consecutive months following the Periodontal surgery.
 - (g) Root Planing, maximum of four (4) treatments within 12 consecutive months.
 - (h) Periodontal Prophylaxis, only if Periodontal disease is diagnosed, maximum of four (4) cleanings within 12 consecutive months.
 - (i) Occlusal Guards for treatment of Periodontal disease only, including adjustment within six (6) consecutive months.
11. Endodontics
- (a) Direct Pulp capping, excluding final Restoration.
 - (b) Therapeutic apical closure.
 - (c) Vital Pulpotomy, excluding final Restoration.
 - (d) Apicoectomy.
 - (e) Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only and excluding final Restoration.
 - (f) Root Canal Therapy, excluding final Restoration. Benefits for any X-ray, test, laboratory examination or follow-up care will be based on the benefits payable for root canal therapy and not for any separate dental service.
12. Amalgam Restorations on Primary Teeth, for one, two, three, four or five Surfaces.
13. Amalgam Restorations on Permanent Teeth, for one, two, three, four or five Surfaces.
14. Synthetic Restorations.
- (a) Silicate cement Filling.
 - (b) Acrylic or plastic Filling.
 - (c) Composite resin, for one, two, three, four or five Surfaces, including Acid-etch.
 - (d) Composite resin involving Incisal angle, including Acid-etch.
15. Pin retention, exclusive of restorative material.
16. Stainless steel Crown, only when the tooth cannot be restored with filling material, limited to Primary Teeth only.
17. Temporary Crowns, only for Dependent children under age 16.

18. Recementing of Inlays, Onlays, Crowns and Fixed Bridges.
19. Repairs to Crowns and Fixed Bridges.
20. Additional teeth to Partial Dentures to replace extracted natural teeth including the necessary Clasp.
21. Repairs to existing Partial and full Dentures, metal or acrylic.
 - (a) Repair Dentures, no teeth damaged.
 - (b) Repair Dentures and replace one broken tooth.
 - (c) Replace additional teeth, each tooth.
 - (d) Replace broken tooth on Denture, no other repair.
22. Relining or Rebasing of Partial and full Dentures

Covered only after six (6) or more months from installation of the original Appliance; Adjustments to the Relined or Rebased Appliance that are made within six (6) months of installation are included in the benefits for installation.

 - (a) Upper or lower Denture duplication (jump case) per Denture, limited to once in a period of 36 consecutive months.
 - (b) Upper or lower Denture Reline, full or partial, office, cold cure, limited to once in a period of 12 consecutive months.
 - (c) Upper or lower Denture Rebase, full or partial, laboratory, limited to once in a period of 12 consecutive months.
 - (d) Tissue conditioning, upper or lower Denture, maximum of two (2) treatments per arch, limited to once in a period of 12 consecutive months.
23. Adjustment to a Partial or full Denture made more than six (6) months after installation or performed by someone other than the licensed practitioner who provided the Appliance.

Class III – Major Procedures - Payable at 75% subject to reasonable & customary guidelines

Covered Services and Supplies

- (a) Inlays
 - (b) Onlays
 - (i) All Surfaces.
 - (ii) Onlay with Inlay.
- (c) Crowns
 - (i) Permanent, processed acrylic.
 - (ii) Acrylic with gold or semiprecious metal.
 - (iii) Porcelain.

- (iv) Porcelain with gold or semiprecious metal.
 - (v) Gold, full cast; $\frac{3}{4}$ cast or full cast with semiprecious metal.
 - (vi) Temporary Crowns, provided that expenses for temporary Crowns will be deducted from the total charges for permanent Crowns.
- (d) Posts
- (i) Cast Post and Core.
 - (ii) Steel Post and Core.
 - (iii) Cast Dowel Pin.
- (e) Bridge Abutments
- (i) Permanent, processed acrylic.
 - (ii) Acrylic with gold or semiprecious metal.
 - (iii) Porcelain.
 - (iv) Porcelain with gold or semiprecious metal.
 - (v) Gold, full cast; $\frac{3}{4}$ cast or full cast with semiprecious metal.
- (f) Bridge Pontics
- (i) Gold cast (sanitary).
 - (ii) Cast with semiprecious metal, sanitary.
 - (iii) Slotted facing.
 - (iv) Slotted Pontic.
 - (v) Porcelain fused to gold or to semiprecious metal.
 - (vi) Plastic processed to gold or to semiprecious metal.
- (g) Maryland Bridge.
- (h) Temporary Bridges, provided that expenses for a temporary Bridge will be deducted from the total charges for the permanent Bridge.
- (i) Dentures and Partial Dentures. Benefits payable with respect to Dentures and Partial Dentures include Adjustments and Relinings within six (6) months after installation; benefits payable for Partial Dentures include base, all Clasps, rests and teeth.
- (i) Complete maxillary Denture.
 - (ii) Complete mandibular Denture.
 - (iii) Upper partial, with two chrome Clasps with rests, acrylic base.
 - (iv) Lower partial, with two chrome Clasps with rests, acrylic base.
 - (v) Lower partial with chrome Lingual bar and Clasps, acrylic base.
 - (vi) Upper partial with chrome Lingual bar and Clasps, acrylic base.
 - (vii) Stayplate base upper (Anterior) teeth only.
 - (viii) Stayplate base lower (Anterior) teeth only.
 - (ix) Removable Appliance (unilateral): one piece chrome casting, Clasp attachments (all types), per unit including Pontics.

Exclusions and Limitations for Major Dental Services and Supplies

Notwithstanding any other provision of the Plan, major dental benefits are payable for services and supplies listed above only as follows:

1. New Inlays, Onlays and Crowns are covered only if a tooth is broken down by decay or traumatic Injury, and the tooth cannot be restored with an Amalgam, silicate, acrylic or Composite Restoration.
2. Replacement Inlays, Onlays and Crowns are covered only if either the replacement is provided at least five (5) years after the initial Inlay, Onlay or Crown or an additional tooth surface is involved. In either case, services and supplies are covered only if the tooth is broken down by decay or traumatic Injury.
3. New Fixed Bridgework or a new removable Partial or full Denture is covered only if the Prosthesis is required to replace one or more natural teeth.
4. Replacement of existing Fixed Bridgework or an existing removable Partial or full Denture is covered only if:
 - (a) Replacement is necessitated by the Extraction of additional teeth;
 - (b) Replacement is provided at least five (5) years after the initial Prosthesis, and the existing Prosthesis cannot be made serviceable; or
 - (c) Replacement is necessitated by the initial placement of an opposing full Denture.

Class IV – Orthodontic Procedures - Payable at 50% subject to reasonable & customary guidelines (**For Eligible Dependent children who are age 6 and up to age 19**)

Covered Orthodontic Treatment Plan

Orthodontic services must be prescribed by a treatment plan that is pre-approved by the Claim Administrator for the correction of an existing, handicapping Malocclusion and its attendant sequelae through the correction of malpositioned teeth, and consists of:

- (a) Diagnosis, including radiographs and study models;
- (b) Extraction of teeth solely for orthodontic purposes;
- (c) Active treatment, including necessary Appliances; and
- (d) Retention treatment following active treatment.

The Lifetime Maximum Benefit for any one Covered Dependent for Class IV Services shall be the amount stated in the Schedule of Benefits. Plan benefits shall be payable over a period not exceeding the length of the approved treatment plan, and will be paid not more frequently than once every three (3) months (“quarterly”). The initial payment shall be no more than 25% of the total amount of the Plan’s benefit liability under the

approved treatment plan. Thereafter, benefits shall be payable in equal quarterly amounts during the period covered by the approved treatment plan, but only for as long as the Covered Dependent remains covered by the Plan. If the orthodontic services are satisfactorily completed in less than the period specified in the approved treatment plan, the Contract Administrator shall, upon appropriate notification from the Dentist, make payment in the amount of the remainder of the Plan's liability for benefits under the approved treatment plan.

Exclusions and Limitations for Orthodontic Services and Supplies

1. If, for any reason, the orthodontic services are terminated before completion of the approved treatment plan, the responsibility of the Plan for benefit payments under the approved treatment plan will cease after payment is made for the month of termination.
2. A treatment plan must be submitted to the Contract Administrator by the Covered Person's Dentist for pre-approval and must include a diagnosis indicating that the orthodontic condition requiring treatment consists of a handicapping Malocclusion that is abnormal and correctable.
3. Upon submission of a treatment plan, the Contract Administrator has the right to review the Covered Dependent's dental records, including necessary radiographs and study models, to determine whether orthodontic needs and treatment are eligible for benefits under the Plan.
4. For the purpose of determining whether and to what extent Plan benefits are payable for orthodontic treatment in progress at the commencement or termination of a Covered Dependent's coverage under the Plan, all orthodontic services and supplies shall be deemed provided on the actual date provided.
5. The Plan does not pay benefits for any charges for the replacement and/or repair of any Appliance furnished under an approved treatment plan or for any duplicate device or Appliance.
6. Notwithstanding any other provision of the Plan:
 - (i) Benefits for orthodontic services and supplies shall be payable only with respect to Covered Dependents who are at least age 6 and under age 19. Benefit payments shall cease at the end of the month in which a Covered Dependent attains age 19 even if an approved course of orthodontic treatment continues thereafter.
 - (ii) No benefits shall be payable for any charges for orthodontic services or supplies, including Appliances, treatment or adjustments for Appliances that were placed, or for which treatment started, prior to the effective date of a Covered Dependent's coverage under this Plan.
 - (iii) A Covered Member is not eligible for benefits for orthodontic services and supplies.

IX. DENTAL LIMITATIONS AND EXCLUSIONS

Charges not covered:

1. **Appliances.** Expenses for appliances (except as described herein) or restorations for increasing vertical dimension; restoring occlusion replacing tooth structure lost by attrition, correcting congenital or developmental malformations, for aesthetic purposes; or implantology techniques.
2. **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
3. **Completion of forms.** Expenses for completion of forms.
4. **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
5. **Excess charge.** Charges which are considered above and beyond the reasonable and customary range.
6. **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
7. **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
8. **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
9. **Illegal acts.** Charges resulting from or occurring during the commission of a crime by the Covered Person or while engaged in an illegal act, illegal occupation or felonious act, or aggravated assault for which they are convicted of a felony charge.
10. **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
11. **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
12. **No listing.** Services which are not included in the list of covered dental services.
13. **No obligation to pay.** Charges for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge.
14. **Not completed.** Expenses for services which have not been completed. Inlays, onlays, crowns, bridges and dentures shall be considered completed on the date prepared and final impressions taken.

15. **Not Medically Necessary.** Charges for a service or supply which are not considered medically necessary as defined in the Article titled “Definitions”, whether or not prescribed and recommended by a Physician or covered provider.
16. **Occupational.** Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker’s Compensation Law, Occupational Disease Law or similar legislation.
17. **Orthognathic Surgery.** Surgery to correct a receding or protruding jaw.
18. **Overlays.** Expenses for overlays. In addition, expenses for veneers or similar overlays on bridges placed on the twelve (12) molar teeth.
19. **Personalization.** Personalization of dentures.
20. **Plan design.** Charges excluded or limited by the Plan designs stated in this document.
21. **Precision attachments.** Expenses for precision attachments.
22. **Relative.** Expenses for treatment, services or supplies provided by a Member, who ordinarily resides with the Covered Person, or is the Covered Person, including but not limited to, his or her spouse, child, brother, sister, or parent.
23. **Replacement.** Replacement of an appliance or prosthetic device unless the appliance or device is at least five (5) years old and cannot be made usable; or the appliance or device is damaged, while in the Covered Person’s mouth in an injury which occurs while insured and it cannot be repaired.
24. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic, except when used to return the tooth to normal form and function.
25. **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) Syndrome.
26. **Tooth bleaching.** Expenses for tooth bleaching unless done to restore color on a tooth which previously had a root canal.
27. **War.** Medical expenses incurred on account of Injury or sickness resulting from war or any act of war, whether declared or undeclared, or expenses resulting from active duty in the Uniformed Services of any international armed conflict or conflict involving armed forces of any international authority.

Charge limitation for certain dental care - if for any charge, a benefit would be provided both under this Plan and any medical plans covering the patient, then that charge will be payable under the medical plan first. The benefits will not be coordinated with this Dental Plan.

X. PARTICIPATION REQUIREMENTS

A. Members Eligible. All full-time Members shall become eligible to participate in the Plan on the end of any required probationary period deemed by his/her Employer (or if later, the date on which such Employee transfers to full-time status) provided he or she submits an application for enrollment (on forms furnished by and delivered to the Plan Administrator) within thirty-one (31) days of such date. For purposes of this Plan, a Member is considered “full-time” if he or she is regularly scheduled to work 100 hours per month, and may remain on the Plan for the month following when the 100 hours are accrued or, the Member must work in accordance with the requirements contained in the Collective Bargaining Agreement.

If husband and wife are both Members, each can be covered individually or as the Eligible Dependent of the other. Neither can be covered both as a Member and as an Eligible Dependent. Only one of the two covered spouses may cover Eligible Dependent children, if any.

B. Dependents Eligible. Except as provided in the Section titled “Special Enrollment Periods and Elections,” in Subsection I., each Eligible Dependent will be eligible to participate in the Plan beginning with the later of the following dates, provided the Plan Administrator is notified in writing within thirty-one (31) days of such event and the enrolled Member has agreed to pay any required contribution for such coverage:

- (1) The date the enrolled Member’s coverage begins, provided the enrolled Member enrolled all Eligible Dependents on or before the date on which such enrolled Member’s participation commenced hereunder.
- (2) The date of enrollment, if the enrolled Member enrolls all Eligible Dependents within thirty-one (31) days of the enrolled Member’s own eligibility date.
- (3) The date the enrolled Member enrolls the Eligible Dependent, if the enrollment is within thirty-one (31) days of the date any new Eligible Dependent is acquired and proof of Eligible Dependent status is furnished. A newborn Eligible Dependent is not considered to be “acquired” until the Eligible Dependent’s birth.
- (4) In the case of an adopted child, the date the child is placed with the enrolled Member for adoption by a court of competent jurisdiction (as defined in Subsection C).

C. Adopted Child Provision. Eligible Dependent children placed for adoption with an enrolled Member shall be eligible for coverage under the same terms and conditions as apply in the case of Eligible Dependent children who are natural children of enrolled Members under the Plan, irrespective of whether or not the adoption has become final.

Pursuant to Article XI(A)(3), coverage under the Plan shall not be restricted for any Eligible Dependent child adopted by the enrolled Member or placed with an enrolled Member for adoption, solely on the basis of a pre-existing condition of such child at the time that such child would otherwise become eligible for coverage under the Plan, if the adoption or

placement for adoption occurs while the enrolled Member is eligible for coverage under the Plan.

As used in this “Adopted Child Provision” section only, the term “child” means in connection with any adoption, or placement for adoption of a child, a child who has not attained age eighteen (18) as of the date of such adoption or placement for adoption. The terms “placement” or “being placed” for adoption in connection with any placement for adoption of a child with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with such person terminates upon the termination of such legal obligation.

The child’s placement for adoption terminates upon the termination of such legal obligations, and in such an event, the child’s coverage shall cease after the last day of the month the placement is terminated unless coverage must be continued pursuant to a qualified medical child support order or continuation coverage is elected.

D. Coverage Pursuant to a Qualified Medical Child Support Order. Certain Eligible Dependents shall be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 4301 of the Omnibus Budget Reconciliation Act of 1993). A participant may obtain a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order 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.

The terms “Qualified Medical Child Support Order” and “Medical Child Support Order” shall have the meanings given to them in Section 609 of ERISA.

An “Alternate Recipient” shall mean any child of an enrolled Member who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such Covered Person.

E. Rights of States with Respect to Group Health Plans where Members Thereunder are Eligible for Medicaid Benefits. Payment of benefits with respect to a Covered Person under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Person as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

F. Enrollment and Provision of Benefits without Regard to Medicaid Eligibility. In enrolling a Member as a Covered Person or in determining or making any payments for benefits of a Member as a Covered Person, the fact that the Member is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

G. Acquisition by States of Rights or Third Parties. This Plan shall provide that, to the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payment for items or services constitutes such assistance; payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Person to such payment for such items or services.

H. Continued Coverage for Cost of a Pediatric Vaccine. The Plan may not reduce its coverage for the cost of pediatric vaccines (as defined under Section 19289(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

I. Special Enrollment Periods and Elections.

- (1) If a Member does not enroll for coverage for himself and/or his Eligible Dependents within thirty-one (31) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the eligible Member may do so under the Plan's Special Enrollment rules.
- (2) A Member may enroll for coverage for the Member and all Eligible Dependents at any time provided that (a) the Member is eligible for coverage under the Plan but is not currently enrolled and (b) the Member declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for waiving such coverage (and the Member signed a written waiver of such coverage on forms furnished by and delivered to the Plan Administrator within thirty-one (31) days of his or her commencement of employment with the Employer) and (c) the alternative coverage has terminated, because either (1) it was COBRA continuation coverage that has been exhausted, or (2) eligibility for the alternative coverage was lost (for reasons other than the Member's failure to pay premiums or for cause) or employer contributions toward the cost of the coverage terminated. In this case, the Member must submit a completed enrollment form within thirty (30) days after the date on which (1) COBRA continuation coverage was exhausted, or (2) such other coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in the Plan will be effective on the date of the qualifying event.
- (3) The Member may enroll for coverage for the Member and all Eligible Dependents at any time provided that (a) the Member is eligible for coverage under the Plan but is not currently enrolled and (b) the Member declined

coverage under the Plan when it was offered previously and (c) another individual (a spouse or child) has become an Eligible Dependent of the Member through marriage, birth, adoption, or placement for adoption. In this case, the Member must submit a completed enrollment form within thirty-one (31) days of the marriage, birth, adoption, or placement for adoption. Enrollment in the Plan for newborns or newly adopted children will be effective as of the date of the adoption, or placement for adoption, or birth. In the case of marriage, the effective date will be the date of marriage.

- (4) A Member who does not enroll for coverage for the Member and/or the Member's Eligible Dependents within thirty-one (31) days of becoming eligible for coverage or does not enroll under the Special Enrollment provisions and subsequently wishes to elect such coverage may apply for coverage as a Late Enrollee. No Late Enrollee may participate in the Plan or in a specified portion of this Plan without the consent of the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877.
- (5) At the time each Member is offered the initial opportunity to enroll in this Plan, he will also be given notice of these Special Enrollment rights.

J. Procedures In Cases of Reemployment.

- (1) No evidence of insurability may be required of and reentry into the Plan will be immediate for any Member who discontinued coverage during a leave of absence taken under the FMLA by the Member, so long as the Member returns to work before or immediately following the expiration of the FMLA leave.
- (2) Reentry into the Plan will be immediate for any former enrolled Member and his or her Eligible Dependents who have continuously been covered under this Plan through continuation coverage where the Member regains eligibility for coverage under the Plan on the basis of full-time employment while such continuation coverage is in effect.
- (3) In each other case of reemployment or return to full-time status from part-time status, the Covered Person will become covered upon the Member's return to work and in accordance with the provisions of Article X(A).

K. Reentry Into Plan at End of Uniformed Service Duty. Whether or not the Member elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the Member returns to active employment with the Employer if the Member returns to employment (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans' Administration to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the Pre-Existing Condition Limitation will be credited as if the Member had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service.)

XI. PRE-EXISTING CONDITION LIMITATION

A. Preexisting Condition.

- (1) A "Preexisting Condition" is any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received by a licensed health care provider or practitioner in the six (6) month period immediately preceding a Covered Person's "Date of Enrollment" under this Plan. However, pregnancy does not constitute a preexisting condition for the purpose of this Article XI. See Paragraph 6 below which defines the "Date of Enrollment."
- (2) No benefits shall be paid for services, supplies, or treatment furnished to a Covered Person in connection with a Preexisting Condition until the completion of a period of twelve (12) consecutive months (or eighteen (18) consecutive months in the case of a Late Enrollee), beginning with the Covered Person's "Date of Enrollment", subject to Paragraph 5 below. See Paragraph 6 below which defines the "Date of Enrollment."
- (3) Notwithstanding any other provision in this Plan, the restriction in Paragraph 2 above shall not apply to a newborn child, an adopted child under age 18, or a child under age 18 who has been placed for adoption with a Participant if that child becomes covered under (i) this Plan, (ii) any other group health plan, or (iii) any other Creditable Coverage within 30 days of birth, adoption, or placement for adoption, unless the child has a Significant Break in Coverage.
- (4) The exclusion of benefits for a Preexisting Condition described in Paragraph 1 above shall not apply to a Member (or to the Member's Eligible Dependents) who has resumed active participation in the Plan immediately following (i) an FMLA leave; or (ii) a period of duty in the Uniformed Service, except with respect to a condition incurred by the Member, or a condition that was aggravated, while the Member was absent on duty in the Uniformed Service.
- (5) Notwithstanding any other provision in this Plan, any period during which benefits for a Preexisting Condition described in Paragraph 1 above otherwise would be excluded shall be reduced by the length of a Member's Creditable Coverage, which is calculated by determining all days during which the Member had one or more types of Creditable Coverage, without regard to specific benefits included in the coverage. However, days of Creditable Coverage that occurred before a Significant Break in Coverage shall not be counted for the purpose of reducing any period of exclusion.
- (6) A Covered Person's "Date of Enrollment" is the first day of coverage under this Plan, or, if there is a Waiting Period, the first day of the Waiting Period (usually the date of hire). In the case of a Special Enrollee or Late Enrollee, the Date of Enrollment is the first day of coverage under this Plan. If the Plan

changes insurers, or if a Covered Person changes benefit package options, the Date of Enrollment remains the same.

B. Proof of Creditable Coverage. A Covered Person may prove Creditable Coverage by either of two methods:

- (1) First, for prior coverage effective on or after July 1, 1996, the Member may present a written Certificate of Coverage from the source or entity that provided the coverage showing:
 - (a) The date the Certificate was issued;
 - (b) The name of the group health plan that provided the coverage;
 - (c) The name of the Member or Eligible Dependent to whom the certificate applies;
 - (d) The name, address, and telephone number of the plan administrator or issuer providing the certificate;
 - (e) A telephone number for further information (if different);
 - (f) Either (a) a statement that the Member or Eligible Dependent has at least 12 months (365 days) or in the case of a Late Enrollee, at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage of Creditable Coverage, or (b) the date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
 - (g) The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.
- (h) An educational statement regarding HIPAA, which explains:
 - (1) Restrictions on the ability of the plan or issuer to impose a pre-existing claim exclusion;
 - (2) Special enrollment rights;
 - (3) Prohibitions against discrimination based on any health factors;
 - (4) The right to individual health coverage;
 - (5) The fact that state law may require issuers to provide additional protections to individuals in that state; and
 - (6) Where to get more information.
- (2) Second, if the Covered Person for any reason is unable to obtain a Certificate from another Plan (including because the prior coverage was effective prior to

July 1, 1996), he may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services.

This Plan will treat a Covered Person as having provided a Certificate if that Covered Person (a) attests to the period of Creditable Coverage, (b) presents relevant corroborating evidence of some Creditable Coverage during the period, and (c) cooperates with the Plan's efforts to verify his coverage. This Plan will treat an Eligible Dependent as having provided a Certificate if that Member (a) attests to the dependency and the period of that status, and (b) cooperates with the Plan's efforts to verify his status.

C. Notice of Preexisting Condition Exclusion.

- (1) If, within a reasonable time after receiving the information about Creditable Coverage described in Section B above, this Plan determines that an exclusion for preexisting conditions applies, it will notify the Member or Eligible Dependent of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification also will explain the Plan's appeals procedures and give the Member or Eligible Dependent a reasonable opportunity to present additional evidence. Notification will be made in accordance of the Claims Procedures as described in Article XX.
- (2) If this Plan later determines that a Covered Person did not have the claimed Creditable Coverage, the Plan may modify its initial determination to the contrary. In that case, the Covered Person will be notified of the reconsideration; however, until a final determination is reached, the Plan will act in accordance with its initial determination in favor of the Member or Eligible Dependent for the purpose of approving medical services.
- (3) The current Plan will assist in obtaining a Certificate of Coverage from any prior Plan or issuer, if necessary.

XII. COORDINATION OF BENEFITS

A. Maximum Benefits Under All Plans. If any Covered Person covered under this Plan also is covered under one or more Other Plans and the sum of the benefits payable under all the Plans exceeds the Covered Person's eligible charges during any claim determination period, then the benefits payable under all the Plans involved will not exceed the eligible charges for such period as determined under this Plan. Benefits payable under another Plan are included, whether or not a claim has been made. For these purposes (a) "Claim Determination Period" means a calendar year, and (b) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include charges specifically excluded from benefits under this Plan that also may be eligible under any Other Plans covering the Covered Person for whom the claim is made.

B. Other Plan. "Other Plan" means the following plans providing benefits or services for medical and dental care or treatment:

- (1) Group insurance or any other arrangement for coverage for Members in a group, whether on an insured or uninsured basis.
- (2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid.
- (3) No-Fault automobile coverage. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each Member will be deemed to have full no-fault coverage to the maximum available in that state. This Plan will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the Member is in compliance with the law, or whether or not the maximum coverage is carried.

C. Determining Order of Payment. If a Covered Person is covered under two or more Plans, the order in which benefits will be determined is as follows:

- (1) The Plan covering the Covered Person as a Member pays benefits first. The Plan covering the Covered Person as an Eligible Dependent pays benefits second.
- (2) If no Plan is determined to have primary benefit payment responsibility under (1), then the Plan that has covered the Covered Person for the longest period has the primary responsibility.
- (3) A Plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.
- (4) The Plan covering the parent of the Eligible Dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The Plan covering the parent of an Eligible Dependent child pays second if the parent's birthday falls later in the year.

- (5) In the event that the parents of the Eligible Dependent child are divorced or separated, the following order of benefit determination applies:
 - (a) The Plan covering the parent with custody pays benefits first;
 - (b) If the parent with custody has not remarried, then the Plan covering the parent without custody pays benefits second;
 - (c) If the parent with custody has remarried, then the Plan covering the step-parent pays benefits second and the Plan covering the parent without custody pays benefits third; and
 - (d) If a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the Plan covering that parent pays benefits first.
- (6) The Plan covering the Covered Person as a Member (or as the Member's Eligible Dependent) who is neither laid-off nor retired pays benefits first. The Plan covering the Covered Person as a laid-off or retired Member (or as that Member's Eligible Dependent) pays benefits second.
- (7) The Plan covering a Covered Person as a Member (or as an Eligible Dependent of the Member) pays benefits first if such an individual is also being provided COBRA continuation coverage under another Plan, and such Other Plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any Member who is provided COBRA continuation under this Plan and who also is covered simultaneously under another Plan as a Member (or as an Eligible Dependent of a Member). In the event of conflicting coordination provisions between this Plan and any Other Plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

D. Facilitation of Coordination. For the purpose of Coordination of Benefits, the Claim Administrator:

- (1) May release to, or obtain from, any other insurance company or other organization or individual any claim information and any individual claiming benefits under the Plan must furnish any information that the Plan sponsor may require.
- (2) May recover on behalf of the Plan any benefit overpayment from any other individual, insurance company, or organization.
- (3) Has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the Plan have been made by such organization.

E. Plan Charges Covered by Medicare. This Plan shall be considered the primary payer, and Medicare the secondary payer, for those services, treatments, and supplies that would otherwise have been provided by Medicare in the case of:

- (1) Any Member (or Member's spouse) who is covered under this Plan by reason of, current employment status with the Employer and who is also entitled to Medicare benefits, for as long as such employment status continues; provided that this subsection (1) shall not apply if the Employer has fewer than 20 Members in current employment status for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year.
- (2) Any disabled Member (or Eligible Dependent) who is entitled to Medicare but still participates in this Plan on the basis of current employment status, for as long as such employment status continues; provided that this subsection (2) shall not apply unless the Employer had at least 100 individuals in current employment status on a typical business day during the previous calendar year.
- (3) Any Member or Eligible Dependent who is entitled to Medicare benefits solely on the basis of having end-stage renal disease ("ESRD"), provided that Medicare shall be considered to be the primary payer of benefits on behalf of an insured Member with ESRD after expiration of the period that begins on the date the individual first becomes entitled to Medicare part A benefits under Social Security Act §226A and ends eighteen (18) months later (thirty (30) months if entitlement began on or after March 1, 1996).

For purposes of this Section, (a) "current employment status" means that an individual is (i) actively at work at the Employer, (ii) is treated as an active Member for payroll tax purposes with respect to amounts paid to such an individual as compensation, or (iii) has a business relationship to the Employer as an independent contractor of personal services rendered to the Employer; and (b) "entitled to Medicare" means that an individual either (i) is receiving Medicare benefits, or (ii) would receive such benefits if he made application to the Social Security Administration.

The Medicare secondary payor rules under Social Security Act Section 1862(b) (42 U.S.C. Section 1395y(b)(5)), as may be amended from time to time, and applicable Federal regulations are hereby incorporated by reference and shall supersede any inconsistent provision(s) of this Plan.

In the event that the Plan would otherwise be allowed (as in accordance with the Medicare secondary payor rules) to be a secondary payor of covered medical expense benefits for Covered Persons who are eligible for Medicare, but who have not applied for entitlement to Medicare Part A or Part B or who have applied for entitlement to Part B but have chosen not to elect part B, the Covered Person's benefits under this Plan will be determined on an assumptive basis, whereby benefits will be calculated as if Medicare provided reimbursement for the expenses being claimed.

F. Discrimination Against Older Participants Prohibited. This Plan will provide benefits for any Covered Person age 65 or older under the same terms and conditions that apply to a Covered Person who is under age 65.

G. Plan Charges Covered by Medicaid. This Plan will not reduce or deny benefits for any Covered Person to reflect the fact that such a Member is eligible to receive medical assistance under a state Medicaid plan.

H. Medicare and Medicaid Reimbursements. The Plan will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any Covered Person that should have been borne by this Plan. Similarly, the Plan will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.

I. Right to Receive and Release Necessary Information. For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the Trust Fund through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes. Any person claiming benefits under this Plan will furnish such information as may be necessary to implement this provision.

J. Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision, have been made under any other plans, the Trust Fund will have the sole right and discretion to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan.

K. Right of Recovery. Whenever payments have been made by the Trust Fund with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Trust Fund will have the right to recover such payments to the extent of such excess from any persons to or for or with respect to whom such payments were made and any other insurance companies and any other organizations.

XIII. PLAN ADMINISTRATION

A. Plan Administrator. The Plan Administrator is the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 (the “Trust Fund”). The Plan is administered by the Board of Trustees. The Board of Trustees employs a full-time administrator, Louis F. Malzone, who is located at the Fund Office, 89 Access Road, Unit 4, Norwood, Massachusetts 02062. A staff assists in the administration of the Fund. The Board of Trustees also has contracted with a third party administrator, Health Plans, Inc., 1500 West Park Drive, Westborough, Massachusetts 01581, to perform claims administration for medical and dental claims.

B. Allocation of Authority. Except as to those functions reserved by the Plan to the Trust Fund or the Board of Trustees of the Trust Fund, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall (except as to matters reserved to the Board of Trustees by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:

- (1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
- (2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator or the Board of Trustees with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

C. Powers and Duties of Plan Administrator. The Plan Administrator will have the following powers and duties:

- (1) To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan.
- (2) To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan.
- (3) To decide on questions concerning the Plan and the eligibility of any Member to participate in the Plan, in accordance with the provisions of the Plan.
- (4) To determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan; to inform the Trust Fund, as appropriate, of the amount of such Benefits; and to provide a full and fair

review to any covered individual whose claim for benefits has been denied in whole or in part.

- (5) To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including Employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration.

D. Delegation by the Plan Administrator. The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Trustees to replace any or all of the members of the committee, or to eliminate the committee entirely.

The Plan Administrator also will have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as medical necessity or experimental treatments.

The Plan Administrator, the Board of Trustees (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Board of Trustees, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

E. Fiduciary Liability. To the extent permitted by law, neither the Plan Administrator nor any other person will incur any liability for any acts or for failure to act.

F. Indemnification and Exculpation. The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and Employees of the Trust Fund will be indemnified and held harmless by the Trust Fund against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Trust Fund's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this Section will not be applicable to any person if the loss, cost, liability, or expense is due to the person's failure to act in good faith or misconduct.

G. Compensation of Plan Administrator. Unless otherwise agreed to by the Board of Trustees, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties will be paid by the Trust Fund.

H. Bonding. Unless required by ERISA, by the Board of Trustees, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates will be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

I. Payment of Administrative Expenses. All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Trust Fund unless the Trust Fund directs the Plan to pay such expenses and such payment by the Plan is permitted by law.

XIV. TERMINATION AND CONTINUATION OF COVERAGE

A. Termination Events. The coverage of any Member and his or her Eligible Dependents shall automatically cease immediately upon the day indicated below:

1. On the last day of the month in which the Member terminates employment.
2. On the day in which the Member ceases to be in a class of eligible Members with his/her Employer.
3. On the day the Member's Employer terminates coverage.
4. On the day this Plan terminates.
5. On the day in which the Member dies.
6. On the day in which the Member enters service in the Uniformed Services on an active duty basis.
7. On the last day of the period in which the Member fails to make any required contributions.

As mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Plan will provide a Certificate of Coverage to any Covered Person after the Member loses coverage in the Plan. In addition, a Certificate will be provided upon request, if the request is made within twenty-four (24) months after the Member loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish the same.

The Plan will make reasonable efforts to locate and provide Certificates of Coverage with respect to Eligible Dependents provided, however, that through June 30, 1998, the Plan will not provide separate Certificates for Eligible Dependents, but will on each Certificate issued to a Member/former Member specify the type of coverage. If the Plan is requested to provide a Certificate for an Eligible Dependent, the Plan will make reasonable efforts to obtain and provide the person's name.

After June 30, 1998, although the Plan will make reasonable efforts to collect information applicable to any Eligible Dependents of the Member and to include that information on the Certificate, the Plan will not issue an automatic Certificate for Eligible Dependents until the Plan has reason to know that an Eligible Dependent has lost coverage under the Plan. A Covered Person may prove Creditable Coverage by either of two methods:

- (1) For prior coverage effective on or after July 1, 1996, the Member may present a written Certificate of Coverage from the source or entity which provided the coverage showing:
 - i. The date the Certificate was issued;

- (ii) The name of the group health plan that provided the coverage;
- (iii) The name of the Covered Person to whom the Certificate applies;
- (iv) The name, address, and telephone number of the plan administrator or issuer providing the Certificate;
- (v) A telephone number for further information (if different);
- (vi) Either a statement that the Covered Person has at least twelve (12) months (365) days or in the case of a Late Enrollee, eighteen (18) months (546) days of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage, or the date any Waiting Period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
- (vii) The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate.
- (viii) An educational statement regarding HIPAA, which explains:
 - a. Restrictions on the ability of the plan or issuer to impose a pre-existing claim exclusion;
 - b. Special enrollment rights;
 - c. Prohibitions against discrimination based on any health factors;
 - d. The right to individual health coverage;
 - e. The fact that state law may require issuers to provide additional protections to individuals in that state; and
 - f. Where to get more information.

(2) If the Covered Person for any reason is unable to obtain a Certificate from another plan (including because the prior coverage was effective prior to July 1, 1996), he or she may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services. This Plan will treat a Covered Person as having provided a Certificate if that Member attests to the period of Creditable Coverage, presents relevant corroborating evidence of some Creditable Coverage during the period, and cooperates with the Plan's efforts to verify his or her coverage. This Plan will treat an Eligible Dependent as having provided a Certificate if that Member attests to the dependency and the period of that status, and cooperates with the Plan's efforts to verify his or her status.

B. Eligible Dependent Coverage. The coverage of any Eligible Dependent shall cease hereunder prior to the termination of the Member's coverage on the earlier of (i) on the day such person ceases to be an Eligible Dependent or on (ii) the date the Member fails to make any required contribution for Eligible Dependent coverage.

The coverage of an Eligible Dependent who has attained the maximum age limit shall not terminate if such Eligible Dependent is permanently and totally disabled (as defined in Internal Revenue Code section 22(e)(B)), at any time during the calendar year in which the taxable year of the Member begins. Written proof of such Eligible Dependent's permanent and total disability must be submitted on an annual basis to the Plan Administrator, and the Employer reserves the right to require, at its expense, an independent medical, psychiatric or psychological evaluation or examination in connection with any such annual review of such Eligible Dependent's disability status.

C. Employees Under Compensation Maintenance Agreements, Etc. and/or a Collective Bargaining Agreement Coverage for a Member and his/her Eligible Dependents will continue for as long as the Trust Fund is obligated to provide continued coverage of the kind provided under the Plan because of an agreement, statute, or order of a regulatory authority.

D. Family Medical Leave Act of 1993.

- (1) Any Member who is entitled to and takes a family or medical leave solely under the terms of the FMLA, along with the Member's Eligible Dependents, shall, at the option of the Member, as provided below, continue to be covered under this Plan while the Member is absent from work on an FMLA leave as if there were no interruption of active employment until the earlier of the expiration of such leave or the date the Member gives notice to the Employer that the Member does not intend to return to work at the end of the FMLA leave. If coverage is maintained during the leave, the Member must continue to make any required contributions, as specified below.
- (2) Continued active participation in this Plan while a Member is on an FMLA leave shall be at the option of the Member; continued coverage is subject to the Member's continuing to make any required contributions, as provided below. If the Member chooses not to participate while on an FMLA leave, but subsequently returns to active working status upon or before the expiration of the leave, the Member and all Eligible Dependents shall immediately become covered under the Plan without being required to give evidence of insurability, and the provisions for excluding benefits for preexisting conditions shall not apply to any medical condition of the Member or Eligible Dependents that has arisen during the FMLA.
- (3) While a Member is on an FMLA leave, the Employer shall continue to make the same contributions to this Plan on behalf of the Member and his or her

covered Eligible Dependents that it would have made had the Member not taken such leave of absence. The Employer shall continue to do so until the earlier of the date that (i) the Member fails to return to work on expiration of the FMLA leave, or (ii) the Member voluntarily gives notice of his or her intent to terminate his or her employment. For these purposes, a Member is considered to "terminate his or her employment" when the Member gives oral or written notice of his or her intent not to return to work due to reasons within the Member's control either to his immediate supervisor or to the Human Resources Department, and other forms of notice (such as word-of-mouth) shall not be effective.

If the Member voluntarily terminates his or her employment due to reasons within his control at or before the end of the FMLA leave, the Employer shall have the right to be reimbursed by the Member for any and all contributions the Employer has made on behalf of the Member and the Member's covered Eligible Dependents during the leave.

Regardless of whether or not the Member returns from an FMLA leave, the Employer shall be entitled to recover from the Member any required Member contributions the Employer has made on behalf of the Member and his Eligible Dependents during an unpaid FMLA leave to ensure continuity of coverage.

The Member's Employer may not recover any of its regular Employer contributions made on behalf of the Member for the time the Member has been on an FMLA leave if the Member's failure to return to employment at the expiration or exhaustion of such leave is due to (i) the continuation, recurrence, or onset of a serious health condition that would entitle the Member to an FMLA leave; or (ii) other circumstances beyond the Member's control. Situations "beyond the Member's control" include (but are not limited to) unexpected transfer of the Member's spouse to a job location that is more than 75 miles from the Member's work site; a relative or Member other than an immediate family member has a serious health condition and the Member is needed to provide care; the Member is laid off while on leave; or the Member is a "Key Member" who decides not to return to work after being notified of the Employer's intention to deny restoration of such Member to his former position (or the equivalent) because of substantial economic injury to the Employer. For this purpose, a "Key Member" is a salaried FMLA-eligible Member who is among the highest paid 10% of all the Members-both salaried and nonsalaried, regardless of eligibility for participation in this Plan-employed by the Employer within 75 miles of the Member's work site. However, a situation is not considered to be "beyond the Member's control" if the Member fails to return to work following an FMLA leave because the Member desires to remain with a parent in a distant city even though the parent no longer requires the Member's care, or the Member-parent decides to remain at home with a newborn or newly-adopted child, or other newly-acquired Eligible Dependent.

- (4) As soon as administratively feasible after a Member qualifies for an FMLA leave, the Plan Administrator shall give the Member the opportunity to choose in writing between continued coverage during the leave of absence, or of suspending coverage for the leave's duration. If the Member chooses ongoing coverage, the Member must continue to make the same premium payments or contributions that he was making immediately before the leave took effect. The written election form given to the Member must reflect that if the Member elects to continue active participation, he will be able to make these payments in any combination of the following methods as permitted by Employer:
- (a) Advance withholding from the Member's last paycheck before any unpaid FMLA leave takes effect;
 - (b) Withholding from any salary continuation check for a paid leave of absence that is considered as part of the Member's FMLA leave;
 - (c) Monthly payment by the Member to the Employer from the Member's own funds either at the same time as it would be made if by payroll deduction or on the same schedule as payments are made for COBRA continuation coverage;
 - (d) Payment through any cafeteria plan under Code Section 125 if such plan so permits; or
 - (e) By any other method acceptable to the Employer, including (where the leave is foreseeable) increased withholding from one or more of the Member's regular paychecks preceding the leave to pay in advance the required premiums during the leave.

The Employer's obligation to provide ongoing coverage under this Plan for a Member on FMLA ceases if the Member is more than thirty (30) days late on making a required minimum payment, provided, however, that (i) the Employer may at its option cover a Member's missed payments so that coverage will be uninterrupted, and (ii) the Employer gives the Member thirty (30) days of advance notice.

E. Continuation Coverage for Members in the Uniformed Services. For purposes of this Article XIV, a Member who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services experiences a qualifying event as of the first day of the Member's absence for such duty. Such a Member and any of the Member's covered Eligible Dependents shall be treated as any other Qualified Beneficiary under Section F for all purposes of COBRA. However, to the extent that the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides greater continuing coverage rights, the provisions of USERRA will apply. The Plan Administrator shall furnish the Member and the Member's covered Eligible Dependents a notice of the right to elect COBRA continuation coverage (as provided below) and shall afford the Member the opportunity to elect such coverage. However, the maximum period of coverage available to the Member and the Member's Eligible Dependents under USERRA is the lesser of (a) 24 months beginning on the date of the Member's absence or (b) the day after the date on which the Member fails to

apply for or return to active employment from active duty under USERRA with the Employer. If the leave is less than thirty (30) days, the contribution rate will be the same as for active Members. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

F. Consolidated Omnibus Budget Reconciliation Act (COBRA). During any Plan Year during which the Employer has more than 20 Members (as defined under COBRA for this purpose), each person who is a Qualified Beneficiary shall have the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage under the Plan. Such extended coverage under the Plan is known as “continuation coverage.”

What is COBRA continuation coverage? COBRA continuation coverage is group health insurance coverage that an employer must offer to certain Plan participants and their eligible family members (called “Qualified Beneficiaries”) at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer’s Plan (the “Qualifying Event”). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Members who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (1) Any Member who, on the day before a Qualifying Event, is covered under a Plan, the Spouse of a covered Member, or an Eligible Dependent child of a covered Member. If, however, a Member is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Member will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Member experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Member during a period of COBRA continuation coverage. If, however, a Member is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Member will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Member experiences a Qualifying Event.
- (3) A covered Member who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the spouse, surviving spouse or Eligible Dependent child of such a covered Member if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or Eligible Dependent child was a beneficiary under the Plan.

The term “covered Member” includes not only common-law Members (whether part-time or full-time) but also any Member who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed Members, independent contractor, or corporate director).

A Member is not a Qualified Beneficiary if the Member's status as a covered Member is attributable to a period in which the Member was a nonresident alien who received from the Member's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, a Member is not a qualified beneficiary, then a spouse or Eligible Dependent child of the Member is not considered a Qualified Beneficiary by virtue of the relationship to the Member.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Member during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provides that the Qualified Beneficiary would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Member.
- (2) The termination (other than by reason of the Member's gross misconduct), or reduction of hours, of a covered Member's employment.
- (3) The divorce or legal separation of a covered Member from the Member's spouse.
- (4) A covered Member's entitlement to Medicare.
- (5) An Eligible Dependent child's ceasing to satisfy the Plan's requirements for an Eligible Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Member retired at any time.

If the Qualifying Event causes the covered Member, or the spouse or an Eligible Dependent child of the covered Member, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a Member does not return to employment at the end of the FMLA

leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Member portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Member or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Member or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (1) An Eligible Dependent child's ceasing to be an Eligible Dependent child under the generally applicable requirements of the Plan.
- (2) The divorce or legal separation of the covered Member.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at

least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Member.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary is entitled to Medicare benefits (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim. In the case of a Member who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Member's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the Member who is not a Qualified Beneficiary.

What is the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18

months after the Qualifying Event if there is no disability extension and 29 months after the Qualifying Event if there is a disability extension.

- (2) In the case of a covered Member's entitlement in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Member ends on the later of:
 - (a) 36 months after the date the covered Member becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Member's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Member ends on the date of the retired covered Member's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Eligible Dependent child of the retired covered Member ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Member.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, your spouse, surviving spouse or Eligible Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension is available to the spouse and any Eligible Dependent children receiving continuation coverage if the Member or former Member dies, or gets divorced or legally separated, or if the Eligible Dependent child stops being eligible under the Plan as an Eligible Dependent child but only if the event would have caused the spouse or Eligible Dependent children to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, the Qualified Beneficiary must notify the Plan Administrator of the second Qualifying Event with 60 days of the Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted in connection with the Qualifying Event that is a termination or reduction of hours of a covered Member's employment, if a Qualified Beneficiary (whether

or not a covered Member) is determined under Title II or XVI of the Social Security Act to have been disabled at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage period.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. The Plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Members or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under the Plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Certificates of Coverage. The Plan will provide Covered Persons with an automatic Certificate of Coverage in cases where they lose coverage under this Plan and are entitled to elect Continuation Coverage. Such Certificates will be provided within the following time frames:

- (1) For a Member who is a Qualified Beneficiary entitled to elect Continuation Coverage, no later than when a notice is required to be provided for a Qualifying Event.
- (2) For a Covered Person who is not a Qualified Beneficiary entitled to elect Continuation Coverage, within a reasonable time after coverage ceases.
- (3) For an Covered Person who is a Qualified Beneficiary and who has elected Continuation Coverage, within a reasonable time after cessation of Continuation Coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

XV. PRESCRIPTION DRUG COVERAGE AND MEDICARE

Covered Persons who are entitled to (covered by) Medicare are also entitled to enroll in a Medicare prescription drug plan. Medicare drug plans are designed to help cover the cost of prescriptions for those who do not have prescription coverage available under another plan.

“Creditable prescription drug coverage” for the purposes of Medicare means coverage at least as good as the minimum coverage available under Medicare. Knowing whether or not this Plan provides credible prescription drug coverage is important because it affects how much you will pay if you enroll in a Medicare drug plan. Here’s how it works:

- If you have credible prescription drug coverage and later lose your coverage, you may enroll in a Medicare drug plan without paying a permanent premium penalty as long as you enroll within 63 days of the date you lose your other coverage. The 63-day period is called your Special Enrollment Period.
- If your coverage is not credible coverage, or if you have no prescription drug coverage, and you do not enroll in a Medicare drug plan when you are first eligible or during your Special Enrollment Period, your premium for the Medicare drug plan may be permanently increased for every month that you wait to enroll.

The premium penalty that you would pay for enrolling late is 1% for each month late. For example, if you enroll 19 months after your initial eligibility period or Special Enrollment Period expires, you will pay 19% more every month for your coverage than if you had enrolled on time.

Every year the Plan Sponsor will send a notice about Medicare drug coverage to all Covered Persons. This notice will include information about whether the prescription drug coverage under this Plan is credible or not, and how enrolling in a Medicare plan would affect your coverage under this Plan. Be sure to save the notice because you may need it to show whether this Plan provided credible coverage if you want to enroll in a Medicare drug plan.

XVI. HIPAA PRIVACY AND SECURITY PROVISIONS

There are three circumstances under which the Plan may disclose an individual's protected health information to the Board of Trustees of the Fund ("Plan Sponsor").

First, the Plan may inform the Plan Sponsor whether an individual is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the individual.

Third, the Plan may disclose an individual's protected health information to the Plan Sponsor for Plan administrative purposes. This is because Members of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan. The Plan Sponsor has certified to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose an individual's protected health information to the Plan Sponsor as described in this summary. Here are the restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information.

- The Plan Sponsor will only use or disclose an individual's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information as required by the HIPAA regulations.
- The Plan Sponsor will not use or disclose an individual's protected health information for employment related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.
- The Plan Sponsor will promptly report to the Plan any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- The Plan Sponsor will allow an individual or the Plan to inspect and copy any protected health information about the individual that is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the Plan must follow in this regard. There are some exceptions.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.
- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2004). An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.
- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of an individual's protected health information available to the Plan and to the U.S. Department of Health and Human Services.
- The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business Employee when the Plan Sponsor no longer needs an individual's protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information for the purposes set forth above:

Trustees of the Plan
 Executive Director
 Administrative Assistant to
 Executive Director

This list includes every class of Employees or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these Employees or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the Employees or workforce members will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to an individual.

Security Provisions

The Plan Sponsor will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the Plan that it agrees to:

- Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;
- Require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;
- Report to the Plan any security incident that the Plan Sponsor becomes aware of;
- Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

XVII. SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Covered Person or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").
2. Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized.
2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all

damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person fails to file a claim or pursue damages against:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) worker's compensation or other liability insurance company; or,
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

D. Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

E. Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. Wrongful Death

In the event that the Covered Person dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
 3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person's cooperation or adherence to these terms.

H. Offset

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

I. Minor Status

1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

K. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

XVIII. AMENDMENT AND TERMINATION OF PLAN

A. Amendment. The Trust Fund has the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice.

Any such amendment will be by a written resolution signed by the Trust Fund, and will become effective as of the date specified in the enabling resolution.

The Trust Fund will notify all Covered Persons of any amendment modifying the material terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications (within the meaning of ERISA § 102(a)(1) and Labor Reg. § 2520.104b-3) unless incorporated in an updated Summary Plan Description (as described in ERISA § 102(b)).

Notwithstanding the above, to the extent the material change is a material reduction in covered services or benefits (as defined in Labor Reg. §2520.104b-3(d)(3)), such Summary of Material Modifications shall be distributed within 60 days of the date of adoption of such change.

B. Termination of Plan. Regardless of any other provision of this Plan, the Trust Fund reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Trust Fund.

The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.

C. Termination by Dissolution, Insolvency, Bankruptcy, Merger, etc. This Plan will automatically terminate if the Trust Fund (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Trust Fund's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

D. Adoption By Additional Employers: Any additional organization that is a controlled group Member of the Trust Fund within the meaning of Internal Revenue Code Sections 414 (b), (c) or (m) may adopt this Plan by a resolution of its Board of Trustees in other governing body, as well as by executing an amendment to this Plan indicating the fact of the adoption.

XIX. GENERAL PROVISIONS

A. Funding. All benefits paid under this Plan shall be paid in cash from the general assets of the Trust Fund. No Member shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Trust Fund may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Trust Fund and a Member or any other person. Neither a Member nor a beneficiary of a Member shall acquire any interest greater than that of an unsecured creditor.

B. In General. Any and all rights accruing to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Trust Fund and any Covered Person, nor shall it be consideration or an inducement for the initial or continued employment of any Member. Likewise, maintenance of this Plan shall not be construed to give any Member the right to be retained as a Member by each Employer or the right to any benefits not specifically provided by the Plan.

C. Waiver and Estoppel. No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Member or eligible Beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Effect on Other Benefit Plans. Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a qualified pension plan maintained by the Trust Fund. The treatment of the amounts paid under this Plan under any other Member's benefit plans shall be determined under the provisions of the applicable Member's benefit plan.

E. Nonvested Benefits. Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Member or Eligible Dependent except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred.

F. Interests not Transferable. The interests of the Member and their Eligible Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered without the written consent of the Plan Administrator.

G. Severability. If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Trust Fund shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

H. Headings. All Article and Section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

I. Applicable Law. This Plan shall be governed and construed in accordance with ERISA.

XX. CLAIMS PROCEDURE AND STATEMENT OF RIGHTS

A. Claims Procedures

How an individual files a claim for benefits depends on the type of claim it is. There are several categories of benefits:

- (1) **Concurrent Care Claim**—A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.
- (2) **Pre-Service Care Claim**—A pre-service claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.
- (3) **Post-Service Care Claim**—A post-service claim is a claim for a benefit under the Plan that is not a pre-service claim.
- (4) **Urgent Care Claim**—An Urgent Care Claim is a 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.

An individual may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, himself or herself, by his or her authorized representative, or by his or her health care service provider. Any of these types of claims must be filed using a written form supplied by the Claims Administrator and must be submitted by U.S. Mail, by hand delivery, electronically or by facsimile (FAX).

If an individual’s claim involves urgent care, an individual may initiate a claim for urgent care benefits himself or herself if he or she is able, or his or her treating Physician may file the claim for him or her. The claim must be made by U.S. Mail, by hand delivery or by FAX.

An individual may file any claim himself or herself, or he or she may designate another person as his or her “authorized representative” by notifying the Claims Administrator in writing of his or her designation. In that case, all subsequent notices will be provided to the individual through his or her authorized representative and decisions concerning that claim will be provided through his or her authorized representative.

The Claims Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing. An individual must submit a claim for benefits within one year after the date of service.

The completed form (and all invoices pertaining to services received if applicable) must be sent within one year after the date of service to the Claims Administrator/Prescription Benefit Manager at the following address:

Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
www.healthplansinc.com

If a non-Network provider submits a claim on an individual's behalf, the individual will be responsible for the timeliness of the submission. If the individual does not provide this information to the Claims Administrator within one year of the date of service, benefits for that health service will be denied or reduced, in the Plan Administrator's discretion. However, when a Covered Person's coverage terminates for any reason, written proof of loss must be given to the Plan Administrator within ninety (90) days of the date of termination of coverage, provided that this Plan remains in force. This time limit does not apply if the individual is legally incapacitated. If an individual's claim relates to an Inpatient stay, the date of service is the date the individual's Inpatient stay ends.

If an individual provides written authorization to allow direct payment to a provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to the individual. We will not reimburse third parties who have purchased or been assigned benefits by physicians or other providers.

The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim. The Plan Administrator has delegated the administration of claims processing under the Plan to the Claims Administrator. In making benefit determinations, the Plan Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims. In any case, an individual will receive only those benefits under the Plan that the Plan Administrator in its sole discretion determines he or she is entitled to receive.

If the individual's claim involves urgent care, the individual or his or her authorized representative will be notified of the Plan's initial decision on the claim whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, an individual or his or her representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. An individual will have at least 48 hours to respond to this request. The Claims Administrator then must inform him or her of its decision within 48 hours of receiving the additional information.

If an individual's claim is one involving concurrent care, the Claims Administrator will notify the individual of its decision, whether adverse or not, within 24 hours after receiving the claim. The individual will be given time to provide any additional information required to reach a decision.

If the individual's claim is for a pre-service authorization, the Claims Administrator will notify him or her of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. An individual will have at least 45 days to provide any additional information requested of the individual by the Claims Administrator.

If the individual has filed a post-service claim for reimbursement of medical care services that already have been rendered, the Covered Person will be notified of the Claims Administrator's decision on the individual's claim only if it is denied in whole or in part. This notification will be issued no more than 30 days after the Claims Administrator receives the claim. The Claims Administrator may extend this 30-day period once for up to 15 days if the extension is required due to matters beyond the Claims Administrator's control. An individual will have at least 45 days to provide any additional information requested of the individual by the Claims Administrator, if the need for the extension is due to the Claim Administrator's need for additional information from the individual or his or her health care providers.

The individual has 180 days after the receipt of a denial notice to request an appeal. His or her appeal must be in writing unless his or her claim involves urgent care, in which case the request may be made orally. His or her written appeal must contain the following information (where applicable):

- (1) The patient's name.
- (2) The patient's contract number.
- (3) Sufficient information to reasonably identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known), and claim number (if available).
- (4) A statement that the individual is filing an appeal.

The appeal must be sent to:

Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
www.healthplansinc.com

In connection with his or her right to appeal the Claim Administrator's initial determination regarding his or her claim, the individual also:

- (1) May review pertinent documents and submit issues and comments in writing.
- (2) Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to his or her appeal.

- (3) Will, at the individual's request and free of charge, have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal.
- (4) Be given a review that takes into account all comments, documents, records, and other information submitted by the individual relating to the appeal regardless of whether such information was submitted or considered in the initial benefit determination.
- (5) Are entitled to have his or her appeal reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment; this person may not have participated in the initial denial.

The Claims Administrator must issue a review decision on his or her appeal according to the following timetable:

- (1) Urgent Care Claims—not later than 72 hours after receiving his or her request for an appeal.
- (2) Pre-Service Claims—not later than 30 days after receiving his or her request for an appeal.
- (3) Post-Service Claims—not later than 60 days after receiving his or her request for an appeal. The Claims Administrator then has 60 days to act on his or her request for an appeal.

Voluntary Final Appeals Procedure

After following the first two levels of appeal, you may appeal the denial of any Fund benefit to the Board of Trustees. Your written appeal should state the reasons for your appeal and must be filed within 180 days after the receipt of the notice of denial. This does not mean that you are required to cite all applicable Plan provisions to make “legal” arguments; however, you should state clearly why you believe you are entitled to the benefit claim or why you disagree with the denial. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

The Board of Trustees will review your appeal and make a benefit determination no later than the date of the Board of Trustees meeting that immediately follows their receipt of your appeal, unless the appeal is filed within 30 days preceding the date of that meeting. In that case, a decision on your appeal will be made at the second meeting of the Board of Trustees immediately following the receipt of the appeal, unless special circumstances require more time to review your appeal. If the Board of Trustees needs more time, you will be provided with written notification of the extension, and a decision on your appeal will be made no later than the third meeting of the Board of Trustees immediately following the receipt of the appeal.

In reviewing your appeal, the Board of Trustees will take into account all comments, documents, records and other information you submit, without regard to whether such

information was considered in the initial determination. However, the Board of Trustees will not take into account the reason why your benefit application was initially denied.

If your application was denied in whole or in part on the basis of medical judgment, the Board of Trustees will consult with a health care professional with appropriate medical training and experience to review the benefit determination. This health care professional will not be the same individual who may have been consulted in connection with the initial medical claim, nor will it be a subordinate of that health care professional. If your disability appeal is denied, you will be provided the identification of the professional. Furthermore, you will be informed of any internal rule, guideline, procedure, protocol or other similar criterion that was relied upon in making the adverse determination, and a copy of the rule, guideline or procedure will be provided to you free of charge upon request. You will be notified within five days after the Board of Trustees rules on your appeal. The decision of the Board of Trustees shall be final and binding on all concerned.

If the Board of Trustees denies your appeal, in whole or in part, the written notice will explain the specific reasons for the decision, will include specific references to Plan provisions on which the decision was based, and may indicate if additional information might help your claim. The notice will include a statement of your right to review documents and other information related to your claim in the Fund Office after making appropriate arrangements, or receive copies of such documents or information free of charge. Finally, the written notice will also include a statement regarding your right to bring a civil action under ERISA Section 502. You and your plan may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency.

B. Statement of Rights

As a participant in this Plan, you are entitled to certain rights and protection under the Member Retirement Income Security Act of 1974. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and update Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for himself or herself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if the individual has Creditable Coverage from another plan. The individual should be provided a certificate of Creditable Coverage, free of charge, from the Plan when the individual loses coverage under the Plan, when the individual becomes entitled to elect COBRA continuation coverage, when his or her COBRA continuation coverage ceases, if the individual requests it before losing coverage, or if the individual requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, the individual may be subject to a preexisting condition exclusion for 12 months (18 months for Late Enrollees) after the individual's enrollment date in his or her coverage under the Plan.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate his or her plan – called “fiduciaries” of the Plan - have a duty to do so prudently and in the interest of the individual and other plan participants and beneficiaries. No one, including his or her employer, his or her union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan or exercising his or her rights under ERISA.

If his or her claim for a benefit under this Plan is denied in whole or in part the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim. Under ERISA, there are steps the individual can take to enforce the above rights. For instance, if the individual requests materials from the Plan and does not receive them within 30 days, the individual may file suit in a federal court. In such a case, the court may require the Claims Administrator to provide the materials and pay the individual up to \$110 a day until the individual receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may file suit in a state or federal court. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

If the individual has any questions about this Plan, the individual should contact the Claims Administrator. If the individual has any questions about this statement or about his or her rights under ERISA, the individual should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his or her telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

IN WITNESS WHEREOF, the Trust Fund has caused this Plan to be executed by its duly authorized representative.

**Health & Welfare Trust Fund of the
International Union of Operating Engineers
(Local 877)**

Date

By: _____
Authorized Signature

Print Name

Title