HEALTH AND WELFARE TRUST FUND OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 877 & 70 (Allina)

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective: November 1, 1990
Restated as of: July 1, 2011

Group No: AC3

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 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 that 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 VIII.

Operating Engineers (Allina)

_____

Member Name (Please Print)

_____

Member Signature

_____

Date

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I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 & 70 (hereinafter the "Trust Fund") on this 1st day of July, 2011 restates the International Union of Operating Engineers Trust Fund (Allina) Medical Plan effective as of July 1, 2011.

A. Establishment of Plan. The Trust Fund hereby restates its group health plan known as the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 & 70 (Allina) 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. 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 July 1, 2011.

C. Applicable Law. This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

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.

The Plan Sponsor believes that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered means the plan may not include certain consumer protections of the Act that apply to other plans, such as providing preventive health services without any cost sharing. However, a grandfathered plan must comply with certain other consumer protections of the Act, such as the elimination of annual and lifetime limits on most benefits.

Questions about which protections do or do not apply, and what causes a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

Health & Welfare Trust Fund of the International Union
of the Operating Engineers Local 877 & 70
89 Access Road, Unit 4
Norwood, MA 02062-5233
(781) 769-5789

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a summary of the protections which do and do not apply to grandfathered health plans.

II. GENERAL INFORMATION

Plan Name:	Health & Welfare Trust Fund of the International Union of the Operating Engineers Local 877 & 70 Plan
Type of Plan:	Health & Welfare Plan providing medical and prescription drug benefits on a self-funded basis
Effective Date:	November 1, 1990, restated as of July 1, 2011
Plan Administrator and Plan Sponsor:	Health & Welfare Trust Fund of the International Union of the Operating Engineers Local 877 & 70 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:	001AC3
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (800) 532-7575
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 (866) 814-1751
Agent for Service of Legal Process:	Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 & 70 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 or Retiree contributions, and any income earned from investment of Employer and Member or Retiree contributions. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or Member/Retiree organization contributes to the Fund, and if so, the Employer or Member/Retiree organization's address. Members or Retirees may also receive, upon written request, a complete list of Employers and Member/Retiree 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 Members or Retirees and their dependents, and for paying all expenses incurred with respect to operating the Plan.

Plan Year Ends:	October 31st
Fiscal 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 in which you terminate employment or otherwise lose eligibility for coverage, 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. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to your or your dependents' coverage under the Plan, or b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, you may be responsible for any benefit payments made during the relevant period. For any rescissions (retroactive termination of coverage that is related to fraud or intentional misrepresentation) the Plan Administrator will provide thirty (30) days advance written notice and you will have the right to appeal the Plan's termination of 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.

Actively at Work – 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 day off 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.

Birthing Center – a facility 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 – 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 or Retirees Creditable Coverage.

Coinsurance – the percentage of coverage provided by the Plan, after the Covered Person has paid any applicable Deductible or Co-payment. For example, if Coinsurance is 80%, the Plan pays 80% and the Covered Person pays 20%, after any applicable Deductible or Co-payment.

Co-payment – a fixed dollar amount a Covered Person pays for a covered service before any applicable Deductible or Coinsurance amount is applied.

Covered Person – a Member, Retiree, or Dependent eligible for benefits and enrolled under this Plan.

Creditable Coverage – coverage a Member or Retiree 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 Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

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 provider by whom or by which they are prescribed, recommended or performed.

Deductible – the amount payable by a Covered Person for services before the Plan's share of the cost is determined.

Eligible Dependent –:

(1) A Member's or Retiree's* opposite-sex lawful spouse.

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

Spouses who become divorced or legally separated on or after October 1, 2010 for whom the court-ordered terms of the divorce or legal separation requires the Member to provide health coverage remains eligible for coverage until the earliest of:

(i) The remarriage of the spouse;
(ii) The remarriage of the Member or Retiree*;
(iii) The court-ordered termination date of coverage; or
(iv) The date the Member or Retiree* ceases to be a Covered Person

(2) A Member's or Retiree's* child under age 26, unless the child is eligible to enroll in another employer-sponsored group health plan, other than the group health plan of either parent.

(3) A Member's or Retiree's* unmarried child age 26 or older who is Permanently and Totally Disabled, whose disability began before age 26, and for whom the Member or Retiree submits proof of Permanent and Total Disability when requested at reasonable intervals.

For purposes of this definition, "Permanently and Totally Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death. Proof of Permanent and Total Disability must be certified by the child's Physician.

For the purposes of this section, "Member's or Retiree's* child" means a:

1. Natural child of the Member or Retiree*;
2. Stepchild by marriage;
3. Child under age 18 who has been legally adopted by the Member or placed with the Member for adoption by a court of competent jurisdiction (as detailed below);
4. Child for whom legal guardianship has been awarded to the Member or spouse; or
5. Child who is the subject of a Qualified Medical Child Support Order (as detailed below).

(a) *Eligibility Due to Adoption or Placement for Adoption*. Children placed for adoption with an enrolled Member are 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.

The terms "placement" or "being placed" for adoption 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 the adoption. 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. Upon termination of placement for adoption, the child's coverage terminates 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.

(b) *Eligibility Due to a Qualified Medical Child Support Order*. Certain Eligible Dependents will 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" means any child of an enrolled Member who is recognized under a Qualified Medical Child Support Order as having a right to enroll under the Plan with respect to such Covered Person.

*A Retiree's Eligible Dependents are limited to the Retiree's spouse and dependent children, if any, as of the Retiree's initial retirement date. A Retiree's spouse or dependent child who is eligible for Medicare is not eligible for coverage under this Plan.

Members or Retirees are obligated to inform the Plan Administrator of any change in a dependent's eligibility status within 30 days of such change. In the event that an ineligible dependent is found to have received benefits under this Plan, the Member or Retiree will be responsible for any benefit payments made on that dependent's behalf.

Emergency Care – care administered in a Hospital, clinic, or Physician's office for a Medical Emergency. Emergency Care does not include ambulance service to the facility where treatment is received.

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 Employee Retirement Income Security Act of 1974 as amended from time to time.

Expense Incurred Date – for the purposes of this Plan, the date a service or supply to which it relates is provided.

Experimental/Investigational – 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, or

(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 requires review and approval by the treating facility's institutional review board or other body serving a similar function, or federal law requires such review or approval, or

(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, except for drugs, devices, medical treatments, technology, procedures or supplies that would otherwise be covered under this Plan if they are provided to a Covered Person enrolled in a clinical trial, are consistent with that standard of care for someone with the patient's diagnosis, are consistent with the study protocol for the clinical trial and would be covered if the patient did not participate in the clinical trial; or

(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 – the Family and Medical Leave Act of 1993, as amended from time to time.

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

Home Health/Hospice Agency – 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 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 – a prearranged, written outline of care for the palliation and management of a Covered Person's terminal Illness.

Hospital – a licensed facility which:

(1) Furnishes room and board;

(2) Is primarily engaged in providing, 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) Regularly and continuously provides day and night nursing service by or under the supervision of a Physician;

(4) Is not, other than incidentally, a place for the aged or a nursing or convalescent home; and

(5) Is operated in accordance with the laws of the jurisdiction in which it is located pertaining to facilities identified as Hospitals.

The term "Hospital" will include a facility 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.

Illness – a sickness or bodily disorder or disease, or mental health 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, miscarriage, abortion (elective or life-threatening) and any complications of pregnancy and related medical conditions.

Infertility – the condition of a presumably healthy individual who is unable to conceive or produce conception.

Injury – a sudden event from an external agent resulting in damage to the physical structure of the body independent of Illness, and all complications arising from such external agent.

In-Network Provider – a member of a network of Physicians, other licensed health care providers and/or health care facilities which provide medical services to Covered Persons under this Plan on the basis of a negotiated fee schedule amount. A Covered Person receiving covered services from an In-Network Provider is not responsible for any charges other than the cost sharing requirements (Deductibles, Coinsurance and/or Co-payments) and charges in excess of any specific benefit limits shown in the Schedule of Medical Benefits.

Inpatient Hospice Facility – a licensed facility which may or may not be part of a Hospital and which:

(1) Complies with licensing and other legal requirements in the jurisdiction where it is located;

(2) 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) Provides pre-death and bereavement counseling;

(4) Maintains clinical records on all terminally ill persons; and

(5) Is not mainly a place for the aged or a nursing or convalescent home.

Inpatient Hospice Facility also includes hospice facilities approved for a payment of Medicare hospice benefits.

Intensive Outpatient Treatment - – mental health or substance abuse care on an individual or group basis two (2) to five (5) days per week for two (2) to three (3) hours per day in a licensed hospital, rural health center, community mental health center or substance abuse treatment facility.

Late Enrollee – 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.

Medical Emergency – The sudden onset of a medical condition of sufficient severity that an individual possessing an average knowledge of health and medicine could reasonably expect that failure to obtain medical treatment would seriously jeopardize the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child); or cause serious harm to bodily functions or any bodily organ or part. Examples of medical emergencies include symptoms of heart attack and stroke; poisoning; loss of consciousness; severe difficulty breathing or shortness of breath; shock; convulsions; uncontrolled or severe bleeding; sudden and/or severe pain; coughing or vomiting blood; sudden dizziness or severe weakness; profound change in vision; severe or persistent vomiting or diarrhea; and profound change in mental status.

Medically Necessary (or Medical Necessity) – a service or supply which is a health care service that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that is:

(1) Legal and is provided in accordance with generally accepted standards of medical practice

(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;

(3) Not Experimental or Investigational; and

(4) Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

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

Member – any individual who is considered to be in an employer-Member relationship with an Employer for purposes of federal withholding taxes.

Mental Health Disorder – manic depression, neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity – as determined by a Covered Person's Physician, a Body Mass Index (BMI) greater than 40, or, in combination with significant medical co-morbidities, greater than 35.

Nurse – a professional nurse who has a current active licenses as a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Registered Nurse Midwife (R.N.M.), other than a nurse who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

Occupational Therapist – a health care provider who is licensed to provide occupational therapy services and who provides such services in the state(s) which issued the license(s).

Out-of-Pocket Maximum – the maximum amount a Covered Person pays for covered services under this Plan before the Plan pays at 100% as specified on the Schedule of Medical Benefits.

Out-of-Network Provider – a licensed Physician, other licensed health care provider and/or health care facility which is not a member of a network of participating providers which provide medical services to Covered Persons under this Plan on the basis of a negotiated fee schedule arrangement with this Plan. Covered Persons receiving covered services from an Out-of-Network Provider are responsible for any applicable Deductibles, Coinsurance and/or Co-payments, amounts in excess of any specific benefit limits shown in the Schedule of Medical Benefits for Out-of-Network Providers, and any amounts in excess of the Reasonable and Customary Charge for the services received, unless specifically stated otherwise in this Plan.

Partial Hospitalization – mental health or substance abuse care on an individual or group basis five (5) days a week, eight (8) hours per day in a licensed hospital, rural health center, community mental health center or substance abuse treatment facility.

Physical Therapist – a health care provider who is licensed to provide physical therapy services and who provides such services in the state(s) which issued the license(s)..

Physician – 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., 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.

Plan Year – the twelve-month period ending on the date shown in the General Information section.

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

Qualified Medical Child Support Order – A court order that meets the requirements of ERISA and provides for coverage of a child under a group health plan. An Eligible Dependent child enrolled under a QMCSO is subject to the same terms and limitations of other Covered Persons under this Plan.

Reasonable and Customary Charges – those fees for covered services that fall within the range of usual fees for comparable services charged by a medical or dental professional in a given geographic area. Reasonable and Customary Charges are based on data from a national database of medical and dental charges which is periodically updated.

Rehabilitation Hospital – a licensed facility or Hospital which is accredited by the Joint Commission on Accreditation of Health Care Organizations and the Commission of Accreditation of Rehabilitation Facilities.

Retiree – A former Member who was employed by a Contributing Employer, under the jurisdiction of Local 877, who has signed an Agreement with the Fund to participate in the Retiree Program and retires on or after January 1, 2007, but before August 1, 2009, **and** satisfies all the following conditions by that retirement date:

(a) Is covered under the Fund's plan on his or her retirement date, and has been continuously covered for at least the preceding five (5) years;

(b) Is age fifty-five (55) if hire date is prior to January 1, 1986; or is age fifty-five (55) or older if hire date is after January 1, 1986;

(c) Has a combined total of age plus years of service with Contributing Employer(s) that equals at least sixty-five (65) if hire date is prior to January 1, 1986; or seventy-five (75) if hire date is after January 1, 1986, as of the date he or she retires;

(d) Is not yet eligible for Medicare;

(e) Has been employed continuously by the same Contributing Employer since most recent date of hire, or employed continuously at the same work site as an active member of a Local Union, or employed continuously with a Contributing Employer; and

(f) The Contributing Employer(s) have been contributing to the Fund during the five (5) years preceding the retirement date.

A former Member who retires on and after August 1, 2009 who satisfies all the requirements of (a) through (f) above and who submits an application for enrollment (on forms furnished by and delivered to the Plan Administrator) within thirty-one (31) days of the retirement date is eligible to participate.

Note: A Retiree may enroll more than thirty-one (31) days after his or her retirement date, providing the Contributing Employer retroactively pays all Employer and Retiree contributions due since the original retirement date.

Routine Nursery Care – routine room and board or nursery charges, Physician's or surgeon's charges, and any other related charges (including charges for circumcision) for a newborn child 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 – 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 – a period of at least 63 consecutive days during all of which a Member, Retiree, or Eligible Dependent did not have any Creditable Coverage, not including waiting periods or affiliation periods.

Skilled Nursing Facility – a licensed facility 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 Nurse. Full-time supervision means a Physician or Registered 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.

Speech Therapist – a health care provider who is licensed to provide speech therapy services and who provides such services in the state(s) which issued the license(s).

Special Enrollee – a Member or his or her Eligible Dependents who satisfy the requirements of Article VII(B) for special enrollment under the Plan.

Total Disability or Totally Disabled – 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.

Transplant Benefit Period – 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 877 & 70.

Uniformed Service – 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 – the period of time a Member must be employed by the Employer before becoming eligible to participate in this Plan.

Well Child Care – treatment that is provided in accordance with the standards and frequencies recommended by the United States Preventive Services Task Force. Coverage includes, but is not limited to; physical examinations, history, sensory screening, developmental screening and appropriate immunizations.

IV. SCHEDULE OF MEDICAL BENEFITS

This Section contains a summary of the benefits made available under the Plan, as well as important information about how this Plan works. Please also refer to the section titled Medical Benefits for additional information about the benefits coverage and limitations under this Plan.

Precertification

Precertification is a process through which a Covered Person receives confirmation that benefits are payable under this Plan based on the Medical Necessity of the treatment recommended by or received from a health care provider. Services which require precertification, regardless of whether the service is rendered inpatient, outpatient, or in an office setting, are identified on the following Schedule of Medical Benefits chart.

The Plan does not cover services that precertification determines in advance are not Medically Necessary. If precertification is required but is not obtained, the Plan may not cover services that are determined not to have been Medically Necessary after they have been provided. The Plan also reserves the right to deny coverage prospectively for any service that may not require precertification if it is determined not to be Medically Necessary.

IMPORTANT
Precertification for inpatient hospitalization is always required.

Preadmission/Precertification for Inpatient Hospitalizations

Call Care Management Services at (866) 325-1550 prior to receiving services shown as requiring precertification to confirm the Medical Necessity of the proposed services.

If a Covered Person is scheduled to be admitted to a Hospital, he or she must have the Hospitalization precertified by Care Management Services prior to the date of admission or within two business days of admission in the case of emergency admissions**. Failure to obtain the precertification for inpatient admissions will result in a reduction in benefits in the amount of fifteen percent (20%) per admission.** The reduction in benefits for inpatient services cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan.

The precertification requirement does not apply to maternity admissions unless it becomes apparent that the maternity admission will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. In such cases, the inpatient stay that extends beyond the applicable 48 or 96 hour period must be precertified.

Other services may also require Care Management Services precertification regardless of whether the service is rendered inpatient, outpatient or in an office setting. See individual benefits for those services requiring precertification. If precertification is required but is not obtained, coverage may not be available for services not determined to be Medically Necessary. The Plan also reserves the right to deny coverage prospectively for any service that may not require precertification but is determined in advance not to be medically necessary. Please call Health Plans, Inc. at (800) 532-7575 to verify benefits.

Pre-Authorization for Other Specific Treatments Required

In addition, treatment for In-patient Mental Health Conditions and Alcohol & Substance Abuse must be authorized by Modern Assistance Program (MAP). **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 20% per admission**. (Note: Outpatient Mental Health and Alcohol & Substance Abuse Treatment do not need to be precertified. However, those services performed at the Non-Network level that *are* precertified by MAP are payable at the In-Network level.)

Other services may also require Modern Assistance Program precertification regardless of whether the service is rendered inpatient, outpatient or in an office setting. See individual benefits for those services requiring precertification.

Pre-existing Condition Limitations

Because this Plan limits benefits for pre-existing conditions for Covered Persons who are enrolled at age 19 or older, the availability of coverage for pre-existing conditions should be also be confirmed before services are received. For questions regarding pre-existing conditions, contact the Claim Administrator, Health Plans, Inc., at 800-532-7575.

Other Questions Regarding Eligibility and Benefits

Please contact the Claims Administrator at 800-532-7575 if you have questions about Plan benefits or eligibility for covered dependents.

IMPORTANT: The Plan is not obligated to pay claims for Covered Persons who receive care determined not to be Medically Necessary or who fail to meet eligibility criteria for coverage.

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS		
Prescription Drug Expense & Mail Order Option **Note:** ***New England Mail Order must be used to obtain diabetic supplies***	**Retail Card Program – You Pay** (up to a 34 day supply) $10 Co-payment per generic drug; $15 Co-payment per brand name drug; **Mail Order Pharmacy – You Pay** (up to a 34-90 day supply) $20 Co-payment per generic drug; $30 Co-payment per preferred brand name drug;	
DEDUCTIBLES/COINSURANCE	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Calendar Year Deductible*	NONE per person NONE per family	$150 per person $450 per family
Reimbursement Percentage ("Coinsurance")	100% of the fee schedule amount (unless otherwise stated)	80% of the Reasonable and Customary Charge (after Deductible; unless otherwise stated) until the Out-of-Pocket Maximum has been reached, then 100% thereafter for the balance of the calendar year (unless otherwise stated)
Out-of-Pocket Maximums* (Including the calendar year Deductible)	NONE per person NONE per family	$1,150 per person $2,450 per family

***Note: The family Deductible amount and family Out-of-Pocket Maximum are/is satisfied by a combination of all family members.**

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

- All co-payments
- Precertification penalties

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

PREVENTIVE CARE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Physical Exams (Age 20 and older; Including routine and travel immunizations, and flu shots)	100%	80% Reasonable and Customary (after Deductible)
Routine Well Child Care (Birth to age 20; Including routine and travel immunizations, and flu shots)	100%	80% Reasonable and Customary (after Deductible)
Routine Immunizations (If not billed with an office visit; includes flu shots and travel immunizations)	100%	80% Reasonable and Customary (after Deductible)
Routine Lab, X-rays, and Clinical Tests	100%	80% Reasonable and Customary (after Deductible)
Routine Colorectal Cancer Screening including sigmoidoscopies and colonoscopies (Age 50 and older)	100%	80% Reasonable and Customary (after Deductible)
Routine Gynecological Exams	100% up to a maximum of one (1)* exam per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of one (1)* exam per person, per calendar year
Routine Pap Smears	100%	80% Reasonable and Customary (after Deductible)
Routine Mammograms (age 40 and older)	100% up to a maximum of one (1) exam per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of one (1) exam per person, per calendar year
One Baseline Mammogram (Between age 35 and 39)	100%	80% Reasonable and Customary (after Deductible)
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100%	80% Reasonable and Customary (after Deductible)
Bone Density Screening (for women)	100%	80% Reasonable and Customary (after Deductible)
VISION CARE	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Routine Vision Exam (***Includes*** contact lens fitting)	100% up to a maximum of one (1)* exam per person, per calendar year	100% (not subject to Reasonable and Customary Charges; Deductible waived) up to a maximum of one (1)* exam per person, per calendar year
Routine Eyewear (Lenses, frames and contact lenses)	NOT COVERED	NOT COVERED
Eyewear (Contact lenses needed to treat keratoconus (including the fitting of these contact lenses); and intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced)	100%	100% (not subject to Reasonable and Customary Charges; Deductible waived)

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

DOCTOR SERVICES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Allergy Testing	$10 Co-payment per visit, then 100%	80% Reasonable and Customary (after Deductible)
Allergy Treatment	100%	80% Reasonable and Customary (after Deductible)
Anesthesia (In/Outpatient)	100%	80% Reasonable and Customary (after Deductible)
Chiropractic Services Up to 10* visits per person, per calendar year (excluding the initial x-ray)	100%	100% Reasonable and Customary (Deductible waived)
Maternity (Includes delivery, pre-natal and post-natal care)	100%	80% Reasonable and Customary (after Deductible)
Physician Hospital Visits	100%	80% Reasonable and Customary (after Deductible)
Physician Office Visits (Includes all related charges billed at time of visit)	$10 Co-payment per visit, then 100%	80% Reasonable and Customary (after Deductible)
Second Surgical Opinion	100%	80% Reasonable and Customary (after Deductible)
Surgery (Inpatient) *(precertification required)*	100%	80% Reasonable and Customary (after Deductible)
Surgery (Outpatient)	100%	80% Reasonable and Customary (after Deductible)
Surgery (Physician's office)	100%	80% Reasonable and Customary (after Deductible)

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

HOSPITAL SERVICES – IN PATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for Inpatient services. Failure to obtain precertification will result in a reduction in benefits in the amount of 20% per admission. The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan.		
Hospital Room & Board *(precertification required)*	100% of the Hospital's semi-private room rate & special care unit	80% Reasonable and Customary of the Hospital's semi-private room rate & special care unit (after Deductible)
Maternity Services *(precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])*	100% of the Hospital's semi-private room rate & special care unit	80% Reasonable and Customary of the Hospital's semi-private room rate & special care unit (after Deductible)
Birthing Center	100%	80% Reasonable and Customary (after Deductible)
Newborn Care (Includes Physician visits & circumcision)	100% of the Hospital's semi-private room rate & special care unit	80% Reasonable and Customary of the Hospital's semi-private room rate & special care unit (after Deductible)
Organ, Bone Marrow and Stem Cell Transplants (*precertification required; see* Medical Benefits *section for limitations*)	100% of the Hospital's semi-private room rate & special care unit	80% Reasonable and Customary of the Hospital's semi-private room rate & special care unit (after Deductible)
Surgical Facility & Supplies	100%	80% Reasonable and Customary (after Deductible)
Miscellaneous Hospital Charges	100%	80% Reasonable and 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%	80% Reasonable and 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 inpatient basis of a Hospital or for life-threatening ER expenses)	$25 Co-payment per visit, then 100% Reasonable and Customary (after Deductible; Co-payment is waived if admitted on an inpatient basis of a Hospital or for life-threatening ER expenses)
Outpatient Department	100%	80% Reasonable and Customary (after Deductible)
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	100%	80% Reasonable and Customary (after Deductible)
Preadmission Testing	100%	80% Reasonable and Customary (after Deductible)
Urgent Care Facility/Walk-In Clinic	$10 Co-payment per visit, then 100%	80% Reasonable and Customary (after Deductible)

MENTAL HEALTH / SUBSTANCE ABUSE	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Inpatient Mental Health Conditions and Alcohol/Substance Abuse services must be precertified by Modern Assistance Program (MAP). Failure to obtain precertification will result in a reduction in benefits in the amount of 20% per admission. (Outpatient Mental Health and Substance Abuse Treatment do not need to be precertified. However, those services performed at the Non-Network level that *are* precertified by MAP are payable at the In-Network level.) The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan.		
Inpatient/Partial Hospitalization/ Intensive Outpatient Programs *(precertification required)*	100%	80% Reasonable and Customary (after Deductible)
Inpatient Physician Visit	100%	80% Reasonable and Customary (after Deductible)
Hospital Clinic Visit	100%	80% Reasonable and Customary (after Deductible)
Office Visit	$10 Co-payment per visit, then 100%	80% Reasonable and Customary (after Deductible)
OTHER SERVICES & SUPPLIES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Ambulance Services (*see* Medical Benefits *section for limitations*)	100%	100% Reasonable and Customary (Deductible waived)
Bariatric Surgery (When related to treatment of Morbid Obesity; *precertification required*;*)*	100%	80% Reasonable and Customary (after Deductible)
Cardiac Rehabilitation (Phase 1 and 2 only*; see* Medical Benefits *section for other limitations*)	100%	80% Reasonable and Customary (after Deductible)
Chemotherapy & Radiation Therapy	100%	80% Reasonable and Customary (after Deductible)
Cochlear Implants *(precertification required)*	100%	80% Reasonable and Customary (after Deductible)
Dental Surgery (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	100%	80% Reasonable and Customary (after Deductible)
Diabetes Self-Management Training and Education	100%	80% Reasonable and Customary (after Deductible)
Diagnostic Imaging (MRI, CT Scan, PET Scan)	100%	80% Reasonable and Customary (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	100%	80% Reasonable and Customary (after Deductible)

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

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Dialysis/Hemodialysis	100%	80% Reasonable and Customary (after Deductible)
Durable Medical Equipment *(precertification required for equipment rental in excess of three (3) months, TENS units, CPAP/BiPAP machines, and equipment in excess of $1,000; see* Medical Benefits *section for other limitations)*	100%	80% Reasonable and Customary (after Deductible)
Elective Termination of Pregnancy	100%	80% Reasonable and Customary (after Deductible)
Family Planning (Including, but not limited to: consultations, diagnostic tests and pregnancy tests, IUDs, diaphragms, levonorgestrel implant system and insertion, and injection of birth control drugs when supplied by Provider at time of visit or purchased under the Prescription Drug Benefit; *see* Medical Benefits *section for limitations*)	100%	80% Reasonable and Customary (after Deductible)
Genetic Counseling, Testing and Related Services *(precertification required for genetic testing)*	100%	80% Reasonable and Customary (after Deductible)
Growth Hormones *(precertification required; see* Medical Benefits *section for limitations)*	100%	80% Reasonable and Customary (after Deductible)
Home Health Care *(precertification required; see* Medical Benefits *section for other limitations)*	$10 Co-payment per visit, then 100% up to a maximum of 100* visits or 200* hours (whichever occurs first) per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of 100* visits or 200* hours (whichever occurs first) per person, per calendar year
Hospice Care (In/Outpatient) *(precertification recommended; see* Medical Benefits *section for other limitations)*	100%	80% Reasonable and Customary (after Deductible)
Injectables *(precertification required for treatments in excess of $2,000)*	100%	80% Reasonable and Customary (after Deductible)
Learning Deficiencies, Behavioral Problems/Developmental Delays (when received with a medical diagnosis)	100%	80% Reasonable and Customary (after Deductible)
Marital Counseling	100%	80% Reasonable and Customary (after Deductible) (Precertification by MAP is required)

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

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Medical and Enteral Formula (Including metabolic formula) (*precertification required; see* Medical Benefits *section for other limitations)*	100%	80% Reasonable and Customary (after Deductible)
Modified Low Protein Food Products (*see* Medical Benefits *section for limitations*)	100%	80% Reasonable and Customary (after Deductible)
Neuromuscular Stimulators including TENS	100%	80% Reasonable and Customary (after Deductible)
Nutritional Counseling (when related to a medical condition)	100%	80% Reasonable and Customary (after Deductible)
Occupational Therapy (For treatment due to Illness or Injury, *excluding* services for developmental delay)	100%	80% Reasonable and Customary (after Deductible)
Orthotics (*see* Medical Benefits *section for limitations*)	100% up to a maximum of one (1)* per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of one (1)* per person, per calendar year
Physical Therapy (For treatment due to Illness or Injury)	100%	80% Reasonable and Customary (after Deductible)
Podiatry Care (*see* Medical Benefits *section for limitations*)	100%	80% Reasonable and Customary (after Deductible)
Private Duty Nursing *(precertification required; see* Medical Benefits *section for other limitations)*	100%	80% Reasonable and Customary (after Deductible)
Prosthetics (*see* Medical Benefits *section for limitations*)	100%	80% Reasonable and Customary (after Deductible)
Respiratory Therapy	100%	80% Reasonable and Customary (after Deductible)
Skilled Nursing Facility/Extended Care Facility/Rehabilitation Hospital *(precertification required; see* Medical Benefits *section for other limitations*)	100% up to a maximum of 90* days per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of 90* days per person, per calendar year
Smoking Cessation Therapy (Including clinics, classes and counseling)	100%	80% Reasonable and Customary (after Deductible)
Speech Therapy (For treatment due to Illness or Injury) *(see* Medical Benefits *section for other limitations)*	100%	80% Reasonable and Customary (after Deductible)

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

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Temporomandibular Joint Disorders (TMJ) Treatment	100% up to a maximum of $1,000* per person, per calendar year	80% Reasonable and Customary (after Deductible) up to a maximum of $1,000* per person, per calendar year
Voluntary Sterilization	100%	80% Reasonable and Customary (after Deductible)
Wigs (When hair loss is due to treatment of cancer or a medical condition)	100% up to a maximum of one (1)* wig per person, every 5 consecutive years	80% Reasonable and Customary (after Deductible) up to a maximum of one (1)* wig per person, every 5 consecutive years

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

Overall Plan Year Benefit Maximum: Unlimited, per person

Important Notes:

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.

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.

In addition, Out-of-Network providers shall be paid as In-Network for services that require MAP approval when those services are precertified by Modern Assistance Program (MAP).

V. MEDICAL BENEFITS

A. Benefit Levels

In-Network Providers – If a Covered Person has incurred covered medical expenses and services are rendered by an In-Network Provider, the Plan will pay the Reimbursement Percentage as shown in the Schedule of Medical Benefits.

Out-of-Network Providers – If a Covered Person has incurred covered medical expenses and services are rendered by an Out-of-Network Provider, the Plan will pay the Reimbursement Percentage (after satisfaction of the calendar year Deductible) as shown in the Schedule of Medical Benefits subject to Reasonable and Customary Charges.

Out-of-Network Providers will be paid at In-Network Provider levels subject to Reasonable and Customary Charges (unless otherwise stated) when ancillary 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 will be paid at In-Network Provider Co-payment and Coinsurance levels in the case of "Emergency Care" as defined in the section titled "Definitions". Ancillary medical services include the following types of professional services: anesthesia, radiology and pathology, as well as covered services provided by non-admitting consulting physicians.

In addition, Out-of-Network Providers shall be paid as In-Network for services that require MAP approval 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.

Traveling benefit – If a Covered Person is traveling out of state or out of country and requires medical treatment from an out-of-network provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at In-Network Provider levels subject to Reasonable and Customary Charges.

Deductible – There is no Deductible that applies to services provided by In-Network Providers. With respect to a Covered Person, the Deductible for services rendered by an Out-of-Network Provider in each calendar year shall be as shown in the Schedule of Medical Benefits. Any number of family members may help to meet the family Deductible, but no more than the per person Deductible will apply to 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 for Covered Expenses related to that accident incurred by all family members shall be limited to a single per person Deductible for that calendar year.

See Schedule of Medical Benefits for services which require precertification.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits. The Out-of-Pocket Maximum excludes charges in excess of the Reasonable and Customary Charges, any Co-payments and any penalties for failure to follow Preadmission/Precertification Requirements.

OVERALL PLAN YEAR BENEFIT MAXIMUM: Unlimited per Covered Person

B. Complex Case Management/Alternate Treatment Coverage

If a Covered Person's condition is, or is expected to become, serious and complex in nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified organization. The purpose of the case management service is to help plan necessary, quality care in the most cost-effective manner with the approval and cooperation of the Covered Person, family and attending Physician(s). This is a voluntary service to help manage both care and cost of a potentially high-risk or long term medical condition, and neither Covered Persons nor treating Physicians are required to participate in complex case management.

If a case is identified as appropriate for complex case management, then the case management organization will contact the treating Physician(s) and Covered Person to develop and implement a mutually agreeable treatment plan. If either the attending Physician or the Covered Person does not wish to follow the treatment plan, benefits will continue to be paid as stated in the Plan.

If the Physician(s) and Covered Person agree to the treatment plan, in some cases services not normally covered by the Plan may be eligible for coverage. If it appears that the most appropriate and cost-effective care will be rendered in a setting or manner not usually covered under the terms of the Plan, such care may be covered under the auspices of a complex case management treatment plan. In such cases, all Medically Necessary services included in the approved treatment plan will be covered under the terms of the Plan. However, the coverage of services under a complex case management plan that are not otherwise covered under this Plan does not set any precedent or create any future liability for coverage of such services with respect to either the Covered Person who is the subject of the plan or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

C. Covered Expenses

Under this Plan, the term "covered expense" refers to the fee schedule amount for In-Network Providers or, for Out-of-Network Providers, the Reasonable and Customary Charge for services prescribed by a Physician and expenses incurred for medical treatment of an Illness or Injury. Covered expenses may be subject to a calendar year Deductible, Coinsurance, Co-payments and other limits as shown in the Schedule of Medical Benefits for the following:

(1) Prescription Drugs

Expenses for covered prescription drugs and medicines, including insulin, birth control medications, pre-natal vitamins, and smoking cessation medications will be covered as described in the section titled "Schedule of Medical Benefits" through retail pharmacies and Express Scripts' mail order program.

Diabetic supplies are available through New England Mail Order Program.

The benefits are payable for Medically Necessary prescription drugs ordered in writing by a Physician for treatment of a Covered Person 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.

Prescription drug charges not covered:

(a) Drugs dispensed by any person 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) Infertility medications and/or drugs;

(h) Investigational or experimental drugs; including compounded medications for non-FDA-approved use;

(i) Prescriptions which an eligible person is entitled to receive without charge from any Worker's Compensation laws, or any municipal, state or federal program;

(j) Retin A, age 26 and over;

(k) Rogaine

(2) Preventive Care

(a) Routine physicals

Routine adult physical examinations including all related charges and tests billed at the time of visit, including, but not limited to x-rays, laboratory and clinical tests and routine immunizations.

(b) Routine Well Child Care

Routine Well Child Care including all charges billed at the time of visit, including, but not limited to physical examinations, history, sensory screening and neuropsychiatric evaluation, and appropriate immunizations.

(c) Nutritional counseling

(d) Smoking cessation counseling

(e) Routine lab, x-rays and clinical tests

(f) Routine colorectal cancer screening

Includes fecal occult screening, sigmoidoscopy and colonoscopy

(g) Routine gynecological care

Includes ovarian cancer screening; cervical cancer screening, including pap smear

(h) Bone density screening

(i) Routine mammograms

(j) Routine prostate exam

Includes Prostate-Specific Antigen (PSA) screening

(3) Vision Care

(a) Routine vision exam, including contact lens fittings

(b) Contact lenses needed to treat keratoconus including the fitting of these contact lenses;

(c) Intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced;

(d) Eye exams for the treatment of any muscle disorders of the eye (e.g. esotropia and strabismus), limited to one office visit 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.

(4) Physician Services

(a) Allergy testing and treatment, including preparation of serum and injections

(b) Anesthesia (In/outpatient)

(c) Chiropractic services from a licensed provider, excluding x-rays

(d) Maternity

Includes delivery, prenatal, and postpartum care of mother and fetus.

Amniocentesis is included for women age thirty-five (35) and older.

(e) Physician Hospital visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including Hospital inpatient care, Hospital outpatient visits/exams and clinic care.

(f) Physician office visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including office visits and home visits.

(g) Second surgical opinion and, in some instances, a third opinion as follows:

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

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 Physician who provided the second opinion or with the Physician who will be performing the actual surgery.

(h) Surgery (inpatient/outpatient/office)

Physician or surgeon charges 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 in the same operative field, the maximum allowable amount for the surgery will be either the fee schedule amount or the Reasonable and Customary charge for the primary procedure and 50% of the fee schedule amount for the secondary or lesser procedure, 25% of the fee schedule amount or the Reasonable and Customary charge for the third, 10% of the fee schedule amount or the Reasonable and Customary charge for the fourth, and 5% of the fee schedule amount or the Reasonable and Customary charge 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.

Surgical procedures include circumcision, termination of pregnancy, vasectomies and tubal ligations, but not reverse sterilization.

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital 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 determined to be 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).

(b) Maternity services

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 Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Note: If the mother chooses to be discharged earlier, coverage is provided for one (1) home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include:

parent education, assistance and training in breast or bottle feeding, and appropriate tests.

No authorization from the Plan need be sought by the attending Physician for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, for a cesarean section). The 48- or 96-hour limit may be exceeded with precertification by Care Management Services in cases of Medical Necessity.

(c) Birthing Center

Birthing center or freestanding health clinic services, with benefits limited to the amount that would have been paid if the Covered Person were in a Hospital.

(d) Newborn care

Routine nursery care (including circumcision and Physician's visits) while confined even though no Illness or Injury exists.

(e) Mastectomy

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:

(i) All stages of reconstruction of the breast on which the mastectomy was performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(iii) Prostheses; and

(iv) 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.

(f) Organ transplants – including bone marrow and stem cell transplants

Coverage is available to Covered Persons for organ and/or tissue transplants listed below only:

Human Heart Transplant	Kidney Transplant
Bone Marrow Transplant	Cornea Transplant
Stem Cell Transplant	Liver Transplant
Heart and Lung Transplant	Pancreas Transplant
Lung Transplant	

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. The term "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.

Covered transplant expenses: Covered Expenses which are Medically Necessary and appropriate to the transplant include:

(i) Evaluation, screening, and candidacy determination process;

(ii) Organ transplantation;

(iii) Organ procurement as follows:

Organ procurement from a non-living donor will be covered for costs involved in removing, preserving and transporting the organ;

Organ procurement from a living donor will be covered 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 as described below;

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.

If the donor is covered under the Plan, eligible charges will be covered.

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 $5,000 per Transplant Period.

(iv) Follow-up care, including immuno-suppressant therapy

Transportation: 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 transportation, 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.

(g) Charges for cosmetic purposes or for cosmetic surgery are covered only if due solely to:

(i) Bodily Injury, providing that coverage is in effect at the time treatment occurs;

(ii) Birth defect of a Covered Person, provided coverage is in effect at the time treatment occurs; or

(iii) 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.

(6) Surgical Facility and Supplies

(7) Miscellaneous Hospital Charges

(a) Medically Necessary supplies and services including X-ray and laboratory charges and charges for anesthetics and administration thereof.

(b) Drugs and medicines charged by a Hospital which are obtained through written prescription by a Physician.

(c) Administration of infusions and transfusions, including 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.

(d) Inpatient respiratory, physical, occupational, inhalation, speech and cardiac rehabilitation therapy.

(8) Hospital Services – Outpatient

(a) Clinic services

(b) Emergency Room services

(c) Outpatient department

(d) Outpatient surgery in Hospital, ambulatory center or other properly licensed facility.

(e) Preadmission testing

Preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery

(f) Urgent care facility/walk-in clinic

Emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a Hospital).

(9) Mental Health/Substance Use Disorders

Inpatient confinement or partial hospitalization/intensive outpatient treatment 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, or confinement or partial hospitalization/intensive outpatient treatment in a public or private substance use disorder facility.

Outpatient treatment of mental health disorders and outpatient treatment of substance use disorders on an outpatient basis provided services are furnished by a:

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

(c) 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) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist, or

(g) Psychiatrist.

(10) Other Services and Supplies

(a) Ambulance services:

To the nearest Hospital or medical facility which is equipped to provide the service required;

When Medically Necessary, from a Hospital; or

For an air ambulance or rail transportation to the nearest medical facility equipped to provide care when failure to do so may seriously jeopardize the health or risk the life of the patient

(b) Bariatric surgery for the treatment of Morbid Obesity

(c) Breast reduction surgery when deemed to be Medically Necessary

(d) Cardiac rehabilitation

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. Phase II consists of supervised outpatient treatment for Covered Persons 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.

(e) Chemotherapy and radiation therapy

(f) Cochlear implants

(g) Dental surgery (limited)

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

(i) Treatment of an Injury to a sound natural tooth, other than from eating or chewing, or treatment of an Injury to the jaw. Surgery needed to correct Injuries to the jaw, cheek, lips, tongue, floor and roof of the mouth;

(ii) Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia;

(iii) Biopsies of the oral cavity and related anesthesia;

(iv) Removal of bony impacted teeth, and related anesthesia; and

(v) Extraction of seven (7) or more permanent teeth performed on the same day.

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 and anesthesiologist charges, but not for the dentist's charges.

(h) Diabetes self-management training and education

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.

(i) Diagnostic imaging (MRI, CT scan, PET scan)

(j) Diagnostic x-ray and laboratory

X-ray, microscopic tests, laboratory tests, including electro-cardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

(k) Dialysis/Hemodialysis

Hemodialysis (renal therapy) at a Medicare-approved dialysis center.

(l) Durable medical equipment

Rental or purchase (whichever is less) of durable medical equipment to aid impaired functions, including but not limited to: wheelchairs, standard hospital-type bed, mechanical respirator, CPAP machines, 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), neuromuscular stimulators including TENS units and related supplies, and other durable medical or surgical equipment.

(m) Elective termination of pregnancy

(n) Family planning services including:

(i) Consultations, exams, procedures and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA)

(ii) Injection of birth control drugs, including prescription drugs when supplied by the Physician during the visit

(iii) Insertion of a levonorgestrel implant system, including the implant system itself

(iv) IUDs, diaphragms and other prescription contraceptive methods approved by the FDA when the items are supplied by the Physician during the visit

(o) Genetic counseling, testing and related services

(p) Growth hormones

Growth hormones when prescribed by a board certified pediatric endocrinologist and a written treatment plan is submitted for approval to Care Management Services. The Covered Person must be seen by the attending Physician every six (6) months and a written response to the treatment must be verified by the Physician. The medication will be covered for a thirty (30) day supply at a time.

(q) Home health care

Home Health Care Agency care in accordance with a home health care plan. 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. Covered expenses include:

(i) Part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);

(ii) Services provided by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

(iii) Services provided by home health aides; and

(iv) 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

No benefits will be provided for services and supplies not included in the home health care plan, 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.

(r) Hospice care benefits are provided for Covered Persons with a life expectancy of less than six (6) months and a Hospice Plan of Care; respite services and bereavement counseling are available to members of his or her immediate family who are Covered Persons under this Plan. Benefits are limited to:

(i) Room and board for a confinement in a hospice;

(ii) 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;

(iii) 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;

(iv) 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.);

(v) Home health aide service;

(vi) 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;

(vii) Medical social services by licensed or trained social workers, psychologists, or counselors;

(viii) Nutrition services provided by a licensed dietitian;

(ix) Respite care for Covered Persons who are members of the hospice patient's immediate family (for the purposes of hospice benefits, the term immediate family means – parents, spouse and children); and

(x) Bereavement counseling for Covered Persons who are members of the deceased's immediate family following the death of the terminally ill Covered Person. Benefits will be payable provided:

(xi) On the date immediately before his or her death, the terminally ill person was a Covered Person under the Plan under a Hospice Plan of Care; and

(xii) Charges for such services are incurred by the Covered Persons within six (6) months of the terminally ill Covered Person's death.

(s) Injectable medications which must be administered in the outpatient department of a Hospital or in a Physician's office

(t) Learning deficiencies, behavioral problems/developmental delays (including services under Early Intervention Programs) when received with a medical diagnosis

(u) Marital counseling when rendered by a licensed provider

(v) Medical and enteral formulas

Special medical and enteral formulas used in the treatment of, or in association with, a demonstrable disease, condition or disorder, or to treat malabsorption. (Regular grocery products that meet the nutritional needs of the patient are not covered; e.g. over-the-counter infant formulas such as Similac and Enfamil. Specialized formulas such as Nutramigen, Alimentum, or Neocate are covered)

(w) Miscellaneous medical supplies (outpatient)

Expendable supplies that are used outside of a health care setting and are available only with a physician's prescription. Covered medical supplies must be related to the use of medical equipment or devices, or are required as a result of medical or surgical treatment. Examples of covered medical supplies are colostomy bags, diabetic supplies, and supplies related to certain home care treatments.

(x) Modified low protein foods

Food products modified to be low protein to treat inherited diseases of amino acids and organic acids. The attending Physician must issue a written order stating that the food product is needed to sustain life, and is the least restrictive and most cost-effective means for meeting the Covered Person's medical needs.

(y) Nutritional counseling (when related to treatment of a medical condition)

(z) Occupational therapy

Treatment and services rendered by a licensed occupational therapist under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility.

(aa) Orthotics

For the purpose of treating an Illness or Injury, services and equipment such as orthopedic braces, including leg braces with attached shoes; arm, back and neck braces; surgical supports; and head halters. Orthotics are limited to one (1) per person, per calendar year.

Specially molded shoes and inserts are limited to one (1) pair per person, per calendar year.

(bb) Oxygen and other gasses and their administration

(cc) Physical Therapy

Services rendered by a licensed physical therapist under direct supervision of a Physician in a home setting or facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility.

(dd) Podiatry care

Physician's services for symptomatic complaints related to the feet when corrected by a major surgical procedure or when the result of a serious medical condition, such as diabetes; routine services, including routine care for bunions, corns, calluses, toenails, flat feet, fallen arches, and chronic foot strain are excluded.

(ee) Private duty nursing

Services by a private duty nurse furnished by a registered nurse (R.N.), or licensed practical nurse (L.P.N.), including charges billed by a Visiting Nurse Association, the need for which is substantiated by a written statement by the attending Physician.

Note: Services provided by an immediate member of the Member's family or a nurse who resides in the Member's home, or provided on a twenty-four (24) hour basis are not covered expenses.

(ff) Prosthetics

Prosthetic appliances such as artificial arms and legs including accessories; larynx prosthesis; eye prosthesis; breast prosthesis (made necessary due to breast removal arising from Illness or Injury), 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 that is being replaced is at least five (5) years old and no longer serviceable.

(gg) Rehabilitation Hospital

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement; and

(ii) 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.

(hh) Respiratory therapy

Inhalation therapy under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility.

(ii) Skilled Nursing Facility

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement, and

(ii) 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.

(jj) Sleep disorders

Sleep disorder testing, treatment, and related supplies, including diagnosis and treatment for Obstructive Sleep Apnea.

(kk) Smoking cessation therapy

Treatment and services include clinics, classes and counseling, as well as prescription and over-the-counter medicine when prescribed by a Physician for the treatment of nicotine addiction. (Charges for prescription and over-the-counter medicines are covered through the Prescription Drug Program only.)

(ll) Speech Therapy

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, or due to surgery performed on account of an Illness or Injury, when precertified by Care Management Services. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

(mm) Temporomandibular joint disorders treatment, excluding devices or orthodontia

(nn) Voluntary sterilization

(oo) Wigs

Wigs for hair loss resulting from the treatment of cancer or other serious medical condition. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

(11) State surcharges on covered benefits paid under the Plan for which the Covered Person is legally liable, to the extent required by law.

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

The following are excluded from Covered Expenses and no benefits shall be paid for:

(1) Expenses incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

(2) Claims submitted more than one (1) year after the Expense Incurred Date, unless the claim was delayed due to a Covered Person's legal incapacitation.

(3) Amounts in excess of the fee schedule amount for In-Network Providers, or, in excess of the Reasonable and Customary Charges for Out-of-Network Providers.

(4) Services or supplies 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, except for benefits specifically stated as covered under the Plan.

(5) Experimental or Investigational drugs, devices, medical treatments or procedures as defined in the Article titled "Definitions."

(6) Services, supplies or treatment not recognized as generally accepted standards of medical practice for the diagnosis and/or treatment of an active Illness or Injury.

(7) Treatment which is not the result of an Injury or Illness, except for benefits specifically stated as covered under the Plan.

(8) Expenses incurred outside the United States if the Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies.

(9) Expenses 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.

(10) 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.

(11) Expenses incurred in connection with an Injury arising out of, or in the course of, 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 the Covered Person is convicted of a felony charge.

See Schedule of Medical Benefits for services which require precertification.

(12) Medical expenses incurred on account of Injury or Illness 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.

(13) Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician except as specifically stated as covered under this Plan.

(14) 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, except for benefits specifically stated as covered under the Plan.

(15) Court-ordered treatment or any treatment not initiated by a Physician or covered provider of any kind.

(16) Treatment, services or supplies provided by a member of the Covered Person's immediate family, any person who ordinarily resides with the Covered Person, or the Covered Person. The term immediate family includes, but is not limited to, the Covered Person's spouse, child, brother, sister, or parent.

(17) Acupuncture therapy

(18) Biofeedback

(19) Chelation therapy

(20) Childbirth classes

(21) Cosmetic or reconstructive surgery, except for benefits specifically stated as covered under the Plan.

(22) Custodial care 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 provider by whom or by which they are prescribed, recommended or performed, except for the custodial care described under benefits titled "Hospice Care."

(23) Dentures, dentistry, oral surgery, treatment of teeth and gum tissues or dental X-rays, except for benefits specifically stated as covered under the Plan.

(24) Erectile dysfunction treatment

(25) Eyewear for routine care (including lenses, frames and contact lenses, and their fitting)

See Schedule of Medical Benefits for services which require precertification.

(26) Health, swim club and tanning club memberships for any reason

(27) Hearing aids or similar devices, and the fitting of hearing aids

(28) Hearing exams for routine care

(29) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, massage therapy, aromatherapy and alternative medicine, except for benefits specifically stated as covered under this Plan

(30) Infertility treatment including medicines and surgical procedures

(31) Medical supplies that are incidental to the treatment received in a physician or other provider's office or are provided as take-home supplies

(32) Methadone maintenance and treatment

(33) Orthoptics and visual therapy for the correction of vision

(34) "Over-the-counter" drugs or medical supplies which can be purchased without a prescription or when no Injury or Illness is involved, except for benefits specifically stated as covered under this Plan

(35) Pain management programs/clinics

(36) Pastoral counseling, marriage therapy, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies, except when approved by Modern Assistance Program (MAP).

(37) 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

(38) Planned home births

(39) Podiatry services for routine care, including care for bunions, corns, calluses, toenails, flat feet, fallen arches and chronic foot strain

(40) Sex therapy or transsexual surgery and related preoperative and postoperative procedures or complications, which, as their objective, change the person's sex

(41) Surrogate parenting (use of a gestational carrier)

(42) Visual refraction surgery, including radial keratotomy.

(43) Vitamins and food supplements, except for benefits specifically stated as covered under this Plan.

See Schedule of Medical Benefits for services which require precertification.

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility.

Full-time Members, and their Eligible Dependents, are initially eligible to participate in the Plan on the day following completion of any required probationary period (Waiting Period) deemed by his/her Employer (or if later, the date on which such Member transfers to full-time status). For the purposes of this Plan, "full-time" means regularly scheduled to work at least 100 hours per month, and the Member 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.. "Waiting Period" means the time between the Member's commencement of employment and the Member's initial eligibility to participate in the Plan.

If a Member ceases to be in class of eligible Members before completing the Waiting Period, the Member is not eligible to participate in this Plan.

In addition, Retirees as defined under this Plan are eligible for coverage.

B. Enrollment.

To enroll in this Plan, a Member or Retiree must elect coverage during an applicable enrollment period shown in the chart below. To make an election, all the required enrollment forms must be submitted to the Plan Administrator by the specified deadlines, unless due to administrative error.

In general, a Member's or Retiree's election to enroll (or not enroll) for coverage under this Plan for the Member, Retiree, and/or Eligible Dependents is irrevocable for the duration of the Plan Year for which the election is made.

In certain limited circumstances, however, Members may be eligible to change their elections to enroll for, cancel or change coverage for themselves and/or their Eligible Dependents during the Plan Year, provided that the required election/enrollment forms are submitted by the specified deadline.

The following chart summarizes the times when a Member or Retiree may enroll or change a current election under this Plan and, the applicable enrollment/election deadlines. The requirements for making elections during each period are detailed below the chart.

Enrollment/Election Periods

Enrollment/Election Due To:	Enrollment/Election Deadline:
1. Initial Eligibility Period	Thirty-one (31) days from completion of Waiting Period
2. Qualified Change in Status	Thirty (30) days after the date of the Qualifying Change in Status*
3. Special Enrollment Period following a gain or loss of eligibility for Medicaid or CHIP	Sixty (60) days after the date of the loss or gain of eligibility for Medicaid or CHIP
4. Special Enrollment Period following loss of other coverage	Thirty (30) days after the date of the loss of other coverage
5.Retirement	Thirty-one (31) days from the date of retirement

*In the case of an adopted child, this means the date the child is placed with the Member for adoption

(1) Initial Eligibility Period.

A Member may elect to enroll in this Plan during the 31-day period following completion of the Member's Waiting Period by submitting all required forms to the Plan Administrator. Any election made to enroll or not to enroll during the initial eligibility period will be irrevocable for the duration of the Plan Year, unless the Member becomes eligible to change an election during an enrollment period described below.

Note: A Retiree may enroll more than thirty-one (31) days after his or her retirement date, providing the Contributing Employer retroactively pays all Employer and Retiree contributions due since the original retirement date.

(2) Qualified Change in Status.

A Member may change an election with regard to coverage under this Plan after the initial eligibility period following a Qualified Change of Status as permitted under Internal Revenue Code of 1986, as amended. The Qualified Changes of Status that are applicable under this Plan include:

- Marriage, legal separation, annulment, or divorce of the Member;
- Birth, adoption or placement for adoption, or change in custody of the Member's child;
- Death of the Member's spouse or other Eligible Dependent;
- A child's loss or gain of Eligible Dependent status;
- A Member's or spouse's commencement of or return from an unpaid leave of absence;
- A significant change in the cost or coverage of the Member's or spouse's employer-provided health care coverage;
- A spouse's employer's open enrollment period during which the spouse changes his or her election regarding health care coverage;
- A change from part-time to full-time employment, or from full-time to part time employment, for the Member or spouse;
- A spouse or other Eligible Dependent becomes employed or unemployed; and

- Other Qualified Changes in Status as may be permitted under the Internal Revenue Code of 1986, as amended.

A change to an election under this section may be to enroll for coverage, terminate coverage or change coverage level under this Plan, provided the election change is consistent with the qualifying change in family or employment status. For example, a Member who gets married may elect to drop coverage under this Plan to enroll in his or her new spouse's plan or may elect to add the new spouse and/or stepchildren to this Plan.

To make an election change under this section, the Member must submit a completed enrollment form to the Plan Administrator, with documentation of the qualifying change in family or employment status, within thirty (30) days of the applicable change.

Note: This provision does not apply to Retirees.

(3) Special Medicaid/CHIP Enrollment Period.
If a Member is not covered under this Plan, or is covered but has not enrolled his Eligible Dependents, he may enroll for himself and/or his Eligible Dependents if:

(a) The Member's or an Eligible Dependent's coverage under Medicaid or CHIP is terminated as a result of loss of eligibility under such programs, or the Member or Eligible Dependent becomes newly eligible for premium subsidy through Medicaid or CHIP to help pay the cost of coverage under this Plan; and

(b) The Member submits a completed enrollment form to the Plan Administrator, with documentation of the loss of Medicaid or CHIP coverage, or of new eligibility for Medicaid or CHIP premium subsidy, within sixty (60) days of the date of the applicable loss of coverage or new eligibility for the premium subsidy.

Note: This provision does not apply to Retirees.

(4) Special Enrollment Period Following Involuntary Loss of Other Coverage

(a) Involuntary Loss of Other Coverage
A Member who is not participating in the Plan, but meets the eligibility requirements, may elect to enroll himself and his Eligible Dependents if all the conditions below are met:

(i) The Member declined coverage under the Plan for himself and his Eligible Dependents when it was offered previously.

(ii) The Member signed a written waiver of coverage under this Plan whenever such coverage was offered, giving the existence of alternative health coverage as the reason for waiving the coverage, on forms furnished by and delivered to the Plan Administrator within the specified enrollment period each time such coverage was offered.

(iii) The alternative health coverage was involuntarily lost because:

- It was COBRA continuation coverage that has been exhausted;
- Eligibility for the alternative coverage was lost (for reasons other than the Member's voluntary cancellation of the coverage, failure to pay premiums or for cause);
- All benefits under the alternative coverage have been exhausted under its lifetime benefit limits; or
- Employer contributions toward the cost of the alternative coverage terminated.

(iv) The Member submits a completed enrollment form to the Plan Administrator, with written documentation that confirms the involuntary loss of alternative coverage, within thirty (30) days after the date on which the alternative coverage was involuntarily lost.

Note: This provision does not apply to Retirees.

(5) Enrollment due to Retirement

A Member who terminates employment and is a Retiree as defined under this Plan may elect to enroll for retirement coverage within thirty-one (31) days of retirement. Alternatively, retirement coverage can be elected more than thirty-one (31) days following initial retirement providing the Contributing Employer retroactively pays all Employer and Retiree contributions due since the original retirement date.

C. Participation.

The chart below provides an overview of when participation begins or ends based on a permitted election, provided all enrollment materials are submitted by the deadlines shown under Section B, *Enrollment*. Except as described in Article XX, Pre-existing Condition Limitation, coverage and participation under this Plan begin and end on the same date.

When Participation Begins/Ends

Election during	Participation for Member or Retiree	Participation for Eligible Dependents enrolled by Member or Retiree
1. Initial Eligibility Period	Begins on the initial eligibility date	Begins on the date the Member's or Retiree's coverage begins, if Eligible Dependents were enrolled on or before that date
2. Enrollment Period following Qualified Change in Status**	Begins or ends on the date of the Qualified Change of Status*	
3. Special Enrollment Period: Gain or loss of eligibility for Medicaid or CHIP**	Begins or ends, as applicable, on the date of the loss or gain of eligibility for Medicaid or CHIP	
4. Special Enrollment Period: Loss of eligibility for other coverage**	Begins on date of loss of coverage	

*In the case of adoption, this means the date the child is placed for adoption.
**This provision does not apply to Retirees.

(1) Participation during Periods of Leave of Absence

(a) Leave of Absence under FMLA.
A Member who is entitled to and takes a family or medical leave under the terms of the FMLA (Family and Medical Leave Act of 1993, as amended), and the Member's covered Eligible Dependents, may continue to participate in this Plan during the FMLA leave until the earlier of the expiration of the 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 participation is maintained during the leave, the Member must continue to make any required contributions.

If the Member chooses not to participate while on an FMLA leave, but subsequently returns to Actively at Work status upon or before the expiration of the leave, the Member and all Eligible Dependents who were covered under the Plan when the leave began shall immediately become covered under the Plan. The provisions for excluding benefits for pre-existing conditions shall not apply to any medical condition of the Member or Eligible Dependents that has arisen during the FMLA.

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 making a required minimum payment.

(2) Participation for Members under Compensation Maintenance Agreements and/or Severance Agreements and/or Collective Bargaining Agreements.

Members who enter into special written arrangements with the Trust Fund are eligible to continue participation in the Plan following termination of employment as specified under the terms of each individual's arrangement. In each such case, coverage following termination of employment continues for the period specified under the terms of each individual's arrangement, and then continuation of coverage under COBRA will be offered.

(3) Participation in Cases of Reemployment.

(a) Participation in the Plan will begin immediately for, any Covered Person who discontinued coverage during a leave of absence taken under the FMLA by the Member, provided the Member returns to Actively at Work status before or immediately following the expiration of the FMLA leave.

(b) Participation in the Plan will begin immediately for any former enrolled Member and his or her Eligible Dependents who have continuously been covered under this Plan through COBRA 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.

(c) Participation in the Plan will begin immediately for a Member absent from work due to military service on the first day the Member returns to Actively at Work status, whether or not a Member elects COBRA continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), provided the Member returns to Actively at Work status:

(i) On the first full business day following completion of the military service for a leave of thirty (30) days or less; or

(ii) Within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or

(iii) Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days

In each case, 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 participation in 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 as if the Member had been continuously covered under this Plan from the original effective date.

(d) In each other case of reemployment or transfer to full-time status from part-time status, the Covered Person will become covered upon the Member's return to Actively at Work full-time status in accordance with the provisions of Section (A) of this Article (relating to initial eligibility following commencement of employment).

VIII. PRE-EXISTING CONDITION LIMITATION

A. Pre-existing Condition.

(1) A "Pre-existing 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 pre-existing condition for the purpose of this Article VIII. 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 Pre-existing Condition under the Medical Benefits section of this plan 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) Not withstanding any other provision in this Plan, the restriction in Paragraph 2 above shall not apply to a Covered Person under age 19. Such Covered Persons will not be subject to any coverage exclusions based on the existence of a Pre-existing Condition even after reaching age 19 provided they remain covered under this Plan with no break in coverage greater than 63 days.

(4) The exclusion of benefits for a Pre-existing 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) Not withstanding any other provision in this Plan, any period during which benefits for a Pre-existing 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) 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, 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.

(2) Second, if the Covered Person for any reason is unable to obtain a Certificate from another Plan, 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 Pre-existing 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 pre-existing 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 XVII.

(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.

IX. 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:

(1) "Claim Determination Period" means a calendar year, and

(2) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include:

(a) 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; or

(b) Charges related to retail or mail-order prescription drug claims which are administered by the Prescription Drug Manager for this Plan.

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 or Retirees 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; or

(3) Vehicle insurance. When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each Member or Retiree will be deemed to have full no-fault coverage to the maximum available in that state, whether or not the Member or Retiree 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 health Plans, the order in which benefits are paid will be determined is as follows:

(1) The Plan covering the Covered Person other than as an Eligible Dependent, for example as a Member, subscriber, policyholder or retiree, 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 that Member's Eligible Dependent) pays benefits first unless the Member is laid-off or retired. The Plan covering the Covered Person as a laid-off or retired Member (or as a laid-off or retired Member’s Eligible Dependent) pays benefits second.

(7) The Plan covering a Covered Person as a Member or Retiree (or as an Eligible Dependent of the Member or Retiree) 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 or Retiree who is provided COBRA continuation under this Plan and who also is covered simultaneously under another Plan as a Member or Retiree (or as an Eligible Dependent of a Member or Retiree). 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. Persons Covered by Medicare. A Covered Person who becomes entitled to medical benefit coverage under Medicare shall remain eligible for benefits under this Plan on the same terms and conditions as any other Covered Person. This Plan will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payor (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. 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. These rules will determine when this Plan will be the primary payer of covered Medical benefit expenses and when Medicare will be the primary payer.

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 A and/or 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. 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.

H. **Plan Charges Covered by Medicaid or CHIP (Children's Health Insurance Plan).** This Plan will not reduce or deny benefits for any Covered Person to reflect the fact that such a Covered Person is eligible to receive medical assistance through Medicaid or CHIP.

I. **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.

J. **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.

K. **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.

L. **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.

X. 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 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 or Retiree 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 or Retirees 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.

XI. TERMINATION AND CONTINUATION OF COVERAGE

A. Termination of Coverage.

1. **Termination Events.** Participation in and coverage under this Plan of any Member and Eligible Dependents terminates on the earliest of:

(a) The last day of the month in which the Member terminates employment.

(b) The day the Member ceases to be in a class of eligible Members with his/her Employer.

(c) The day the Member fails to return to Actively at Work status following expiration of an approved leave of absence.

(d) The day the Members Employer terminates coverage.

(e) The day this Plan terminates.

(f) The day the Member dies.

(g) The day the Member enters service in the Uniformed Services on an active duty basis.

(h) The first day of the period for which the Member fails to make any required contributions.

The coverage of any Retiree and his or her Eligible Dependents shall automatically cease immediately upon the day indicated below:

(a) On the day the Retiree becomes eligible for Medicare

(b) On the day the Retiree returns to work in a the jurisdiction of Local 877 for forty (40) or more hours in any calendar month

(c) On the day the Retiree and/or the Contributing Employer fail to make timely contributions for coverage to the Fund

(d) On the day that the Contributing Employer's CBA or participation agreement terminates

Note: Once coverage is terminated, Retirees are not eligible to re-enroll at any later date unless the Retiree again satisfies the conditions as described under the definition of Retiree as of a new retirement date.

The coverage for any Retiree's Eligible Dependents shall automatically cease prior to the termination of a Retiree's coverage immediately upon the earliest day as indicated below:

(a) On the day the Eligible Dependent ceases to be in a class of Eligible Dependents.

(b) On the day the Eligible Dependent becomes eligible for Medicare.

(c) For spouses, on the effective date of any divorce or legal separation (except for those who qualify as an Eligible Dependent as defined in the General Definitions section under this Plan).

2. *Earlier Termination of Eligible Dependent Coverage.* The coverage of any Eligible Dependent will terminate before the termination of the Member's coverage on the earlier of (i) the date that the dependent no longer satisfies the definition of an Eligible Dependent, or (ii) the last day of the period in which the Member fails to make any required contribution for Eligible Dependent coverage.

3. Rescissions. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to your or your dependents' coverage under the Plan, b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, you may be responsible for any benefit payments made during the relevant period. For any rescission (retroactive termination of coverage that is related to fraud or intentional misrepresentation), the Plan Administrator will provide thirty (30) days advance written notice and you will have the right to appeal the Plan's termination of coverage.

B. Certificate of Coverage. As mandated by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan will provide a Certificate of Coverage to any Covered Person after the Member or Retiree loses coverage under the Plan. In addition, a Certificate will be provided upon request, if the request is made within twenty-four (24) months after the Covered Person 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 Certificate of Creditable Coverage will document the coverage for the Covered Person(s), including:

1. The name of the Plan;
2. The date of the Certificate;
3. A statement that the Covered Person has at least twelve (12) months or in the case of a Late Enrollee, eighteen (18) months 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;
4. The date Creditable Coverage began;
5. The Plan Administrator; and
6. Contact information for the Plan.

C. COBRA (Consolidated Omnibus Budget Reconciliation Act, as amended). 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, as defined below, has the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event, as defined below, that would otherwise result in a loss of coverage under the Plan. Extended coverage under the Plan is known as "COBRA continuation coverage" or "COBRA coverage."

COBRA 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 certain events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage will 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 will be identical to the coverage provided to similarly situated active Members or Retiree who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

1. Qualified Beneficiaries. In general, a Qualified Beneficiary is:

(a) Any Member or Retiree who, on the day before a Qualifying Event, is covered under the Plan, or the spouse of a covered Member or Retiree or an Eligible Dependent child of a covered Member or Retiree. If, however, a Member or Retiree 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 or Retiree will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Member or Retiree experiences a Qualifying Event.

(b) 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.

(c) 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 no earned income from the Employer that constituted income from sources within the United States. Nor are such Members' spouse or Eligible Dependent children considered Qualified Beneficiaries.

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.

2. Qualifying Events. 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:

(a) The death of a covered Member or Retiree.

(b) The termination (other than by reason of the Member's gross misconduct), or reduction of hours, of a covered Member's employment.

(c) The divorce or legal separation of a covered Member or Retiree from the Member's or Retiree's spouse.

(d) A covered Member's or Retiree's entitlement to Medicare.

(e) An Eligible Dependent child's ceasing to satisfy the Plan's definition of an Eligible Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(f) 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 Retiree, or the spouse or an Eligible Dependent child of the covered Member or Retiree, 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.) 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.

A voluntary waiver of coverage by a Member or Retiree on behalf of the Member, Retiree, or an Eligible Dependent, such as during an Open Enrollment Period, is not a Qualifying Event.

3. **Election Periods.** To be eligible for COBRA coverage, a Qualified Beneficiary must make a timely election. An election is timely if it is made during the election period. The election period begins no later than the date the Qualified Beneficiary loses coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary loses coverage on account of the Qualifying Event or the date the Qualified Beneficiary is notified of the right to elect COBRA continuation coverage.

4. **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, Retiree, or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(a) An Eligible Dependent child ceasing to be an Eligible Dependent child under the generally applicable requirements of the Plan.

(b) The divorce or legal separation of the covered Member or Retiree.

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.

5. **Revoking a Waiver of Coverage during the Election Period.** 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 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.

6. Termination of COBRA continuation coverage. Except for an interruption of coverage in connection with the revocation of 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:

(a) The last day of the applicable maximum COBRA coverage period.

(b) The first day for which Timely Payment (as defined below) is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Member or Retiree.

(d) 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.

(e) 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).

(f) In the case of a Qualified Beneficiary entitled to a disability extension (as described below), the later of:

(i) 29 months after the date of the Qualifying Event, or 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

(ii) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

In the case of a Member or Retiree who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Member's or Retiree'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 or Retiree who is not a Qualified Beneficiary.

7. Maximum COBRA coverage periods. The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) 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.

(b) 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:

(i) 36 months after the date the covered Member becomes enrolled in the Medicare program; or

(ii) 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.

(c) 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.

(d) 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.

(e) In the case of any Qualifying Event other than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

8. Limited circumstances under which the maximum coverage period can be expanded. If a Member experiences a second Qualifying Event while receiving 18 months of COBRA continuation coverage, the Member's or Retiree's 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 Retiree or former Member or former Retiree 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.

9. **Disability extensions of coverage.** 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. The disability 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.

10. **Payment for COBRA Continuation Coverage.** For any period of COBRA continuation coverage, the Plan requires the payment of an amount that equals 102% of the applicable premium, unless the Plan requires the payment of an amount that equals 150% of the applicable premium for any period of COBRA continuation coverage based on a disability extension. The Plan will 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.

    Payments for COBRA continuation coverage may be made in monthly installments or may be made for multiple months in advance.

11. **Timely Payment for COBRA Continuation Coverage.** Timely Payment for a period of COBRA coverage means payment that is made to the Plan by 30 days after the first day of that period. Notwithstanding the above, a Qualified Beneficiary has 45 days after the date of the election of COBRA continuation coverage to make the initial payment for coverage. The initial payment for coverage must include payment for the entire period that begins on the date of the Qualifying Event (or revocation of waiver) and ends on the last day of the month in which the initial payment is submitted. Payment is considered made on the date on which it is sent to the Plan.

12. **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:

(a) For a Member or Retiree 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.

(b) For a Covered Person who is not a Qualified Beneficiary entitled to elect Continuation Coverage, within a reasonable time after coverage ceases.

(c) For a 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.

13. *COBRA Coverage for Members in the Uniformed Services.* For purposes of this Article XI, a Member who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services will experience 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 will be treated as any other Qualified Beneficiary under Section C, item1. 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 will furnish the Member and the Member's covered Eligible Dependents a notice of the right to elect COBRA continuation coverage (as provided above) 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 thirty (30) days or less, the contribution rate will be the same as for active Members. If the leave is longer than thirty (30) days, the required contribution is 102% of the cost of coverage.

XII. 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 Member 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 Members 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
- Members and other workforce members at the direction of the above listed classes of Members
- Administrative Assistant to the Executive Director

This list includes every class of Members or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these Members 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 Members 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.

XIII. 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, illness, 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 illness 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 illness injury, disease or disability.

D. Excess Insurance

If at the time of injury, illness, 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 illness, 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 dependent 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.

XIV. AMENDMENT AND TERMINATION OF PLAN

A. Amendment. The Employer 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 instrument signed by a duly authorized Officer of the Employer.

The Plan Administrator 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 Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. 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 Employer (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 Employer's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

XV. GENERAL PROVISIONS

A. **Company Funding.** All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Members shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer 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 Employer and a Member, Retiree, or any other person. Neither a Member, nor a Retiree, nor a beneficiary of a Member or Retiree shall acquire any interest greater than that of an unsecured creditor.

B. **In General.** Any and all rights provided 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 Employer 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 the 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, Retiree, 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 Employer. The treatment of the amounts paid under this Plan under other Member benefit plans shall be determined under the provisions of the applicable Member benefit plan.

E. **Nonvested Benefits.** Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Member, Retiree, or Eligible Dependent.

F. **Interests not Transferable.** The interests of the Member, Retiree, and their Eligible Dependents under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, 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 Employer 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 the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

XVI. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

This section describes a Covered Member's or Covered Retiree's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator makes initial claim and initial appeal determinations based on the specific terms of the Plan. The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim, and has 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.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Covered Members' or Covered Retiree's rights are included in Sections A-F below.

1. All initial claims must be filed within one (1) year of the Expense Incurred Date (defined in Article III of this Plan Document).

2. As directed by the Plan Administrator, the Claim Administrator will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Member or Covered Retiree within the period specified for the type of claim filed (see *D. Initial Claim Determination,* and Chart A, below).

3. If the claim is denied in whole or in part, and the Covered Member or Covered Retiree disputes the determination, he or she may contact the Claim Administrator to confirm that the claim was properly processed. The Covered Member or Covered Retiree may also immediately file a formal appeal (see *F. Appeals of Denied Claims,* below).

4. As directed by the Plan Administrator, the Claim Administrator will review any appeal filed, and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Appeals of Denied Claims,* Chart B below).

5. If the first appeal is denied, the Covered Member or Covered Retiree may file a second appeal within the time periods specified in Chart B, below. The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final appeal available under the Plan.

A. Who May File a Claim

A claim may be filed by a Covered Member or Covered Retiree, his or her authorized representative, or his or her health care service provider. To designate an "authorized representative," a Covered Member or Covered Retiree must submit a request in writing to the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Member or Covered Retiree through his or her authorized representative. The forms required to authorize a representative are available from the Claim Administrator.

For the purposes of this Article, "claimant" refers to the Covered Member or Covered Retiree to whom the claim relates or, as applicable, to the Covered Member's or Covered Retiree's authorized representative.

B. Types of Claims

The time limits applicable to claims and appeals depend on the type of claim at issue. The categories of potential claims are defined below.

1. Urgent Care Claim–A claim for medical care or treatment where using the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the Covered Member or Covered Retiree or the ability of the Covered Member or Covered Retiree to regain maximum function, or (b) in the opinion of a physician with knowledge of the Covered Member's or Covered Retiree's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment being claimed.

2. Concurrent Care Claim–A claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim.

3. Pre-Service Care Claim–A claim for a benefit that requires approval (usually referred to as precertification or preauthorization) under the Plan in advance of obtaining medical care.

4. Post-Service Care Claim–A claim for services that have already been provided or that do not fall into any of the categories above.

C. When and How to File a Claim

A Covered Member or Covered Retiree must submit, or ensure that his or her provider submits, an initial claim for inpatient benefits no later than one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the Covered Member or Covered Retiree is legally incapacitated.

How a claim may be filed depends on the type of claim:

1. *Urgent care claims* may be submitted verbally by calling the Claim Administrator at (800) 532-7575 or by any method available for non-urgent and post-service claims.
2. *Non-urgent care claims* and *post-service claims* must be filed using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

   - U.S. Mail
   - Hand delivery
   - Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	**Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581

D. Initial Claim Determination

After a claim has been submitted to the Claim Administrator, the Plan is obligated to make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the claimant will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

The following table shows the applicable time limits based on type and specific circumstances of the claim.

CHART A – Time Limits Regarding Initial Claims

Type of Initial Claim	Maximum period after receipt of claim for initial benefits determination	Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator	Maximum period to notify Claimant of improperly filed claim or missing information	Period for Claimant to provide missing information
URGENT CARE CLAIMS (not including urgent concurrent care claims)	72 hours	No extension permitted	24 hours	48 hours minimum*
URGENT CONCURRENT CARE CLAIMS**	24 hours	No extension permitted	24 hours	48 hours minimum*
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.
**If the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise the time limits are the same as for Urgent Care Claims.

E. How Claims are Paid

If a claim is approved, in whole or in part, and a Covered Member or Covered Retiree has authorized payments to a provider in writing, all or a portion of any eligible expenses due to a provider will be paid directly to the provider; otherwise payment will be made directly to the Covered Member or Covered Retiree. Third parties who have purchased or been assigned benefits by physicians or other providers will *not* be reimbursed directly by the Plan.

F. Appeals of Denied Claims

If a claim is denied in whole or in part, a claimant may file an appeal of the adverse benefit determination. Before filing an appeal, a claimant may first want to contact the Claim Administrator at (800) 532-7575 to verify that the claim was correctly processed under the terms of the Plan, but is not required to do so.

Initial appeals must be filed within 180 days of the initial claim denial; second appeals must be filed within 60 days of the initial appeal denial. Any appeal received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

How an initial or second appeal may be filed depends on the type of appeal:

1. *Urgent care appeals* may be submitted verbally by calling the Claim Administrator at (800) 532-7575 or by any method available for non-urgent and post-service appeals.

2. *Non-urgent care appeals* and *post-service appeals* must be in writing and must be submitted to the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

   - U.S. Mail
   - Hand delivery
   - Facsimile (FAX): (508) 329-4812

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Written appeals *must* include the following information:

(a) The patient's name.
(b) The patient's Plan identification number.
(c) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available).
(d) A statement that the Covered Member or Covered Retiree (or authorized representative on behalf of the Covered Member or Covered Retiree) is filing an appeal.

In making an appeal, the Covered Member or Covered Retiree also may:

- Review pertinent documents and submit issues and comments in writing.
- Designate an authorized representative to act on the Covered Member's or Covered Retiree's behalf for the purposes of the appeal.
- Submit written comments, documents, records, or any other matter relevant to his or her appeal, even if the material was not submitted with the initial claim.
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal, upon request and free of charge.

All appeals will be given a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the appeal, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the claimant will have 60 days to request a second appeal. In filing a second appeal, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the Plan Administrator who holds final authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits.

CHART B – Time Limits Regarding Initial and Second Appeals

Type of Claim	Maximum period for Claimant to file initial appeal after initial denial	Maximum period for issuing determination regarding initial appeal	Maximum period for Claimant to file second appeal following denial of initial appeal in whole or in part	Maximum period for issuing determination regarding second appeal
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours	60 days	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	180 days	15 days	60 days	15 days
POST-SERVICE CLAIMS	180 days	30 days	60 days	30 days

If the second appeal is denied in whole or in part, the Covered Member or Covered Retiree has the right to bring a civil action against the Plan under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

Statement of Rights

Participants in this Plan are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants will be entitled to:

(1) 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, if applicable, by the Plan with the U.S. Department of Labor;

(2) 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), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;

(3) Receive a summary of the Plan's annual financial report, if the Plan is required to distribute such summary annual financial report;

(4) 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; and

(5) Reduction or elimination of exclusionary periods of coverage for pre-existing 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 pre-existing 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 Plan 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 after exhausting the administrative appeals process described in this Article. 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 Plan 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 & 70 (Allina)

By: _____

Date

Authorized Signature

Print Name

Title