TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA

HEALTH & WELFARE FUND

ACTIVE EMPLOYEE

PLAN DOCUMENT

Amended and Restated

Effective June 1, 2023

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Introduction

On November 10, 1952, Teamsters Joint Council No. 83 of Virginia affiliated with the International Brotherhood of Teamsters ("Joint Council") and the various Employers who had entered into labor contracts with the Local Unions affiliated with the Joint Council executed an Agreement and Declaration of Trust ("Trust Agreement") and adopted a Health and Welfare Fund (the "Plan" or "Fund") to provide health and welfare benefits to contributing Employers' Employees who were represented by the Union for collective bargaining purposes, together with Employees of such other Employers that agreed to provide coverage for them under the Fund, and such other persons whom the Trustees desired to permit to be covered under the Fund. The Plan and Trust Agreement were subsequently revised from time to time.

The Plan and Trust Agreement are intended to meet the requirements of Sections 401(a) and 501(a) of the Internal Revenue Code of 1986 (the "Code"), as amended, and the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The Plan has been established for the exclusive benefit of Employees and their Beneficiaries.

Pursuant to the authority derived from Article IV, Section 18 and Article VI, Sections 1 and 6 of the Reaffirmation and Restatement of Agreement and Declaration of Trust, the Board of Trustees of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund hereby established effective June 1, 2023, the following rules and regulations and plan of benefits. These rules and regulations and this plan of benefits shall remain in effect until changed by future action of the Board. The Board of Trustees has the sole and exclusive authority and the unfettered discretion to determine the type and level of benefits the Plan will provide, to determine all questions pertaining to the eligibility for Plan benefits, and to interpret all provisions of the Plan. Any decision the Trustees make in regard to any matter effecting Plan administration is final and binding. No one speaking on behalf of the Plan or the Fund can alter the terms of the Plan. If any statement made to an Employee or the Employee's Beneficiary conflicts with the Plan, the Plan's written terms as set forth herein will prevail. In addition, Employees and their Beneficiaries cannot rely on any oral statements made by a representative of the Fund as evidence that benefits are available or payments will be made for a particular service or supply.

Article 1 Definitions

Section 1.1 Accidental Bodily Injury or Injury

The term "Accidental Bodily Injury" or "Injury" is defined as the conversion of any specific body structure or function from a normal healthy state to a disabled state through operation of a sudden, outside agent or force - physical or chemical - which cannot be reasonably foreseen or prevented and which results in disability directly and independently of all other causes.

Section 1.2 Active Service

An Employee shall be considered in "Active Service" with an Employer on a day which is one of the Employee's scheduled work days if the Employee is performing in the customary manner all of the regular duties of the Employee's employment with the Employer on a full time basis on that day either at one of the Employer's business establishments or at some location to which the Employer's business requires the Employee to travel. An Employee shall be considered in Active Service with an Employer on a day which is not one of the Employee's scheduled work days only

if the Employee is performing, in the customary manner, all of the regular duties of the Employee's employment on the immediately preceding scheduled work day.

Section 1.3 Adverse Benefit Determination

The term "Adverse Benefit Determination" is defined as any of the following: a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for, a benefit, that is based on a determination of a Participant's, Dependent's or Beneficiary's eligibility to participate in a Plan, or for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational, or not Medically Necessary or appropriate. If related to a grandfathered Schedule of Benefits, a non-grandfathered Schedule of Benefits or to a claim for disability benefits, "Adverse Benefit Determination" also includes rescission of coverage.

Section 1.4 Allowable Charge

The term "Allowable Charge" for any service or supply (except for No Surprises Services) is defined as: (a) with respect to an In-Network provider, the charge agreed to by the provider under the provider's agreement with the Plan's Preferred Provider Organization; (b) with respect to an Out-Of-Network provider, the charge (1) that the Plan's vendor(s) for negotiating Out-of-Network claims is able to negotiate on behalf of the Plan; or (2) if the charge is not negotiated, the charge that the Plan's Preferred Provider Organization provides to the Plan using its methodology for determining the allowable charge for non-participating provider claims. Notwithstanding the foregoing, with respect to No Surprises Services, the Allowable Charge shall be determined in compliance with the No Surprises Act.

Section 1.5 Ambulatory Surgical Facility

The term "Ambulatory Surgical Facility" is defined as a certified facility or Hospital where surgery is performed in which the intended duration between admission and discharge is less than twenty-four (24) hours.

Section 1.6 Annual Maximum

The term "Annual Maximum" shall apply only to benefits not deemed "Essential" and benefits for which a visit maximum applies.

Section 1.7 Beneficiary

The term "Beneficiary" is defined as any persons designated in writing by the Participant or by the terms of the Plan, who is now or may hereafter, become entitled to a benefit from the Plan, consistent with the Plan's payment of benefits provisions.

Section 1.8 Chiropractor

The term "Chiropractor" is defined as an individual who is licensed to treat conditions relating to musculoskeletal problems of the spine and who is operating within the scope of a current license.

Section 1.9 Coinsurance

The term "Coinsurance" is defined as that portion of an Allowable Charge, as determined in accordance with the No Surprises Act, that is not covered by the Schedule of Benefits of the Plan and thus payable by the Participant.

Section 1.10 Continuing Care Patient

The term "Continuing Care Patient" is defined as an individual who is:

(a) undergoing a course of treatment for a "serious and complex condition," which (1) in the case of an acute illness, means a condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability; or (2) in the case of a chronic illness or condition, means a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time;

(b) undergoing a course of institutional or inpatient care;

(c) scheduled to undergo non-elective surgery (including any post-operative care);

(d) pregnant and undergoing a course of treatment for the pregnancy; or

(e) determined to be terminally ill and receiving treatment for the illness.

Section 1.11 Co-payment

The term "Co-payment" is defined as a fixed dollar amount payable by the Participant to a provider upon incurring certain claim types as identified in the applicable Schedule of Benefits.

Section 1.12 Contributions

The term "Contributions" is defined as the amount paid by an Employer to the Fund on behalf of its Employees, on a weekly or monthly basis, pursuant to the terms of an applicable Collective Bargaining Agreement or Participation Agreement. The term "Contributions" shall also mean the amounts paid to the Fund on behalf of their Employees by the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund and Pension Fund, the Teamsters Joint Council No. 83, and Teamsters Local Unions that constitute "Employers" within the meaning of Section 1.22. When, pursuant to the terms of a Collective Bargaining Agreement or Participation Agreement, Contributions are paid to the Fund on a monthly basis, one (1) month of Contributions will be deemed the equivalent of four (4) weeks of Contributions.

Section 1.13 Custodial Care

The term "Custodial Care" is defined as that type of care, wherever furnished, which is designed essentially to assist the individual in meeting the activities of daily living, which is not given primarily to assist such person in recovering from an Injury or Illness, and which does not entail or require the continuing attention of trained professional medical personnel.

Section 1.14 Deductible

The term "Deductible" is defined as the amount which the Participant pays for medical expenses before benefits are paid by the Plan. The Deductible is not applied to claims considered under the Dental Expense Benefit or Vision Expense Benefit, if such benefits are available under a Participant's Schedule of Benefits; certain screenings, immunizations, and other preventive services; orthodontic claims; prescription claims; penalties; dollar amounts above the Fund's Allowable Charge, or Co-payments for Physician and/or emergency room visits. The Deductible is applied only once per person or, if applicable, per family, in any calendar year in an amount defined in the Participant's Schedule of Benefits.

Section 1.15 Dentist

The term "Dentist" is defined as an individual who is licensed to practice dentistry, including orthodontics, in the state where the dental service is performed and who is operating within the scope of a current license.

Section 1.16 Dependent

The term "Dependent" is defined as any of the following:

(a) The Participant's lawful Spouse;

(b) The Participant's Qualifying Child;

(c) A Qualifying Child who would terminate on the last day of the month in which the child reaches age twenty-six (26) remains a Qualifying Child under the following conditions:

(1) The Qualifying Child was eligible for benefits under Section 1.16(b) and is and continues to be both:

(A) incapable of self-sustaining employment by reason of mental retardation or physical handicap as determined by the appropriate state, federal regulatory agencies, or Fund's Medical Consultant; and

(B) chiefly dependent upon the Participant for support and maintenance as confirmed by a Physician in writing; and

(C) such incapacity commenced while the Qualifying Child was eligible for benefits under this Plan and before the Qualifying Child would have otherwise ceased to be a Dependent; and

(D) proof of such incapacity is submitted to the Fund Office within ninety (90) days after the date that the Qualifying Child would have otherwise ceased to be a Dependent; and subsequently, as may be required by the Fund, but not more often than annually following the date initial proof is received.

(2) The Qualifying Child was not eligible for benefits under Section 1.16(b), but meets all the conditions of Section 1.16(c)(1) except that the disability commenced before the Participant was eligible for benefits under this Plan.

(A) Proof of such incapacity is submitted to the Fund Office within ninety (90) days after the Participant's eligibility commencement date; and subsequently, as may be required by the Fund but not more often than annually following the date initial proof is received.

(d) In cases where divorce has occurred:

(1) A Qualifying Child whose coverage is determined by the terms of a divorce decree or a Qualified Medical Child Support Order will be considered a Dependent without regard to the Coordination of Benefits provisions in Article 5.

(e) A Spouse who receives health benefits from another health plan may waive, in writing, the right to receive benefits under the Plan. Any such waiver must include the signature of the Spouse and will be effective on the first (1st) day of the month after the month in which the waiver is received.

(1) A Spouse that previously waived coverage under the Plan while coverage from the Spouse's employer was in effect may apply to recommence receiving benefits under the Plan if either the Spouse loses eligibility for the employer coverage or if the Spouse's employer stops contributing toward the cost of that coverage. However, a Spouse who has waived coverage must:

(A) within 60 days of the loss of the employer coverage, apply for coverage under the Plan;

(B) provide the Fund Office with proof that the Spouse was continuously covered under another health plan, including Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage, from the effective date of the waiver until the date that the other coverage was lost; and

(C) satisfy all other requirements set out in this Plan Document, as it appears at the time the Spouse applies for coverage and as determined by the Trustees in their sole discretion.

(2) A Spouse that previously waived coverage under the Plan while Medicaid coverage was in effect may apply to recommence receiving benefits under the Plan if the Spouse subsequently loses eligibility for Medicaid coverage. However, the Spouse must request enrollment within 60 days after Medicaid coverage ends.

(3) A Spouse that previously waived coverage who as a result of a subsequent marriage, birth, adoption, or placement for adoption has a new Dependent may apply to recommence receiving benefits under the Plan. However, a Spouse who has waived coverage must request enrollment within 60 days of the birth, adoption, or placement for adoption of the new Dependent.

(f) A Qualifying Child who receives health benefits from another health plan may waive the right to receive benefits under the Plan on a form satisfactory to the Fund Office. Any such waiver will be effective on the first (1st) day of the month after the month in which the waiver is received.

(g) A Spouse or Qualifying Child that previously waived coverage and subsequently loses Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage or becomes eligible for a state premium assistance subsidy from Medicaid or CHIP may request enrollment as a Dependent within 60 days of changes related to Medicaid or CHIP.

Section 1.17 Durable Medical Equipment ("DME")

The term "Durable Medical Equipment ("DME") is defined as equipment that is Medically Necessary and used solely by the patient for the treatment of an Illness or Injury. If the purchase of DME totals $1,000 or more or if the DME is rented (regardless of cost), the DME must be approved by the Fund's Medical Consultant. DME does not include items that are environmental in nature or solely for convenience, or equipment to be used in the home, such as humidifiers, vacuum cleaners, waterbeds, etc.

Section 1.18 Elective

The term "Elective" is defined as any procedure or admission that at the time when it is scheduled does not involve a medical emergency.

Section 1.19 Emergency Medical Condition

The term "Emergency Medical Condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part, which necessitates the use of the most accessible Hospital or licensed emergency medical care facility equipped to furnish such care. Such conditions include, but are not limited to: suspected heart attacks, cardiovascular accidents, suspected poisoning, loss of consciousness or respiration, convulsions, and other acute conditions determined to be an Emergency Medical Condition by the Plan.

Section 1.20 Emergency Services

The term "Emergency Services" is defined as (a) anything a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care; (b) an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or "Independent Freestanding

Emergency Department" (as defined under the No Surprises Act), including "Ancillary Services" (also as defined under the No Surprises Act) routinely available to the emergency department to evaluate such Emergency Medical Condition; (c) such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and (d) services provided by an Out-of-Network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

(a) The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

(b) The patient is supplied with a written notice, as required by federal law, that the provider is an Out-of-Network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any In-Network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the In-Network providers listed; and

(c) The patient gives informed consent to continued treatment by the Out-of-Network provider, acknowledging that the patient understands that continued treatment by the Out-of-Network provider may result in greater cost to the patient.

Section 1.21 Employee

The term "Employee" is defined as a person who is employed by an Employer and for whom the Employer is required by a Collective Bargaining Agreement or Participation Agreement to make Contributions to the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund. Employees shall also mean full-time employees of the Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund, full-time employees of all Teamsters Local Unions in the State of Virginia, full-time employees of the Teamsters Joint Council No. 83 of Virginia, for whom Contributions are made to the Fund from the date of full-time employment and who do not participate in or receive benefits of any other union-management Welfare Plan while so employed.

Section 1.22 Employer

The term "Employer" is defined as any Employer who has been and remains approved for participation by the Fund's Board of Trustees and has a Collective Bargaining Agreement in effect with the Union or a Participation Agreement requiring periodic Contributions to the Fund. The term Employer shall also mean the Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund and the Teamsters Joint Council No. 83 of Virginia Pension Fund, Teamsters Local Unions in the Commonwealth of Virginia which are members of the Teamsters Joint Council No. 83 of Virginia, and other Teamsters Local Unions, provided such Employers make Contributions to the Health and Welfare Fund at the rate required by current Collective Bargaining Agreements or Participation Agreements.

Section 1.23 Essential Benefit

The term "Essential Benefit" includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services,

including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an "Essential Benefit" for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen the State of Utah as its benchmark state.

Section 1.24 Experimental or Investigational

The term "Experimental or Investigational" is defined as treatments, procedures, devices, or drugs which the Trustees determine, in the exercise of their discretion, are Experimental, Investigational, or done primarily for research. Treatments, procedures, devices, or drugs are excluded under this Plan unless:

(a) Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law;

(b) Reliable evidence shows that the treatment, procedure, device, or drug is not the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

(c) Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses;

(d) "Reliable evidence" includes anything determined to be such by the Trustees, within the exercise of their discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

Section 1.25 Fee Allowance

The term "Fee Allowance" is defined as the maximum amount considered for each charge as provided on a claim for benefits as provided for by the Fund's Medical Consultant, HIAA, American Dental Association or any other provider chosen by the Board of Trustees.

Section 1.26 Hospital

The term "Hospital" is defined as a certified institution constituted and operated in accordance with the laws pertaining to Hospitals that provides for medical and surgical treatment for Injury and Illness under the care of Physicians on an inpatient basis with continuous twenty-four (24) hour nursing services by Registered Nurses. The term Hospital does not include an institution which is, other than incidentally, a place for rest, a place for the aged, a nursing home, or a place where the Participant is not legally required to make payment for the service and supplies provided unless such services and supplies are provided by a department or agency of the United States.

Section 1.27 Hospital Confinement or Confined in a Hospital

An individual shall be considered "Confined in a Hospital" if the individual is a registered patient in a Hospital upon the recommendation of a Physician or is a patient in a Hospital because of a surgical operation. This definition also includes a patient undergoing outpatient surgery in a Hospital or a patient receiving emergency care in a Hospital because of an Injury and the treatment is within one (1) week after the date the Injury incurred.

Section 1.28 Illness

The term "Illness" includes physical illness, mental illness, functional nervous disorders, and pregnancy.

Section 1.29 In-Network

The term "In-Network" is defined as the use of a provider that is a member of the Fund's appointed Preferred Provider Organization such that all claims incurred by such a provider will be processed under the "In-Network" benefit level as described in the applicable Schedule of Benefits.

Section 1.30 Intensive Care Unit

The term "Intensive Care Unit" is defined as an accommodation or part of a Hospital which is established by the Hospital for a formal intensive care program and which, in addition to providing Room and Board, is exclusively reserved for critically ill patients who require constant audio-visual observation by a Physician, or, at the direction of a Physician, by a Registered Nurse specially trained for service in an Intensive Care Unit. To qualify as an Intensive Care Unit, the facility must provide, in the immediate vicinity on a standby basis, all necessary lifesaving equipment, drugs and supplies. The term Intensive Care Unit shall not include a postoperative recovery program.

Section 1.31 Lifetime Maximum

The term "Lifetime Maximum" is defined as the maximum collective payment by the Fund on behalf of a Participant or Dependent over their lifetime for certain benefit categories as identified in the applicable Schedule of Benefits.

Section 1.32 Medical Benefits

The term "Medical Benefits" is defined as all benefits provided under Article 3 of this Plan, other than the Accidental Death and Dismemberment Benefit.

Section 1.33 Medical Consultant

The term "Medical Consultant" is defined as an entity appointed by the Trustees to provide selected consulting and management services as defined in the general medical community.

Section 1.34 Medically Necessary

The term "Medically Necessary" is defined as services or supplies which the Trustees determine, in the exercise of their discretion, are generally acceptable by the national medical professional community as being safe and effective in treating a covered Illness or Injury, consistent with the symptoms or diagnoses, furnished at the most appropriate medical level and not primarily for the

convenience of the patient, a health care provider, or anyone else. Because a health care provider has prescribed, ordered, or recommended a service or supply does not, by itself, mean that it is Medically Necessary.

Section 1.35 Necessary Services and Supplies

The term "Necessary Services and Supplies" is defined as any charges, other than charges for Room and Board, made by a Hospital on its own behalf for Necessary Medical Services and Supplies actually administered during Hospital Confinement. Necessary Services and Supplies shall also include any charges for the administration of anesthesia, radiology and pathology during Hospital Confinement, and charges for professional ambulance service (as described in Section 3.14(b)(7)), but shall not include any charges for special nursing fees, dental fees, or medical fees. Necessary Services and Supplies shall also mean charges made by a Hospital, Ambulatory Surgical Facility or physician surgery site on its own behalf for necessary medical services and supplies actually administered for outpatient surgery.

Section 1.36 No Surprises Act

The term "No Surprises Act" is defined to mean the surprise billing legislation enacted as part of the Consolidated Appropriations Act of 2021, and any applicable regulations promulgated thereunder.

Section 1.37 No Surprises Services

The term "No Surprises Services" is defined to include the following services, to the extent covered under the Plan: (a) Out-of-Network provider services to treat an Emergency Medical Condition; (b) Out-of-Network provider air ambulance services; (c) ancillary services as defined under the No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, neonatology and diagnostic services) when performed by Out-of-Network providers at In-Network facilities; and (d) other services to treat a condition that is not an Emergency Medical Condition performed by an Out-of-Network provider at In-Network health care facilities with respect to which the provider does not comply with the notice and consent requirements under the No Surprises Act and its implementing regulations.

Section 1.38 Out-of-Network

The term "Out-of-Network" is defined as the use of a provider that is not a member of the Fund's appointed Preferred Provider Organization such that all claims incurred by such a provider, unless otherwise required by the No Surprises Act, will be processed under the "Out-of-Network" benefit level as described in the applicable Schedule of Benefits.

Section 1.39 Participant

The term "Participant" is defined as an Employee who has met the necessary requirements to receive benefits from the Fund.

Section 1.40 Permanently and Totally Disabled

As used in Section 2.6, a Participant will be considered Permanently and Totally Disabled if, on the basis of evidence satisfactory to the Trustees, the Participant is found to be permanently and totally unable, as a result of an Injury or Illness, to engage in any further employment that provides

earned income in excess of that allowed by the Social Security Administration to maintain Social Security Disability Benefits. The Trustees shall be the sole and final judges of Permanent and Total Disability and of the entitlement to Continuation of Life Insurance During a Period of Permanent and Total Disability under the Plan.

Section 1.41 Physician

The term "Physician" is defined as an individual who is licensed to prescribe and administer drugs or to perform surgery and is operating within the scope of a current license. Licensed psychologists and midwives are also included in the definition of Physician. Notwithstanding the foregoing, only a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) may certify a Participant's Total Disability for purposes of Section 3.3(b).

Section 1.42 Plan

The term "Plan" is defined as this Plan or program of benefits established by the Trustees pursuant to the Agreement and Declaration of Trust.

Section 1.43 Preferred Provider Organization

The term "Preferred Provider Organization" is defined as the provider network for which Participants must use a contracted provider to obtain applicable "In-Network" benefits as provided for in a given Schedule of Benefits.

Section 1.44 Procedures Requiring Pre-certification

(a) The term "Procedures Requiring Pre-certification" is defined by the list below. These procedures require pre-certification by the Fund's Medical Consultant prior to the date of service, if such benefits are provided for in the Plan Document and Schedule of Benefits in accordance with the rules set forth in Section 3.4:

(1) All inpatient admissions. This includes admissions for surgeries, skilled nursing facilities (for patients requiring rehabilitation from hip replacements, strokes, etc.), and treatment centers for psychiatric conditions and/or substance abuse disorders.

(2) DME purchases exceeding $1,000 and all DME rentals (regardless of cost).

(3) Prescription drugs administered in an outpatient medical setting with a billed amount of $15,000 or more require prior authorization in order to be considered a covered expense under the Plan.

(b) Non-Compliance. Failure to contact the Fund's Medical Consultant as described in subsection (a). will result in a denial of coverage for benefits applied to services listed in this Section 1.44.

Section 1.45 Qualified Beneficiary

The term "Qualified Beneficiary" is defined as:

(a) The Spouse and Qualifying Children of a Participant who, on the day before a Qualifying Event, were eligible for benefits under the Plan;

(b) Any Qualifying Child who is born to or placed for adoption with a covered Participant during a period of COBRA Continuation Coverage; and

(c) Any covered Participant who had retired before the date of termination of benefits caused by the bankruptcy of the Participant's last regular Employer, the Participant's Spouse or surviving Spouse, and Dependent children.

Section 1.46 Qualifying Child

The term "Qualifying Child" means a Participant's natural child, adopted child (including a child placed for adoption), stepchild, or a child for whom the Participant has legal custody under the age of twenty-six (26). For purposes of this Plan Document, a "stepchild" is defined as the natural child or adopted child (including a child placed for adoption) of the Participant's lawful Spouse or a child for whom the lawful Spouse has legal custody.

Section 1.47 Registered Nurse/Licensed Practical Nurse

The term "Registered Nurse" is defined as a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N." The term "Licensed Practical Nurse" is defined as a professional nurse who has the right to use the title "Licensed Practical Nurse" and the abbreviation "L.P.N."

Section 1.48 Regular Treatment by a Physician for a Disability

The term "Regular Treatment by a Physician for a Disability" is defined as examination, and administration or prescription of medication and/or therapy by a Physician that is customarily accepted and/or considered proper according to the Fund's Medical Consultant and is repeated at intervals which result in the reduction of termination of the disability.

Section 1.49 Room and Board

The term "Room and Board" is defined as all charges commonly made for room, meals, and nursing services.

Section 1.50 Schedule of Benefits

The term "Schedule of Benefits" is defined as the benefits listed and described within a document entitled "Schedule of Benefits" available to all Participants.

Section 1.51 Spouse

The term "Spouse" means a Participant's legally married spouse, regardless of whether such spouse is of the same or opposite sex of the Participant.

Section 1.52 Total Disability

(a) A Participant will be considered Totally Disabled during any period when, as a result of a non-occupational Injury or Illness, the Participant is completely unable

to engage in each and every material duty of any employment for wage or profit as documented by a treating Physician in accordance with generally accepted clinical guidelines and objective tests;

(b) A Dependent will be considered Totally Disabled during any period when, as a result of a non-occupational Injury or Illness, the Dependent is unable to engage in the normal activities of a person of the same age and sex as determined by the Fund's Medical Consultant.

Section 1.53 Trust Agreement

The term "Agreement and Declaration of Trust" or "Trust Agreement" is defined as the Agreement and Declaration of Trust of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund made and entered into on November 10, 1952, and as restated and amended from time to time.

Section 1.54 Trust Fund or Fund

The term "Fund" or "Trust Fund" is defined as the trust estate of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund, which shall consist of all monies received by the Trustees as Employer Contributions, COBRA, Direct Pay, and Retiree Contributions, or as income from investments made and held by the Trustees or otherwise, all policies together with all dividends, refunds or other sums payable (if any) to the Trustees on account of such policies, and any other property received and held by the Trustees for uses, purposes and trusts set forth in the Agreement and Declaration of Trust.

Section 1.55 Trustees

The term "Trustees" as used herein is defined as "Trustees," "Board of Trustees," "Board" or "Trustee" or "one of the Trustees," as the context may require, designated by the Agreement and Declaration of Trust, together with their successors designated and appointed to administer the Fund. The Trustees, collectively, shall be the "Plan Administrator" of this Plan as that term is used in ERISA.

Section 1.56 Union

The term "Union" is defined as any local union affiliated with the International Brotherhood of Teamsters, which has a Collective Bargaining Agreement with an Employer requiring periodic Contributions to the Fund created by the Trust Agreement.

Section 1.57 Urgent Care

The term "Urgent Care" is defined as any claim for medical care or treatment in which the application of the time periods for making non-urgent care determinations:

(a) would, in the opinion of a physician with knowledge of the claimant's medical condition, either:

(1) subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or

(2) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) could, in the opinion of an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function.

Article 2 Eligibility

Section 2.1 General Provisions

Plan coverage is provided only to those Employees and their Dependents who meet the eligibility requirements of this Article 2. The benefits available to a Participant and the Participant's Dependents who meet such eligibility requirements shall only be those benefits shown in the Schedule of Benefits for the particular Plan (e.g., schedule 12, 11, etc.) that covers the Participant, as determined by the contribution rate set forth in the applicable Collective Bargaining Agreement. Such benefits are payable only if the expense in question is incurred:

(a) while the Participant and/or Dependent is eligible for benefits under this Plan, subject to the limitations contained herein; or

(b) in cases where a particular benefit is extended under the Plan, during the period of such extension.

For purposes of the Plan, an expense is considered "incurred" on the date the service or supply is rendered or delivered.

Section 2.2 Participants - Initial Eligibility

(a) A person who commences Active Service as set forth in Section 2.2(b) shall be eligible for benefits under the Plan on the first (1st) day of the week specified in the applicable collective bargaining agreement for which Contributions are made to the Fund, and such eligibility shall continue for the remainder of the calendar month in which eligibility commences and for two (2) calendar months immediately following such month, unless eligibility is terminated earlier by the provisions of Section 2.4(a).

(b) For purposes of Section 2.2(a), Active Service shall commence upon any one of the following:

(1) Becomes an Employee in Active Service, or

(2) Is a full-time or part-time bargaining unit Employee who is not in Active Service and who is covered for health and welfare benefits provided by a provider other than the Fund, and commences Active Service with the same Employer due to a change in job position, or

(3) Is an Employee in Active Service of a newly participating Employer, or

(4) Is an Employee in Active Service who transfers to the Fund from another Teamster health and welfare fund.

(c) Special Rule Where Collective Bargaining Agreement Establishes Different Standards for Eligibility. A Union and an Employer may, through their Collective Bargaining Agreement, establish conditions for eligibility different than those contained in Section 2.2(a) and (b) and 2.13, provided that the following minimum conditions are met:

(1) No Employee will be eligible for benefits for any month in which the Employer is not obligated to make Contributions on the Employee's behalf.

(2) If the Collective Bargaining Agreement and/or Participation Agreement make coverage optional:

(A) The first (1st) full calendar month following the effective date of the Collective Bargaining Agreement and that same month in subsequent contract years will be an enrollment period in which an eligible Employee must decide whether to elect coverage, to continue, or to refuse coverage.

(B) New Employees will have thirty (30) days from the date of initial eligibility to elect to participate and must continue to participate until the earlier of the end of the next enrollment period or until the termination of the Employee's employment.

(C) An Employee who elects coverage during any enrollment period must continue such coverage until the earlier of the end of the next enrollment period or until the termination of the Employee's employment.

(D) At least seventy-five percent (75%) of the Employees in the collective bargaining unit must participate at the conclusion of any enrollment period.

(3) The Employer will submit a monthly eligibility file no later than the twenty-fifth (25th) day of the month prior to the month for which the eligibility file applies. The employer will submit related Contributions no later than the fifteenth (15th) calendar day of the month for which coverage is provided.

(4) If any Employee is covered by other employer-provided coverage on the first (1st) day coverage is available through Employer Contributions to the Fund, the Employee will become eligible for benefits from this Fund on the day immediately following the date of termination of the Employee's other coverage. If the Collective Bargaining Agreement or Participation Agreement makes coverage optional, the Employee must elect coverage with the Fund within thirty (30) days of the termination of such other coverage and provide to the Fund proof of creditable coverage.

(5) An Employee who has elected optional coverage from the Fund may change the form of coverage (e.g., single, married, or family) by providing notice to the Fund within thirty (30) days after a Qualifying Event (e.g. marriage, divorce, birth, adoption, placement for adoption, death).

(6) In no event shall any eligibility waiting period established by a Collective Bargaining Agreement, when combined with any eligibility waiting period set forth in the Plan document, cause the Fund to violate Section 9815(a)(1) of the Code or Section 701(b)(4) of ERISA, and applicable regulations and rulings thereunder, implementing Section 2708 of the Public Health Act, which provides that a group health plan offering group health insurance coverage shall not apply any waiting period that exceeds 90 days, as determined by the Trustees in their sole discretion.

Section 2.3 Participants — Continued Eligibility

All Participants meeting the level of monthly Contributions as described below will continue to be eligible for the benefits specified in the Plan for the associated month provided until their eligibility for benefits terminates in accordance with Section 2.4 and Section 2.18, or some other applicable provision of the Plan.

Contributions for 3 of 4 weeks or 4 of 5 weeks in the month of	**Provides eligibility in the month of**
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

Section 2.4 Participants — Termination of Eligibility

Except as provided in Section 2.5, Section 2.6, Section 2.7, Section 2.8, Section 2.9, Section 2.10, and Section 2.11, a Participant's eligibility for benefits will terminate automatically on the earliest of the following dates:

(a) The last day of the last calendar month for which coverage was earned as provided in Section 2.2(c) or 2.3;

(b) The date immediately preceding the Participant's induction into the Armed Forces of the United States, provided that the Participant will immediately be eligible for coverage upon the Participant's return to covered employment; provided that the termination of the Participant's coverage will not terminate any coverage for the Participant's Dependents required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

(c) The last day for which group coverage is in effect due to the Employer ceasing to be a participating Employer;

(d) The date of the Participant's death.

Section 2.5 Participants — Continuation of Medical Benefits During Period of Short Term Disability ("Free Coverage")

If provided in the Schedule of Benefits covering the Participant, and if Active Service with an Employer terminates because the Participant becomes disabled as described in Section 3.3(a). and per the Collective Bargaining Agreement, the Employer pays the required Contributions after the Employee becomes disabled, the Medical Benefits of the Participant and the Participant's Dependents shall be continued beyond the termination date set forth in Section 2.4 at no cost to the Participant for a period up to and including the earliest of the following dates:

(a) The date that is two (2) months following the date of the termination of Short Term Disability Benefits;

(b) The date that is two (2) months after the date immediately preceding the Participant's return to Active Service provided that the Active Service lasts for a period of at least fourteen (14) days, beginning the day the Participant returns to work;

(c) The date that is two (2) months following the date of the Participant's death;

(d) The date that is two (2) months following the last day of the coverage period, as set forth in the Schedule of Benefits last covering the Participant;

(e) In the case of a Dependent, the date on which such Dependent's eligibility for benefits would otherwise terminate under any other provision of this Plan;

(f) The last day for which group coverage is in effect due to the Employer ceasing to be a participating Employer; or

(g) The date immediately preceding the date on which the Participant commences receipt of benefits from Medicare/Medicaid, any union, union-management pension fund or any other retirement plan. This section shall not apply to an active Participant who receives pension benefits solely because of required minimum distribution requirements under the Code.

Section 2.6 Participants — Continuation of Life Insurance Benefits During Permanent and Total Disability ("PTD")

(a) General Rule. If, before the Participant's sixtieth (60th) birthday, a Participant becomes Permanently and Totally Disabled ("PTD"), the PTD Life Insurance Benefit will be extended while the Participant continues to be Permanently and Totally Disabled, but for not more than one (1) year from the date that the Participant's eligibility for the Life Insurance Benefit otherwise would have terminated in accordance with Article 2.

(b) Proof of Initial Eligibility. Within one (1) year after the date on which Permanent and Total Disability commenced, the Participant must submit proof to the Fund Office showing that the Permanent and Total Disability has existed continuously for nine (9) months and that it commenced prior to the Participant's sixtieth (60th) birthday in order to continue coverage for a period of one (1) year from the date of the signed doctor's statement and upon approval by the Fund Office (provided such Participant continues to be Permanently and Totally Disabled during this period). Proof of Permanent and Total Disability shall consist of a copy of the Participant's Social Security Disability Award or a copy of the Participant's Social Security Disability application if the award is not yet available, a doctor's statement of Permanent and Total Disability including commencement date, and a certified copy of the Participant's birth certificate. A Participant will not be automatically ineligible for PTD Life Insurance Benefits if proof of disability or a copy of the Social Security Disability Award cannot be supplied within one (1) year. Eligibility for PTD Life Insurance Benefits shall be contingent upon receipt of the Social Security Disability Award which must be consistent with the requirements of this Section 2.6(b) and received by the Fund Office within one (1) year after the date of the award.

(c) Proof of Continuing Permanent and Total Disability. Unless evidence is provided to the Trustees which conclusively proves a Participant's Permanently and Totally disabled condition cannot improve in the future, the PTD Life Insurance Benefit will be continued after the initial eligibility period for further periods of one (1) year provided the following proof of continuing Permanent and Total Disability is submitted to the Fund annually:

(1) Physician's statement of Permanent and Total Disability; and

(2) Statement from the Social Security Administration verifying that the Participant is still receiving Social Security Disability, or, in the case of a Participant who has attained age sixty-five (65), the forms necessary to obtain a completed Social Security earnings report. At any time during the period in which the Permanent and Total Disability Life Insurance Benefit is extended, the Fund will have the right to require proof of continuing Permanent and Total Disability and/or to have a Physician of its choice examine the Participant.

(d) Amount of Life Insurance Benefit. The amount of the Permanent and Total Disability Life Insurance Benefit under the preceding paragraphs in Section 2.6 will be the amount shown for PTD Life Insurance Benefits in the Schedule of Benefits covering the Participant on the date Contributions were last paid on the Participant's behalf by a contributing Employer. In cases where the Participant's eligibility for Continuation of Life Insurance Benefits During Permanent and Total Disability ("PTD") was initially approved prior to January 1, 1994, the amount of the Permanent and Total Disability Life Insurance Benefit will be equal to the Life Insurance Benefit amount listed in the Schedule of Benefits covering the Participant on the date Contributions were last paid on the Participant's behalf by a contributing Employer.

(e) Payment of Benefits. No payment will be made on account of a Participant's death when the benefit is extended under Section 2.6 unless a certified copy of the death certificate is received by the Fund Office within one (1) year after the date of death.

(f) Termination. The Permanent and Total Disability Life Insurance Benefit which is being extended under this Section 2.6 will automatically terminate on the earliest of the following dates:

(1) The date the Participant ceases to be Permanently and Totally Disabled, unless at that time the Participant has returned to work for an Employer and becomes otherwise eligible for benefits under the Plan based on Contributions by the Employer;

(2) The Participant refuses to submit to any physical examination required by the Fund;

(3) The Participant fails to provide proof of continuing Permanent and Total Disability as required hereunder; or

(4) On the date that the Participant's past Employer ceases to be a participating Employer unless the Participant's past Employer ceased to be a participating Employer prior to January 1, 1994.

(A) In cases where the employer of a Participant eligible for Continuation of Life Insurance Benefits During Permanent and Total Disability ("PTD") ceased to be a participating Employer prior to January 1, 1994, the Participant's eligibility for this benefit does not terminate except under the conditions described in Section 2.6(f)(1), Section 2.6(f)(2), or Section 2.6(f)(3).

(g) Limitations. No payment shall be made for Life Insurance Benefits During Permanent and Total Disability in cases where the Participant's death precedes the Fund Office's receipt of all required documentation listed in Section 2.6(b).

Section 2.7 Extension of Benefits While Totally Disabled

(a) In General. This Section governs the extension of Medical Benefits (other than dental, vision, and the Out-of-Pocket Expense Benefit) for Participants and eligible Dependents, and extension of Life Insurance eligibility for Participants only. There is no extension of benefits for the Accidental Death and Dismemberment Benefit (Section 3.2) or Short-Term Disability Income Benefit (Section 3.3).

(b) Extension of Medical Benefits (other than dental and vision care benefits and the Out-of-Pocket Expense Benefit). If a Participant or Dependent becomes Totally Disabled while eligible for benefits under this Plan, and if that person's eligibility for benefits terminates while that person is Totally Disabled, that person's Medical Benefits, other than the Dental Expense Benefit, Vision Care Benefit, and Out-of-Pocket Expense Benefit, will be extended beyond the termination date while that person remains Totally Disabled, subject to the following limitations:

(1) Such extension applies only to benefits for expenses that are incurred as a result of, or in order to treat, the Injury or Illness that caused the Total Disability;

(2) The extension will end on the earliest of the following dates:

(A) the date immediately preceding the date on which the Participant or Dependent ceases to be Totally Disabled or ceases undergoing Regular Treatment by a Physician for the Disability;

(B) the date that is three (3) months after the termination date, except for Major Medical Expense Benefits;

(C) The date that is one (1) year after the termination date, in the case of Major Medical Expense Benefits; or

(D) The date the Participant or Dependent becomes eligible for retiree coverage;

(3) The extension is subject to the same conditions otherwise applicable under the terms of the Plan, as set forth in this Plan Document, had the benefits remained in force;

(4) No benefits shall be paid under Section 2.7 until coverage under Continuation of Medical Benefits During Period of Short Term Disability (Section 2.5, if provided in the Participant's Schedule of Benefits), Direct Pay (Section 2.9, if elected) and COBRA/USERRA Continuation Coverage (Section 2.10, if elected), have been exhausted.

(c) Extension of Life Insurance. Subject to the following provisions, the Plan shall provide an extension of the Life Insurance Benefit covering Participants, if such benefit is provided under the Participant's Schedule of Benefits:

(1) In General. If a Participant becomes Totally Disabled due to a non-occupational Injury or Illness, the full Life Insurance Benefit amount will be extended for a maximum period of six (6) months;

(2) Life Insurance Benefit Amount. The Life Insurance Benefit payable under Section 2.7(c) shall be the Life Insurance Benefit amount listed in the Schedule of Benefits covering the Participant on the date Plan coverage terminated due to Total Disability;

(3) Termination. The extension of the Life Insurance Benefit will end on the earlier of:

(A) the date six (6) months from the date on which the Participant's coverage under the Plan would have otherwise terminated due to Total Disability; or

(B) the date on which the Participant ceases to be Totally Disabled.

(d) Termination of Group Coverage. Notwithstanding any other provision contained herein, there will be no extension of Life Insurance Benefits beyond the last day for which group coverage is in effect due to the Employer ceasing to be a participating Employer. This limitation applies to all Schedules of Benefits provided by the Plan.

Section 2.8 Extension of Dental and Vision Care Benefits

(a) In General. If a Participant's eligibility for benefits under this Plan terminates, Dental Expense Benefits under Section 3.11, Orthodontic Benefits under Section 3.12, and Vision Care Benefits under Section 3.13 for which the Participant or Dependent is otherwise eligible will be extended beyond the termination date, subject to the following limitations:

(1) Treatment before Termination Date. This extension applies only to benefits for expenses incurred for treatment that commenced before the termination date;

(2) Eligibility. This extension does not apply if the eligibility of the Dependent terminates as a result of the Dependent's ceasing to be a Dependent; and

(3) Termination.

(A) The extension will end on the date that is three (3) months after the termination date; or

(B) The date the Participant's past Employer ceases to be a participating Employer.

Section 2.9 Direct Pay Benefit

(a) In General. If a Participant knows in advance that the Participant's Employer will not be required to make sufficient Contributions to the Fund on the Participant's behalf because the Participant will be laid off, on leave of absence, or will not be offered sufficient work to retain eligibility for benefits, the Participant may arrange to make Contributions to the Fund. A Participant may also arrange to make Contributions to the Fund to continue benefit eligibility due to the expiration of benefits provided under Section 2.5(a)(1)(D) and 2.5(a)(2)(D), for reasons that qualify a Participant for benefits under Section 2.7 and upon expiration of active coverage for a Participant eligible for retirement health benefits.

(b) Benefits Provided. When a Participant qualifies for and elects Direct Pay Benefits, the Participant must select a Schedule of Benefits that is equal to or below the Schedule of Benefits the Participant was previously eligible for through Employer Contributions. All benefits under the chosen Schedule of Benefits will be provided with the exception of Short Term Disability Income Benefits, if applicable. After the payment deadline described in Section 2.9(e), the Participant may not change the Participant's election.

(c) Election of Coverage. A Participant must designate the Participant's election of Direct Pay Benefits and the Schedule of Benefits selected on a form satisfactory to the Fund Office.

(d) Duration of Coverage. A Participant may receive benefits from the Fund for a period of eighteen (18) consecutive months. If at any time the Participant earns active coverage solely through Employer Contributions and then meets the conditions specified in Section 2.9(a), the Participant may again elect Direct Pay Benefits for up to eighteen (18) consecutive months.

(e) Premium Due Date. Participant payments must be received by the Fund Office no later than the tenth (10^{th}) calendar day of the month 2 months prior to the month for which coverage is desired.

(f) Amount of Payment. The amount a Participant must pay to receive Direct Pay Benefits under Section 2.9 will be as follows:

(1) If the Participant elects the same Schedule of Benefits provided through Employer Contributions, the amount will equal the number of contribution weeks in the month multiplied by the weekly contribution rate the Participant's Employer was paying into the Fund on the Participant's behalf prior to losing active coverage less the monthly cost of Short Term Disability Income Benefits as most recently determined by the Fund's actuary. If for any month in which Direct Pay Benefits are elected, the Contributing Employer contributes on the Participant's behalf, such Contributions plus an amount equivalent to one (1) additional week of Contributions from the Participant's Employer will be deducted from the Participant's liability to the Fund. If at any time during the use of Direct Pay

Benefits, the Employer incurs a contribution rate increase, the same increase with the same effective date shall apply when calculating the Participant's contribution amount;

(2) If the Participant elects a reduced Schedule of Benefits than that previously provided through Employer Contributions, the amount will equal the number of contribution weeks in the month multiplied by the weekly contribution rate approved by the Trustees for such Schedule of Benefits for the year in which Direct Pay Benefits are desired. If in the month for which Direct Pay Benefits are elected, a Contributing Employer contributes on the Participant's behalf, such Contributions plus an amount equivalent to the weekly rate described above will be deducted from the Participant's liability to the Fund. If the Participant continues to use Direct Pay Benefits at the end of twelve (12) months without a break in use, the contribution rate utilized to calculate the amount payable for Direct Pay Benefits shall increase as provided for in the multi-year rate structure adopted by the Trustees in the year Direct Pay Benefits began.

Section 2.10 COBRA/USERRA Continuation Coverage

This Section describes the procedures for continuing health coverage, as required by COBRA and by USERRA. Unless stated otherwise, "COBRA Continuation Coverage" includes the coverage required by USERRA.

(a) In General. The Participant, the Participant's eligible Spouse and other eligible Dependents may continue eligibility for benefits for specified periods set forth in Section 2.10(d), by making self-payments at the rates determined by the Trustees where eligibility would have otherwise terminated as a result of a "Qualifying Event."

(b) Benefits Provided. When a Participant or Qualified Beneficiary elects COBRA Continuation Coverage pursuant to Section 2.10, they must select a Schedule of Benefits. An individual electing COBRA Continuation Coverage will be eligible for the same benefits provided under the Schedule of Benefits that the individual was covered by on the date coverage otherwise would have terminated as a result of the Qualifying Event. However, individuals electing COBRA may select benefits provided under any lower Schedule of Benefits offered by the Fund. The individual may not change the Schedule of Benefits selected once COBRA Continuation Coverage has begun.

(1) Core and Non-Core Benefits — If an individual is covered under a Schedule of Benefits which provides Dental and/or Vision Care Benefits (Non-Core Benefits), the individual may reject coverage for such and elect coverage only for medical coverage (Core Benefits).

(2) Benefits Not Covered — COBRA Continuation Coverage does not provide coverage for any benefit other than Medical Benefits. For the purpose of this section only, Medical Benefits does not include Life

Insurance, Continuation of Life Insurance Benefits During Permanent and Total Disability ("PTD") and the Short Term Disability Benefit, in addition to the exclusions listed in Section 1.32. If, after the Reinstatement of Active Coverage Eligibility, there is another Qualifying Event, the individual may elect COBRA Continuation Coverage and may elect among applicable Schedules of Benefits.

(c) Qualifying Events and Duration of Coverage. In order to be eligible for COBRA Continuation Coverage, an individual must incur a "Qualifying Event" which would otherwise result in the termination of eligibility for benefits under the Plan.

(1) Participant Qualifying Event. Qualifying Events for eligible Participants, their eligible Spouse, and other eligible Dependents are as follows:

(A) Termination of Covered Employment for reasons other than gross misconduct;

(B) Reduction of hours of employment; and

(C) Absence from employment because of service in the uniformed services of the United States;

(D) Termination of Direct Pay benefits.

(2) Spouse and Qualifying Child Qualifying Events. Qualifying Events for a Participant's eligible Spouse and other eligible Dependents are as follows:

(A) The Participant's death;

(B) Divorce from the Participant;

(C) The Participant's entitlement to Medicare coverage; and

(D) Loss of Dependent status under the terms of the Plan, i.e., the Dependent no longer meets the definition of Dependent under the Plan

(d) Duration and Termination of Coverage. An individual's eligibility to continue self-paying for COBRA Continuation Coverage shall terminate upon the end of the Applicable Continuation Period or a Termination Event, whichever occurs first.

(1) Applicable Continuation Period:

(A) COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or, in some cases, a Qualifying Child's loss of eligibility as a dependent, COBRA continuation coverage can be

extended for thirty-six (36) months. When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until thirty-six (36) months after the date of Medicare entitlement.

(B) Where a Participant's eligibility for benefits would have terminated as the result of a reduction of hours, the Applicable Continuation Period is eighteen (18) months from the date coverage would have otherwise terminated.

(C) Where a Participant's eligibility for benefits would have terminated as the result of the termination of employment, the Applicable Continuation Period is eighteen (18) months from the date coverage would have otherwise terminated.

(D) In the event that a Qualified Beneficiary becomes disabled under Title II or XVI of the Social Security Act within sixty (60) days after a qualifying event defined in 2.10(c)(1)(A), then the Applicable Continuation Period is twenty-nine (29) months, provided that the Fund Office is notified of the Social Security determination before the close of the initial eighteen (18) month period of COBRA coverage. In the event the Participant or Qualified Beneficiary ceases to be disabled, the Participant's or Qualified Beneficiary's Dependents shall cease to be eligible to self-pay beyond the later of:

(i) the end of the initial eighteen (18) month period; or

(ii) the end of the month in which the date falls that is thirty (30) days after a final determination that the Participant or Qualified Beneficiary is no longer disabled.

(E) In the event that a Participant becomes disabled under Title II or XVI of the Social Security Act within sixty (60) days after a Qualifying Event defined in 2.10(c)(1)(A), then the Applicable Continuation Period is twenty-nine (29) months, provided that the Fund Office is notified of the Social Security determination before the close of the initial eighteen (18) month period of COBRA coverage. In the event the Participant ceases to be disabled, the Participant's Dependents shall cease to be eligible to self-pay beyond the later of:

(i) the end of the initial eighteen (18) month period; or

(ii) the end of the month in which the date falls that is thirty (30) days after a final determination that the Participant or Qualified Beneficiary is no longer disabled.

(F) In the event of the Participant's death, the Applicable Continuation Period is thirty-six (36) months from the date of death.

(G) Where a Participant loses eligibility because of the Participant's service in the uniformed services of the United States, the maximum period for coverage of the Participant and the Participant's Dependents is the lesser of:

(i) the thirty-six (36) month period beginning on the date on which the person's absence begins; or

(ii) the date on which the person fails to apply for, or return to, the Participant's position of covered employment within the meaning of USERRA Section 4312(e). The period is reduced one (1) month for each month Direct Pay Benefits were purchased.

(H) For all other Qualifying Events, the Applicable Continuation Period is thirty-six (36) months from the date on which benefit eligibility otherwise would have terminated.

(I) If two (2) or more Qualifying Events occur, the Applicable Continuation Period for the Participant's Spouse and other Dependents is thirty-six (36) months from the first (1st) date on which benefit eligibility otherwise would have terminated. In any event, a Spouse who was not eligible to elect COBRA Continuation Coverage at the time of the first (1st) Qualifying Event is not entitled to do so upon subsequent Qualifying Events.

(e) Termination Events. No other self-pay coverage (other than retiree coverage, if eligible) is available from the Plan once an individual's COBRA coverage ceases as a result of a Terminating Event. A Terminating Event occurs on the earliest of the following dates:

(1) The conclusion of the Applicable Continuation Period;

(2) The date on which all health care coverage offered by the Fund terminates;

(3) The date on which the individual becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition of the individual;

(4) The date on which the individual becomes entitled to Medicare coverage;

(5) The last day of the period preceding any period for which a premium is not timely paid; or

(6) Reinstatement of active coverage eligibility.

(f) Notice Requirements. In order to obtain COBRA Continuation Coverage from the Fund, an individual must comply with the following notice requirements:

(1) Timeliness. A covered Participant or Qualified Beneficiary must notify the Fund Office in writing of each Qualifying Event within sixty (60) days after the later of:

(A) the date of the Qualifying Event; or

(B) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

An individual will be considered to have satisfied the notice requirements set forth in this paragraph if the Participant's Employer reports a Qualifying Event in a timely-filed contribution report covering the period during which the event occurred;

(2) Fund Notification. Within thirty (30) days of receipt of notice that a Qualifying Event has occurred, the Fund Office will notify the Participant, the Participant's eligible Spouse, and any other Qualifying Child not living with the Participant (whose address is known to the Fund) whose coverage is affected by the Qualifying Event of the right to elect COBRA Continuation Coverage. The Fund Office also will provide notice of the applicable premiums, and instructions for electing COBRA Continuation Coverage;

(3) Election of COBRA Continuation Coverage. To elect COBRA Continuation Coverage, the Participant, the Participant's eligible Spouse, or the Participant's Qualifying Child must complete the COBRA election form provided by the Fund Office and must pay the premium for such coverage. This completed election form must be postmarked no more than sixty (60) days after the later of the following dates:

(A) the date that eligibility for benefits would otherwise terminate as a result of the Qualifying Event; or

(B) the date of the notice of the Participant's right to elect COBRA Continuation Coverage sent out by the Fund Office;

If the completed form is submitted by email, the email must be date stamped no later than sixty (60) days after the later of the dates above.

Failure to timely elect COBRA Continuation Coverage will result in the loss of eligibility for such coverage.

(4) Notice of Subsequent Qualifying Events. A Participant or Qualified Beneficiary who is eligible to self-pay under Section 2.10(d)(1)(E) must notify the Fund of the determination of disability by Social Security within sixty (60) days of such determination, but in no event later than the close of the initial eighteen (18) month period. In the event the Participant or Qualified Beneficiary is subsequently determined by Social Security to be no longer disabled, the Participant or Qualified Beneficiary must notify the Fund within thirty (30) days of such determination.

(g) Payment of Premiums for COBRA Continuation Coverage. In order to remain eligible for COBRA Continuation Coverage, an individual must pay the premium for such coverage by the premium due date as described below:

(1) First Premium. The first (1st) monthly premium for COBRA Continuation Coverage (which includes payment of the premiums for each month from the date coverage would otherwise have terminated through the month in which payment is made), must be postmarked no later than forty-five (45) days after the date on which an individual elects such coverage if the premium is being mailed.

(2) Subsequent Premiums. The premium due date for all subsequent monthly premiums is the first (1st) day of the calendar month for which COBRA Continuation coverage is being obtained; provided, however, that a monthly premium for any particular month shall be considered to be timely as long as it is postmarked no later than by the thirtieth (30th) day of such month ("grace period").

(h) Amount of Premium.

(1) The Fund will charge a monthly premium for COBRA Continuation Coverage. The Board of Trustees, on an annual basis, will establish the monthly premiums to be charged for such coverage for each Schedule of Benefits offered by the Fund. The amount of the premium shall be based on family coverage and shall not exceed one hundred and two percent (102%) of the Fund's actual cost for providing benefits to similarly situated individuals, as determined by the Fund's actuary. The premium shall not exceed one hundred fifty percent (150%) of such actual cost for all months of COBRA Continuation Coverage after the eighteenth (18th) month for a Participant whose coverage was extended under the special disability rule set forth in Section 2.10(d)(1)(E).

(2) The Fund will credit the Participant for the dollar amount of all Contributions actually made on the Participant's behalf in any month by any participating Employer; provided that a Participant who elects COBRA

Continuation Coverage at a lower Schedule of Benefits than that provided by the Participant's Employer's Contributions shall not be entitled to any cash refund in excess of the cost of the COBRA Schedule of Benefits and shall not have any Employer Contributions credited from one (1) month to the next.

(3) For any Participant who elects COBRA Continuation Coverage at the same Benefit Schedule as provided by the Participant's Employer's Contribution, the first (1st) week of Employer Contributions paid on the Participant's behalf in any month shall be credited as two (2) weeks of Contributions.

(i) Types of Premiums. Core coverage, or if eligible, core and non-core coverage, shall be offered under Section 2.10.

Section 2.11 Participants – Extension of Eligibility

A Participant for whom the required Contributions to provide eligibility for benefits are not remitted by a contributing Employer, shall be considered to have earned a sufficient number of Contribution weeks in a month provided that the Participant's Employer has contributed on the Participant's behalf for at least twenty (20) weeks in the six (6) month period ending that month.

Section 2.12 Coverage Pursuant to Qualified Medical Child Support Orders

(a) In General. The Fund shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order. A Qualified Medical Child Support Order with respect to any Participant or Beneficiary shall apply to the Fund when it has received such an order with respect to a Participant or Beneficiary who is eligible to receive such benefits, and with the respect to which the requirements of Section 2.12(d) are met.

(b) Definitions. For purposes of this subsection:

(1) Qualified Medical Child Support Order. The term "Qualified Medical Child Support Order" is defined as a Medical Child Support Order:

(A) which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Beneficiary is eligible under the Fund's Plan of Benefits; and

(B) with respect to which the requirements of Section 2.12(c) and Section 2.12(d) are met.

(2) Medical Child Support Order. The term "Medical Child Support Order" is defined as any judgment, decree, or order (including approval of a settlement agreement) which:

(A) provides for child support with respect to a Qualifying Child of a Participant or provides for health benefit coverage to such a

Qualifying Child, is made pursuant to a State domestic relations law (including community property law), and relates to benefits under the Plan; or

(B) is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, if such judgment, decree, or order:

(i) is issued by a court of competent jurisdiction; or

(ii) is issued through an administrative process established under State Law and has the force and effect of law under applicable State law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (ii) of the preceding sentence and which has the effect of an order described in clause (a) or (b) of the preceding sentence shall be treated as such an order.

(3) Alternate Recipient. The term "Alternate Recipient" is defined as any Qualifying Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such Participant;

(4) Qualifying Child. The term "Qualifying Child" includes any Qualifying Child adopted by, or placed for adoption with, a Participant of the Plan.

(c) Information to be included in qualified order. A Medical Child Support Order meets the requirements of Section 2.12 only if such order clearly specifies:

(1) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

(2) a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(3) the period to which such order applies.

(d) Restriction on new types or forms of benefits. A Medical Child Support Order meets the requirements of Section 2.12 only if such order does not require the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

(e) Procedural Requirements.

(1) Timely notifications and determinations. In the case of any medical child support order received by the Fund,

(A) within five (5) business days after the receipt of such order, the Fund shall promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Fund's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and

(B) within fifteen (15) business days after receipt of such order, the Fund shall determine whether such order is a Qualified Medical Child Support Order or if additional information is necessary to make a determination. The Fund shall notify the Participant and each Alternate Recipient of either the determination or the need for additional information.

(2) Requirement for additional information. In the event that it cannot be determined from the face of the judgment, decree or order, based on the ready knowledge of the Fund, that such judgment, decree, or order meets the requirements set forth in Section 2.12(f)(1), the Fund shall promptly request in writing from the Participant, the Participant's representative, and/or the Alternate Recipient's designated representative such additional information as is deemed necessary to make a determination.

(A) If the information requested is not received within thirty (30) days of its request, the judgment, decree, or order shall be considered as not constituting a QMCSO (Qualified Medical Child Support Order), and the Fund shall within five (5) business days so notify in writing all persons who received initial notification of receipt of the judgment, decree or order by the Fund.

(i) Any appropriate party aggrieved by such decision may exercise the right of appeal to the Trustees of the Fund as provided in Section 6.2(d) of the Plan Document.

(3) Establishment of procedures for determining qualified status of orders. The Fund shall establish and maintain reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of benefits under such qualified orders. Such procedures:

(A) shall be in writing;

(B) shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the Plan (at the address included in the Medical Child Support

Order) of such procedures within five (5) business days after receipt by the Fund of the Medical Child Support Order; and

(C) shall permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

(f) National Medical Support Notice deemed to be a Qualified Medical Child Support Order.

(1) In general. If the Participant or Beneficiary of the Plan is a non-custodial parent of a Qualifying Child and the Fund receives an appropriately completed National Medical Support Notice promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such Qualifying Child, and the Notice meets the requirements of Sections 2.12(c) and 2.12(d), the Notice shall be deemed to be a Qualified Medical Child Support Order in the case of such Qualifying Child.

(2) Enrollment of Qualifying Child in Plan. In any case in which an appropriately completed National Medical Support Notice is issued in the case of a Qualifying Child of a Participant under the Plan who is a non-custodial parent of the Qualifying Child, and the Notice is deemed under Section 2.12(f)(1) to be a Qualified Medical Child Support Order, the Fund, within (forty) 40 business days after the date of the Notice, shall:

(A) notify the State agency issuing the Notice with respect to such child whether coverage of the Qualifying Child is available under the terms of the Plan and, if so, whether such Qualifying Child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision thereof substituted for the name of such Qualifying Child pursuant to Section 2.12(c)(1) to effectuate the coverage; and

(B) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage;

(3) Rule of construction. Nothing in Section 2.12(f) shall be construed as requiring the Fund, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.

(g) Actions taken by fiduciaries. If a Fund fiduciary acts in accordance with the Fund fiduciary's responsibilities as established in ERISA in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order,

then the Fund's obligation to a Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

(h) Treatment of Alternate Recipients.

(1) Treatment as Beneficiary generally. A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a Beneficiary under the Plan for all purposes.

(2) Treatment as Participant for purposes of reporting and disclosure requirements. A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a Participant under the Plan for purposes of reporting and disclosure requirements of ERISA.

(i) Direct provision of benefits provided to Alternate Recipients. Any payment for benefits made by the Fund 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.

(j) Payment to State official treated as satisfaction of obligation to make payment to Alternate Recipient. Payment of benefits by the Fund to an official of a State or a political subdivision thereof whose name and address have been substituted for the address of an Alternate Recipient in a Qualified Medical Child Support Order, pursuant to Section 2.12(c)(1), shall be treated, for purposes of Section 2.12(j), as payment of benefits to the Alternate Recipient.

(k) Rights of Payment where Participants or Beneficiaries are eligible for Medicaid benefits.

(1) Assignment of rights. Payment for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by on or behalf of such Participant or a Beneficiary of the Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act.

(2) Enrollment and provision of benefits without regard to Medicaid eligibility. In enrolling an individual as a Participant or Beneficiary or in determining or making any payments for benefits of an individual as a Participant or Beneficiary, the fact that the individual 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.

(3) Acquisition by States of rights of third parties. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Fund has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance

with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

(l) Coverage of Dependent children in cases of adoption.

(1) Coverage effective upon Placement for Adoption. In any case in which the applicable Schedule of Benefits provides coverage for Qualifying Children of Participants or Beneficiaries, the Fund shall provide benefits to Qualifying Children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Qualifying Children who are natural children of Participants or Beneficiaries under the Plan, irrespective of whether the adoption has become final.

(2) Definitions. For purposes of this Section 2.12(l):

(A) Qualifying Child. The term "Qualifying Child" is defined as, in connection with any adoption, or placement for adoption, of the Qualifying Child, an individual who has not attained the age 18 as of the date of such adoption or Placement for Adoption.

(B) Placement for Adoption. The term "placement", or being "placed", for adoption, in connection with any Placement for Adoption of a Qualifying Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such person of a legal obligation for a total or partial support of such Qualifying Child in anticipation of adoption of such Qualifying Child. The Qualifying Child's placement with such person terminates upon the termination of such legal obligation.

Section 2.13 Participants –Reinstatement of Active Coverage Eligibility

A Participant whose eligibility for benefits terminates under the Plan, may again become eligible as follows:

(a) Except as set forth in Section 2.13(b) and 2.13(c),

(1) for a Participant who initially became eligible for benefits under Section 2.2(a), on the first (1st) day of the month which represents the second (2nd) month following the month to which the Participant's Employer contributes to the Fund on the Participant's behalf the appropriate weekly Contribution for all, or all but one (1), of the weeks of the month; or

(2) for a Participant who initially became eligible for benefits under Section 2.2(c), on the first (1st) day of the month for which the Employer submits an eligibility file and Contributions according to Section 2.2(c)(3), which includes the Participant as an Employee; or

(b) On the first (1st) day of the week for which Contributions are first (1st) paid upon return from active duty as provided for by USERRA 38 U.S.C. § 4312(e)(1)(a)(i). As a general rule, if an Employee left Covered Employment for induction into the uniformed services of the United States, the Employee's coverage shall be reinstated when the Employee returns to Covered Employment under the following general schedule:

(1) If the period of service in the uniformed services was less than thirty-one (31) days, the Participant or Dependent must report no later than the beginning of the first (1st) full regularly scheduled work period on the first (1st) full calendar day after the Participant or Dependent completes service. Allowance will be made, however, for the Participant or Dependent's safe transportation from the place of service to the Participant or Dependent's residence plus an eight (8) hour period. If this is impossible or unreasonable through no fault of the returning veteran, then the returning veteran must give notice as soon as possible after the eight (8) hour period;

(2) If the period of uniformed service is more than thirty (30) days but less than one hundred eighty (180) days, the Participant or Dependent must submit an application no later than fourteen (14) days after completion of service. If meeting the deadline is impossible or unreasonable, the next first (1st) full calendar day when making application is possible is sufficient;

(3) If the period of uniformed service is more than one hundred eighty (180) days, the Participant or Dependent has ninety (90) days after completion of service to reapply for employment;

(4) A veteran who is hospitalized or convalescing from a service-related Injury or Illness is allowed up to two (2) years for recovery before deadlines apply. This schedule is for information purposes only and is not intended to address the various exceptions to the general rules. The provisions of 38 U.S.C. § 4312(e)(1)(A)(i) will control the administration of the Fund.

Section 2.14 Dependents – Initial Eligibility

(a) General Rule. Except as otherwise provided in Section 2.14, a person who is a Dependent of a Participant shall become eligible for benefits on the later of the following dates:

(1) The date that the Participant becomes eligible for benefits or;

(2) The date that the person becomes a Dependent of the Participant.

(b) Orthodontic Exceptions. If Orthodontic Expense Benefits are provided in the Schedule of Benefits covering the Participant, the Participant's Qualifying Children shall become eligible for such Orthodontic Benefits on the date set forth in Section 2.14(a) if the Participant's initial eligibility for benefits is based on Section 2.2(b). In all other cases, the Participant's Qualifying Children shall not become eligible

for such Orthodontic Expense Benefits until the later of the date specified in Section 2.14(a) or the first (1st) day of the calendar month after the Participant has been eligible for Dental Expense Benefits for twenty-four (24) calendar months.

Section 2.15 Dependents – Continued Eligibility

All Dependents who are eligible for benefits will continue to be eligible for the benefits specified in the Plan until their eligibility for benefits terminates in accordance with Section 2.16, and 2.18 or some other applicable provision of the Plan.

Section 2.16 Dependent's Termination of Eligibility

Except as provided in Section 2.7, 2.9, 2.10, and 2.11 the eligibility for benefits of any Dependent of a Participant shall terminate on the earliest of the following dates:

(a) The last date on which such person is a Dependent as defined in Section 1.16;

(b) The date the Participant's eligibility for benefits terminates unless;

(1) sufficient Contributions are provided by the Participant's Employer as required under the USERRA to maintain eligibility as though the Participant were employed or

(2) in cases of death of the Participant, the last day the Participant would have been eligible for contribution based benefits;

(c) The date the Participant's Employer ceases to be a Participating Employer.

(d) The day of the Dependent's death.

Section 2.17 Dependents – Reinstatement of Eligibility

(a) General Rule. If a Dependent's eligibility for benefits terminates as a result of the termination of a Participant's eligibility, the Dependent will again become eligible at the same time that the Participant's eligibility is reinstated in accordance with Section 2.13.

(b) Exceptions. The following exceptions apply to the reinstatement of eligibility rule contained in Section 2.17(a):

(1) A Dependent's eligibility will not be reinstated unless they are a Dependent on the Participant's reinstatement date;

Section 2.18 Termination of Group Coverage for Active Participants

If a Participating Employer ceases to make Contributions on behalf of its Employees in Active Service, the Fund will cease providing benefits to every Participant employed by that Employer and to the Participant's Dependents on the date the eligibility of those Active Service Employees ceases, except as prohibited by federal laws and regulations (including COBRA) and notwithstanding any other provisions of this Plan Document.

Section 2.19 Continuing Care Patients

If a provider ceases to be an In-Network provider or a Preferred Provider Organization, a Continuing Care Patient who is receiving care with that provider will receive notification of such change in network status and the Continuing Care Patient and may elect to continue to receive such care at the same In-Network Co-Payment for up to ninety (90) days after the later of the provider leaving the network or being notified of such change.

Article 3 Benefits

Section 3.1 Life Insurance Benefit

(a) Participants.

(1) If provided in the Schedule of Benefits covering the Participant, and except as provided in Section 3.1(b), below, upon receipt by the Fund of due proof of the death of a Participant and any other required documents while eligible for benefits, the Fund or the Fund's life insurance carrier will pay to the Participant's designated Beneficiary the amount of Life Insurance Benefits determined in accordance with the Schedule of Benefits covering the Participant on the date of the Participant's death.

(2) If, at the time of death, there is no designated Beneficiary with respect to all or any part of the Life Insurance Benefit, or if the designated Beneficiary does not survive the Participant or dies within twenty-four (24) hours of the Participant's death, the Life Insurance Benefit (or any portion thereof) for which there is no designated Beneficiary will be paid in the following order of priority to the Participant's:

(A) Spouse,

(B) child or children,

(C) mother and/or father,

(D) executors or administrators of the Estate

(3) A Participant may designate or change the name of the Participant's Beneficiary by filing a written, signed and witnessed request in a form satisfactory to the Fund Office. No change of Beneficiary will take effect until received by the Fund. When the change has been received, however, regardless of whether the Participant is then living or not, it will take effect as of the date of execution of the written request but without prejudice to the Fund on account of any payment made or any action taken or permitted by the Fund or its life insurance carrier before receipt of the request. Consent of the Beneficiary will not be required to change the Beneficiary.

(b) Dependents.

(1) For the purpose of Section 3.1 only, the term "Dependent" shall be defined to include a child who was delivered stillborn within the last trimester of the pregnancy. The Fund shall not provide Life Insurance Benefits as the result of an abortion even if the abortion was lawful under state or federal law.

(2) If provided in the Schedule of Benefits covering the Participant, and upon receipt by the Fund of sufficient proof of the death of a Dependent while the Dependent is eligible under the Plan and any other required documents, the Fund or the Fund's life insurance carrier will pay to the Participant as Beneficiary the amount of Life Insurance Benefits determined in accordance with the Schedule of Benefits covering the Dependent on the date of death.

(3) If the Participant does not survive the Participant's Dependents, the benefits payable under this section will be paid in the following order of priority to surviving relatives of the Dependent:

(A) mother and/or father

(B) child or children

(C) brothers or sisters

(D) the Dependent's executors or administrators

(c) Facility of Payment (Participants and Dependents).

(1) Upon receipt of a certified copy of the death certificate and any other required documents, the Fund or the Fund's life Insurance carrier may, at its option, pay all or any part of the proceeds of the Life Insurance Benefit, not to exceed the amount of burial expenses, to any person who has incurred expenses in connection with the burial of the Participant or Dependent. Such action shall be considered a proper payment of the Life Insurance Benefit to the extent paid, and the Beneficiary or alternate payee shall be entitled to receive only the remainder, if any, of the proceeds.

(2) If an individual to whom payment would otherwise be made under Section 3.1(a), or 3.1(b)(1), above, is a minor or otherwise adjudged not competent to give valid receipt for any payment due him, and if no request for payment has been received by the Fund from a duly appointed guardian or other legally appointed representative of such individual, the Fund, at its option, may direct its life insurance carrier to make direct payment to any person or institution appearing to the Fund to have assumed the custody of or the principal support of such individual.

(3) Payment to anyone described in Section 3.1(a)(1), 3.1(a)(2), 3.1(b)(2), or 3.1(b)(3), will discharge the Fund and/or its life insurance carrier from all further liability to the extent of the payment made.

(4) Any claims and appeals related to the Life Insurance Benefit shall be subject to the Plan's claims procedures set forth in Section 6.2.

(d) Suicide. For certified death certificates presented on behalf of any Participant that list cause of death as suicide, a Life Insurance Benefit at 50% of that provided in the applicable Schedule of Benefits, not to exceed $13,500, shall be paid. This Life Insurance Benefit is subject to a two year waiting period, calculated from the first (1st) day of the calendar month after the Participant is benefit eligible.

Section 3.2 Accidental Death and Dismemberment Benefit

(a) In General. If provided in the Schedule of Benefits covering the Participant, and upon receipt by the Fund of sufficient proof that a Participant, while eligible for benefits, has received an Accidental Bodily Injury and, as a result, has suffered any of the losses set forth in Section 3.2 within ninety (90) days after the date on which the Accidental Bodily Injury was received, the Fund's life insurance carrier shall pay a benefit based on the loss suffered. The amount of benefit payable shall be the percentage shown below, multiplied by the principal sum shown in the Schedule of Benefits covering the Participant at the time the loss occurred; in no event, however, shall the total amount payable for all losses suffered by a Participant as a result of any one (1) accident exceed one hundred percent (100%) of that principal sum.

For loss of life	100%
For loss of one hand by severance at or above the wrist	50%
For loss of one foot be severance at or above the ankle	50%
For loss of the sight of one eye entirely and irrevocably	50%
For loss of more than one of the above in any one accident	100%

(b) Payment of Benefits. Payment of benefits under Section 3.2 shall be made in accordance with the rules of Section 3.1, "Life Insurance Benefit," in the case of loss of life, in accordance with the rules of 3.1 and otherwise in accordance with Section 6. Section 3.1(d) does not apply to Accidental Death and Dismemberment Benefits.

(c) Limitations. No payment shall be made under this Section 3.2 for any loss that results directly or indirectly from:

(1) illness or infection (except pyogenic infections which occur through an accidental cut or wound) or disease, where the illness or infection or disease is the proximate or a contributing cause of the loss;

(2) any Illness or Injury arising, either in whole or in part, from the Participant's commission of or participation in, or attempted commission of or participation in, an Illegal Act, as defined in Section 4.1;

(3) war, declared or undeclared, or any act of war; or

(4) the Participant's participation in insurrection, rebellion, riot or civil commotion.

(d) Additional Provisions.

(1) No civil action at law or inequity to obtain benefits under Section 3.2 may be commenced prior to sixty (60) days from the date on which proof of loss as provided herein is received by the Fund, nor more than three (3) years after the date on which proof of loss as provided herein is received by the Fund.

(2) The Fund or it's appointed life insurance carrier, at its expense, shall have the right to have any Participant filing a claim for benefits under Section 3.2 examined by medical practitioners of its choice when and as often as it deems reasonably necessary during the pendency of such claims.

(3) When a claim for benefits under Section 3.2 is made due to loss of life, the Fund or its appointed life insurance carrier, may require, at its expense and if permitted by applicable law, an autopsy to be performed on the body of the decedent.

Section 3.3 Short Term Disability Income Benefit

(a) In General. If provided in the Schedule of Benefits covering the Participant, and if while eligible for benefits, a Participant becomes totally disabled to perform each and every material duty of the Participant's occupation or employment because of Injury or Illness, the Fund shall pay Short Term Disability Income Benefits to the Participant at the weekly rate shown in the Schedule of Benefits covering him. Such payments will be made for the period that begins as described in Section 3.3(b), and ends as described in Section 3.3(c). The Fund may require a Participant seeking Short Term Disability Income Benefits to submit to an examination by an independent medical reviewer selected by the Fund to verify the existence and continuation of a total disability.

(b) Commencement. The period for which Short-Term Disability Income Benefits are payable shall begin as follows:

(1) In the case of an Injury, on the first (1st) day that the Participant receives treatment by a Physician related to the disability after the last day that the Participant worked because of such Injury. Documentation of the treatment by a Physician must be submitted to the Fund Office. If the disability begins more than ninety (90) calendar days after the Injury is sustained, the Short Term Disability Income Benefit shall begin as described in Section 3.3(b)(2).

(2) In the case of an Illness, seven (7) calendar days after the first (1st) day that the Participant receives treatment by a Physician related to the disability after the last day that the Participant worked because of such Illness.

(c) Termination. The period for which Short Term Disability Income Benefits are payable shall end on the earlier of:

(1) the last day that the Participant is disabled as described in Section 3.3(a), above, as determined by the Trustees, except in cases where the Participant is released to light duty by the Participant's Physician and there is no light duty available from the Employer;

(2) the date the Participant fails to provide proof that the Participant meets the definition of Total Disability;

(3) the date the Participant refuses to be examined or otherwise cooperate with the Fund's independent medical reviewer;

(4) the date the Participant refuses any treatment by the Participant's Physician, that in the Trustees' opinion would cure, correct, or improve the Total Disability;

(5) the expiration of the number of weeks set forth in the Participant's Schedule of Benefits;

(6) the date the Participant commences receipt of retirement benefits under the Federal Social Security Act, from any union, union-management pension fund or any other retirement plan. This section shall not apply to an active Participant who receives pension benefits solely because of required minimum distribution requirements under the Code; or

(7) the date the Participant's Employer ceases to be a Participating Employer.

(8) The Participant's death.

(d) Short Term Disability Income Benefit Successive Disabilities. Successive periods of disability resulting from a different Injury or from an unrelated Illness will be considered a new period of disability if the periods of disability are separated by the Participant's return to Active Service for at least one (1) day.

For Plans 9, 9ARS, 9NG, 9ACME, 11, 11NG and 12 only, successive periods of disability resulting from the same Injury or from a related Illness will be considered a new period of disability if the periods of disability are separated by the Participant's return to Active Service for at least one (1) day.

(e) Limitations. No payment shall be made under Section 3.3:

(1) for any employment related Illness or Injury, as set forth in Section 4.1(a);

(2) for any disability incurred while the Participant is on strike;

(3) for disability that begins while the Participant is on layoff, unless:

(A) the Employer is obligated to pay sufficient Contributions to keep the Participant's coverage in effect due to work performed by the Participant for the Employer during the layoff period, or

(B) Coverage was in effect that month due to Contributions previously paid by the Employer;

(4) for any period during which the Participant is engaged in any type of occupation for which the Participant receives any renumeration;

(5) for any disability incurred after a Participant commences receipt of retirement benefits under the Federal Social Security Act, from any union, union-management pension fund or any other retirement plan. This section shall not apply to an active Participant who receives pension benefits solely because of required minimum distribution requirements under the Code; or

(6) for any period in which the Employee receives the Employee's regular salary from the Employee's Employer.

(7) if the Participant declines or otherwise refuses to submit to examination by an independent medical reviewer as requested by the Fund or declines or otherwise refuses to submit the results of the independent medical examination to the Fund for review;

(8) if the Participant is not actively seeking treatment from a Physician to improve the condition which is causing the Total Disability.

(f) Additional Provisions. The Fund or its appointed disability insurance carrier, at its expense, shall require any Participant filing a claim for benefits under Section 3.3 to be examined by medical practitioners of its choice when and as often as it deems reasonably necessary during the pendency of such claims.

Section 3.4 Pre-certification Requirement

(a) Hospital.

(1) Elective. Participants or their Dependents must contact the Fund's Medical Consultant prior to any non-emergency Hospital Confinement.

Procedures Requiring Pre-certification are limited to those defined in Section 1.44.

(2) Emergency Admissions. Participants or their Dependents must contact the Fund's Medical Consultant within two (2) calendar days of any inpatient Hospital admission for emergency treatment. If, due to the emergency Injury or Illness, the Participant or the Participant's Dependent is unable to contact the Fund's Medical Consultant within the specified period, such contact must be made by someone on behalf of the Participant or the Participant's Dependent.

(b) Participants or their Dependents must contact the Fund's Medical Consultant prior to purchases of DME exceeding $1,000 and all DME rentals (regardless of cost).

(c) Participants or their Dependents must contact the Fund's Medical Consultant prior to obtaining prescription drugs administered in an outpatient medical setting, with a billed amount of $15,000 or more in order to be considered a covered expense under the Plan.

(d) Non-Compliance with Pre-Certification Requirements. Failure to contact the Fund's Medical Consultant for pre-certification as described in this Section 3.4 will result in a denial of coverage and no benefit payments for services listed in Sections 3.4 and 1.44.

(e) Limitations.

(1) No benefit payment will be made for weekend admissions, unless they are certified as being medical emergencies;

(2) No benefit payment will be made for inpatient Hospital care on the day prior to surgery, unless the early admission is pre-certified as being medically necessary;

(3) No benefit payment will be made for charges associated with days of inpatient Hospital care determined not medically necessary, whether or not the Fund's Medical Consultant was contacted as specified above.

(4) Limitations set forth in Article 4 of this Plan Document ("General Limitations").

(f) Fifty (50) Mile Rule. If a Participant or the Participant's Dependent must travel more than fifty (50) miles to the Hospital for admission, the Fund will reimburse the Participant for the cost of lodging for the one (1) night immediately preceding the date of surgery at a pre-approved hotel or motel.

(g) Newborns and Mothers. In cases where a newborn baby or the newborn baby's mother remains in the Hospital after two (2) calendar days following a vaginal delivery, or four (4) calendar days following a Cesarean section, the Fund's Medical Consultant must be contacted. Contact must be made by the Participant or the Participant's Dependents within three (3) calendar days of the expiration of the initial two (2) calendar day or four (4) calendar day confinement.

(h) Appeals Procedure. If a Participant or Dependent disagrees with the initial conclusion of the Fund's Medical Consultant regarding medical necessity, the Participant or Dependent must appeal the decision as provided in the Medical Consultant's internal regulations. If, upon the decision of the Medical Consultant's appeal body, the Participant or Dependent is still in disagreement, the Participant or Dependent may file an appeal with the Fund's Board of Trustees as outlined in Section 6.2(d).

Section 3.5 Disease Management Program

(a) In General. The Fund may provide cost-free access to a Disease Management Program to all Participants and Dependents. As used in the preceding sentence, a "Disease Management Program" is defined as a program that identifies and/or predicts through the use of medical and pharmaceutical data and other claim information, Participant and/or Dependents who have incurred or will incur certain chronic conditions such that active interaction with skilled personnel may reduce the cost involved to care for the condition.

(b) Participation. A Participant's participation in the program is not mandatory, but the Participant's Schedule of Benefits may include incentives to encourage participation and may include penalties for non-participation in the program.

Section 3.6 Inpatient Hospital Expense Benefit

(a) In General. The Fund shall pay the expenses incurred by a Participant or Dependent for charges by a Hospital if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Fee Allowances, Co-insurances, Co-payments, out-of-pocket and day maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's approved Preferred Provider Organization for the following:

(1) Room and Board for each day of Hospital Confinement.

(2) Necessary Services and Supplies for each day of Hospital Confinement (including drugs provided by the Hospital for use in the Hospital).

(b) Limitations. No payment will be made under this section for:

(1) drugs provided by the Hospital for use at home;

(2) personal comfort items;

(3) expenses which are not payable under the limitations set forth in Article 4 of this Plan Document ("General Limitations"); or

(4) any Room and Board or Necessary Supplies received on days of Hospital Confinement that are deemed uncertified by the Fund's Medical Consultant.

Section 3.7 Emergency Room Benefit

(a) In General. The Fund shall pay the emergency room charge and any related charges incurred as a result of an emergency room visit incurred by a Participant and/or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of the appropriate Deductibles, discounts, Fee Allowances, Co-payments, out-of-pocket, and day maximums, and other applicable provisions.

(b) Limitations. No payment will be made under Section 3.7 for:

(1) charges made for professional ambulance service; or

(2) expenses which are not payable under the limitations set forth in Article 4 of this Plan Document ("General Limitations").

Section 3.8 Surgical Expense Benefit

(a) In General. The Fund shall pay the Physician's fee incurred by a Participant or Dependent for an Allowable Surgical Procedure if such benefits are provided under the Participant's Schedule of Benefits after application of appropriate Deductibles, discounts, Fee Allowances, Coinsurance, Co-payments, out-of-pocket maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization. As used in the preceding sentence, "Allowable Surgical Procedure" is defined as a surgical procedure that is performed as a result of a non-occupational Injury or Illness, including the removal of impacted teeth by a dentist or dental surgeon.

(b) Certified Surgical Assistant. If deemed medically necessary, the Fund shall pay the charges for a Certified Surgical Assistant if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, fee allowances, Coinsurance, Co-payments, out-of-pocket maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

(c) Multiple Operations. If two (2) or more surgical procedures are performed at one (1) time through the same incision or in the same operative field, the maximum amount payable for these procedures will be the maximum amount otherwise payable for the most expensive procedure. If two (2) or more surgical procedures are performed because of the same or related Injury or because of the same or related Illness and performed through separate incisions and in separate operative

fields, the maximum amount payable will be the maximum amount otherwise payable for each procedure. The Fund reserves the right to allow additional payment for procedures based on time and complexity of such procedures as determined by the Fund's Medical Consultant.

(d) Unlisted Operations. In the case of a surgical procedure performed by a non-network provider for which the Fund's surgical schedules do not have an allowance, the Fund reserves the right to determine the maximum payment for any such surgical procedure as determined by the Fund's Medical Consultant.

(e) Ambulatory Surgery. The Surgical Expense Benefits provided under Section 3.8 will be equally available for surgery performed at a Hospital or at a certified Ambulatory Surgical Facility.

(f) Limitations. The payment of the Surgical Expense Benefit is subject to the limitations set forth in Article 4 of this Plan Document ("General Limitations").

Section 3.9 Diagnostic X-ray and Laboratory Expense Benefit

(a) In General. The Fund shall pay Allowable X-ray/Lab Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization. As used in the preceding sentence, the term "Allowable X-ray/Lab Expenses" is defined as expenses for a diagnostic X-ray or laboratory examination that is performed by or under the supervision of a legally qualified Physician as the result of a non-occupational Injury or Illness.

(b) Limitations. No payment shall be made under this section for:

(1) charges incurred during a Hospital Confinement;

(2) diagnostic X-ray or laboratory examinations performed by or under the supervision of a Chiropractor (such charges are considered under Section 3.20);

(3) dental x-rays, except in connection with an accident;

(4) examinations that are not recommended and approved by a legally qualified Physician;

(5) radium, chemotherapy, radioactive-isotope therapy;

(6) diagnostic x-ray or laboratory procedures performed within the confines of a doctor's office or ambulatory care center;

(7) diagnostic x-ray or laboratory procedures performed in connection with an emergency room visit;

(8) any diagnostic x-rays or laboratory procedures conducted by an Out-of-Network provider, unless ordered and collected at In-Network facility or office; and

(9) expenses which are not payable under the Plan according to Article 4, "General Limitations."

Section 3.10 Prescription Drug Expense Benefit

(a) In General. If provided in the Participant's Schedule of Benefits, after application of the appropriate Coinsurance or Co-payment, and in the fill limits established in a Participant's Schedule of Benefits, the Plan shall provide Prescription Drug Expense Benefits to Participants and Dependents for Allowable Drugs.

(b) Allowable Drugs. As used in this section, "Allowable Drugs" shall include the following non-Hospital items:

(1) Drugs and Medicines lawfully obtainable upon the written prescription of a licensed Physician;

(2) Insulin and supplies, including syringes, continuous glucose monitoring systems, meters, needles and test materials considered necessary items in cases of a diabetic individual.

(c) Purchase Location. All Allowable Drugs must be purchased at either a participating retail pharmacy or the Fund's appointed mail order prescription drug company.

(d) Controlled Substances. No "controlled substance" as defined in the Controlled Substances Act (21 U.S.C. § 812) may be purchased from the mail order pharmacy.

(e) Limitations. No payment shall be made under Section 3.10 for:

(1) drugs or medicines dispensed by a licensed Hospital or convalescent facility during confinements (drugs can only be dispensed within the pharmacy network with which the Fund contracts);

(2) dietary supplements, vitamins (except vitamins covered under the Fund's appointed prescription benefit manager, preventive items and services as required by the Affordable Care Act for non-grandfathered plans, and Rx Medical Foods) and immunization agents (except preventive care immunizations), as well as appliances and other non-drug items;

(3) drugs or medicines lawfully obtainable without a written prescription, except as specifically provided under the definition of Allowable Drugs;

(4) patent medicines, biologicals, allergens, sickroom supplies, nose drops or other nasal preparations;

(5) drugs or medicines supplied in a Physician's Office;

(6) fertility drugs;

(7) drugs or medicines dispensed for cosmetic purposes;

(8) drugs or medicines, which are not payable under the Plan according to Article 4, "General Limitation;"

(9) drugs not approved by the Fund's prescription benefit manager according to the Fund's pre-certification requirements set forth in Section 1.44;

(10) drugs appearing on the Fund's prescription benefit manager's "Exclusion List";

(11) drugs under the "Exclude at Launch Program" as defined by the Fund's prescription benefit manager;

(12) Spinraza; and

(13) Zolgensma.

Section 3.11 Dental Expense Benefit

(a) In General. The Fund shall pay expenses incurred by a Participant or Dependent for eligible dental services, if such benefits are provided under the Participant's Schedule of Benefits and not to exceed the maximums provided in the Participant's Schedule of Benefits. Notwithstanding anything herein to the contrary, any Annual Maximum shall not apply to the Essential Benefit of oral care pediatric services.

(b) Pre-Authorization and Review. Although it is not required, pre-authorization and review by the Fund Office is available for all dental services rendered to any Participant or Dependent. Any pre-authorization given by the Fund Office for such services will be conditioned upon the Participant's and/or the Participant's Dependent's Schedule of Benefits maximums, family maximums, eligibility under the Plan for Dental Benefits at the time such services are rendered, Coordination of Benefits, if applicable, and the Subrogation provisions of Section 6.6.

(c) Endosseous Surgery and Dental Implants. Procedures related to endosseous surgery in preparation for and including dental implants are covered solely under the Dental Expense Benefit provisions of the Plan, and are subject to all of the maximums, conditions and requirements applicable to other dental benefits.

(d) Jaw Joint Dental Benefits. Charges in connection with treatment of jaw joint problems, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone

and skull and complex of muscles, nerves, and other tissues related to that joint, shall be covered solely under the Dental Expense Benefit provisions of the Plan, except TMJ surgery and TMJ related diagnostic tests, x-rays, therapy, treatment and other procedures for which an American Dental Association charge code does not apply which shall be considered under the Fund's Medical Benefits, and subject to the maximums, conditions, and requirements applicable to other Medical Benefits.

(e) Limitations.

(1) No payment shall be made under Section 3.11 for:

(A) expenses incurred for dental services rendered for cosmetic purposes including, but not limited to, bleaching;

(B) charges for special, non-standard, techniques in denture construction to the extent the cost exceeds the cost of standard techniques;

(C) charges for replacing lost or stolen appliances or repairing appliances damaged when not in the mouth;

(D) expenses incurred for the replacement of any prosthetic appliance, gold restoration, crown, or bridge within five (5) years following the date of the last placement of such appliance, gold restoration, crown or bridge;

(E) expenses incurred for the replacement of any prosthesis by a different type of prosthesis within five (5) years, except for those expenses that result from the difference in cost of a second (2^{nd}) prosthesis minus the cost of the first (1^{st}) prosthesis;

(F) expenses for any crown, other than a stainless steel crown, for Qualifying Children less than fourteen (14) years of age unless teeth involved are permanent;

(G) charges for supplies normally used at home including but not limited to toothpaste, toothbrushes, waterpiks and mouth washes;

(H) expenses incurred for a dental service that is not performed by or under the supervision of a Physician or Dentist;

(I) temporary restorations or prosthesis except when necessary to replace tooth numbers 6 (six), 7 (seven), 8 (eight), 9 (nine), 10 (ten), and 11 (eleven), or tooth numbers 22 (twenty-two), 23 (twenty-three), 24 (twenty-four), 25 (twenty-five), 26 (twenty-six) and 27 (twenty-seven) in preparation for an implant;

(J) expenses incurred for more than two (2) examinations during any calendar year;

(K) expenses incurred for more than two (2) prophylaxes during any calendar year;

(L) expenses incurred for more than one (1) full mouth x-ray and panorex x-ray during any three (3) year period and two (2) sets of bite wing x-rays in a calendar year;

(M) expenses incurred for adjustments and relines of dentures during the six (6) month period following installation;

(N) any charges for or related to orthodontic services; or

(O) expenses which are not payable according to Article 4, "General Limitations."

(2) In the event a Participant or Dependent transfers from the care of one Dentist to that of another Dentist during the course of treatment, or if more than one Dentist renders services for one (1) dental procedure, the Plan shall be liable for not more than the amount it would have been liable for had only one Dentist rendered the service.

Section 3.12 Orthodontic Care Expense Benefit

(a) In General. The Fund shall pay Allowable Orthodontic Care Expenses incurred by a Participant's Qualifying Child up to the age of eighteen (18) years if such benefits are provided and up to maximum lifetime amount established in the Participant's Schedule of Benefits, in cases where severe deformity does not exist. In cases where severe deformity does exist, as determined by the Fund's Medical Consultant, the maximum lifetime amount established in the Participant's Schedule of Benefits does not apply. As used in the preceding sentence, the term "Allowable Orthodontic Care Expenses" is defined as all expenses incurred for one (1) or more of the following conditions:

(1) Extreme bucco-lingual version of teeth;

(2) Protrusion of maxillary anterior teeth;

(3) Maxillary or mandibular arch is either protrusive or retrusive relaxation; or

(4) Malalignment of teeth unquestionably interferes with function or creates marked facial deformity.

(5) Severe deformity, as determined by the Fund's Medical Consultant, is an Essential Benefit and not subject to the lifetime maximum.

Benefits up to the maximum available will be paid upon submission of appropriate claim forms without consideration of whether treatment began during a period of eligibility but whether treatment is still being provided upon date of orthodontic benefit eligibility. Notwithstanding anything herein to the contrary, any Annual Maximum or Lifetime Maximum shall not apply to orthodontia determined by the Fund's Medical Consultant to be medically necessary, and therefore within the Essential Benefit of oral care pediatric services.

(b) Limitations. No payment will be made under this section for:

(1) charges for replacing lost or stolen appliance or repairing appliances damaged when not in the mouth;

(2) charges for supplies normally used at home including but not limited to toothpaste, toothbrushes, waterpiks, and mouth washes;

(3) expenses incurred for a dental service that is not performed by or under the supervision of a Physician or Dentist;

(4) services and/or supplies for a Qualifying Child age eighteen (18) or older;

(5) expenses which are not payable according to Article 4 of this Plan Document ("General Limitations");

(6) expenses incurred during the applicable waiting period as described in Section 2.14(b).

Section 3.13 Vision Care Expense Benefit

(a) In General. The Fund shall pay Allowable Vision Care Expenses incurred by a Participant or Dependent, if provided for and up to the maximum amount shown in the Participant's Schedule of Benefits or if utilizing the Fund's appointed vision network, the amount provided for in the vision contract. As used in the preceding sentence, the term "Allowable Vision Care Expenses" means expenses for charges made by a licensed optometrist or by a Physician for a complete eye examination or for eyeglasses, lenses, or contact lenses. Notwithstanding anything herein to the contrary, any Annual Maximum shall not apply to the Essential Benefit of vision care pediatric services.

(b) Limitations. No payment shall be made under Section 3.13 for expenses incurred:

(1) for more than one (1) complete eye examination during any calendar year;

(2) for more than one (1) set of contact lenses once a year and one (1) set of frames and lenses once a year;

(3) for tinted glasses, contact lenses, sunglasses, or their fittings, unless prescribed by a Physician or a licensed optometrist for the treatment of a visual defect, Injury or disease;

(4) for surgical care of eye disease or Injury;

(5) for artificial eyes;

(6) for visual training, reading rate, and comprehension studies; and

(7) for benefits which are not payable according to Article 4 of this Plan Document ("General Limitations").

Section 3.14 Major Medical Expense Benefit

(a) In General. The Fund shall pay Allowable Major Medical Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits, are not covered by any other applicable Section of this Article and after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits.

(b) Allowable Major Medical Expenses. For the purposes of Section 3.14, the term "Allowable Major Medical Expenses" is defined as those expenses actually incurred by a Participant or the Participant's Dependent for the charges listed below, but only if the expenses are incurred while such Participant or Dependent is eligible for benefits, and only to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of the Injury or Illness suffered:

(1) Charges made by a Hospital, not to exceed the amount shown in the applicable Schedule of Benefits;

(2) Charges made by a Physician, psychologist, psychiatrist or ophthalmologist in accordance with their license for professional services;

(3) Charges made by a licensed counselor or social worker;

(4) Charges made by a Registered Nurse or a Licensed Practical Nurse, other than a member of the Participant's or the Participant's Dependent's family, for professional services;

(5) Charges made for anesthesia and its administration; radium and radioactive isotope treatment, chemotherapy, blood transfusions; oxygen and other gases and their administration; use of any Durable Medical Equipment; physical therapy, speech therapy or occupational therapy, prosthetic appliances and dressings, artificial limbs or artificial eyes. If any of these items are approved by the Fund's Medical Consultant for services in the patient's home as described in Section 1.44, the maximum amount payable shall be determined by the Fund's Preferred Provider Network's Allowable Charge;

(6) Charges made for drugs lawfully obtainable only upon the written prescription of a Physician by a Participant or Dependent for whom the Fund is the secondary Plan;

(7) Charges made for professional ambulance service, only when medically necessary and not merely for the convenience of the patient, used to transport a Participant or the Participant's Dependent:

(A) directly from the place where such Participant or Dependent is injured in an accident or stricken by Illness to the nearest Hospital where necessary care and treatment can be given;

(B) from one Hospital to another Hospital when medically necessary; or

(C) from a Hospital to the patient's home when medically necessary;

(8) Charges made for contact lenses or cataract glasses and lenses when cataract surgery has been performed and for contact lenses when contact lenses are used as a prosthetic appliance for other medically necessary reasons;

(9) If provided in the Schedule of Benefits covering the Participant, charges made for the purchase of one (1) set of hearing aids for any five (5) year period, up to the applicable fee schedule. Such hearing aids must be prescribed by a Physician or licensed audiologist based on the results of the following diagnostic services: complete examination, audiogram (air/bone/speech), impedance audiometry, and hearing aid evaluation;

(10) Charges for braces, crutches, or the rental of a wheelchair, Hospital-type bed, or artificial respirator. If any of these items over $1,000 are approved by the Fund's Medical Consultant for home use, the maximum amount payable shall be determined by the Fund's Preferred Provider Network's Allowable Charge;

(11) Charges made by a Dentist or dental surgeon for repair of damage to the jaw and/or natural teeth as the direct result of an Injury, osseous surgery not connected with dental implants, or medical procedures relating to the treatment of the lips, tongue or cheeks;

(12) Charges made by a nursing home or a skilled nursing facility for skilled care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care and rehabilitation services as well as other related health services. The skilled nursing care can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled rehabilitation services received must be under the general direction of a Physician. Eligible charges will not include convalescent or Custodial Care;

(13) Charges for the administration of allergy injections, without regard to the place of service;

(14) Out-patient cardiac rehabilitation.

(c) Limitations. Allowable Major Medical Expenses will not include, and no payment will be made for expenses incurred:

(1) to the extent that the Participant or the Participant's Dependent receives or is entitled to receive any other benefits under the Plan for such expenses;

(2) for or in connection with cosmetic surgery unless the Participant or the Participant's Dependent receives an Injury as a result of an accident while eligible for Major Medical Expense Benefits, which results in damage to the person requiring the cosmetic surgery;

(3) for eyeglasses, or examination for the prescription, or fitting of eyeglasses or for hearing aids, except where provided under "Allowable Major Medical Expenses."

(4) for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:

(A) charges made for, or in connection with dental work necessitated by Injury to natural teeth sustained while the Participant or the Participant's Dependent is eligible for benefits; and

(B) Hospital charges for Room and Board or Necessary Services and Supplies, if approved by the Fund's Medical Consultant;

(5) for marriage counseling, by whomever charged;

(6) for charges by an optometrist who is not licensed to prescribe and administer drug

(7) for charges related to musculoskeletal conditions of the spine except as set forth in Section 3.20 of this Plan Document;

(8) for charges for treatment related to Hospital days that exceed the maximum number of days specified in the applicable Schedule of Benefits;

(9) for charges for treatment in connection with treatment of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and complex of muscles, nerves, and other tissues related to that joint except for charges for TMJ surgery and TMJ related diagnostic tests, x-rays, therapy, treatment and other procedures for which an American Dental Association charge code does not apply;

(10) in connection with weight loss programs;

(11) for charges related to the treatment of learning disabilities;

(12) for which benefits are not payable under the Plan according to Article 4 of this Plan Document ("General Limitations");

(13) for Spinraza

(14) for Zolgensma.

Section 3.15 Physician Office Visit Benefit

(a) In General. The Fund shall pay Allowable Physician Office Visit Charges incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate discounts, Co-Payments, fee allowances, out-of-pocket, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

(b) Allowable Physician Office Visit Charges. As used in this section, "Allowable Physician Office Visit Charges" shall include the office visit charge, related network charges and fees, as well as all lab, x-ray, drugs (i.e. chemotherapy, allergy), administration charges (i.e. vaccines) and all other products or services provided within the confines of and charged by a Physician's office. In addition to charges from a Physician, benefits under Section 3.15 will be provided for charges submitted by a physician's assistant, nurse practitioner, licensed psychologist, licensed optometrist or ophthalmologist, licensed counselor or social worker, and Registered or Licensed Practical Nurse (other than a member of the Participant's or the Participant's Dependent's family). Notwithstanding Section 3.15(a) and (b), administration of the COVID-19 vaccine will be covered at 100% when administered by an In-Network provider. If the Participant receives other services during the same office visit, such services shall be subject to a separate charge. Out-of-Network COVID-19 vaccines will be processed under the "Out-of-Network" benefit level as described in the applicable Schedule of Benefits.

(c) Limitations.

(1) Charges for the administration of allergy injections; and

(2) The payment of Physician Office Visit benefits is subject to the limitations set forth in Article 4 of this Plan Document ("General Limitations").

Section 3.16 Out-of-Pocket Expense Benefit for Grandfathered Plans

(a) General Rule. Except as otherwise required by the No Surprises Act, the Fund will pay 100% of Allowable Out-of-Pocket Expense Charges after a Participant, a Dependent, or the Participant's family satisfies the out-of-pocket limit specified in the applicable Schedule of Benefits.

(b) Allowable Out-of-pocket Expense Charges. As used in Section 3.16, "Allowable Out-of-pocket Expense Charges" is defined as all expenses incurred that require payment of Coinsurance other than those listed in Section 3.16(c).

(c) Limitations. Benefits under this section are not payable with respect to:

(1) Dental, Orthodontic or Vision Benefits;

(2) any expenses incurred prior to the date the Participant or Dependent becomes eligible for benefits;

(3) any individual who is receiving or is eligible to receive benefits in accordance with Section 2.7, "Extension of Benefits While Totally Disabled;

(4) charges that exceed the Allowable Charge;

(5) charges that are the result of reduction of benefit payment due to non-compliance with Pre-certification guidelines set forth in Sections 1.44(a), Section 3.4(a) and Section 3.4(e);

(6) charges that are for services and supplies that are not covered by the Plan;

(7) charges that are in excess of Schedule of Benefits maximums;

(8) charges incurred under the Plan's Prescription Drug Expense Benefit;

(9) charges that are applied to the annual Deductible;

(10) charges that are in connection with follow-up care related to the Organ Transplant Expense Benefit; or

(11) Benefits that are not payable according to Article 4 of this Plan Document ("General Limitations").

Section 3.17 Out-of-Pocket Expense Benefit for Non-Grandfathered Plans

(a) General Rule. Except as otherwise required by the No Surprises Act, the Fund will pay 100% of Allowable Charges after a Participant, a Dependent, or the Participant's family satisfies the out-of-pocket limits specified in the applicable Schedule of Benefits.

(b) Limitations. Benefits that do not apply to the out-of-pocket limits:

(1) Dental, Orthodontic or Vision Benefits;

(2) payments related to Out-of-Network charges;

(3) any expenses incurred prior to the date the Participant or Dependent becomes eligible for benefits;

(4) charges that exceed the Allowable Charge;

(5) charges that are the result of reduction of benefit payment due to non-compliance with Pre-certification guidelines set forth in Sections 1.44(a), Section 3.4(a) and Section 3.4(e);

(6) charges that are for services and supplies that are not covered by the Plan;

(7) charges that are in excess of Schedule of Benefits maximums; or

(8) benefits that are not payable according to Article 4 of this Plan Document ("General Limitations").

Section 3.18 Comprehensive Rehabilitation Expense Benefit

(a) In General. The Fund will pay Allowable Rehabilitative Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization for a Comprehensive Rehabilitation Program connected to the recovery from a non-occupational Injury or Illness==.

(b) Allowable Rehabilitative Expenses. For the purposes of Section 3.18, the term "Allowable Rehabilitative Expenses" is defined as those expenses actually incurred by a Participant or the Participant's Dependent for the charges listed in Section 3.18(b)(1) through Section 3.18(b)(5), but only if the expenses are incurred while such Participant or Dependent is eligible for benefits, and only to the extent that the services or supplies provided are recommended by a Physician or a qualified Rehabilitation Program Specialist, and are essential for the necessary care and treatment of the Injury or Illness suffered:

(1) Charges for the services of a registered physical therapist, registered occupational therapist or registered speech therapist;

(2) Treatment in an extended care or skilled nursing facility, i.e., specially qualified facilities which provide skilled nursing care and rehabilitative services;

(3) Charges made by a Registered Nurse or a Licensed Practical Nurse, other than a member of the Participant's or the Participant's Dependents' family, for medically required professional services;

(4) Charges made by a Physician for professional services;

(5) Charges for medically necessary DME (all DME rentals and all purchases exceeding $1,000 must be approved by the Fund's Medical Consultant as described in Section 1.44), prosthetic appliances, dressings, and drugs and medicines lawfully obtainable only upon the written prescription of a Physician, that are not otherwise payable under the Plan.

(c) Limitations. Allowable Rehabilitative Expenses will not include, and no payment will be made for expenses incurred for:

(1) Custodial Care in any extended care facility, skilled nursing facility or "nursing home;"

(2) expenses no longer recommended for coverage under the rehabilitation program by the Fund whether or not these expenses are otherwise payable under the Plan; and

(3) benefits which are not payable under the Plan according to Article 4 of this Plan Document ("General Limitations").

Section 3.19 Organ Transplant Expense Benefit

(a) In General. Subject to Section 3.19(d) below, the Fund will pay Allowable Organ Transplant Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization. As used in the preceding sentence, the term "Allowable Organ Transplant Expenses" is defined as expenses for the transplantation of an organ, patient screening, organ procurement, and transportation of the organ.

(b) Follow Up Care. The Fund will pay Follow Up Care Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization. As used in the preceding sentence, the term "Follow-up Care" is defined as expenses for immunosuppressant drugs as administered under the Section 3.10 and medical care provided in the home or Hospital. If any of these services are approved by the Fund's Medical Consultant for administration in the patient's home, the maximum amount payable shall be determined by the Fund's Preferred Provider Network's Allowable Charge.

(c) Live Donor Charges. After application of appropriate Deductibles, discounts, Co-insurance, Co-payments, Fee Allowances, out-of-pocket, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits

as determined by the provider's participation in the Plan's appointed Preferred Provider Organization, live donor charges shall be paid for the donor who donates to a covered Participant. However, if the live donor has other group insurance coverage for these expenses, this Fund will consider the charges as secondary payer only. If the live donor who donates to a covered Participant is an eligible member of this Fund, charges will be considered for the donor after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

(d) Limitations. No payment shall be made under Section 3.18 for:

(1) any transplant that is considered experimental or investigational as determined by the Fund's Medical Consultant:

(2) expenses for transportation of surgeons or family members;

(3) expenses related to any transplant not performed at a transplant facility approved by the Fund's Medical Consultant.

Section 3.20 Chiropractic Expense Benefit

(a) In General. The Fund shall pay Allowable Musculoskeletal Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Co-Payments, Fee Allowances, out-of-pocket, visit maximums, and other applicable provisions and in the percentage specified in the Participant's Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

The term "Allowable Musculoskeletal Expenses" is defined as expenses for all treatment by a Doctor of Chiropractics.

Allowable Musculoskeletal Expenses include, but are not limited to, comprehensive and progress examinations, office visits including manipulation, physical therapy modalities, braces, cervical collar, spinal x-rays and lab work.

(b) Limitations. The payment of Chiropractic Expense Benefits is subject to the limitations set forth in Article 4 of this Plan Document ("General Limitations").

Section 3.21 Acupuncture Expense Benefit

(a) In General. The Fund shall pay Allowable Acupuncture Expenses incurred by a Participant or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate Deductibles, discounts, Coinsurance, Copayments, Fee Allowances, out-of-pocket, visit maximums, and other applicable provisions and in the percentage specified in the Participant's

Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

The term "Allowable Acupuncture Expenses" is defined as expenses for all treatment by a licensed acupuncturist. Allowable Acupuncture Expenses include acupuncture services provided by a licensed acupuncturist when it is Medically Necessary.

Section 3.22 Member Assistance Program

(a) In General. If provided for in the Schedule of Benefits, the Fund shall provide access to short term counseling assistance without cost to a Participant or any of the Participant's household members for a set number of visits per problem per year through the Fund's appointed Member Assistance Program.

(b) Services Provided. Services provided will be those typically found in a Member Assistance Program and include but not be limited to marital counseling, legal concerns, family conflict, stress, alcohol/drugs, depression and financial issues.

Section 3.23 COVID-19 Testing and Treatment

The Fund shall pay for the following services, subject to applicable In-Network or Out-of-Network cost sharing:

(a) Diagnosis products for the detection of SARS-CoV-2 or the diagnosis of COVID-19, including serological tests and the administration of such diagnostic products. The types of test that will be covered include:

(1) Diagnostic testing authorized by the FDA or Secretary of HHS;

(2) Diagnostic testing that is under review, or will be submitted for review, by the FDA for emergency use; and

(3) Diagnostic testing authorized by a State, if that State has notified the Secretary of HHS.

(b) Items and services furnished to a Participant or Dependent during health care provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnosis product, but only to the extent such items and services relate to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test.

Section 3.24 Telehealth Services

The Fund will cover items and services furnished to a Participant or Dependent via telehealth visits by an In-Network healthcare provider. Coverage for such medically necessary In-Network telehealth visits will be covered as though the visit took place in the In-Network health care provider's office and are subject to appropriate discounts, co-payments, fee allowances, out-of-

pocket charges, co-insurance percentages, and other applicable provisions specified in the applicable Schedule of Benefits as determined by the provider's participation in the Plan's appointed Preferred Provider Organization.

Section 3.25 Sleep Apnea Services

Sleep apnea services such as sleep testing, a CPAP device and supplies for obstructive sleep apnea will be covered at the normal level of co-insurance for commercial drivers required to undergo testing by the Department of Transportation in accordance with the schedule set forth in the applicable Schedule of Benefits.

Article 4 General Limitations

Section 4.1 Limitations

(a) Employment Related Injury or Illness. No payment will be made for expenses for or in connection with an Injury or Illness for which a Participant or Dependent is entitled to benefits under any Workers' Compensation or similar law.

(1) Payment of Benefits Pending Appeal. If a Participant or Dependent is denied Worker's Compensation benefits after providing the Participant's or Dependent's Employer's Worker's Compensation carrier a timely and valid application for benefits, the Fund may pay benefits after receipt of an initial administrative agency determination that no benefits are available under a Worker's Compensation law, provided the Participant or Dependent continues to promptly and timely exhaust the Participant's or Dependent's remedies through the agency appeals process as required in Section 4.1(a)(2) and executes a Subrogation and Reimbursement Agreement as required in Section 6.6 providing that if the appeal is successful, the Participant or Dependent will pay the Fund the lesser of the amount previously paid by the Fund or the amount received in Worker's Compensation benefits.

(2) Exhaustion of Remedies. The Fund shall require a Participant or Dependent to promptly and timely exhaust the Participant's or Dependent's remedies under the Workers' Compensation law as a condition for obtaining coverage under the Plan. Except as may result from an appeal to a court as provided in Section 4.1(a)(3), below, the decision of the tribunal of last resort within the agency administering the Workers' Compensation law will be considered final and binding on all issues under its jurisdiction which affect this limitation.

(3) Appeals to Court. If the Fund has paid benefits and after the tribunal of last resort of the appropriate administrative agency determines that no benefits are available under a Workers' Compensation law, the Participant or Dependent shall, if requested by the Fund, execute a written authorization to the Fund to appeal the decision to court at the Fund's expense on behalf of the Participant or Dependent. The Participant or Dependent shall also execute a written assignment providing that if the appeal is successful, the

Participant or Dependent will pay the Fund the lesser of the amount previously paid by the Fund including applicable fees paid by the Fund Office to the Fund's Preferred Provider Organization directly attributable to benefit payments or the amount received in Worker's Compensation benefits.

(4) Exception to Limitation. Notwithstanding the limitation of this Section 4.1(a), payment will be made for benefits provided in the Schedule of Benefits covering the Participant or the Participant's Dependent for such benefits which are not provided or paid under an applicable Worker's compensation award of benefits.

(b) Prohibited Payments. No payment will be made for expenses to the extent that payment under the Plan is prohibited by law of the jurisdiction in which the Participant or the Participant's Dependent reside at the time the expenses are incurred.

(c) Non-legally required payments. No payment will be made for expenses for charges which the Participant or the Participant's Dependent are not legally required to pay except to the extent as required by the Federal Government for services furnished by a department or agency of the United States.

(d) Excess of Fee Schedule. No payment will be made which is in excess of the applicable fee schedule.

(e) Failure to Keep Visit. No payment will be made for expenses for failure to keep a scheduled visit.

(f) Claim Form Charges. No payment will be made for expenses for completion of any claim forms, administrative services or service charges.

(g) Cosmetic. No payment will be made for expenses for or in connection with any procedures, products or services that affect appearance only, or which are performed for a purely aesthetic superficial benefit, except as required to repair damage received in an Injury incurred while eligible for benefits, or as provided for by Federal law including, but not limited to, the provisions of the Women's Health and Cancer Rights Act of 1998.

(h) Work-Related Examination. No payment will be made for expenses for or in connection with any work-related examination such as a Department of Transportation physical.

(i) Experimental Procedures/Drugs. No payment will be made for expenses for or in connection with any experimental or investigational procedures or drugs unless deemed medically necessary by the Fund's Medical Consultant or in the case of drugs, Pharmacy Benefit Manager. However, in no case, will any payment be made for Spinraza or Zolgensma.

(j) Medically Unnecessary. No payment will be made for expenses for services and supplies provided by a Hospital, Physician, Chiropractor or other provider of health care services not consistent with the patient's condition, diagnosis, Illness or Injury or for services not consistent with standards of good medical practice.

(k) Pre-certification. No payment will be made for expenses for any charges that are the result of reduction of benefit payment due to noncompliance of the pre-certification requirements described in Section 1.44, Section 3.4(a) and Section 3.4(e).

(l) Non-Prescribed. No payment will be made for expenses for charges for any treatment or services not prescribed by a Physician or Chiropractor.

(m) Reverse Sterilization. No payment will be made for expenses for charges for or in connection with reversal of sterilization procedures.

(n) Custodial Care. No payment will be made for expenses for charges for Custodial Care.

(o) Endosseous Surgery. No payment will be made for expenses for or in connection with endosseous surgery in preparation of and including dental implants except as set forth in Section 3.11(c).

(p) Promotion of Pregnancy. No payment will be made for expenses for any charges in connection with artificial insemination or any other means to promote pregnancy.

(q) Not Listed. No payment will be made for expenses or services not listed or otherwise described in this Plan Document. For avoidance of doubt, services related to autism, or conditions on the autism spectrum, are not listed or otherwise described in this Plan Document, and therefore not covered.

(r) Employer Ceasing to be a Participating Employer. If a Participating Employer ceases to make Contributions on behalf of its Employees in Active Service, the Fund will cease providing benefits to every Participant employed by that Employer and to the Participant's Dependents on the date the eligibility of those Active Service Employees ceases, except as prohibited by federal laws and regulations (including COBRA) and notwithstanding any other provisions of this Plan Document.

(s) Illegal Act. No benefit coverage will be provided for charges incurred for any Illness or Injury arising, either in whole or in part, from the Participant's commission of or participation in, or attempted commission of or participation in, an Illegal Act. An Illegal Act is defined as an action taken which violates any federal, state or local law, regardless of whether the Participant or Dependent is prosecuted or convicted for such Illegal Act.

(t) Unnecessary Treatment. No payment will be made for any unnecessary procedures, treatment or supplies as determined by the Fund's Medical Consultant.

(u) Patient Not Present for Treatment. No payment will be made for charges in connection with the treatment of mental illness or substance abuse when the patient undergoing the treatment is not present.

(v) Procedures Requiring Pre-certification. No payment will be made for expenses relating to procedures requiring pre-certification unless approved by the Fund's Medical Consultant.

(w) No payment shall be made for any charge for service rendered by a member of the Participant or Dependent's family.

Section 4.2 Non-duplication

To the extent that the Participant or the Participant's Dependent receives or is entitled to receive benefits under more than one provision of the Plan, the Participant or the Participant's Dependent shall only be entitled to receive benefits from the provision of the Plan that provides the greatest benefit.

Section 4.3 Termination of Group Coverage for Active Participants

If a Participating Employer ceases to make Contributions on behalf of its Employees in Active Service, the Fund will cease providing benefits to every Participant employed by that Employer and to all of those Participant's Dependents on the date the eligibility of those Active Service Employees ceases, except as prohibited by federal laws and regulations (including COBRA) and notwithstanding any other provisions of this Plan Document.

Section 4.4 Limitations on Uses and Disclosures of Health Information

USES AND DISCLOSURES OF HEALTH INFORMATION

As part of its operations, the Fund creates or receives certain information about individuals relating to past, present, or future physical or mental health or condition, the administration of health care to Individuals, and the past, present, or future payments for the administration of health care to Individuals.

"Individual" refers to all Participants in the Fund, including deceased Individuals or their personal representative, personal representatives of Individuals, and parents or guardians of minor children, so long as disclosure to the personal representative or parent or guardian is not otherwise prohibited by state law.

Protected Health Information is information that is identifiable to a particular Individual. An Individual's Protected Health Information may be disclosed by the Fund to the Board of Trustees, the Plan Sponsor for the Health and Welfare Fund. Disclosure to the Board of Trustees is dependent upon the Board of Trustees' certification that it will not use or disclose information other than as set out in these plan documents, or as otherwise permitted by law. The Board of Trustees' certification may be found in Section 4.5 Additionally, Section 4.4(b)(16)(D) describes the classes of employees of the Fund who have access to Protected Health Information. These employees use Protected Health Information to perform plan administration functions. Employees of the Fund may not use or disclose Protected Health Information except as described in the plan documents, or as otherwise permitted by law. Employees who violate their duties with respect to

Protected Health Information shall be sanctioned up to and including discharge from their employment.

The following sets forth required and permitted uses and disclosures of an Individual's Protected Health Information that the Board of Trustees may make.

(a) Required Disclosures.

(1) All Protected Health Information must be disclosed when required by the Secretary of Health and Human Services or any other officer or employee of Department of Health and Human Services to whom the authority involved has been delegated;

(2) All records contained in a designated record set must be disclosed to the Individual, when requested in writing, except for

(A) psychotherapy notes; or

(B) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

(b) Permitted Disclosures. The Board of Trustees may make the following uses or disclosures without obtaining the Individual's prior consent, either oral or written:

(1) The Board of Trustees may make disclosures to the Individual;

(2) The Board of Trustees may disclose Protected Health Information for the treatment activities of a health care provider;

(3) The Board of Trustees may use or disclose Protected Health Information to any person or entity for the purposes of carrying out the Fund's payment, or health operations;

(4) The Board of Trustees may disclose Protected Health Information to another covered entity or health care provider for the payment activities of the entity that receives the information;

(5) The Board of Trustees may disclose Protected Health Information to another covered entity for the health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the Individual who is the subject of the Protected Health Information being requested, the Protected Health Information pertains to such relationship, and the disclosure is:

(A) for a purpose of conducting quality assessment and improvement activities, including outcomes, evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from

such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of heath care providers and patients with information about treatment alternatives; and related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; or

(B) for the purpose of health care fraud and abuse detection or compliance;

(6) The Board of Trustees may use or disclose Protected Health Information as incident to a use or disclosure otherwise permitted or required by the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R Parts 160 and 164 provided that the Board of Trustees only uses or discloses the minimum necessary information and has in place other safeguards to protect an Individual's health information;

(7) The Board of Trustees may use Protected Health Information to create information that is not individually identifiable health information or disclose Protected Health Information only to a business associate for such purpose, whether or not the de-identified information is to be used by the Board of Trustees. Information that has been de-identified is not covered by the requirements of the Standards for Privacy of Individually Identifiable Health Information provided that:

(A) disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of Protected Health Information; and

(B) if de-identified information is re-identified, the Board of Trustees may use or disclose such re-identified information only as permitted or required by the Standards for Privacy of Individually Identifiable Health Information;

(8) The Board of Trustees may use Protected Health Information to create a limited data set, or it may disclose Protected Health Information to a business associate for such purpose, whether or not the limited data set will be used by the Board of Trustees. The Board of Trustees may also use or disclose a limited data set, only for the purpose of research, public health,

or health care operations, if the Board of Trustees has entered into a data use agreement with the limited data set recipient;

(9) The Board of Trustees may disclose Protected Health Information to a business associate and may allow a business associate to create or receive Protected Health Information on its behalf, if the Board of Trustees obtains satisfactory assurance that the business associate will appropriately safeguard the information. This standard does not apply:

(A) with respect to disclosures by the Board of Trustees to a health care provider concerning the treatment of the individual; or

(B) with respect to disclosures by the Fund to the Board of Trustees, so long as the requirements for certification are met;

(10) A member of the Board of Trustees or a business associate may make a disclosure if:

(A) the member or business associate believes in good faith that another Trustee or the Fund has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

(B) the disclosure is to:

(i) a health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the Trustee or the Fund; or

(ii) an attorney retained by or on behalf of the Trustee or business associate for the purpose of determining the legal options of the member or business associate with regard to the conduct described in Section 4.5(a);

(11) The Board of Trustees may disclose Protected Health Information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(A) the health care system;

(B) government benefit programs for which health information is relevant to Beneficiary eligibility;

(C) entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(D) entities subject to civil rights laws for which health information is necessary for determining compliance.

For purposes of disclosures permitted by this paragraph, a health oversight activity does not include an investigation or other activity in which the Individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(A) the receipt of health care;

(B) a claim for public benefits related to health; or

(C) qualifications for, or receipt of public benefits or services when a patient's health is integral to the claim for public benefits or services. However, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of this paragraph;

(12) The Board of Trustees may disclose Protected Health Information for a law enforcement purpose to a law enforcement official:

(A) as required by law including laws that require the reporting of certain types of wounds or their physical injuries, except for laws subject to Section 4.4(b)(12)(B) and about victims of domestic abuse; or

(B) in compliance with and as limited by the relevant requirements of:

(i) a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

(ii) a grand jury subpoena; or

(iii) an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

I. the information sought is relevant and material to a legitimate law enforcement inquiry;

II. the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

III. de-identified information could not reasonably be used;

(13) The Board of Trustees may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related Injuries or Illness without regard to fault;

(14) The Board of Trustees may make uses or disclosures of Protected Health Information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Uses or disclosures under this paragraph must also comply with Section 4.5(b)(12) and Section 4.5(b)(16).

(15) Oral Agreement Required Prior to Use or Disclosure. The Board of Trustees may disclose to a family member, other relative, or a close personal friend of the Individual, or any other person identified by the Individual, the Protected Health Information directly relevant to such person's involvement with the Individual's care or payment related to the individual's health care.

(A) if the Individual is present for, or otherwise available prior to, a use or disclosure described above and has the capacity to make health care decisions, the Board of Trustees may use or disclose the Protected Health Information if it:

(i) obtains the Individual's agreement;

(ii) provides the Individual with the opportunity to object to the disclosure, and the individual does not express an objection; or,

(iii) reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

(B) If the Individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the Individual's incapacity or an emergency circumstance, the Board of Trustees may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the Individual and, if so, disclose only the Protected

Health Information that is directly relevant to the person's involvement with the Individual's health care.

(16) Notice of Disclosure Must Be Given to the Individual. The Board of Trustees may disclose Protected Health Information in the course of any judicial or administrative proceeding:

(A) in response to an order of a court or administrative tribunal, provided that the Board discloses only the Protected Health Information expressly authorized by such order; or

(B) in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if

(i) the Board receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the Individual who is the subject of the Protected Health Information that has been requested has been given notice of the request. For purposes of this Section 4.5(b)(16)(B)(i), satisfactory assurances from a party seeking Protected Health Information means that the Board must receive from such party a written statement and accompanying documentation demonstrating that:

I. the party requesting such information has made a good faith attempt to provide written notice to the Individual (or, if the Individual's location is unknown, to mail a notice to the Individual's last known address);

II. the notice included sufficient information about the litigation or proceeding in which the Protected Health Information is requested to permit the Individual to raise an objection to the court or administrative tribunal; and

III. the time for the Individual to raise objections to the court or administrative tribunal has elapsed, and:

a. no objections were filed; or

b. all objections filed by the Individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution; or

(ii) the Board receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order. For purposes of this Section 4.5(b)(16)(B)(ii), satisfactory assurance means that the Board will receive from such party seeking information a written statement and accompanying documentation demonstrating that:

I. the parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

II. the party seeking the Protected Health Information has requested a qualified protective order from such court or administrative tribunal;

(iii) for purposes of this section, a qualified protective order means, with respect to Protected Health Information requested under Section 4.5(b)(16), an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

I. prohibits the parties from using or disclosing the Protected Health Information for any purpose other than the litigation or proceeding for which such information was requested; and

II. requires the return to the covered entity or destruction of the Protected Heath Information (including all copies made) at the end of the litigation or proceeding;

(iv) notwithstanding Section 4.5(b)(16)(B), the Board may disclose Protected Health Information in response to lawful process described in Section 4.5(b)(16)(B) above without receiving satisfactory assurance if the Board makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of Section 4.5(b)(16)(B)(i) or Section 4.5(b)(16)(B)(ii) of this paragraph.

(C) Written Authorization From Individual Required. Except for the uses and disclosures above, or as otherwise required or permitted by law, the Board of Trustees will make no uses or disclosures of Protected Health Information unless the Individual has given their

written authorization to the Board permitting it to use or disclose the information. Furthermore, the Individual may revoke the written authorization given to the Board at any time, provided that the revocation is also in writing. There are certain circumstances under which the Individual may not revoke the written authorization. Those circumstances are:

(i) If the Board has taken action in reliance on the authorization; or

(ii) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the Board with the right to contest a claim under the policy or the policy itself.

(D) Classes of Health and Welfare Fund Employees and their access to Protected Health Information.

(i) Executive Director. The Executive Director proofreads and presents all appeals submitted by Fund's Participants to the Board of Trustees. The Executive Director has access to all files necessary to proofread and present such appeals. The Executive Director may from time to time review participant records to determine if the provisions of the Plan Document have been properly applied to individual claims, eligibility, etc. The Executive Director may access identifiable health information to address Participant complaints. The Executive Director may accumulate and review identifiable health information as prepared for use by business associates of the Fund.

(ii) Health and Welfare Benefits Manager. The Health and Welfare Benefits Manager is responsible for creation of policy and procedures to be used by appropriate staff in the administration of plan provision in partnership with the Executive Director. The development and resulting analysis of such procedures may utilize identifiable health information. The Health and Welfare Benefits Manager prepares all appeals submitted by the Fund's Participants to the Board of Trustees and also informs the relevant Participants of the Trustees' rulings. The Health and Welfare Benefits Manager addresses complaints by Participants, which requires a review of historical Participant health information maintained by the Fund. The Health and Welfare Benefits Manager also responds to staff claim inquiries and other staff issues involving individual Participant's or claim issues.

(iii) Receptionist. The receptionist receives all faxes, mail and UPS packages sent to the Fund Office. The faxes, mail and packages regularly contain individually identifiable health information, including, but not limited to, claim forms, operative notes, therapy requests, receipts for prescription purchases, appeal requests, and vendor invoices. The receptionist also sends out all faxes for the Fund and is therefore exposed to individually identifiable health information necessary to respond to the above types of submissions or documents created in-house for use in day-to-day operations.

(iv) Claim Coordinators. The Claim Coordinators interact, via the toll free phone system, with Participants and family members, providers and vendors (i.e. pharmacies). They are responsible for answering and routing benefit questions that may require dissemination of individually identifiable health information. Due to the broad nature of questions they may be asked, they have access to all Protected Health Information except for that of other Health and Welfare Fund employees. Claim Coordinators receive and process claims. They have access to the individually identifiable health information regarding a particular claim and other related Protected Health Information required to properly adjudicate each claim. The other related Protected Health Information consists of the identity and benefit structure of other insurance coverage a Participant or the Participant's family may have, information related to previous claims presented, the identity of all covered family members, information describing work related injuries, and other data necessary to adjudicate a given claim.

(v) Cost Containment Specialist. The Cost Containment Specialist is exposed to all data described under the Claim Coordinator heading. The Cost Containment Specialist also forwards surgical notes, therapy notes and other information to the Fund's Medical Consultant to assist in determining if proposed or performed procedures are medically necessary and are the appropriate form or level of treatment for a particular medical case or to approve and disapprove ongoing therapies such as physical or speech therapy.

(vi) Records Coordinator. The Records Coordinator is responsible for filing and retrieving health claim forms and other documentation containing Personal Health Information. In certain situations, the Records Coordinator may substitute as Receptionist and therefore be exposed to

all health information described under the Receptionist heading.

Section 4.5 Board of Trustees Limitations on Uses and Disclosure of Health Information

The Board of Trustees certifies that the Plan Document has been amended to incorporate the following provisions and the Board of Trustees agrees to the following provisions:

(a) The Board of Trustees will not use or further disclose an Individual's Protected Health Information other than as permitted or required by the plan documents or as required by law;

(b) The Board of Trustees ensures that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Health and Welfare Fund agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

(c) The Board of Trustees will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) The Board of Trustees will report to the Health and Welfare Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided, for which it becomes aware;

(e) The Board of Trustees will make available any Protected Health Information it maintains to the Individual who is the subject of the Protected Health Information in accordance with the procedures set out in 45 C.F.R. § 164.524;

(f) The Board of Trustees will make available any Protected Health Information it maintains for amendment and incorporate any amendments to Protected Health Information in accordance with the procedures set out in 45 C.F.R. § 164.526;

(g) The Board of Trustees will make available the information required to provide an accounting of disclosures in accordance with the procedures set out in 45 C.F.R. § 164.528;

(h) The Board of Trustees will make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Health and Welfare Fund available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Health and Welfare Fund with the requirements to provide Notice in the plan documents;

(i) The Board of Trustees will, if feasible, return or destroy all Protected Health Information received from the Health and Welfare Fund that the Board still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or

destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) The Board of Trustees will ensure that adequate separation exists between it and the Health and Welfare Fund. The Plan Documents identify the classes of employees at the Health and Welfare Fund and the types of health information to which they have access in Section 4.4 of the Plan Document. Furthermore, all employees' access to individually identifiable health information is restricted to that necessary to perform their functions for plan administration. Any employee who violates the Health and Welfare Fund's privacy practices and procedures will be subject to sanction, up to and including discharge.

Article 5 Coordination of Benefits

Section 5.1 Coordination of Benefits

All benefit provisions of this Plan are subject to Article 5 except those provisions pertaining to Life Insurance, Accidental Death and Short Term Disability Income Benefits.

Section 5.2 Definitions

For purposes of Article 5, the following definitions shall apply:

(a) Plan. The term "Plan" includes any Plan providing benefits or services for Hospital, medical, dental or vision care, which are provided by:

(1) group or blanket insurance coverage (excluding blanket school accident coverage, youth sports accident coverage, or a single policy affording multiparty coverage at the individual's expense);

(2) any coverage under prepaid group plans, labor-management Trusteed plans, union welfare plans, employer organization plans, employee organization benefits plans, or any other arrangements of benefits for individuals of a group; or

(3) any coverage under governmental programs including any statute whether or not such plan is covered by ERISA (for example, CHAMPUS, Medicare, or any other employee benefit plan.).

(b) Construction. The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(c) Benefits. The term "Benefits" is defined as that portion of this Plan which provides benefits that are subject to this Article 5.

(d) Allowable Expense. "Allowable Expense" is defined as any necessary item of expense at least a portion of which is covered under at least one of the plans covering the individual for whom claim is made. No benefits will be provided by the Fund for any services as secondary carrier when those services are denied coverage by the primary insurance carrier if the denial is a result of the Individual's failure to follow the guidelines of the primary plan. This limitation includes, but is not limited to: pre-certification, second (2^{nd}) surgical opinion, pre-authorization of dental services, and health maintenance organizations (HMO). No benefits will be provided by the Fund for any service as secondary carrier when those services are denied coverage by the primary carrier due to the Dependent's failure to complete the necessary enrollment forms or apply during the proper enrollment period when the benefits are provided to the Dependent by an Employer on a group basis at no cost to the Dependent.

Section 5.3 Order of Determination for Active Coverage

(a) In General. When a Participant or Dependent is eligible for benefits with the Fund as an active Employee and eligible for coverage from any other plan, the order of plan priority will be determined as stated in Section 5.3. Any Participant or Dependent offered free group health insurance is required to enroll in the Plan offered, unless the Participant or Dependent would be forfeiting any other benefit (i.e., additional vacation).

(b) Medicare. Medicare will be the primary plan, except to the extent prohibited by law.

(c) No Non-Duplication Provision. If the other plan, except Medicare, does not have a Non-Duplication or Coordination of Benefits provision, the other plan will automatically be primary.

(d) Non-Duplication Provision. If the other plan has a Non-Duplication or Coordination of Benefits provision, the following will apply:

(1) The plan which covers the Participant or Dependent as an employee or as the certificate holder will be the primary plan and the plan covering the Participant or Dependent as a Dependent will be the secondary plan;

(2) For a Qualifying Child:

(A) Except as set forth in Section 5.3(d)(2)(B), the primary plan for a Qualifying Child will be the plan of the parent whose birthday month and day (excluding year of birth) occurs earlier in a calendar year. (Example: If the father's birthday is September 15, 1940, and the mother's birthday is January 30, 1942, the mother's Plan will be primary.);

(B) In cases where the parents are separated or divorced:

(i) For Qualifying Children under the age of eighteen (18) where there is a court order which establishes financial responsibility for the medical, dental, or other health care expenses with respect to a Qualifying Child, the benefits for the Qualifying Child will be determined in accordance to the court order. Otherwise, the plan of the parent with custody will be primary; if the parent with custody has remarried, the plan of the parent with custody will be primary, the stepparent's plan will be secondary, and the plan of the parent without custody will be tertiary (3rd). If the parents have joint custody, the parent who claims the Qualifying Child for tax purposes will be primary;

(ii) For Qualifying Children age eighteen (18) or older, the plan of the parent with whom the Qualifying Child resides will be primary. If the Qualifying Child does not live with either parent, the Plan of the parent whose birthday month and day (excluding year of birth) occurs earlier in a calendar year will be primary. (Example: If the father's birthday is September 15, 1940, and the mother's birthday is January 30, 1942, the mother's Plan will be primary.);

(C) Notwithstanding Section 5.3(d)(2)(A) and Section 5.3(d)(2)(B) if the other plan specifies a different rule for coordinating the benefits of a Qualifying Child, such benefits shall be coordinated as follows: The rule of Section 5.3(d)(3), below will apply, except the other plan's rule will apply if it provides that the plan covering the Participant or Dependent as a Qualifying Child of a male person will be primary and the plan covering the Participant or Dependent as a Qualifying Child of a female person will be secondary;

(3) If the foregoing provisions of Section 5.3(d), do not establish an order of benefit determination, the plan which has covered the person for the longer period of time shall be primary, with the following exception: The benefits of a plan covering the person under Extension of Benefits, as a laid-off employee or as a retired employee, or Dependent of such person, shall be determined after the benefits of any other plan covering the person as an employee or Dependent thereof.

Section 5.4 Calculation of Benefits Payable in which the Plan is not primary

For any claim received in which the Plan is not the primary plan, the Plan will pay the difference between the primary plan's reimbursement and 100% of the Allowable Charge, provided this amount does not exceed the benefits payable under the Plan in the absence of duplicate coverage. For purposes of this Section 5.4, Allowable Charge is defined as the billed charges less the greater of the discounts allowed under the primary plan or the Fund's plan, any reduction necessary to limit the billed charge to the applicable fee schedule for Out-of-Network claims, or if required by contract with the Fund's Preferred Provider Organization, the billed charge reduced by the primary

Plan's Preferred Provider Organization's discount. Notwithstanding the foregoing, to the extent permitted by the No Surprises Act, any calculation of benefits payable where the Plan is not primary will be determined by the Fund on a reasonable and consistent basis in its sole discretion.

Article 6 Payment of Benefits and Miscellaneous

Section 6.1 Payment of Benefits

(a) Persons to Whom Benefits are Payable. The proceeds of any benefits, other than Life Insurance Benefits, shall be paid solely to:

(1) the Participant or Dependent. Benefits for Life Insurance will be payable in accordance with the provisions of Section 3.1; or

(2) the Alternate Recipient of the Participant if provided for under a Qualified Medical Child Support Order (QMCSO).

(b) Facility of Payment of Benefits. If a Participant is a minor or, in the opinion of the Trustees, otherwise not competent to give a valid receipt for any benefit due him, and if no request for payment has been received by the Fund from a duly appointed guardian or other legally appointed representative of the Participant, the Fund may, at its option, make direct payment to the Individual or institution appearing to the Fund to have assumed the custody of or the principal support of the Participant. If the Participant dies while benefits for Hospital, nursing, medical, surgical, dental, optical or other services remain unpaid, the Fund may at its option, make direct payment to the Individual or institution on whose charges claim is based or to any of the following surviving relatives of the Participant: wife, husband, mother, father, Child or Children, brothers or sisters, or to the executors or administrators of the Participant. If a Participant dies while Dismemberment Benefits or Short Term Disability Income Benefits remain unpaid, the Fund, at its option, may make direct payment to any of the following surviving relatives of the Participant: wife, husband, mother, father, Child or Children, brothers or sisters, or to the executors or administrators of the Participant's estate. Any payment by the Fund in accordance with Section 6.1 will discharge the Fund from all further liability to the extent of the payment made.

Section 6.2 Claims Procedures

(a) Notice of Claim.

(1) Written Notice of Claim must be given to the Fund Office. Written Notice of Claim given by or on behalf of the Participant or Dependent to the Fund with sufficient information to identify the Participant or Dependent will be considered notice to the Fund. As used in Section 6.2, "Notice of Claim" is defined as the first (1st) time that the Fund Office is made aware that a claim was incurred on a specific date. No charges can be considered for payment by the Fund until all information required for processing is on file. No claim will be paid or considered for payment if the charges incurred more than twelve (12) months prior to the date Notice of Claim is received unless the

claim is for benefits for which the Fund is secondary. In such cases, no claim will be paid or considered for payment if the final payment by the primary carrier took place more than twelve (12) months prior to the date notice of claim is received. However, failure to give written notice within the twelve (12) month period will neither invalidate nor reduce any claim if proof can be submitted of a provider or Participant's attempt to submit a claim to the Fund within twelve (12) months or it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as reasonably possible.

(2) Authorized Representative. An Authorized Representative of a Participant or Dependent may act on behalf of such Participant or Dependent in pursuing a benefit claim or appeal of an Adverse Benefit Determination. A Participant's Spouse or a parent of a minor Participant or Dependent may serve as the Participant or Dependent's representative without prior notice to the Fund Office. Except in cases involving "urgent care", a Participant or Dependent must submit a written designation of any other representative to the Fund. In the case of a claim involving urgent care, a health care professional with knowledge of a Participant or Dependent's medical condition shall be permitted to act as the Authorized Representative of the Participant or Dependent. An Authorized Representative appointed under this provision does not have any independent rights under this Plan or ERISA.

(3) In the case of a failure by a Participant or Dependent or an Authorized Representative of a Participant or Dependent to follow the Plan's procedures for filing a "pre-service claim", the Participant or Dependent or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Participant or Dependent or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a claim involving "urgent care") following the failure. Notification may be oral, unless written notification is requested by the Participant or Dependent or Authorized Representative.

(4) Section 6.2(a)(3) shall apply only in the case of a failure that:

(A) is a communication by a Participant or Dependent or an Authorized Representative of a Participant or Dependent that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) is a communication that names a specific Participant or Dependent; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(b) Proof of Loss. As used in Section 6.2, "Proof of Loss" is defined as the submission of any additional charges, reasonably expected to be connected to a claim that has already been submitted to the Fund within the time limit for "Notice of Claim." Charges for prescription drugs, office visits, and other services for which additional charges cannot be expected, will not be considered "Proof of Loss", but instead will be considered "Notice of Claim." Written Proof of Loss must be received by the Fund Office by the end of the calendar year after the calendar year that includes the date the charges incurred with the exception of claims for which the Fund is secondary. Written Proof of Loss for claims in which the Fund is secondary must be received by the Fund Office by the end of the calendar year after the calendar year in which final payment is made by the primary carrier. No claim shall be paid or considered for payment unless adequate written Proof of Loss containing all information required for processing is provided to the Fund Office. Failure to furnish written Proof of Loss within that time will neither invalidate nor reduce any claim if proof can be submitted of a provider or Participant's attempt to submit a claim to the Fund Office within twelve (12) months or it can be shown that it was not reasonably possible to furnish written Proof of Loss within that time and that written Proof of Loss was furnished as soon as was reasonably possible

(c) Claim Review Procedure.

(1) Manner and content of notification of benefit determination. The Fund Office shall provide a Participant or Dependent with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by 29 C.F.R § 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the Participant or Dependent:

(A) The specific reason or reasons for the Adverse Benefit Determination;

(B) Reference to the specific Plan provisions on which the determination is based;

(C) A description of any additional material or information necessary for the Participant or Dependent to perfect the claim and an explanation of why such material or information is necessary;

(D) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Participant or Dependent's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review;

(E) The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant or Dependent's Adverse Benefit Determination, without regard to

whether the advice was relied upon in making the benefit determination;

(F) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant or Dependent upon request;

(G) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant or Dependent's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(H) In the case of an Adverse Benefit Determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(i) the information described in Section 6.2(c)(1) may be provided to the Participant or Dependent orally within the time frame prescribed in Section 6.2(c)(2)(B), provided that a written or electronic notification is furnished to the Participant or Dependent not later than three (3) days after the oral notification.

(I) With respect to disability claims, any notification of Adverse Benefit Determination shall set forth:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination; and/or a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration

(ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits as set forth in Section 6.2(d)(1); and

(iv) A statement prominently displayed in any applicable non-English language, as defined in guidance published by the Secretary of Labor pursuant to 29 C.F.R. § 2560.503-1(o) clearly indicating how to access the language services provided by the Fund.

(2) Timing of notification of benefit determination. The Fund shall notify a Participant or Dependent of the Plan's benefit determination in accordance with the following schedule:

(A) Disability claims. The Fund shall notify the Participant or Dependent of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Plan. This period may be extended by the Plan for up to thirty (30) days, provided that the Fund determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant or Dependent, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first (1st) thirty (30) day extension period, the Fund determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Fund notifies the Participant or Dependent, prior to the expiration of the first (1st) thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this Section 6.2(c)(2)(A), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant or Dependent shall be afforded at least forty-five (45) days within which to provide the specified information;

(B) Urgent care claims. The Fund or the Fund's appointed case management organization shall notify the Participant or Dependent Urgent care claims. The Fund or the Fund's appointed case management organization shall notify the Participant or Dependent of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account medical urgency, but no later than seventy-two (72) hours after receipt of the claim by the Plan, unless the Participant or Dependent fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Fund shall notify the Participant or Dependent as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant or Dependent shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Fund shall notify the Participant or Dependent of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

(i) the Plan's receipt of the specified information, or

(ii) the end of the period afforded the Participant or Dependent to provide the specified additional information.

(C) Concurrent care decisions. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

(i) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Fund shall notify the Participant or Dependent of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Participant or Dependent to appeal and obtain a determination or review of that Adverse Benefit Determination before the benefit is reduced or terminated;

(ii) any request by a Participant or Dependent to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account medical urgency, and the Fund shall notify the Participant or Dependent of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim

by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments;

(D) Pre-service claims. The Fund shall notify the Participant or Dependent of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Fund determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant or Dependent, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant or Dependent to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant or Dependent shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(E) Post-service claims. The Fund shall notify the Participant or Dependent of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Fund determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant or Dependent, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant or Dependent to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant or Dependent shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(3) Calculating time periods. For purposes of Section 6.2(c)(2), the period of time within which a benefit determination is required to be made shall begin at the time a claim is received by the Fund, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a Participant or Dependent's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Participant or Dependent until the date on which the Participant or Dependent responds to the request for additional information.

(d) Appeal Procedure.

(1) A Participant or Dependent or their designated Authorized Representative may appeal an Adverse Benefit Determination by filing a notice of appeal to the Board of Trustees within one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination. In support of an appeal, the Participant or Dependent may submit written comments, documents, records, and other information relating to the claim for benefits. Upon the Participant, Dependent or Authorized Representative's request, the Fund will provide, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant or Dependent's claim for benefits. In addition, the individual making the request will automatically be provided with any and all new information generated in connection with the appeal. A document, record, or other information shall be considered relevant to a Participant or Dependent's claim if such document, record, or other information:

(A) was relied upon in making the benefit determination;

(B) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(C) demonstrates that the benefit determination is made in accordance with governing Plan Documents and that the Plan provisions have been applied consistently with respect to similarly situated Participant or Dependent; or

(D) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Participant or Dependent's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination;

(2) The Board of Trustees, or a duly appointed subcommittee thereof (Trustees), will consider each appeal, taking into account all comments, documents, records, and other information submitted by the Participant or Dependent relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In considering an appeal, the Trustees will not give deference to the initial Adverse Benefit Determination. No Trustee may consider an appeal if that Trustee participated in making the initial adverse decision or is the subordinate of any such person;

(3) In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental,

investigational, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Consultation with a health care professional will alternate between three (3) external independent review organizations for non-grandfathered plans and for grandfathered plans only with respect to No Surprises Services. The health care professional engaged for purposes of a consultation on an appeal shall not be an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal or the subordinate of any such individual. The Fund will identify to the Participant or Dependent any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant or Dependent's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

(4) Expedited Appeals of "Urgent Care" Claims: Where a Participant or Dependent appeals from an adverse decision on a claim involving urgent care, the Participant or Dependent may request an expedited appeal either orally or in writing. Upon receipt of a request for an expedited appeal, all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant or Dependent by telephone, facsimile, or other available similarly expeditious method.

(5) Appeals of Disability Claims: With respect to appeals related to disability claims:

(A) Before the Plan can issue an Adverse Benefit Determination on review on a disability benefit claim, the Fund will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Trustees, Fund, or other person making the benefit determination (or at the direction of the Trustees, Fund or such other person) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is to be provided under Section 6.2(e)(4). to give the claimant a reasonable opportunity to respond prior to that date;

(B) Before the Plan can issue an Adverse Benefit Determination on review on a disability benefit claim based on a new or additional rationale, the Fund will provide the Participant, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is to be provided under Section 6.2(e)(4). to give the claimant a reasonable opportunity to respond prior to that date.

(e) Timing of notification of benefit determination on appeal.

(1) General Rule. The Fund's Board of Trustees, having regularly scheduled meetings at least quarterly, shall make a benefit determination no later than the date of the meeting of the Board of Trustees that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date upon which the benefit determination will be made, prior to the commencement of the extension. The Fund shall notify the Participant or Dependent of the Plan's adverse benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

(2) Urgent care claims. In the case of a claim involving urgent care, the Fund shall notify the Participant or Dependent of the Plan's benefit determination on the appeal as soon as possible, taking into account medical urgency, but not later than seventy-two (72) hours after receipt of the Participant or Dependent's request for review of an Adverse Benefit Determination by the Plan.

(3) Pre-service claims. In the case of a pre-service claim, the Fund shall notify the Participant or Dependent of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the Participant or Dependent's request for review of an Adverse Benefit Determination.

(4) Disability claims. If the Trustees hold regularly scheduled meetings at least quarterly, the Trustees shall make a benefit determination within the schedule established in Section 6.2(e)(1).

(5) Calculating time periods. For purposes of Section 6.2(e), the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant or Dependent's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant

or Dependent until the date on which the Participant or Dependent responds to the request for additional information.

(6) Furnishing documents. In the case of an Adverse Benefit Determination on review, the Fund shall provide such access to, and copies of, documents and records.

(f) Manner and content of notification of benefit determination on appeal. The Fund shall provide a Participant or Dependent with written or electronic notification of a Plan's benefit determination on appeal. Any electronic notification shall comply with the standards imposed by 29 C.F.R § 2520.104b 1(c)(1)(i),(iii), and (iv). In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Participant or Dependent the information described in Section 6.2(c)(1) and the following statement: You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

(1) Appeals of Disability Claims: With respect to a decision regarding an appeal of a disability claim, the notification of benefit determination on appeal shall include the information described in Section 6.2(f), and shall include after the information described in Section 6.2(c)(1)(D) that the claimant's right to bring a Section 502 claim is subject to a limitations period, such as the period set forth in Section 3.2(d)(1), if applicable, including the calendar date on which the contractual limitations period expires for the claim.

(g) External Review – Non-Grandfathered Schedules and Both Non-Grandfathered and Grandfathered Schedules Only With Respect to No Surprises Services.

(1) Notwithstanding anything else in the Plan to the contrary, a Participant or Dependent may request external review in accordance with the provisions of this Section 6.2(g) for any No Surprises Service, regardless of whether such Participant or Dependent participates in a grandfathered or non-grandfathered plan.

(2) Once the appeals procedures of Section 6.2(d) have been exhausted, a request for an external review may be filed within four (4) months from the date the final adverse benefit determination is received. If the deadline falls on a Saturday, Sunday or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday. A request may be made for external review of any denied claims that involve a question of medical judgment, decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including claims related to eligibility or claims related to life/death benefits

or disability benefits, or a legal or contractual interpretation of the Plan's terms. Requests for external review should be sent to the Fund Office.

(3) Within five (5) business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request to determine whether:

(A) the Participant or Dependent was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

(B) the adverse benefit determination that is being appealed does not relate to the Participant or Dependent's failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;

(C) the Participant or Dependent has exhausted the Plan's internal claims appeal process; and

(D) the Participant or Dependent has provided all the information and forms required to process an external review. Within one (1) business day after completion of this preliminary review, the Plan will issue notification of its decision to the Participant or Dependent. If the request is not eligible for external review, the notice will explain the reasons for its ineligibility and provide any other information required, including contact information for the Employee Benefits Security Administration. If the request for external review is incomplete, the Plan will identify what is needed and the Participant or Dependent will have the longer of forty-eight (48) hours or the remaining portion of the four (4) month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization (IRO) that is accredited by URAC or a similar nationally-recognized accrediting organization. The Plan will ensure independence of such IROs, will contract with at least three (3) IROs for assignments, and will alternate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The assigned IRO will use legal experts where appropriate to make coverage determinations under the plan.

(h) Review by IRO. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten (10) business days

following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

Within five (5) business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO will notify the Participant or Dependent and the Plan.

Upon receipt of any information submitted by you, the assigned IRO will within one (1) business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external 50 review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Plan, and the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim again and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) the Participant or Dependent's medical records;

(2) the attending health care professional's recommendation;

(3) reports from appropriate health care professionals and other documents submitted by the Plan, the Participant or Dependent or the treating provider;

(4) the terms of the Plan;

(5) appropriate practice guidelines;

(6) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) the opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The IRO will provide written notice of the final external review decision to the Plan and the Participant or Dependent within forty-five (45) days after the IRO received the request to review. The assigned IRO's decision notice will contain:

(1) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the availability of treatment codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);

(2) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(3) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, considered in reaching its decision;

(4) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or to the claimant;

(5) a statement that judicial review may be available to the Participant or Dependent; and contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

After a final external review decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. The IRO will make such record available for examination by you, the Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

(i) Expedited External Review. You may request an expedited external review if you receive:

(1) a claim determination involving a medical condition for which the time frame for completion of the Plan's expedited internal review process would seriously jeopardize the Participant or Dependent's life or health or would

jeopardize the ability to regain maximum function and the request for an expedited internal appeal has been filed; or

(2) an appeal, if the Participant or Dependent has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the Participant or Dependent's life or health or would jeopardize the ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which emergency services were received, but has not been discharged from a facility.

If the Plan receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify the Participant or Dependent of its determination. If the Plan determines that the Participant or Dependent is eligible for a standard external review, the Plan will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review.

The IRO will notify the Plan and the Participant or Dependent of its determination as expeditiously as the medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request or an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the Participant or Dependent and the Plan.

(j) Access to Medical Records. In order to process claims and any appeals from initial determinations of claims, the Fund reserves the right to review medical records as deemed necessary to accurately apply the benefits of the Plan.

(k) Statute of Limitations and Venue. Any legal action brought against the Plan or the Trustees under Section 502(a) of ERISA must be filed no later than 1 year from the date of the Trustees' or IRO's final determination on appeal. Any such action must be brought in the United States District Court for the Eastern District of Virginia.

Section 6.3 Physical Examination and Autopsy

The Fund, at its own expense, will have the right and opportunity, while a claim is pending, to have a Physician of its choice examine any Individual whose Injury or Illness is the basis of a claim when and so often as it may reasonably require. The Fund may also require, at its expense and if permitted by law, an autopsy be performed in the case of death.

Section 6.4 Physician-Patient or Dentist-Patient Relationship

Although the Fund provides financial incentives to encourage the use of In-Network Hospitals and Physicians, Participants and Dependents will have free choice of any Physician or Dentist practicing legally.

Section 6.5 Assignment

A Participant or Dependent cannot assign, transfer or convey any of the benefits provided by the Fund. Similarly, no Participant or Dependent may assign, transfer, or convey any rights that the Participant or Dependent has or may have under ERISA. This prohibition on assignments or rights specifically includes any legal right a Participant or Dependent has or may have to bring claims for benefits, breaches of fiduciary duty, prohibited transactions, statutory violations, and statutory penalties. Any attempt to assign any benefits provided under the Fund or under any of the Fund's Schedule of Benefits, or legal rights to any third party, including, but not limited to, a healthcare provider, shall be immediately invalid, void, and unenforceable. The purported assignments a Participant or Dependent may be asked to sign by a healthcare provider, at or around the time of service, do not invalidate, alter, or supersede these prohibitions. The Fund's Trustees, in their sole and absolute discretion, may decide to pay benefits due to a Participant or Dependent from the Fund directly to a healthcare provider. When this happens, it is done solely for the Participant's or Dependent's convenience. Nothing in this Plan document obligates the Fund to pay any benefits directly to any healthcare provider or alters the Fund's prohibition on assigning rights and benefits under the Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

Section 6.6 Subrogation

If the Fund pays Medical Benefits, including Prescription Drug, Accidental Death and Dismemberment Benefits, and/or Short Term Disability Income Benefits ("Benefits") under any schedule to any Participant or Dependent, or health care provider for Injuries, expenses, or loss caused by the negligence or wrongful act of a third party, the Fund shall be subrogated, and entitled to first right of reimbursement, for the amount of such payments to all rights of the Participant or Dependent against any person, firm, corporation, or other entity which is, or may become, liable or otherwise obligated to said Participant or Dependent, as respects, arises, or results from such Injuries, expenses, or loss, of such Participant or Dependent. The Fund shall also be entitled to obtain reimbursement of any and all sums (including applicable fees) paid by the Fund to the Fund's Preferred Provider Organization directly attributable to benefit payments to any such Participant, Dependent or health care provider on account of such Injuries, expenses or loss.

The Fund shall furthermore have a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any amount received by a Participant or Dependent or a representative of a Participant or Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by a Participant or Dependent for the benefit of the Fund until paid to the Fund. A Participant or Dependent consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, a Participant or Dependent agrees to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in Section 6.6, if the Participant or Dependent submits claims for any Benefits from the Fund for an Injury, expense, or loss that may give rise to any claim against any third party, the Participant or Dependent will be required to execute the Fund's Subrogation and Reimbursement Agreement ("Subrogation Agreement") affirming the Funds' rights of reimbursement and subrogation with respect to such Benefits before the Fund will pay Benefits. However, even if the Participant or Dependent does not execute the required Subrogation Agreement and the Fund nevertheless pays Benefits to or on behalf of the Participant or Dependent, the Participant or Dependent's acceptance of such Benefits shall constitute the Participant or Dependent's agreement to the Fund's right to subrogation or reimbursement from any payment, amount and/or recover by the Participant or Dependent from a third party that is based on the circumstance from which the Benefits paid by the Fund arose, and the Participant or Dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund.

Any refusal by a Participant or Dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery the Participant or Dependent receives, no matter how characterized, up to the full amount paid by the Fund on a Participant or Dependent's behalf relating to the applicable Injury, loss, or expense will be considered a breach of the agreement between the Fund and a Participant or Dependent that the Fund will provide the benefits available under the Fund. Further, by accepting benefits from the Fund, a Participant or Dependent affirmatively waives any defenses, the Participant or Dependent may have in any action by the Fund to recover amounts due under this Section 6.6 or any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense to the extent permissible under applicable law.

If the Participant or Dependent refuses to reimburse the Fund from any payment, amount, and/or recovery the Participant or Dependent receives, or refuses to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all Benefits paid by any and all methods which include, but are not necessarily limited to, filing a lawsuit and/or offsetting the Benefit amounts paid against the Participant or Dependent's future claims for Benefits under the Fund.

If the Fund is required to pursue legal action against the Participant or Dependent to enforce its equitable lien, establish a constructive trust, obtain repayment of the Benefits advanced by the Fund, or obtain any other equitable relief that may be allowed by law, the Participant or Dependent shall pay all costs and expenses, including attorney's fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. If legal action is required, the Participant or Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Participant or Dependent becomes obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against the Participant or Dependent in any state or federal court that has jurisdiction over the Fund's claim.

The Fund, by counsel of its choice, may sue, compromise, or settle in the name of the Participant or Dependent, or otherwise, all such rights, claims, interest, or causes of action to the extent of the benefits paid. The Participant or Dependent, or their attorney, shall not discharge or release any such right, claim, interest, or cause of action against any third party without first obtaining the express written consent of the Fund.

If the Participant or Dependent chooses to proceed by legal action against the third party with the assistance of their own attorney, the Fund shall be fully reimbursed without any deductions for legal fees or costs. The Fund does not recognize and is not bound by the "common fund" doctrine. If the Participant or Dependent resolves their claim, by settlement or judgment, with or without the assistance of an attorney, they shall fully reimburse the Fund from the proceeds of such judgment or settlement proceeds without any deductions.

The Fund's right of subrogation shall apply regardless of whether the Participant who suffers the Injury, expense, or loss is made whole from the recovery realized from said third party. The Fund is entitled to reimbursement first and completely from any recovery. The Fund does not recognize and is not bound by the so called "make whole" doctrine.

The Participant or Dependent who suffers any such Injuries, expenses, or loss shall so notify the Fund as soon as practicable after the date of the first occurrence of such Injury, expense, or loss, and shall provide the Fund with all information the Fund requests, and shall assist the Fund in prosecuting any such rights, interests, claims, or causes of action (civil and/or criminal) against any person, firm, corporation, or other entity which is or may become liable or otherwise obligated therefore.

Section 6.7 Overpayment Policy

(a) Except for Participant or Dependent overpayments of twenty-five dollars ($25) or less, in cases where an overpayment is made by the Fund on behalf of a Participant or a Dependent, the Fund will attempt to recover the overpayment from the party to whom the benefit check was made payable.

(1) Participant, Dependent or Fund's prescription carrier. In cases where such overpayment has been made directly to a Participant, Dependent, or the Fund's prescription carrier on behalf of a Participant or Dependent and after advising the Participant or Dependent in writing, the Fund shall deny payments on any and all claims submitted on behalf of the overpaid Participant or overpaid Dependent until a Satisfactory Payment Arrangement is executed. A "Satisfactory Payment Agreement" must provide for repayment within the maximum term set forth below and include annual interest on the amount of the overpayment at the prime rate of interest as stated in the Wall Street Journal on the 31st day following the first repayment request.

Satisfactory Payment Agreement

Debt Amount	Maximum Payoff Period	Related Monthly Payment (includes interest at prime
Under $1,000	12 months	$82 for $1,000
$1,001 - $5,000	24 months	$215 for $5,000
$5,001 - $10,000	36 months	$292 for $10,000
$10,001 and over	48 months	$334 for $15,000

If applicable, a second (2nd), third (3rd), and final repayment request letters are to be issued.

(2) The Fund shall furthermore have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid benefits received by a Participant or a Dependent or a representative of a Participant or Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by a Participant or a Dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, a Participant or a Dependent consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien and/or equitable lien by agreement, agrees to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by a Participant or a Dependent to reimburse the Fund for an overpaid amount will be considered a breach of the agreement with the Fund that the Fund will provide the benefits available under the Fund and a Participant or a Dependent will comply with the rules of the Fund. Further, by accepting benefits from the Fund, a Participant or Dependent affirmatively waives any defenses they may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against a Participant or the Participant's Dependent to obtain repayment of the benefits advanced by the Fund, a Participant or the Participant's Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, a Participant or the Participant's Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Participant or the Participant's Dependent becomes obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against a Participant or the Participant's Dependent in any state or federal court that has jurisdiction over the Fund's claim.

(3) Provider. In cases where such overpayment has been made to a provider, with the exception of the Fund's prescription carrier, the Fund shall:

(A) for claims related to providers participating in the Fund's Preferred Provider Organization, refer the matter to the Preferred Provider Organization for collection;

(B) for claims unrelated to the Fund's Preferred Provider Organization;

(i) Issue repayment request letter to the overpaid party,

(ii) Apply benefit payments on any and all claims submitted on behalf of the affected Participant or the Participant's Dependents payable to the overpaid service provider to the debt,

(iii) If applicable, issue a second (2^{nd}), third (3^{rd}) and final repayment request letter.

(C) for claims incurred greater than 18 months prior to the attempt to collect;

(i) Apply benefit payments on any and all claims submitted on behalf of the affected Participant or the Participant's Dependents payable to the overpaid service provider; and

(ii) Issue up to four (4) repayment request letters directly to the provider.

In cases where the full overpayment is not received through the procedures established in Section 6.7(a)(1) and Section 6.7(a)(3) within the first (1^{st}) six (6) months of the first (1^{st}) attempt, refer the matter to the Board of Trustees.

(b) Ineligible Individual: The following rules shall apply with respect to overpayments made by the Fund on behalf of any person deemed ineligible for benefits under the Plan:

(1) The Fund will offset any available or future claims received that would otherwise have been payable in order to recover the amount overpaid in full;

(2) If claims as described in Section 6.7(a)(1), are not available, or if such claims fail to offset the full amount of the overpayment, then the Fund shall make four (4) attempts to recover the overpayment from the party to whom the benefit check was made payable.

(c) If the Fund is unsuccessful in all attempts to recover the overpayment, the matter will be referred to the Board of Trustees.

Section 6.8 Miscellaneous

(a) Law Applicable. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in

accordance with ERISA and, as to matters not preempted by ERISA, the laws of the Commonwealth of Virginia.

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

(c) Captions. Captions shall be read as integral elements of this Plan to assist in the interpretation of the Plan provisions to which they relate.

(d) Schedule of Benefits. References in this plan to the "Schedule of Benefits" shall be deemed references to the benefits that cover the Participant and eligible Dependents.

(e) Construction. The Trustees are empowered to determine all questions pertaining to the interpretation, administration, construction, and application of the Plan, including, but not limited to, the determination of all questions of eligibility and the status and rights of all individuals claiming an interest in benefits provided by the Plan; their decisions are final and binding on all parties.

(f) Trustees. All questions arising under or with respect to the Plan shall be determined by the Board of Trustees, whose decisions shall be final and binding on all parties. The Trustees have absolute discretion to review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Trustees determine such should be paid. This authority specifically permits the Trustees to settle disputed claims for benefits and any other disputed claims made against the Plan.

(g) Termination of Group Coverage. To the extent permitted by law and unless otherwise specifically set forth herein, no benefits will be provided after the date coverage hereunder for any group ceases due to termination of the group coverage.

(h) Abandoned Property. Plan benefits that are payable directly to a Participant, Spouse, or a Participant's family member or estate, shall be considered abandoned if, after reasonable efforts to contact said Participant, Spouse, family member or estate, such benefits remained unclaimed for more than three (3) years after the date the claim is incurred. "Reasonable efforts" shall include, but not be limited to, mailing or delivering the benefits payments to the last known address of the Participant, Spouse, family member or estate.

(i) No Vesting in Fund. No Participant shall have any right to, or interest in, any assets of the Fund upon termination of the Participant's employment or otherwise, except as provided under this Plan, and then only to the extent of the benefits payable under the Plan to such Participant out of the assets of the Fund. No Participant, Dependent, or Qualified Beneficiary shall at any time have any vested right to any benefits currently provided or hereafter provided by the Plan, including retiree health

benefits. Except as otherwise may be provided under Title IV of ERISA, all payments of benefits as provided for in this Plan shall be made solely out of the assets of the Fund and none of the fiduciaries shall be liable therefore in any manner.

(j) Amendment and Termination of Benefits. Notwithstanding any other provision of the Plan, the Trustees shall have the absolute right, in their sole discretion, to amend or terminate Health and Welfare Benefits for Participants, Dependents, and Qualified Beneficiaries at any time.

(k) Waiver. No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppels against enforcing any provision of the Plan, except in writing by the Trustees. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and 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 Participant other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

(l) Severability of Provisions. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provisions had not been included.

(m) Submission of Documents. Documents received electronically or by facsimile are deemed official and equivalent in status to an original. However, the Trustees reserve the right to require the submission of original documents and/or signatures as they may see fit.