SUMMARY PLAN DESCRIPTION

of the

PLUMBERS AND PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND

PLUMBERS AND PIPEFITTERS LOCAL NO. 520
HEALTH AND WELFARE FUND

℅ BeneSys, Inc.
P.O. Box 1889 ● Troy, MI 48099-1889
Phone: 717-565-1101 ● Toll Free: 833-263-5750
Fax: 717-775-3434

TABLE OF CONTENTS

MESSAGE FROM THE BOARD OF TRUSTEES TO THE PARTICIPANTS OF THE PLUMBERS AND PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND

The Plumbers and Pipefitters Local No. 520 Health and Welfare Fund, referred to as the "Fund" or "Health and Welfare Fund," is an employee benefit plan covering members of the Plumbers and Pipefitters Local Union No. 520, referred to as the "Union" or "Local 520." The Health and Welfare Fund is sponsored by Local 520 and the Mechanical Contractors Association of Central Pennsylvania. The Fund was established in 1958 to provide various health and welfare benefits, such as hospitalization, medical, surgical, disability, death, accidental death and dismemberment, loss-of-sight, prescription drug, vision care, and dental benefits, as determined by the Health and Welfare Fund's rules set forth in this Summary Plan Description. Not all participants are eligible to receive all of these benefits. Read this Summary Plan Description carefully to determine whether you are eligible to receive any benefits, and if so, which benefits.

This Summary Plan Description is designed to describe the benefits which are provided by the Health and Welfare Fund and to inform you of your rights under the Health and Welfare Fund and the Employee Retirement Income Security Act. Although extreme care has been taken to provide accurate information in this Summary Plan Description, it is important for you to understand that if any of the terms in this Summary Plan Description are inconsistent with any of the terms of the "Health and Welfare Plan Agreement and Declaration of Trust" ("Trust Agreement"), the terms of the Trust Agreement control.

To assist you in understanding the benefits under the Fund, there are Overview and Summary charts throughout this Summary Plan Description. However, it is important for you to read the entire Summary Plan Description in order for you to fully understand the benefits that you are entitled to receive under the Fund.

We have tried to write this Summary Plan Description in language that you can easily understand. If you have questions, however, feel free to call the Contract Administrator, whose name, address and telephone number are given inside.

You should also be aware that from time to time the Health and Welfare Fund increases, decreases, adds and eliminates benefits and sometimes changes eligibility rules, and this Summary Plan Description may not be completely up to date. To be sure you are covered, and for up-to-date information about the benefits, contact the Contract Administrator at the Fund Office.

IMPORTANT

THE CONTRACT ADMINISTRATOR MUST BE NOTIFIED IN WRITING IF YOU CHANGE YOUR ADDRESS, ACQUIRE A NEW DEPENDENT, OR CHANGE YOUR MARITAL STATUS OR BENEFICIARY. DEATH BENEFIT AUTHORIZATION FORMS ARE AVAILABLE AT THE UNION OFFICE AND AT THE CONTRACT ADMINISTRATOR'S OFFICE. FAILURE TO NOTIFY THE CONTRACT ADMINISTRATOR OF SUCH CHANGES COULD JEOPARDIZE YOUR ELIGIBILITY FOR BENEFITS. ALSO, THE LATEST DEATH BENEFIT AUTHORIZATION FORM RECEIVED IS THE ONE RECOGNIZED BY THE FUND.

This Summary Plan Description is a valuable piece of property. Please put it in a safe place for your future reference. Notices of changes will be sent to you as the Summary Plan Description is amended or revised.

A replacement Summary Plan Description will cost you the actual cost of the Summary Plan Description, plus postage and handling charges. You may also examine the Summary Plan Description, without charge, at the Contract Administrator's Office.

PART A: GENERAL FUND INFORMATION

SECTION A-1: Definitions Of Terms Used In This Summary Plan Description

1. "**Active Employee**" means an Employee who is covered by the Fund and who is not retired or totally disabled. "Active Employee" also includes Employees who are covered through employer contributions, self-contributions, and reciprocal contributions.

2. "**Active Participant**" means an individual who is an Active Employee, a Retired Participant, or a Disabled Participant.

3. **"Allowable Charge"** means a charge for Benefits.

4. "**Ambulatory Surgical Facility**" means a Facility Provider licensed and approved by the state in which it provides covered health care services or as otherwise approved by the Fund and which:

a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

b. provides treatment by or under the supervision of Physicians whenever the patient is in the facility;

c. does not provide Inpatient accommodations; and

d. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

5. "**Applicant Journeyman**" means an individual who becomes a Journeyman Plumber/Pipefitter under the terms of the collective bargaining agreement between Local 520 and the Mechanical Contractors Association of Central Pennsylvania by virtue of being certified by Local 520.

6. "**Apprentice**" means an individual who is party to an Apprenticeship Agreement with the Plumbers and Pipefitters Local 520 Joint Apprenticeship, Educational and Training Trust Fund.

7. **"Approved Clinical Trial"** means a Phase I, Phase II, Phase III or Phase IV clinical trial being conducted in relation to the prevention, detection or treatment for cancer or other life-threatening disease or condition.

8. "**Benefit Month**" means the month that the Covered Participant is eligible for benefits under the Fund, and not the month in which the Employee or Covered Participant works to become or remain eligible.

9. "**Benefit Period**" The Benefit Period for the Hospital and Medical and Surgical Benefits is the calendar year.

10. "**Benefits**" means those Medically Necessary health care services, supplies, equipment and facilities charges covered under and in accordance with the Fund.

11. "**Birth Defect**" means an internal or external congenital abnormality that is present at birth and that does not develop, appear or manifest later in life.

12. "**Birthing Facility**" means a Facility Provider, licensed and approved by the appropriate governmental agency, which is primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

13. "**COBRA**" means the federal law called the "Consolidated Omnibus Budget Reconciliation Act."

14. "**COBRA Beneficiary**" means an individual who is eligible to receive certain Fund Benefits because of COBRA.

15. "**Coinsurance**" means a form of cost sharing (indicated as a percentage amount on the Schedule of Benefits) which requires an Eligible Participant to pay a specified portion of the Maximum Allowable Charge after the Deductible, if any, has been paid by the Eligible Participant.

16. "**Collective Bargaining Agreement**" means a collective bargaining agreement between Plumbers and Pipefitters Local No. 520 and any Employer, requiring the Employer to make contributions to the Fund for individuals represented by Local 520. For purposes of this Summary Plan Description, the term "collective bargaining agreement" also includes any Participation Agreement between the Union and the Fund under which the Union is obligated to make contributions to the Fund for individuals employed by the Union.

17. "**Copayment**" means the fixed dollar amount that an Eligible Participant must pay for certain Benefits. The Eligible Participant must pay copayments directly to the Provider at the time services are rendered. Copayment amounts do not count toward satisfaction of any Deductible amounts.

18. "**Covered Employment**" means employment under the terms of a collective bargaining agreement or a Participation Agreement which requires the employer to contribute directly to this Fund or to another fund that is party to a Reciprocal Agreement with this Fund.

19. "**Covered Participant**" means a Participant who has met the initial qualification for coverage by the Fund and whose coverage has not been terminated, and who is an Active Employee, Dependent, COBRA Beneficiary, Retired Participant, Disabled Participant, or a spouse or Dependent of a Deceased Active Employee or a Deceased Retired Participant.

20. "**Covered Service**" means a service or supply specified in this Summary Plan Description for which benefits will be provided when rendered by a Provider.

21. "**Cosmetic Surgery or Procedure**" means an elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function but is considered unpleasant or unsightly.

22. "**Cost-Sharing Amount**" means the amount subtracted from the Customary and Reasonable Allowance which the Eligible Participant is obligated to pay before the Fund makes payment for Benefits. Cost-Sharing Amounts can include Preauthorization Penalties, Copayments, Deductibles, Coinsurance and Out-of-Pocket Maximums, if applicable.

23. "**Custodial Care**" means care provided primarily for maintenance of the Eligible Participant or which is designed essentially to assist the Eligible Participant in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

24. "**Deductible**" means the amount of the Customary and Reasonable Allowance that must be incurred and paid by an Eligible Participant or Family each Benefit Period before Benefits are covered by the Fund.

25. "**Dependent**" means an Active Participant's:

a. Spouse under a legally valid existing marriage.

i. The term "married" refers to any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who were legally married in a state that recognizes such marriages but who are domiciled in a state that does not recognize such marriages. The term "married" includes a same-sex marriage that is legally recognized as a marriage under any state law.

ii. In the case of a Retired Participant, spouse shall only mean the individual who was the Retired Participant's spouse at the time the Retired Participant became a Retired Participant under the Fund.

b. Children of the Active Participant, whether natural or adopted, unmarried or married, who are:

i. under the age of 26, unmarried or married; or

ii. upon attaining age 26, unmarried or married, incapable of self-support by reason of a physical or mental handicap, and who are primarily dependent on the Active Participant for support and maintenance. The Fund will continue coverage for such child so long as the Active Participant's eligibility continues and such incapacity continues. The Fund has the right to require the Active Participant and Dependent to periodically submit continuing proof of physical or mental disability and dependency status.

iii. "Children" includes adopted children; a child for whom the Active Participant has assumed the legal obligation for total or partial support of such child in anticipation of adoption of such child; and a child of an Active Participant who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under the Fund with respect to the Active Participant. Children does not include children of a Covered Participant's unmarried or married children.

iv. "Children" includes step-children not subject to a Qualified Medical Child Support Order of a court directing the parent who is not a Covered Participant in the Fund to provide coverage for the step-child; adopted children and children placed with the Covered Participant for adoption in addition to the Covered Participant's natural children. Children does not include children of a Covered Participant's unmarried or married children.

c. unmarried grandchildren who are natural or adopted children of an Active Participant's natural or adopted children and who are solely dependent upon the Active Participant for maintenance and support subject to a court order granting custody and/or legal guardianship to the Active Participant, and who are:

i. under the age of 26; or

ii. upon attaining age 26, incapable of self-support by reason of a physical or mental handicap, and who are primarily Dependent on the Active Participant for support and maintenance. The Fund will continue coverage for such child so long as the Active Participant's eligibility con-

tinues and such incapacity continues. The Fund has the right to require the Active Participant and Dependent to periodically submit continuing proof of physical or mental disability and dependency status.

iii. No grandchild within the above categories will be considered as a Dependent unless taken as a Dependent for federal and state income tax purposes, and proof thereof is submitted upon request by the Contract Administrator and, where deemed appropriate by the Contract Administrator, the Active Participant has completed an Affidavit demonstrating dependency status.

A person who is an Active Participant as well as a Dependent shall receive only the benefits of an Active Participant.

26. "**Disabled Participant**" means a Participant who the Fund finds to be disabled from working as a plumber or pipefitter in the construction industry.

27. "**Eligible Participant**" means an individual who is eligible to receive some or all of the benefits under the Fund.

28. "**Emergency Service**" means any health care services provided to an Eligible Participant after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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 Eligible Participant, 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.

d. Transportation and related Emergency Services provided by a licensed ambulance service are Benefits if the condition is as described in this definition.

29. "**Employee**" means an individual who works under the terms of a collective bargaining agreement that requires the employer to contribute directly to this Fund or to another fund that is party to a Reciprocal Agreement with this Fund.

30. "**Experimental or Investigational**" means:

a. A drug, treatment, device, or procedure:

i. which cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use;

ii. which is the subject of a current Investigational new drug or new device application on file with the FDA;

iii. for which usage should be substantially confined to research settings, in the predominant opinion among experts as expressed in medical literature;

iv. for which further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives, in the predominant opinion among experts as expressed in medical literature; or

v. which is not investigational in itself, but would not be Medically Necessary except for its use with a drug, device, treatment, or procedure that is experimental or investigational.

b. In determining whether a drug, treatment, device or procedure is experimental or investigational, the following information may be considered:

i. the Eligible Participant's medical records;

ii. The protocol(s) pursuant to which the treatment or procedure is to be delivered;

iii. any consent document the patient has signed or will be asked to sign, in order to undergo the treatment or procedure;

iv. the referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;

v. regulations and other official actions and publications issued by the federal government; and

vi. the opinion of a third party medical expert in the field, obtained by the Fund, with respect to whether a treatment or procedure is experimental or investigational.

c. Notwithstanding the foregoing, the Fund shall not deny participation of a qualified individual in a clinical trial, deny coverage of "routine costs" in connection with a clinical trial, or discriminate on the basis of participation in a clinical trial. For this purpose, a "qualified individual" is a Covered Participant who: (i) is

eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or other life-threatening diseases or conditions, and (ii) is referred by a Provider to participate in the clinical trial or provides information establishing that participation in the clinical trial would be appropriate.

31. "**Facility Providers**" include:

a. Ambulance Service Provider

b. Ambulatory Surgical Facility

c. Birthing Facility

d. Durable Medical Equipment Supplier

e. Freestanding Outpatient/Diagnostic Facility

f. Freestanding Dialysis Treatment Facility

g. Home Health Care Agency

h. Hospice

i. Hospital

j. Hospital Laboratories

k. Infusion Therapy Provider

l. Long-Term Acute Care Hospital

m. Orthotics Supplier

n. Prosthetics Supplier

o. Psychiatric Hospital

p. Rehabilitation Hospital

q. Skilled Nursing Facility

r. Substance Abuse Treatment Facility

s. Urgent/Immediate Care Center

32. "**Family**" means the Active Participant and all of the Active Participant's Dependents.

33. "**Former Participant**" means a Covered Participant whose eligibility was terminated pursuant to the provisions of the Fund.

34. "**Freestanding Dialysis Facility**" means a Facility Provider, licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing dialysis treatment, maintenance or training to Eligible Participants on an Outpatient or home care basis.

35. "**Freestanding Outpatient Facility**" means a Facility Provider, licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing Outpatient diagnostic and/or therapeutic services by or under the supervision of Physicians.

36. "**Health Care Provider**" means a Hospital, Physician, person or practitioner licensed, where required, and performing services within the scope of such licensure and as identified in this Summary Plan Description.

37. "**Hearing Aid**" means any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal, devices that produce sound by mechanically vibrating bone, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids.

38. "**Home Health Care Agency**" means a Facility Provider, licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, which provides skilled nursing and other services on an intermittent basis in the Eligible Participant's home; and is responsible for supervising the delivery of such services under a plan prescribed by the attending Physician.

39. "**Hospice**" means a Facility Provider, licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing palliative care to terminally ill Eligible Participants and their families with such services being centrally coordinated through an interdisciplinary team directed by a Physician.

40. "**Hospital**" means:

a. A Facility Provider that:

i. is licensed by the state in which it is located,

ii. provides twenty-four (24) hour nursing services by certified registered nurses on duty or call,

iii. provides services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions, and

iv. is certified by the Joint Commission on the Accreditation of Healthcare Organizations, an equivalent body, or as accepted by the Fund.

b. Hospital does not include: residential or nonresidential treatment facilities; nursing homes, Skilled Nursing Facilities; facilities that are primarily providing custodial, domiciliary or convalescent care; or Ambulatory Surgical Facilities.

41. "**Identification Card**" means the card issued by the Fund to a Covered Participant which is for identification purposes only. Possession of a Identification Card confers no right to Covered Services specified in this Summary Plan Description.

42. "**Infertility**" means the medically documented diminished ability to conceive, or to conceive and carry to live birth. A couple is considered infertile if conception does not occur after a one-year period of unprotected coital activity without contraceptives, or there is the inability on more than one occasion to carry to live birth.

43. "**Infusion Therapy Provider**" means an entity that meets the necessary licensing requirements and is legally authorized to provide home infusion/IV therapy services.

44. "**Inpatient**" means an Eligible Participant who is admitted as a patient and spends greater than 23 hours in a Hospital, a Rehabilitation Hospital, a Skilled Nursing Facility or a non-residential Substance Abuse Treatment Facility and for whom a room and board charge is made. This term may also describe the services rendered to such an Eligible Participant. The term Inpatient does not apply to an Eligible Participant who is admitted to a Substance Abuse Treatment Facility for non-Hospital residential services.

45. "**Licensed Practical Nurse (LPN)**" means a nurse who has graduated from a formal practical or vocational nursing educations program and is licensed by the appropriate state authority.

46. "**Long-Term Acute Care Hospital (LTACH)**" means an acute care Hospital designed to provide specialized acute care for medically stable, but complex, patients who require long periods of hospitalization (average 25 days) and who would require high-intensity services. LTACHs are often described as a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, LTACHs are licensed by the Pennsylvania Department of Health as an acute care facility.

47. "Maximum Allowable Charge" means the maximum payment level that the Fund reimburses for Benefits provided to a Participant and which is the lesser of (a) the PPO Allowable Amount, (b) the Allowable Charge specified in this Summary Plan Description, or (c) the actual billed charges for Covered Services.

48. "**Medicaid**" means Hospital or medical insurance benefits financed by the United States Government under Title XIX of the Social Security Act of 1965 and its related regulations, each as amended.

49. "**Medical Necessity (or Medically Necessary)**" means:

a. Services or supplies delivered by a Provider that the Fund or its designees determines are:

i. appropriate and necessary for the diagnosis and/or the direct care and treatment of the Eligible Participant's medical condition, disease, illness or injury;

ii. in accordance with accepted standards of good medical practice;

iii. consistent with the Fund's or its designee's clinical protocols and utilization guidelines;

iv. not primarily for the convenience of the Eligible Participant, the Eligible Participant's Physician or other health care Provider; and

v. provided at the most appropriate level or service, supply, or setting to safely diagnose or treat the Eligible Participant. When applied to Hospital services, this means that the Eligible Participant requires care in an emergency room or as an Inpatient due to the symptoms presented or the Eligible Participant's condition, and the Eligible Participant cannot receive safe or adequate care as an Outpatient in another setting.

b. The fact that a Provider may prescribe, recommend, order or approve a service or supply does not of itself determine medical necessity or make such service or supply a covered Benefit.

50. "Medicare" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

51. "Medicare Coinsurance" means the amount which the Covered Participant is required to pay toward the cost of health care expenses that are covered by Medicare.

52. "Medicare Deductible" means the initial amount of Hospital and medical expenses eligible for Medicare benefits which the Covered Participant is required to pay, and the first three pints of blood if not replaced by or on behalf of the Covered Participant.

53. "Medicare Part A" means the Hospital Insurance Benefits provided by the United States Government under Title XVIII of the Social Security Act.

54. "Medicare Part B" means the Medical Insurance Benefits provided by the United States Government under Title XVIII of the Social Security Act.

55. "Medicare Part D" means the Prescription Drug Benefits provided by the United States Government under Title XVIII of the Social Security Act.

56. "**Mental Health Care**" means care received in connection with the treatment of a Mental Illness or a Serious Mental Illness.

57. "**Mental Illness/Disorder**" means a health condition as described in the most recent edition of the Diagnostic and Statistical Manual that is characterized by alterations in thinking, mood, or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and/or impaired functioning.

58. "**Non-Participating Provider**" means a Health Care Provider who is not party to an agreement with a Participating Provider Organization that is party to an agreement with the Fund to provide health care services to Eligible Participants.

59. "**Out-of-Pocket Maximum**" means the amount of the Maximum Allowable Charge that an Eligible Participant or Family is required to pay during a Benefit Period. After this amount has been paid, the Eligible Participant is no longer required to pay any portion of the Maximum Allowable Charge for Benefits during the remainder of that Benefit Period.

60. "**Outpatient**" means an Eligible Participant who receives services or supplies while not an Inpatient. This term may also describe the services rendered to such an Eligible Participant.

61. "**Outside of the U.S.**" means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

62. "**Partial Hospitalization**" means the provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a Hospital or non-Hospital facility licensed as a Mental Health Care or Substance Abuse treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in Outpatient treatment but

who does not require Inpatient care. To qualify, the partial hospitalization services must be provided for a minimum of four (4) hours, with a maximum of twelve (12) hours per day without incurring a charge for an overnight stay.

63. **"Participating Provider"** means a Health Care Provider who has entered into an agreement with a Participating Provider Organization that is party to an agreement with the Fund to provide health care services to Covered Participants.

64. "**Participation Agreement**" means an agreement that the Fund is party to with an employer which requires the employer to make contributions to this Fund on behalf of designated employees.

65. "**Physician**" means a person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.), licensed, and legally entitled to practice medicine in all its branches, and/or perform Surgery and prescribe drugs.

66. "**PPO Allowable Amount**" means the payment level that the Fund reimburses for Benefits provided to a Participant by a Participating Provider based on the amount provided for in the contract between the Provider and the Participating Provider Organization, which shall constitute payment in full for Covered Services. Any Deductible, Coinsurance or Copayment shall be the responsibility of the Participant.

67. "**Professional Providers**" include:

a. Audiologist

b. Certified Registered Nurse Anesthetist

c. Certified Registered Nurse Midwife

d. Certified Registered Nurse Practitioner

e. Chiropractor

f. Clinical or Physician Laboratory

g. Doctor of Medicine (M.D.)

h. Doctor of Osteopathy (D.O.)

i. Licensed Dietitian-Nutritionist

j. Licensed Social Worker

k. Occupational Therapist

l. Oral Surgeon

m. Physical Therapist

n. Physician's Assistant

o. Podiatrist

p. Psychologist

q. Respiratory Therapist

r. Retail Clinic

s. Speech Language Pathologist

68. "**Psychiatric Hospital**" means a Provider licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing diagnostic and therapeutic services for the Mental Health Care. Such services are provided by or under the supervision of an organized staff of Physicians.

69. "**Reciprocal Agreement**" means an agreement between the Fund and another collectively bargained employee welfare benefit plan that provides for the transfer of contributions received by the fund for Covered Employment to an Employee's fund where the Employee regularly works in Covered Employment.

70. "**Reconstructive Surgery**" means a procedure performed to improve or correct a functional impairment, restore a bodily function or correct deformity resulting from a Birth Defect or accidental injury. The fact that an Eligible Participant might suffer psychological consequences from a deformity does not, in the absence of bodily functional impairment, qualify Surgery as being reconstructive surgery.

71. "**Rehabilitation Hospital**" means a Provider licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing skilled rehabilitation services for injured or disabled individuals to restore function following an illness or accidental injury. Skilled rehabilitation services consist of the combined use of medical and vocational services to enable Eligible Participants disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of Physicians.

72. "**Retired Participant**" means an individual who is receiving pension benefits from the Plumbers and Pipefitters Local No. 520 Pension Fund or the Plumbers and Pipefitters Local No. 520 Annuity Fund, and who was eligible for benefits under the

Fund at the time retirement benefits began under the Plumbers and Pipefitters Local No. 520 Pension Fund or the Plumbers and Pipefitters Local No. 520 Annuity Fund.

73. "**Serious Mental Illness**" means any of the following Mental Illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual or as otherwise approved by the Fund: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

74. "**Skilled Nursing Facility**" means a Provider, licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund, and which is primarily engaged in providing daily Skilled Nursing Services and related skilled services to Eligible Participants requiring twenty-four (24) hour skilled nursing services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

a. minimal care, Custodial Care, ambulatory care, or part-time care services; or

b. care or treatment of Mental Illness or Substance Abuse.

75. "**Skilled Nursing Services**" means services that must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

76. "**Special Accommodations Unit**" means a designated unit within an acute care Hospital which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, including neonatal intensive care and cardiac intensive care that is not critical care.

77. "**Substance Abuse**" means the use of alcohol and/or other addictive drugs which produce a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Drugs are defined as addictive drugs and drugs of abuse listed as scheduled drugs in the Pennsylvania Controlled Substances, Drug, Device and Cosmetic Act.

78. "**Substance Abuse Treatment Facility**" means a Provider licensed and approved by the state in which it provides health care services, or as otherwise approved by the Fund and which primarily provides non-residential detoxification and/or

rehabilitation treatment for Substance Abuse. This facility must also meet all applicable standards set by the state in which health care services are received.

79. "**Surgery**" means the performance of operative procedures, consistent with medical standards of practice, which physically changes some body structure or organ and includes usual and related pre-operative and post-operative care.

80. "**Urgent Care**" means medical care for an unexpected illness or injury that does not require Emergency Services but which may need prompt medical attention to minimize severity and prevent complications.

81. "**Work Month**" means the month that the Covered Participant works in Covered Employment and has dollars of contributions submitted to the Fund in order to be eligible in the corresponding Benefit Month.

82. "**Within the U.S.**" means the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

SECTION A-2: Some Basic Facts About The Fund

1. NAME AND ADDRESS OF THE FUND

The "PLUMBERS AND PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND" is a collectively bargained employee welfare plan governed by the Board of Trustees of the Health and Welfare Fund, c/o BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery).

2. EMPLOYER IDENTIFICATION NUMBER OF FUND

The Fund's Employer Identification Number ("EIN") is 23-6280075

3. PLAN NUMBER

The Fund's Plan Number is 501.

4. LIST OF PLAN SPONSORS AVAILABLE

You may obtain a list of all employers and unions who sponsor this Fund by making a written request to the Contract Administrator. There is a small charge for this service. You may also examine such a list free of charge at the office of the Contract Administrator during normal business hours.

Should you wish, you may make a request to the Contract Administrator in writing for information as to whether a particular employer or labor union is a sponsor of this Fund and, if it is, you may obtain its address. There is no charge for this service.

5. COLLECTIVE BARGAINING AGREEMENTS THAT RELATE TO THE FUND

This Fund is maintained pursuant to collective bargaining agreements. All collective bargaining agreements that relate to the Fund are on file at the office of the Contract Administrator, and may be examined by you there during normal business hours. Upon request made in accordance with the procedure set by the Contract Administrator, you may examine the agreements at the offices of the Union. For a small charge, you may also obtain a copy of any collective bargaining agreement by making a written request to the Contract Administrator.

6. TYPE OF FUND

The Plumbers and Pipefitters Local No. 520 Health and Welfare Fund is an employee welfare benefit plan. It provides benefits of the following types: hospitalization, medical, surgical, prescription drug, death, accidental death and dismemberment, loss-of-sight, disability, vision care, and dental benefits.

The Fund is self-insured for all of the benefits provided to Eligible Participants. None of the benefits are guaranteed under a contract or policy of insurance issued by an insurer.

7. TYPE OF ADMINISTRATION OF THE FUND AND AUTHORITY AND POWER OF BOARD OF TRUSTEES

The administration of the Fund is in the hands of a Board of Trustees, composed of representatives of management and labor.

The Board of Trustees have full and exclusive discretionary authority and power to construe all Plan documents; to make all decisions concerning the interpretation, application, construction and administration of the Fund and all Plan documents; to determine all questions of eligibility for benefits, including the amount of benefits; to make final and binding decisions on all appeals; to modify, amend, discontinue or terminate benefits and/or coverage provided under this Fund; and to amend the terms of the Plan and all Plan documents.

Only the entire Board of Trustees is authorized to interpret the Fund's governing documents and exercise the discretionary authority and power described above. No officer, agent, or employee of the Employer or the Union, nor any other person, is authorized to speak for or on behalf of the Fund, or to commit the Board of Trustees on any matter relating to the Fund, or to interpret the Fund's governing documents.

8. BOARD OF TRUSTEES

UNION-APPOINTED TRUSTEES:

Frank Kelly
Plumbers Local No. 520
7193 Jonestown Road
Harrisburg, PA 17112

Michael W. Martinozzi
202 Green Pine Road
Montgomery, PA 17752-8984

Scott E. Christ
7193 Jonestown Road
Harrisburg, PA 17112-3649

EMPLOYER-APPOINTED TRUSTEES:

William Sponaugle
G. R. Sponaugle & Sons
P. O. Box 4456
Harrisburg, PA 17111

Todd C. Ray
McClure Company, Inc.
P. O. Box 1579
Harrisburg, PA 17105-1579

Lori A. Eshenaur
Mechanical Contractors Association
1751 Lamplight Circle
Middletown, PA 17057

9. CONTRACT ADMINISTRATOR

The day-to-day administration of the Fund, however, is in the hands of a professional administration company, called the "Contract Administrator" or "Administrator," to whom the Board has delegated some of its duties. The Contract Administrator which has been hired by the Board of Trustees is BeneSys, Inc. The Contract Administrator may be reached at the Fund Office at the following address and telephone number:

Plumbers and Pipefitters Local No. 520 Health and Welfare Fund
c/o BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)
Phone: 717-565-1101, Toll Free: 833-263-5750
Fax: 717-775-3434

10. CLAIMS PAYORS

In addition to the processing of benefit claims for hospital, medical and surgical health benefits, vision care, disability, and death, accidental death and dismemberment and loss-of-sight benefits by the Fund's Contract Administrator, the processing of benefits claims for certain types of benefits is handled on a self-insured basis by private companies retained by the Health and Welfare Fund for that purpose.

The processing and administration of the Fund's self-funded Prescription Drug Benefit claims is done by BeneCard PBF, 5040 Ritter Road, Mechanicsburg, PA 17055.

The processing and administration of the Fund's self-funded Dental claims and benefits is handled by Delta Dental, One Delta Drive, Mechanicsburg, Pennsylvania 17055-6999. Under this contract, Delta Dental serves as claims administrator.

For purposes of claims adjudication, Delta Dental is the named fiduciary for dental claims. Delta Dental has the authority to interpret the Fund provisions and determine the coverage and benefits of Participants and their beneficiaries.

11. WHERE THE MONEY COMES FROM TO OPERATE THE FUND

The Health and Welfare Fund primarily operates on contributions that are received from employers who have signed collective bargaining agreements with the Union or signed Participation Agreements with the Fund, and in some cases, from Covered Participants and from reciprocating health and welfare funds sponsored by other Plumbers and Pipefitters local unions. The contribution rate for an employer is set forth in the applicable collective bargaining agreement.

Since this is a multiemployer plan, costs are calculated on a pooled basis. An employer contribution of a specified amount is made for every hour worked by an Employee covered by a collective bargaining agreement. These rates of contributions are changed from time to time by agreements between the Union and employers to ensure that enough money is available to operate the Fund.

Contributions by Active Employees (self-contributions) are permitted in certain circumstances when the Employee is unemployed and is in danger of losing his or her coverage.

Contributions by Retired Participants, Disabled Participants, and spouses and Dependents of Deceased Active Employees or Deceased Retired Participants are also permitted in certain circumstances.

Money is accepted from health and welfare funds that are signatory to the United Association Health and Welfare Fund Reciprocal Agreement. Under such arrangement, contributions earned by Local 520 members working in the jurisdiction of other local unions are transferred to this Fund so that the Local 520 member continues to receive credit for the contributions earned.

12. MEANS BY WHICH THE FUND ACCUMULATES ITS FUNDS

Benefits described in this Summary Plan Description are provided through Employer contributions. The exact dollar amount of the contributions is determined through collective bargaining between the Employers and the Union. All assets are held in trust by the Board of Trustees for the purpose of providing benefits for eligible Participants and defraying reasonable administrative expenses. Contributions from employers are made on a monthly basis to the Health and Welfare Fund, which places the money in

interest-bearing accounts and securities. Fund assets are invested in accordance with applicable law. These investments are made only after consultation with professional investment managers employed by the Fund.

Contributions by Active Participants, and spouses and Dependents of Deceased Active Employees or Deceased Retired Participants, when permitted, are made directly to the Fund and are immediately placed in the Fund's account until they are reinvested or used to pay benefits.

13. WHEN YOU WORK IN THE JURISDICTION OF A RECIPROCATING FUND

Whenever an Employee works in the area of another fund signatory to the United Association Health and Welfare Fund Reciprocal Agreement, the Employee shall, upon this Fund's receipt of contributions from the other fund, receive credit toward eligibility with this Fund.

An Active Employee shall only make claim for and receive benefits from this Fund, even though he or she might otherwise meet eligibility requirements in one or more other funds signatory to the United Association Health and Welfare Fund Reciprocal Agreement.

Participants covered by other funds signatory to the United Association Health and Welfare Fund Reciprocal Agreement may make no claims for or receive benefits under this Fund even though they might otherwise meet the eligibility requirements of this Fund.

Participants who work in the jurisdiction of a fund signatory to the United Association Health and Welfare Fund Reciprocal Agreement have the duty to inform the Contract Administrator of the location and dates of their employment.

Since the status of funds that are signatory to the United Association Health and Welfare Fund Reciprocal Agreement may change over time, you are encouraged to contact the Contract Administrator if you have any questions regarding the United Association Health and Welfare Fund Reciprocal Agreement.

14. END OF "PLAN YEAR"

The Fund operates on a fiscal year, May 1 to April 30.

15. AGENT FOR SERVICE OF LEGAL PROCESS

Legal papers and process issued by a court may be served upon the Contract Administrator or a member of the Board of Trustees. All of these people may be served at the following address:

Plumbers and Pipefitters Local No. 520 Health and Welfare Fund
c/o BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

16. TERMINATION OF THE FUND

a. In order that the Fund may carry out its obligations to maintain—within the limits of its resources—a program dedicated to providing the Benefits for all Covered Participants, the Board of Trustees has the sole power, discretion and authority to amend or terminate the Fund or merge it into another Fund. Under the terms of the Fund, the Fund is to be terminated if any of the following occur:

i. The Fund's assets are, in the opinion of the Board of Trustees, inadequate to carry out the intent and purpose of the Fund or are inadequate to meet the payments due or which may become due to Covered Participants;

ii. The Union and the contributing Employers agree to terminate the Fund; or

iii. Any other event which, by law, requires termination of the Fund.

b. If the Fund terminates, the Board of Trustees will take the following steps under the terms of the Fund:

i. Provide for the payment, out of Fund assets, of expenses (including Benefits) incurred by the Fund and Covered Participants up to the date of termination, and for the payment of any expenses incidental to termination;

ii. Arrange for a final audit and report of the Fund's transactions and accounts for the purposes of ending the trusteeship; and

iii. Distribute and apply any surplus Fund assets in a manner that will inure to the exclusive benefit of the Covered Participants in accordance with the purposes of the Fund and with any requirements of law.

SECTION A-3: Changes In Fund Rules And Benefits

The Board of Trustees has authority to increase, decrease, modify or eliminate the benefits provided by the Fund as well as the rules under which you and your Dependents may become covered or have your coverage continued. You will be sent a description of changes that affect you. Please remember, however, that months may elapse between the time the Board makes a change and the time you are sent either a Summary of Material Modifications or a new page for your Sum-

mary Plan Description. If you want to be sure about the existence of a benefit or eligibility requirement or such, telephone the Contract Administrator.

PART B: ELIGIBILITY FOR BENEFITS UNDER THE FUND

SECTION B-1: Eligibility For Coverage Under The Fund

(All benefits under the Fund are subject to the following eligibility provisions.)

1. WHO MAY BECOME ELIGIBLE UNDER THE FUND

The Fund provides benefits to eligible Active Participants and, in certain cases, their Dependents. Whether or not an Active Participant or a Dependent may become eligible for one or more types of benefit coverages depends on the terms of the Fund described in this Summary Plan Description. The words "Active Employee," "Active Participant," "Covered Participant," "Dependent," "Disabled Participant," and "Retired Participant" have special meanings, specified in SECTION A-1: DEFINITIONS OF TERMS USED IN THIS SUMMARY PLAN DESCRIPTION.

2. HOW YOU BECOME AND REMAIN COVERED BY THE FUND

A. INITIAL ELIGIBILITY

You will become eligible for benefits:

i. If you are an Employee and your initial Covered Employment is by an Employer who had not been obligated to make contributions to the Fund prior to the initial contributions made on your behalf, an Applicant Journeyman, Utility Pipefitter Helper, or an Apprentice, you will become an Active Employee and will be eligible for coverage on the first day of the month following the month in which contributions were initially payable on your behalf. If you are an Apprentice, you will be provided coverage for three (3)months. If you are an Applicant Journeyman or Utility Pipefitter Helper, your initial coverage will be established as a result of the Fund's loaning to you 360 hours. You will be required to repay to the Fund the hours loaned to you out of future monthly hours that exceed 120. If you have not repaid the hours loaned to you within the first fifteen (15) months of your initial eligibility, you will receive a bill from the Contract Administrator for the remaining amount of unpaid hours. If these hours are not repaid, your eligibility will be terminated.

ii. If you were previously eligible for Benefits, you will become eligible for Benefits if you are an Employee and you have completed 360 hours of work during a period of nine consecutive months or less working for an employer who is obligated to make contributions to this Fund, and has been obligated to make contributions to the Fund prior to the date contributions were first made on your behalf, or to another Plumbers and Pipefitters Health and Welfare Fund that is party to the United Association Health and Welfare Fund Reciprocal Agreement.

Benefits become effective on the first day of the month following the second month in which eligibility requirements were met, provided you are working or are available for work in Covered Employment on that day. This initial period of coverage will continue for a period of three months. For example, if you satisfied the eligibility requirements in January, your Benefits will begin in March.

In addition to satisfying the requirements for initial eligibility set forth above, in order to actually receive benefits after you become eligible you must first fill out enrollment forms, which the Fund's Contract Administrator shall send to you upon your becoming eligible for coverage under the Fund. If you do not receive an enrollment form from the Contract Administrator immediately after you satisfy all criteria for eligibility, you should contact the Contract Administrator to request an enrollment form. Benefits will not be paid for you and your Dependents until an enrollment form is completed. All of your Dependents must be listed on the enrollment form.

B. CONTINUATION OF COVERAGE

After you satisfy the initial eligibility requirements set forth in SECTION B-1: ELIGIBILITY FOR COVERAGE UNDER THE FUND, (360 hours of work in Covered Employment within a nine-month period, or loaning of 360 hours), your coverage will be continued after the initial eligibility period of three months if you satisfy one of the following continuation of eligibility requirements:

I. BY WORKING

Your eligibility will be continued from month to month only if you have 120 hours of work in Covered Employment during a Work Month.

There is a two-month delay between the month in which you actually earn coverage by working or by making self-contributions and the month in which your coverage is effective. The Fund calls the month in which you earn coverage your "Work Month." The month in which you are covered for benefits on the basis of your work or your self-contributions is called your "Benefit Month." They are as follows:

Work Month	Benefit Month
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January

November ..... February
December .....March

To determine whether you have sufficient hours of work to your credit, the following rules apply:

- If you work 120 hours during a Work Month, you meet the hours-of-work requirement and will have your coverage continued for the corresponding Benefit Month.

- If you work enough hours during a Work Month so that the amount of contributions paid by your employer to the Fund exceeds 120 times the Fund's current hourly contribution rate called for in the Local 520 collective bargaining agreement, those contributions in excess of 120 times the Fund's current hourly contribution rate called for in the Local 520 collective bargaining agreement will be credited to a Dollar Bank. The Dollar Bank will be maintained for you to provide Extended Coverage Dollars. The maximum amount of Extended Coverage Dollars that may be maintained in your Dollar Bank is equal to 720 times the Fund's current hourly contribution rate called for in the Local 520 collective bargaining agreement, which is equivalent to six (6) months of coverage.

- If you fail to work 120 hours in Covered Employment in a month, your coverage will be continued if you have sufficient Dollars in your Dollar Bank to make up the difference between the amount of hours you actually worked and 120 hours. The amount of Dollars you will need to maintain your coverage is calculated by multiplying the actual shortage of hours between the 120 hours and the number of hours worked times the current hourly employer contribution rate provided in the Local 520 contract. If you fail to work the required 120 hours and have an available balance in your Dollar Bank, your Dollar Bank will automatically be applied against your shortage to reduce or eliminate the need to make a self-contribution, provided you are available for work in Covered Employment within the jurisdiction of Local 520. If you are not available and even if you have Dollars in your Dollar Bank, your coverage will cease immediately.

When Employees work in the jurisdiction of a reciprocating health and welfare Fund, this Fund's receipt of the contributions is usually delayed. It is possible that you will receive a bill for a self-contribution on account of this delay. If you do, you must notify the Contract Administrator that you are working in a reciprocating Fund's jurisdiction. You will have to provide written proof to the Contract Administrator that you are, in fact, working in the other Fund's jurisdiction in order for benefits to continue.

II. BY MAKING SELF-CONTRIBUTIONS

(1) ACTIVE EMPLOYEES.

If you fail to work at least 120 hours during a Work Month and you do not have any Dollars remaining in your Dollar Bank, you may make a self-contribution. The rates for self-contribution are set by the Fund's Board of Trustees and may be revised from time to time as the costs of the Fund's benefits change.

The current rate of self-contribution is determined by multiplying the actual shortage of hours between the 120 hours and the number of hours worked times the current hourly employer contribution rate provided in the Local 520 contract.

An Active Employee whose coverage will be terminated unless he or she makes a self-contribution will be billed by mail. Payment must be made within the allowed time or your coverage will terminate and you will lose your right to have coverage continued through self-contribution.

There are some limitations on your right to make self-contributions to the Fund. They are as follows:

- An Active Employee (other than an eligible retiree) may not make full self-contributions for more than 12 consecutive months without special permission from the Board.

- In special, unusual circumstances, the Board may continue the privilege to maintain coverage by self-contribution beyond the normal 12-month self-contribution period. To obtain this privilege, the Active Employee must apply in writing to the Board before the normal 12-month self-contribution period expires, and must cite reasons of hardship to support his or her application. The self-contribution period may be continued for up to 12 additional months.

During the extension period and while coverage is being maintained by self-contribution, an Active Employee may regain active status by working at least 120 hours in a Work Month. Restoration to active status shall be effective the first day of the Benefit Month corresponding to the Work Month in which the 120-hour requirement is met.

(2) RETIRED PARTICIPANTS.

(A) ELIGIBILITY.

i. An Active Participant who retires from the Plumbers and Pipefitters Local No. 520 Pension Fund may be eligible for benefits as a Retired Participant by using their Dollar Bank and/or by making self-contributions if the Active Participant was eligible for benefits under the Fund: (1) during the Benefit Month prior to the effective date of

their pension benefits under the Plumbers and Pipefitters Local No. 520 Pension Fund, and (2) during at least 48 of the last 60 months prior to the effective date of their pension benefits under the Plumbers and Pipefitters Local No. 520 Pension Fund. The rates for self-contribution are set by the Fund's Board of Trustees and may be revised from time to time as the costs of the Fund's benefits change.

ii. If you remarry after you retire, your new spouse will not be eligible for benefits under the Fund. If, at the time you retired, you elected to not cover your spouse due to existing coverage through your spouse's employment, but your spouse loses such coverage through no fault of your spouse, you may add your spouse to your coverage at the time the coverage is lost.

iii. The rates of self-contribution differ among Retired Participants depending on when you retired and your age. When you become eligible to self-contribute, you will be notified by the Contract Administrator prior to the due date for the payment of the self-contributions of the monthly amount. If the Board of Trustees revises the rate, you will be notified by the Contract Administrator. If you are eligible to maintain your coverage by making self-contributions only your spouse at the time you retire will be eligible for benefits as your spouse.

(B) BENEFITS.

i. Retired Participants who are not eligible for Medicare but are eligible for coverage under the Fund shall receive the same type of coverage that they last enjoyed prior to their retirement, with the following exceptions: (i) you will not be eligible for disability benefits; (ii) your death benefits will be reduced (see PART P: DEATH BENEFITS); (iii) you will not be eligible for Accidental Death and Dismemberment Benefits; and (iv) you will have to pay a deductible for Dental Benefits (see PART M: DENTAL BENEFITS).

ii. Retired Participants who are eligible for Medicare shall receive Medicare Supplement Benefits and all other Fund benefits except: (i) you will not be eligible for disability benefits; (ii) your death benefits will be reduced (see PART P: DEATH BENEFITS); (iii) you will not be eligible for Accidental Death and Dismemberment Benefits; and (iv) you will have to pay a deductible for Dental Benefits (see PART M: DENTAL BENEFITS). Retired Participants eligible for Medicare Part D may elect to enroll in Medicare Part D, and terminate their Prescription Drug Benefits under the Fund, and continue to maintain their Medicare Supplement Benefits under the Fund.

(C) RETURN TO COVERED EMPLOYMENT.

If you return to Covered Employment and continue to be a Retired Participant, any contributions received during a Work Month will be credited against your monthly self-contribution obligations. If the amount of Hours that you work in a Work Month results in contributions which exceed 120 times the Fund's current hourly contribution rate

called for in the current Local 520 collective bargaining agreement, the excess contributions will not be credited to a Dollar Bank.

If you return to Covered Employment, you will cease being a Retired Participant as of the end of the Benefit Month which coincides to the Work Month when you have worked 1200 Hours in Covered Employment in a Plan Year. Thereafter, you will be an Active Employee until such time that you have no Hours of Covered Employment in any two consecutive Work Months. You will be reclassified as a Retired Participant as of the Benefit Month corresponding to the second consecutive Work Month in which there were no Hours of Covered Employment.

III. BY RECEIVING WEEKLY DISABILITY BENEFITS FROM THE FUND, WORKERS' COMPENSATION, OR DETERMINED TO BE A DISABLED PARTICIPANT.

If you receive weekly Disability Benefits from the Fund, Workers' Compensation, or are determined to be a Disabled Participant by the Fund during a Work Month, you will be given credit for Dollars of Contributions in an amount sufficient to maintain your coverage for the corresponding Benefit Month. Credits for Dollars of Contributions will be limited to periods of disability of six (6) months or less. If you are receiving Workers' Compensation or have been determined to be a Disabled Participant and your period of disability exceeds six (6) months, you may apply to the Board of trustees for an extension of credits for Dollars of Contributions for up to an additional six (6) months. If at the time you are given your initial credits for Dollars of Contributions you have a Dollar Bank, your Dollar Bank will be frozen until such time that you are no longer eligible to receive credits.

A Participant receiving Workers' Compensation or a Disabled Participant whose coverage has been terminated and the Participant registers with Local 520 to resume Covered Employment within six months of when the individual ceased to be disabled, the Participant shall be reinstated the first day of the Benefit Month corresponding to completion of 120 hours of Covered Employment during a Work Month. The Participant may obtain immediate reinstatement of coverage by making a self-contribution.

If you are a Disabled Participant and return to Covered Employment, you will cease being a Disabled Participant as of the end of the Benefit Month that coincides with the Work Month that you received your last monthly pension benefit from the Plumbers and Pipefitters Local 520 Pension Fund. Former Disabled Participants will not be required to satisfy the initial eligibility rules. If you were formerly a Disabled Participant and you cease Covered Employment, you will continue to be an Active Employee subject to the Active Employee rules for making self-contributions.

3. WHEN ELIGIBLE DEPENDENTS BECOME COVERED FOR BENEFITS UNDER THE FUND

A. RULE FOR DEPENDENTS AT THE TIME OF YOUR INITIAL ELIGIBILITY.

Any eligible Dependent that you have on the initial date that your coverage becomes effective shall become covered on the same date that you do.

B. RULES FOR NEWLY ACQUIRED OR DISCLOSED DEPENDENTS

I. NOTIFICATION TO FUND OF NEWLY ACQUIRED DEPENDENTS WITHIN 90 DAYS.

If you are already an Active Participant of the Fund and you acquire a new Dependent, such as through marriage or the birth or placement for adoption of a child, you must immediately notify the Fund in writing of the new Dependent in order for the new Dependent to begin coverage. If you notify the Fund within ninety (90) days of the birth, marriage, placement for adoption or other event through which the person becomes your Dependent, that Dependent shall be eligible for coverage effective on the date of such marriage, birth, adoption or other event. **IF YOU DO NOT COMPLETE AND SUBMIT TO THE FUND AN ENROLLMENT FORM OR OTHER WRITTEN NOTICE OF ENROLLMENT FOR THE NEW DEPENDENT UNTIL MORE THAN NINETY (90) DAYS AFTER THE BIRTH, MARRIAGE, ADOPTION OR OTHER EVENT, YOUR DEPENDENT WILL NOT BE ELIGIBLE FOR COVERAGE UNDER THE FUND UNTIL THE DATE THAT THE ENROLLMENT FORM OR OTHER WRITTEN NOTICE IS RECEIVED BY THE FUND.** The Enrollment Form or other written notice must be accompanied by the necessary supporting documentation for the new Dependent.

You may provide notice of a new Dependent by submitting to the Contract Administrator a completed Enrollment Form listing the new Dependent. If you do not have an Enrollment Form, you may notify the Contract Administrator of the new Dependent in a letter, and an official Enrollment Form will be sent to you.

II. NOTIFICATION TO FUND OF NEWLY DISCLOSED DEPENDENTS.

If you are already an Active Participant of the Fund and you notify the Fund that you previously failed to notify the Fund of the existence of a Dependent, you must complete a new enrollment form. Dependent coverage for the newly disclosed Dependent will not begin until the first day of the month following the date Fund receives a new enrollment form listing the newly disclosed Dependent along with all other Dependents, along with the necessary supporting documentation for the new Dependent.

C. RULES FOR SPOUSES AND DEPENDENTS OF DECEASED ACTIVE AND RETIRED PARTICIPANTS.

Following the death of a covered Active Employee or Retired Participant, coverage will continue for his or her Dependents as follows:

For the surviving spouse of an Active Employee, 12 months or until death or remarriage, whichever occurs first, and thereafter coverage will continue based upon previously accrued eligibility or Dollar Bank coverage and/or continuing self-contributions.

For the surviving spouse of a Retired Participant, coverage will continue based upon previously accrued eligibility or Dollar Bank coverage and/or continuing self-contributions.

For the children of an Active Employee, until such time that the child is no longer a Dependent Child as defined in SECTION A-1: DEFINITIONS OF TERMS USED IN THIS SUMMARY PLAN DESCRIPTION.

For the children of a Retired Participant, until such time that the child is no longer a Dependent Child as defined in SECTION A-1: DEFINITIONS OF TERMS USED IN THIS SUMMARY PLAN DESCRIPTION.

4. RIGHT TO ENROLLMENT UNDER HIPAA

To the extent that you need to enroll newly acquired Dependents under the Fund, there are some special rules under federal law that apply to group health coverage (*i.e.*, Medical, Prescription, Dental and Vision Benefits) of which you should be aware. Under a federal law known as the Health Insurance Portability and Accountability Act ("HIPAA"), plans must permit late enrolments for group health plan coverage in certain situations in which coverage under another plan or insurance is lost, or in which an individual becomes a Dependent after the normal enrollment period has closed.

The law requires that employees and Dependents who lose group health coverage under another plan or insurance (and who are not enrolled but would otherwise be eligible for group health coverage under a plan) be permitted in certain circumstances to enroll late for group health coverage.

HIPAA also provides for a special enrollment period for group health coverage for an individual (otherwise eligible for coverage) who becomes a Dependent of a Participant through marriage, birth, adoption or placement for adoption. In situations of birth and adoption, the spouse of the Participant may also enroll if otherwise eligible for coverage.

Under HIPAA, in order to take advantage of this right to special enrollment, you must provide timely notice to the Fund of the loss of the other coverage or the change in

family circumstances. Notice of a loss of other coverage is to be given by you in writing to the Fund's Contract Administrator within sixty (60) days of the loss of other coverage. The Special Enrollment following a loss of other coverage then becomes effective the first day of the first calendar month after the notice requesting the change is made.

Notice of your acquiring a Dependent for the purposes of seeking a Special Enrollment under HIPAA must be given by you in writing to the Fund's Contract Administrator within ninety (90) days of the later of: (i) the date of the marriage, birth, adoption or placement for adoption; or (ii) the date that Dependent coverage is made available. Such group health coverage under this Fund is retroactive to the date of the marriage, birth, adoption or placement for adoption, if elected within the first ninety (90) days of the Dependent Special Enrollment period.

HIPAA further provides for a Special Enrollment Period for group health plan coverage for employees and Dependents (otherwise eligible for coverage) who lose eligibility for Medicaid or SCHIP or CHIP (State Children's Health Insurance Program or Children's Health Insurance Program), or become eligible to participate in a premium assistance program under Medicaid or SCHIP or CHIP (a premium assistance program is an optional state program under Medicaid or SCHIP that pays a share of the premium for the group health plan coverage).

Under HIPAA, in order to take advantage of the Medicaid or SCHIP or CHIP right to special enrollment, you must provide timely notice to the Fund of the loss of eligibility for Medicaid or SCHIP or CHIP coverage or become eligible to participate in a premium assistance program under Medicaid or SCHIP or CHIP. Notice of the loss of eligibility or becoming eligible to participate in a premium assistance program is to be given by you in writing to the Fund's Contract Administrator within ninety (90) days of the loss of eligibility for Medicaid or SCHIP or CHIP coverage or becoming eligible to participate in a premium assistance program under Medicaid, SCHIP or CHIP. The Special Enrollment following a loss of eligibility for Medicaid or SCHIP or CHIP coverage or becoming eligible to participate in a premium assistance program then becomes effective the first day of the first calendar month after the notice requesting the change is made.

5. SUSPENSION OF COVERAGE AND REINSTATEMENT FOLLOWING SUSPENSION

Coverage is suspended upon any of the following events:

a. If you become covered by reason of your work under another jointly trusteed health and welfare plan where the employers are party to a collective bargaining agreement with the United Association in the construction industry, or a group insurance plan or jointly trusteed health and welfare plan in another industry, the coverage of you and your Dependents is suspended immediately. If:

i. at the time of suspension you had Dollars sufficient in your Dollar Bank, and

ii. you return to work in Covered Employment,

then your Dollar Bank that you accumulated previously will be reinstated to you, and you will be entitled to use the Dollar Bank to satisfy the Continuation of Coverage requirements of the Fund.

b. If you so elect, your coverage will be suspended immediately if you enter the Uniformed Services, as that term is defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your coverage and Dollar Bank will be reinstated on the first day of the month following notice to the Contract Administrator of your discharge, provided you have not been on active duty for more than five years (except in situations where the Covered Participant's initial enlistment did not terminate within the five-year period, or where, through no fault of the Covered Participant, he or she was otherwise required to serve beyond the five-year period), and provided you return to Covered Employment within the time frames set forth in USERRA. If you fail to return to Covered Employment within those time frames, you will forfeit any coverage and Dollar Bank that you previously accumulated. You must notify the Contract Administrator prior to entering the Uniformed Services and again when discharged, so that the Contract Administrator may assist you with rights you have under USERRA and any COBRA benefits that may be available to you or your Dependents.

SECTION B-2: How And When You Or A Dependent Lose Coverage

1. HOW AND WHEN ELIGIBILITY OF AN ACTIVE PARTICIPANT IS TERMINATED

a. Your eligibility for coverage (other than COBRA coverage under the Fund) terminates on the earliest of the following events:

b. Failure to make self-contribution, when eligible to do so. Your coverage will terminate at the end of the Benefit Month.

c. The end of any extension period or period in which coverage is being maintained through self-contributions. Your coverage will terminate at the end of the Benefit Month.

d. Commencement of work for an employer in the trade jurisdiction of Local 520 that does not contribute to this Fund, unless the employer contributes to another jointly trusteed health and welfare plan that is affiliated with the United Association or a Local of the United Association. Your coverage will terminate immediately and irrespective of whether you have any entitlement to any extended coverage under the Fund.

e. Non-availability for Covered Employment in the geographical jurisdiction of Local 520 on account of employment outside the trade jurisdiction of Local 520. Your coverage will terminate immediately and irrespective of whether you have any entitlement to any extended coverage under the Fund.

2. HOW AND WHEN ELIGIBILITY FOR A DEPENDENT IS TERMINATED

Your Covered Dependent shall lose eligibility for coverage (other than COBRA coverage) on the earliest of the following events:

a. You cease to be a Covered Participant under the Fund and your eligible Dependent's coverage will terminate when your coverage terminates.

b. Your Dependent ceases to satisfy the Fund's definition of "Dependent."

SECTION B-3: Election By Active Employees And Dependents To Make Medicare Your Exclusive Coverage

If you are an Active Employee and Medicare eligible, or a spouse of an Active Employee and Medicare eligible, you may elect to have Medicare as your exclusive form of hospital, medical and surgical coverage. If you make this election you will lose all your coverage for hospital, medical and surgical coverage under the Fund as described in PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS, because the Fund is prohibited by law from providing you with any benefits that supplement those under Medicare. If you do not make this election, the law requires that the Fund remain your primary coverage for hospital, medical and surgical benefits, with Medicare being the secondary coverage. If you desire to have Medicare as your exclusive form of coverage for the hospital, medical and surgical benefits, you must file a written election with the Contract Administrator.

PART C: CONTINUATION COVERAGE RIGHTS UNDER COBRA

SECTION C-1: Introduction

COBRA continuation coverage is a temporary extension of health coverage under the Fund under certain circumstances when coverage would otherwise end, subject to the Continuation Coverage Offset Rules of the Fund described in SECTION C-10: CONTINUATION COVERAGE OFFSET RULES. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your health coverage under the Fund. It can also become available to your spouse and Dependent children, if they are covered under the Fund, when they would otherwise lose their health coverage under the Fund. The following Sections generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Summary Plan Description) applies only to the Hospital, Medical, Surgical, Prescription Drug, Dental and Vision Benefits offered by the Fund (hereinafter referred to as "COBRA," "COBRA coverage," or "health coverage"), and not to any other benefits offered by the Fund (such as Death, Disability, or Accidental Death Or Dismemberment Benefits). The Fund provides no greater COBRA rights than what COBRA requires, and nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Fund and under federal law, you should contact the Contract Administrator.

SECTION C-2: What Is COBRA Coverage?

COBRA coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below in SECTION C-3: WHO IS ENTITLED TO ELECT COBRA COVERAGE?

After a Qualifying Event occurs and any required notice of that event is properly provided to the Contract Administrator, COBRA coverage must be offered to each person losing Fund coverage who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Fund is lost because of the Qualifying Event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun “you” in the following paragraphs regarding COBRA to refer to each person covered under the Fund who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Fund gives to other participants or beneficiaries under the Fund who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Fund as other participants or beneficiaries covered under Fund, including open enrollment and special enrollment rights. Under the Fund, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Hospital, Medical, Surgical, Prescription Drug, Dental and Vision Benefits of the Fund is available in other Parts of this Summary Plan Description.

SECTION C-3: Who Is Entitled To Elect COBRA Coverage?

If you are an Active Employee, you will be entitled to elect COBRA if you lose your health coverage under the Fund because either one of the following Qualifying Events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Active Employee, you will be entitled to elect COBRA if you lose your health coverage under the Fund because any of the following Qualifying Events happens:

- your spouse dies;
- your spouse’s hours of employment are reduced;
- your spouse’s employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- you become divorced or you no longer maintain a regular spousal relationship with your spouse. Also, if your spouse (the Active Employee) reduces or eliminates your health coverage in anticipation of a divorce or termination of the regular spousal relationship, and a divorce or termination of the regular spousal relationship later occurs, then the divorce or termination of the regular spousal relationship may be considered a Qualifying Event for you even

though your coverage was reduced or eliminated before the divorce or termination of the regular spousal relationship.

If you are the Dependent child of an Active Employee, you will be entitled to elect COBRA if you lose your health coverage under the Fund because any of the following Qualifying Events happens:

- your parent / Active Employee dies;
- your parent / Active Employee's hours of employment are reduced;
- your parent / Active Employee's employment ends for any reason other than his or her gross misconduct;
- your parent / Active Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
- you stop being eligible for coverage under the Fund as a "Dependent child."

If an Active Employee takes FMLA leave and does not return to work at the end of the leave, the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if: (1) they were covered under the Fund on the day before the FMLA leave began (or became covered during the FMLA leave); or (2) they will lose Fund coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Fund during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA Qualifying Events of termination of employment and reduction of hours. (See SECTION C-7: LENGTH OF COBRA COVERAGE.)

SECTION C-4: When Is COBRA Coverage Available?

When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Active Employee, the Fund will offer COBRA coverage to qualified beneficiaries. You need not notify the Contract Administrator of the end of employment or reduction of hours of employment, but you must notify the Contract Administrator of the Death of an Active Employee.

For the other Qualifying Events (divorce of the Employee and spouse or termination of the regular spousal relationship; a Dependent child's losing eligibility for coverage as a Dependent child; or the Active Employee's becoming entitled to Medicare under Part A, Part B or both), a COBRA election will be available to you only if you notify the Contract Administrator in writing within 60 days after the later of: (1) the date of the

Qualifying Event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Fund as a result of the Qualifying Event.

In providing this notice, you must use the Fund's form entitled "Notice of Qualifying Event Form and Notice Procedures," and you must follow the procedures specified in SECTION C-17: NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENTS. If these procedures are not followed or if the notice is not provided in writing to the Contract Administrator during the 60-day notice period, you will lose your right to elect COBRA. (You may obtain a copy of the Notice of Qualifying Event Form and Notice Procedures from the Contract Administrator.)

SECTION C-5: Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Fund's COBRA Election Notice and submit it to the Contract Administrator. (An Election Notice will be provided to qualified beneficiaries at the time of a Qualifying Event. You may also obtain a copy of the Election Form from the Contract Administrator.) Under federal law, you must have 60 days after the date of the COBRA Election Notice provided to you at the time of your Qualifying Event to decide whether you want to elect COBRA coverage under the Fund.

Mail or hand deliver the completed Election Form to the Fund's Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

The COBRA Election Form must be completed in writing and mailed or hand delivered to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

If mailed, your election must be postmarked (and if hand delivered, your election must be received by the Contract Administrator at the address specified above) no later than 60 days after the date of the COBRA Election Notice provided to you at the time of your Qualifying Event. If you do not submit a completed Election Form by this due date, you will lose your right to elect COBRA coverage.

If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA coverage. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA coverage. For example, the Active Employee's spouse may elect COBRA coverage even if the Active Employee does not. COBRA coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. Active Employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Fund's COBRA Election Notice will lose his or her right to elect COBRA coverage.

When you complete the Election Form, you must notify the Contract Administrator if any qualified beneficiary has become entitled to Medicare (under Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the Contract Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA coverage may do so even if they have other health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA coverage is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other health plan coverage. See SECTION C-9: TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD.

SECTION C-6: Special Considerations In Deciding Whether To Elect COBRA Coverage

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your health coverage under the Fund ends because of one of the Qualifying Events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

SECTION C-7: Length Of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods, subject to the Continuation Coverage Offset Rules of the Fund. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in SECTION C-9: TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD.

When Fund coverage is lost due to the death of the Active Employee, the Active Employee's divorce or termination of the regular spousal relationship, or a Dependent child's losing eligibility as a Dependent child, COBRA coverage can last for up to a total of 36 months, subject to the Continuation Coverage Offset Rules of the Fund.

When Fund coverage is lost due to the end of employment or reduction of the Active Employee's hours of employment, and the Active Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA coverage for qualified beneficiaries (other than the Active Employee) who lose coverage as a result of the Qualifying Event can last until up to 36 months after the date of Medicare entitlement, subject to the Continuation Coverage Offset Rules of the Fund. For example, if an Active Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, subject to the Continuation Coverage Offset Rules of the Fund, which is equal to 28 months after the date of the Qualifying Event (36 months minus eight months). This COBRA coverage period is available only if the Active Employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when Fund coverage is lost due to the end of employment or reduction of the Active Employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months, subject to the Continuation Coverage Offset Rules of the Fund.

SECTION C-8: Extension Of Maximum Coverage Period

If the Qualifying Event that resulted in your COBRA election was the Active Employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second Qualifying Event occurs. You must notify the Contract Administrator of a disability or a second Qualifying Event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second Qualifying Event will eliminate the right to extend the period of COBRA coverage.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Contract Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months, subject to the Continuation Coverage Offset Rules of the Fund. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the Active Employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the Active Employee's termination of employment or reduction of hours, and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the Contract Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the Active Employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Fund as a result of the Active Employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the Active Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

In providing this notice, you must use the Fund's form entitled "Notice of Disability Form and Notice Procedures," and you must follow the procedures specified in SECTION C-18: NOTICE PROCEDURES FOR NOTICE OF DISABILITY. If these procedures are not followed or if the notice is not provided in writing to the Contract Administrator during the 60-day notice period and within 18 months after the Active Employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage. (You may obtain a copy of the Notice of Disability Form and Notice Procedures from the Contract Administrator.)

An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the Active Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second Qualifying Event occurs is 36 months. Such second Qualifying Events may include the death of an Active Employee, divorce

from or termination of the regular spousal relationship with the Active Employee, the Active Employee's becoming entitled to Medicare Benefits (under Part A, Part B or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Fund. These events can be a second Qualifying Event only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first Qualifying Event had not occurred.

This extension due to a second Qualifying Event is available only if you notify the Contract Administrator in writing of the second Qualifying Event within 60 days after the later of: (1) the date of the second Qualifying Event; or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Fund as a result of the second Qualifying Event (if it had occurred while the qualified beneficiary was still covered under the Fund).

In providing this notice, you must use the Fund's form entitled "Notice of Second Qualifying Event Form and Notice Procedures," and you must follow the procedures specified in SECTION C-19: NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT. If these procedures are not followed or if the notice is not provided in writing to the Contract Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second Qualifying Event. (You may obtain a copy of the Notice of Second Qualifying Event Form and Notice Procedures from the Contract Administrator.)

SECTION C-9: Termination Of COBRA Coverage Before The End Of The Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another health plan;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see SECTION C-8: EXTENSION OF MAXIMUM COVERAGE PERIOD.

COBRA coverage may also be terminated for any reason the Fund would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the Contract Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other health plan. You must use the Fund's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures," and you must follow the procedures specified in SECTION C-20: NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT OR CESSATION OF DISABILITY. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures from the Contract Administrator.)

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other health coverage. The Contract Administrator will require repayment to the Fund of all benefits paid after the termination date, regardless of whether or when you provide notice to the Contract Administrator of Medicare entitlement or other health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Contract Administrator of that fact within 30 days after the Social Security Administration's determination. You must use the Fund's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures," and you must follow the procedures specified in SECTION C-20: NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT OR CESSATION OF DISABILITY. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures from the Contract Administrator.)

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Contract Administrator will require repayment to the Fund of all benefits paid after the termination date, regardless of whether or when you provide notice to the Contract Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see SECTION C-8: EXTENSION OF MAXIMUM COVERAGE PERIOD.)

SECTION C-10: Continuation Coverage Offset Rules

If you and your spouse or Dependent children have a right to continue coverage under the Fund through the use of a Dollar Bank or the payment of self-contributions after a Qualifying Event, the period of time you are entitled to continuation coverage will be reduced by the period of coverage provided through the use of a Dollar Bank and/or the payment of self-contributions (the "Continuation Coverage Offset").

SECTION C-11: Cost Of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the Fund for coverage of a similarly situated plan Participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

SECTION C-12: Payment For COBRA Coverage

All COBRA premiums must be paid by check or Money Order.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received by the Contract Administrator at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is post-marked, if mailed, or the date your Election Form is received at the address specified for delivery of the Election Form, if hand delivered.) See SECTION C-5: ELECTING CO-BRA COVERAGE.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Fund would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for

making sure that the amount of your first payment is correct. You may contact the Contract Administrator using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Fund.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the Election Notice provided to you at the time of your Qualifying Event. Under the Fund, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Fund will continue for that month without any break. The Contract Administrator will not send periodic notices of payments due for these coverage periods (that is, you will not receive a bill for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Fund will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated:

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Fund.

SECTION C-13: More Information About Individuals Who May Be Qualified Beneficiaries

A Dependent child born to, adopted by, or placed for adoption with an Active Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the Active Employee is a qualified beneficiary, the Active Employee has elected COBRA coverage for himself or herself. The Dependent child's COBRA coverage begins when the Dependent child is enrolled in the Fund, whether

through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Active Employee. To be enrolled in the Fund, the Dependent child must satisfy the otherwise applicable Fund eligibility requirements (for example, regarding age).

A Dependent child of the Active Employee who is receiving benefits under the Fund pursuant to a qualified medical child support order (QMCSO) received by the Contract Administrator during the Active Employee's period of employment with the Contract Administrator is entitled to the same rights to elect COBRA coverage as an eligible Dependent child of the Active Employee.

SECTION C-14: If You Have Questions

Questions concerning the Fund or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

SECTION C-15: Keep The Fund Informed Of Address Changes

In order to protect your family's rights, you should keep the Contract Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Contract Administrator.

SECTION C-16: Fund Contact Information

You may obtain information about the Fund and COBRA coverage on request from the Contract Administrator at the following address and phone number:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)
Phone: 717-565-1101, Toll Free: 833-263-5750
Fax: 717-775-3434

SECTION C-17: Notice Procedures For Notice Of Qualifying Events

The deadline for providing this notice is 60 days after the later of: (1) the Qualifying Event (i.e., a divorce or termination of the regular spousal relationship with the Ac-

tive Employee, entitlement to Medicare benefits (under Part A, Part B or both), or a Dependent child's loss of Dependent status); or (2) the date on which the covered spouse or Dependent child would lose coverage under the terms of the Fund as a result of the Qualifying Event.

You must mail or hand deliver this notice to the Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

Your notice must be in writing (using the Fund's form described below) and must be mailed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received at the address specified above no later than the deadline described above.

You must use the Fund's form entitled "Notice of Qualifying Event Form and Notice Procedures" to notify the Contract Administrator of a Qualifying Event (i.e., a divorce or termination of the regular spousal relationship with the Active Employee, entitlement to Medicare Benefits (under Part A, Part B or both), or a Dependent child's loss of Dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Qualifying Event Form and Notice Procedures from the Contract Administrator.

Your notice must contain the following information:

- the name of the Fund;
- the name and address of the Active Employee or former Active Employee who is or was covered under the Fund;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the Qualifying Event (divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or Dependent child's loss of Dependent status);
- the Qualifying Event (divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or Dependent child's loss of Dependent status);

- the date that the divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or Dependent child's loss of Dependent status happened; and

- the signature, name, and contact information of the individual sending the notice.

If you are notifying the Contract Administrator of a divorce or termination of a regular spousal relationship, your notice must include a copy of the decree of divorce or evidence of termination of regular spousal relationship.

If your coverage is reduced or eliminated and later a divorce or termination of the regular spousal relationship occurs, and you are notifying the Contract Administrator that your Fund coverage was reduced or eliminated in anticipation of the divorce or termination of the regular spousal relationship, you must provide notice within 60 days of the divorce or the termination of the regular spousal relationship in accordance with these Notice Procedures for Notice of Qualifying Event, and must in addition provide evidence satisfactory to the Contract Administrator that your coverage was reduced or eliminated in anticipation of the divorce or termination of regular spousal relationship.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand delivered to the individual and address specified above;

- the notice is provided by the deadline described above;

- from the written notice provided, the Contract Administrator is able to determine that the notice relates to the Fund;

- from the written notice provided, the Contract Administrator is able to identify the Active Employee and qualified beneficiary(ies), the Qualifying Event (the divorce, termination of regular spousal relationship, entitlement to Medicare Benefits under Part A, Part B or both, or Dependent child's loss of Dependent status), and the date on which the Qualifying Event occurred; and

- the notice is supplemented in writing with the additional information and documentation necessary to meet the Fund's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request from the Contract Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be offered. If all of these conditions are met, the Fund will treat the notice as having been provided on the date that the Fund receives all of the required information and documentation but will accept the notice as timely.

The Active Employee (i.e., the Active Employee or former Active Employee who is or was covered under the Fund), a qualified beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the Qualifying Event described in the notice.

If your notice was regarding a Dependent child's loss of Dependent status, you must, if the Contract Administrator requests it, provide documentation of the date of the Qualifying Event that is satisfactory to the Contract Administrator (for example, a birth certificate to establish the date that a Dependent child reached the limiting age, a marriage certificate to establish the date that a Dependent child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Contract Administrator to determine if you gave timely notice of the Qualifying Event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Contract Administrator that the Dependent child ceased to be a Dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Contract Administrator will require repayment to the Fund of all benefits paid after the termination date.

SECTION C-18: Notice Procedures For Notice Of Disability

The deadline for providing this notice is 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date of the Active Employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Fund as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the Active Employee's termination of employment or reduction of hours.

You must mail or hand deliver this notice to the Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

Your notice must be in writing (using the Fund's form described below) and must be mailed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received at the address specified above no later than the deadline described above.

You must use the Fund's form entitled "Notice of Disability Form and Notice Procedures" to notify the Contract Administrator of a qualified beneficiary's disability, and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Disability Form and Notice Procedures from the Contract Administrator.)

Your notice must contain the following information:

- the name of the Fund;
- the name and address of the Active Employee or former Active Employee who is or was covered under the Fund;
- the initial Qualifying Event that started your COBRA coverage (the Active Employee's termination of employment or reduction of hours);
- the date that the Active Employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the Contract Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Contract Administrator is able to determine that the notice relates to the Fund and a qualified beneficiary's disability;
- from the written notice provided, the Contract Administrator is able to identify the Active Employee and qualified beneficiary(ies) and the date on which the Active Employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Fund's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the Contract Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be extended. If all of these conditions are met, the Fund will treat the notice as having been provided on the date that the Fund receives all of the required information and documentation but will accept the notice as timely.

The Active Employee (i.e., the Active Employee or former Active Employee who is or was covered under the Fund), a qualified beneficiary who lost coverage due to the Active Employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

SECTION C-19: Notice Procedures For Notice Of Second Qualifying Event

The deadline for providing this notice is 60 days after the later of: (1) the date of the second Qualifying Event (i.e., a divorce or termination of the regular spousal relationship with the Active Employee, entitlement to Medicare benefits (under Part A, Part B or both), the Active Employee's death, or a Dependent child's loss of Dependent sta-

tus); and (2) the date on which the covered spouse or Dependent child would lose coverage under the terms of the Fund as a result of the second Qualifying Event (if this event had occurred while the qualified beneficiary was still covered under the Fund).

You must mail or hand deliver this notice to the Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

Your notice must be in writing (using the Fund's form described below) and must be mailed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received at the address specified above no later than the deadline described above.

You must use the Fund's form entitled "Notice of Second Qualifying Event Form and Notice Procedures" to notify the Contract Administrator of a second Qualifying Event (i.e., a divorce or termination of the regular spousal relationship with the Active Employee, entitlement to Medicare benefits (under Part A, Part B or both), the Active Employee's death, or a Dependent child's loss of Dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Second Qualifying Event Form and Notice Procedures from the Contract Administrator).

Your notice must contain the following information:

- the name of the Fund;
- the name and address of the Active Employee or former Active Employee who is or was covered under the Fund,
- the initial Qualifying Event that started your COBRA coverage (the Active Employee's termination of employment or reduction of hours);
- the date that the Active Employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second Qualifying Event (a divorce or termination of the regular spousal relationship with the Active Employee, entitlement to Medicare benefits (under

Part A, Part B or both), the Active Employee's death, or a Dependent child's loss of Dependent status);

- the date that the divorce or termination of the regular spousal relationship with the Active Employee, entitlement to Medicare benefits (under Part A, Part B or both), the Active Employee's death, or a Dependent child's loss of Dependent status happened; and

- the signature, name, and contact information of the individual sending the notice.

If you are notifying the Contract Administrator of a divorce or termination of the regular spousal relationship with the Active Employee, your notice must include a copy of the decree of divorce or termination of the regular spousal relationship with the Active Employee.

If you provide a written notice to the Contract Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

- the notice is mailed or hand delivered to the individual and address specified above;

- the notice is provided by the deadline described above;

- from the written notice provided, the Contract Administrator is able to determine that the notice relates to the Fund;

- from the written notice provided, the Contract Administrator is able to identify the Active Employee and qualified beneficiary(ies), the first Qualifying Event (the Active Employee's termination of employment or reduction of hours), the date on which the first Qualifying Event occurred, the second Qualifying Event, and the date on which the second Qualifying Event occurred; and

- the notice is supplemented in writing with the additional information and documentation necessary to meet the Fund's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from the Contract Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be extended. If all of these conditions are met, the Fund will

treat the notice as having been provided on the date that the Fund receives all of the required information and documentation but will accept the notice as timely.

The Active Employee (i.e., the Active Employee or former Active Employee who is or was covered under the Fund), a qualified beneficiary who lost coverage due to the Active Employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second Qualifying Event reported in the notice.

If your notice was regarding a Dependent child's loss of Dependent status, you must, if the Contract Administrator requests it, provide documentation of the date of the Qualifying Event that is satisfactory to the Contract Administrator (for example, a birth certificate to establish the date that a Dependent child reached the limiting age, a marriage certificate to establish the date that a Dependent child married, or .a transcript showing the last date of enrollment in an educational institution). This will allow the Contract Administrator to determine if you gave timely notice of the second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Contract Administrator that the Dependent child ceased to be a Dependent on the date specified in your Notice of Second Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of Dependent status. The Contract Administrator will require repayment to the Fund of all benefits paid after the termination date.

If your notice was regarding the death of the Active Employee, you must, if the Contract Administrator requests it, provide documentation of the date of death that is satisfactory to the Contract Administrator (for example, a death certificate or published obituary). This will allow the Contract Administrator to determine if you gave timely notice of the second Qualifying Event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Contract Administrator that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the Active Employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the Active Employee's death. The Contract Administrator will require repayment to the Fund of all benefits paid after the termination date.

SECTION C-20: Notice Procedures For Notice Of Other Coverage, Medicare Entitlement Or Cessation Of Disability

If you are providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing COBRA, under other health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective.

If you are providing a Notice of Medicare Entitlement (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must provide these notices to the Contract Administrator at the following address:

BeneSys, Inc.
P. O. Box 1889, Troy MI 48099-1889 (mailing address)
700 Tower Drive, Suite 300, Troy, MI 48098-2835 (overnight delivery)

Your notice must be provided no later than the deadline described above.

You should use the Fund's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures" to notify the Contract Administrator of any of these events, and all of the applicable items and the form should be completed. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form and Notice Procedures from the Contract Administrator.)

Your notice should contain the following information:

- the name of the Fund;
- the name and address of the Active Employee or former Active Employee who is or was covered under the Fund;
- the name(s) and address(es) of all qualified beneficiary(ies);
- the Qualifying Event that started your COBRA coverage;

- the date that the Qualifying Event happened; and

- the signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective, and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

The Active Employee (i.e., the Active Employee or former Active Employee who is or was covered under the Fund), a qualified beneficiary with respect to the Qualifying Event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by other health plan coverage after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described in SECTION C-9: TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD, regardless of whether or when a Notice of Other Coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described in SECTION C-9: TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD, regardless of whether or when a Notice of Medicare Entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in SECTION C-9: TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD, regardless of whether or when a Notice of Cessation of Disability is provided.

PART D: RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

SECTION D-1: Background

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in PART C: CONTINUATION COVERAGE RIGHTS UNDER COBRA), you are entitled under USERRA to continue the coverage you had under the Fund.

SECTION D-2: You Have Rights Under Both COBRA And USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or Dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in PART C: CONTINUATION COVERAGE RIGHTS UNDER COBRA (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

SECTION D-3: Definitions Specific To USERRA

1. "Uniformed Services" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

2. "Service in the Uniformed Services" or **"Service"** means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

SECTION D-4: Duration Of USERRA Coverage

General Rule: 24 month maximum. When an Active Employee takes a leave for Service in the Uniformed Services, USERRA coverage for the Active Employee (and covered Dependents for whom coverage is elected) begins the day after the Active Employee (and covered Dependents) loses coverage under the Fund, and it continues for up to 24 months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the Active Employee's leave, and they continue for up to 24 months. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the attached COBRA Election Notice. For example, an Active Employee takes a leave of absence for service in the Uniformed Services beginning on February 1, 2004. The Active Employee elects COBRA/USERRA continuation coverage and pays the required 102% of the insurance premium each month for the next 24 months. The Active Employee's COBRA and USERRA coverage both terminate at the end of this 24-month period, unless the coverage is terminated earlier due to non-payment of premiums or other permitted event.

SECTION D-5: Premium Payments For USERRA Continuation Coverage

If you elect to continue your health coverage (or your spouse or Dependent children's coverage) pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service leave of absence is less than 31 days, you are not required to pay more than the amount that you pay as an Active Employee for that coverage.

SECTION D-6: Option Of Suspension Of Coverage And Reinstatement Of Coverage Following Suspension

If you so elect, your coverage will be suspended immediately if you enter the Uniformed Services, as that term is defined in USERRA. Your coverage and Dollar Bank will be reinstated on the first day of the month following notice to the Contract Administrator of your discharge, provided you have not been on active duty for more than five years (except in situations where the Covered Participant's initial enlistment did not terminate within the five-year period, or where, through no fault of the Covered Participant, he or she was otherwise required to serve beyond the five-year period), and provided you return to Covered Employment within the time frames set forth in USERRA. If you fail to return to Covered Employment within those time frames, you will forfeit any coverage and Dollar Bank that you previously accumulated. You must notify the Contract Administrator prior to entering the Uniformed Services and again when discharged, so

that the Contract Administrator may assist you with rights you have under USERRA and any COBRA benefits that may be available to you or your Dependents.

PART E: GENERAL RULES CONCERNING PAYMENT OF FUND BENEFITS

SECTION E-1: Failure Of Covered Participant To Provide Information Or To Provide Correct Information

As a condition for being eligible for the payment of benefits, Covered Participants must provide accurate and up-to-date information and must permit the Fund and its agents to have full access to all information, including all medical information necessary for the Fund to determine claims. Covered Participants may be requested by the Fund from time to time to sign medical release forms to confirm for physicians, hospitals and others that the Fund has such authority. A Covered Participant is also responsible for providing and/or seeing that Dependents provide accurate and up-to-date information, and permit the Fund and its agent full access to all information, including medical information necessary for the Fund to determine claims. "Information" includes but is not limited to information regarding eligibility for benefits and/or claims, employment status, circumstances surrounding the onset of illness or injury, insurance coverage, receipt of benefits from any government agency or other insurance policy or plan, medical and hospital reports, records of employment, proof of date of birth, disability or death, evidence of existence of marriage, or claims or suits against those parties relating to injuries or conditions for which the Fund has paid benefits.

If a Covered Participant fails to provide accurate and up-to-date information or submit any information required by the Fund, or submits false, incomplete or outdated information required by the Fund, the Fund may terminate, suspend, deny or discontinue coverage or benefits, in whole or in part, of the Covered Participant, and/or may seek to recover any benefit payment from the Covered Participant, to the extent that the Fund relied upon false, incomplete or outdated information in the processing of claims for the Covered. If a Dependent fails to submit any information required by the Fund, or submits false, incomplete our outdated information required by the Fund, the Fund may seek to recover any benefit payment to the extent that it relied upon false, incomplete or outdated information from the Covered Participant's Dependent.

SECTION E-2: Non-Assignment Of Rights And Benefits

With one exception, the Fund provides that your rights under the Fund, including but not limited to your rights to receive benefits, appeal Fund determinations, or obtain information, may not be validly assigned to any other party, including any medical providers.

Payment for benefits with respect to a Participant under the Fund will be made in accordance with any assignment of rights made by or on behalf of such Participant or Beneficiary of the Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Administration pursuant to Section

1912(a)(1)(A) of such Act, as in effect as of August 10, 1993. 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 Administration will not be taken into account. To the extent payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Administration in any case in which the Fund has a legal liability to make payments for items or services constituting such assistance, payment for benefits under the Fund 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.

Under the Fund's non-assignment rule, a provider or other party does not obtain any legally enforceable rights against the Fund by virtue of having you sign a standard "Assignment of Benefits" form or similar document. Those legal rights remain solely with you.

Nevertheless, the Fund in its discretion may, as a courtesy to you, honor a written request by you to send on your behalf directly to a provider payment of benefits due to you. In this regard, the Fund may treat any assignment of benefits form executed by you as a request by you to the Fund to send payment on your behalf directly to a provider. By honoring any request by you to send payment on your behalf to a provider as a convenience, the Fund does not intend to create any legal rights in favor of the provider. The Fund makes such direct payments solely on the basis of the Fund's legal obligations owed to you as a participant.

Any oral or written representation made regarding coverage to any person or entity is made solely in the person or entity's capacity as a representative of a Covered Participant covered under the Fund inquiring on the Covered Participant's behalf concerning projected levels of Fund coverage. Any such representation provides no right to a person or entity independent of the rights of the Covered Participant under the terms of the Fund. It does not provide the person or entity with an independent right to recover from the Fund or its representatives under any state or federal law, including state contract and tort law. Any rights a person or entity might have against the Fund or its representatives are solely those which derive from the rights of a participant under the terms of the Fund. No references to coverage and levels of benefits are binding upon the Fund or its representatives unless they have been provided by the full Board of Trustees following a construction of the governing Fund documents. Any representation regarding coverage and benefit amounts may not be relied upon by any person or entity if it is any way contrary to the terms of governing written Fund documents. Entitlements to payment under the Fund may only be obtained through action of the Trustees administering the Fund, and these Trustee actions may only be appealed by a Covered Participant covered under the Fund pursuant to the Fund's appeal procedures and by a benefits claim cause of action brought in a court of competent jurisdiction under ERISA.

SECTION E-3: Suspension Of Benefits Due To Overpayment Of Benefits And Failure To Repay Fund Benefits

If a Covered Participant has been paid benefits under this Fund that are in excess of the benefits that should have been paid, or that should have been reimbursed to the Fund, the Fund may cause the deduction of the amount of such excess or improper payment (which includes amounts due to be reimbursed to the Fund on account of the subrogation or advance of benefits provisions of the Fund, plus any costs of collection—including all reasonable attorneys' fees and litigation costs incurred by the Fund to collect any benefits advanced or to protect the Fund's subrogation interest—and interest at the rate of six (6%) percent per annum, compounded monthly, on the amount of the reimbursement obligation, from the date of any recovery until the date of reimbursement) from any benefits payable to the Covered Participant, and/or any Dependent of the Covered Participant. In addition, the Fund, at its option, may recover such amount by any other legal method that the Fund shall determine. Further, the Fund may suspend the coverage of the Covered Participant and/or any Dependent of the Covered Participant for any benefit under the Fund until the Fund is fully reimbursed for such excess or improper payment.

If a Dependent has been paid benefits under this Fund that are in excess of the benefits that should have been paid, or that should have been reimbursed to the Fund, the Fund may cause the deduction of the amount of such excess or improper payment (which includes amounts due to be reimbursed to the Fund on account of the subrogation or advance of benefits provisions of the Fund, plus any costs of collection—including all reasonable attorneys' fees and litigation costs incurred by the Fund to collect any benefits advanced or to protect the Fund's subrogation interest—and interest at the rate of six (6%) percent per annum, compounded monthly, on the amount of the reimbursement obligation, from the date of any recovery until the date of reimbursement) from any benefits payable to the Dependent, the Dependent's parents, and any other Dependent of the parents. Further, the Fund may suspend the coverage of the Dependent, the Dependent's parents, and any other Dependents of the parents.

SECTION E-4: Coordination Of Benefits

(What happens when you have other coverage that provides a benefit or service that is also provided by this Fund?)

This Fund has been designed to help provide specific benefits to meet expenses of disease or injury to the extent that payment is not available from other sources. Benefits are not paid by this Fund to the extent that payment may be obtained by the Covered Participant from some other source such as another plan/fund, insurance, a legal claim, or an administrative claim. Benefits are not paid by this Fund to the extent that services or supplies may be furnished, paid for, or otherwise provided for under any law or government program.

1. BENEFITS SUBJECT TO THIS PROVISION

All benefits under this Fund except Disability and Death, Accidental Death, Dismemberment and Loss-of-Sight Benefits, shall be coordinated with those provided by other plans.

2. DEFINITIONS SPECIFIC TO COORDINATION OF BENEFITS

a. "Benefit Period" means the specified period of time during which charges for benefits must be incurred in order to be eligible for payment under the Fund. A charge for benefits shall be considered incurred on the date the service or supply was provided to the Participant.

b. "Other Contract" means any individual coverage or group arrangement providing health care benefits or services through:

i. individual, group, blanket or franchise insurance coverage, whether insured or self-insured, except that it shall not mean any blanket student accident coverage or hospital indemnity plan of one hundred ($100) dollars or less;

ii. Blue Cross, Blue Shield, group practice, individual practice, medical care components of long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, and other prepayment coverage;

iii. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

iv. coverage under any tax-supported or any government program to the extent permitted by law.

"Other Contract" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take benefits or services of Other Contracts into consideration in determining its benefits and that portion which does not.

c. "Covered Expenses," as used in this SECTION E-4: COORDINATION OF BENEFITS, means a service, expense, amount or supply specified in the Fund for which Benefits will be provided, including deductibles, co-insurance and co-payments, to the extent that such item is not covered completely under the Other Contract.

When Benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the Benefit.

You must file a claim for any benefits you are entitled to from any other source. Whether or not you file a claim with these other sources, the benefits payable by this Fund will be calculated as though you have received any benefits you are entitled to from the other source(s).

When benefits are reduced under the primary contract because a Participant does not comply with the provisions of the Other Contract, the amount of such reduction will not be considered an allowable expense under the Fund. Examples of such provisions are those related to second surgical opinions and preauthorization of admissions or services.

d. **"Dependent"** means, for any Other Contract, any person who qualifies as a Dependent under that contract.

3. EFFECT ON BENEFITS

a. This provision shall apply in determining the Benefits of the Fund for any Benefit Period if, for the Covered Expenses received during that period, the sum of the benefits payable under the Fund and the benefits payable under Other Contracts would exceed the Covered Expenses.

b. Except as provided in Paragraph c. below, the Benefits payable under the Fund for the Covered Expenses received during a Benefit Period will be reduced so that the sum of the reduced Benefits and the benefits payable for Covered Expenses under Other Contracts would not exceed the total of the Covered Expenses. Benefits payable under Other Contracts include the benefits that would have been payable had a claim been made.

c. If Another Contract contains a provision coordinating its benefit with those of the Fund and its rules require the benefits of the Fund to be determined first, and the rules set forth in Paragraph d. below require the benefits of the Fund to be determined first, then the benefits of the Other Contract will be ignored in determining the benefits under the Fund.

d. For the purpose of Paragraph c. above, the order of benefit determination rules are:

i. The benefits of a contract which covers the person as other than a Dependent shall be determined first;

ii. In the case of a Dependent child, the following rules apply:

(1) Dependent Child/Parents Not Separated or Divorced. Except as stated in Paragraph d. ii. (2) below, when the Fund and the Other Con-

tract cover the same child as a Dependent of different persons, called "parents":

(a) The benefits of the contract of the parent whose birthday falls earlier in a year are determined before those of the contract of the parent whose birthday falls later in that year; but

(b) If both parents have the same birthday, the benefits of the contract which covered the parent longer are determined before those of the contract which covered the other parent for a shorter period of time.

However, if the Other Contract does not have the rule described in Paragraph d. ii. (1) above, but instead has a rule based upon gender of the parent, and if, as a result, the contracts do not agree on the order of benefits, the rule in the Other Contract will determine the order of benefits.

(2) Dependent Child/Separated or Divorced Parents. If two (2) or more contracts cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) First, the contract of the parent with custody of the child;

(b) Then, the contract of the spouse of the parent with custody of the child; and

(c) Finally, the contract of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the contract of that parent has actual knowledge of those terms, the benefits of that contract are determined first. This Paragraph does not apply with respect to any Benefit Period during which any benefits are actually paid or provided before the Fund has that actual knowledge.

(3) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the contracts covering the child shall follow the order of benefit determination rules outlined in Paragraph d. ii. (1) above.

iii. When rules in Paragraphs d. i. and ii. above do not establish an order of benefit determination, the benefits of the contract which has covered the person for the longest period of time shall be determined first; provided that:

(1) the benefits of a contract covering the person on whose expense claim is based as a laid-off or retired employee or as the Dependent of such person shall be determined after the benefits of any Other Contract covering such person as an employee other than as a laid-off or retired employee or a Dependent of such person; and

(2) if either contract does not have a provision regarding laid-off or retired employees and, as a result, each contract determines its benefits after the other, then the provisions of Paragraph d. iii. (1) above shall not apply.

e. If another Contract does not contain provisions establishing the same order of benefit determination rules, the benefits under the Other Contract will be determined before the benefits under the Fund.

f. If there is a difference between the amount the primary plan allows and the amount allowable by this Fund, this Fund will coordinate its benefits using the higher amount. However, if the primary plan has a contract with the provider (HMOs and PPOs usually have such contracts with their providers), the combined payments of both plans will not be more than the primary plan's contract calls for. Exception: If both plans have a contract with the same provider, the allowable expense will be the higher of the two contracted or negotiated fees.

g. If a Covered Participant is covered under one or more other plans in addition to this Fund, this Fund will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Fund will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the Covered Participant failed to take the action required under the other plan's rules. This could occur in a case where the Covered Participant was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the Covered Participant failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.

4. FACILITY OF PAYMENT

Whenever payments should have been made under the Fund in accordance with this provision, but the payments have been made under any Other Contract, the Fund

has the right to pay to those organizations making the other payments any amounts it determines to be warranted to satisfy the intent of this provision. Amounts paid shall be deemed to be benefits paid under the Fund and the Fund shall be fully discharged from liability under the Fund.

5. RIGHT OF RECOVERY

a. Whenever payments have been made by the Fund for benefits in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Fund shall have the right to recover the excess from among the following, as the Fund shall determine: any person to or for whom such payments were made, any insurance company, or any other organizations.

b. The Participant, personally and on behalf of his or her Dependents, shall, upon request, execute and deliver such documents as may be required to secure the Fund's rights to recover the excess payments.

6. COORDINATION OF BENEFITS WITH MEDICARE

A. ACTIVE EMPLOYEES AND SPOUSES AGE 65 AND OLDER AND RETIREES

If a Participant is age sixty-five (65) or older, or the spouse of a Participant is age sixty-five (65) or older and is entitled to benefits under Medicare and has satisfied the Fund's eligibility rules for Retiree coverage, the following rules apply:

i. The Fund will be primary for any person age 65 or older who is an Active Employee (defined as a person who qualifies as "working aged" under applicable Medicare statutes) or the spouse of an Active Employee of any age.

ii. A Participant may decline coverage under the Fund and elect Medicare as the primary form of coverage. If the Participant elects Medicare as the primary form of coverage, the Fund, by law, cannot pay benefits secondary to Medicare for Medicare-covered Participants. However, the Participant will continue to be covered by the Fund as primary unless he/she: (a) notifies the Fund, in writing, that he/she does not want Benefits under the Fund; or (b) otherwise ceases to be eligible for coverage under the Fund.

B. DISABILITY

If a Participant is under age 65 and becomes disabled and entitled to benefits under Medicare due to such disability, then Medicare shall be primary for the Participant. The Fund will then be the secondary form of coverage.

If a Dependent is under age 65 and becomes disabled and entitled to benefits under Medicare due to such disability (other than ESRD as discussed below) the Fund will be primary for the Dependent and Medicare will be the secondary form of coverage.

C. END STAGE RENAL DISEASE (ESRD)

The Fund will remain primary for the first 30 months of a Participant's entitlement to Medicare due to End Stage Renal Disease (as defined under applicable Medicare statutes). However, if the Fund is currently paying benefits as secondary to Medicare for a Participant, the Fund will remain secondary upon a Participant's entitlement to Medicare due to ESRD.

7. COORDINATION OF BENEFITS WITH COBRA COVERAGE

If a Participant's coverage is provided pursuant to COBRA and the Participant also has another contract covering the Participant, even as a Dependent, then the other contract shall be primary. The Benefits of the Fund will then be the secondary form of coverage.

8. COORDINATION OF BENEFITS WITH SUB-PLANS

If this Fund is secondary on a Covered Participant's claim under the Fund's order of benefit determination rules stated above, but the Covered Participant's primary plan has a rule allowing it to pay less than its normal benefits when there is secondary coverage, without regard to whether the lesser benefits are payable under the terms of sub-plan or wrap-around provision, then such Covered Participant will be deemed covered under this Fund's sub-plan. The maximum payable by this Fund for all claims incurred by a Covered Participant covered under the sub-plan is $1,000 per calendar year, or, if less, the amount payable after application of this Fund's coordination of benefits rules.

If the primary plan has a no-loss provision, and if the sum of the primary plan's sub-plan benefits plus this Fund's sub-plan benefits plus any additional benefits payable by the primary plan's regular benefit plan under its no-loss provision, is less than the sum of the benefits otherwise payable under this Fund's regular benefit plan, then this Fund's regular benefit plan will pay the difference.

If the primary plan lacks a no-loss provision or if the primary plan refuses to apply its no-loss provision after this Fund's secondary sub-plan benefits are paid, and if the sum of the primary plan's sub-plan benefits and this Fund's secondary sub-plan benefits is less than the sum of the benefits otherwise payable under this Fund's regular benefit plan, then this Fund's sub-plan may, if the Trustees in their sole discretion choose to do so and notwithstanding the otherwise applicable benefit limit under this Fund's sub-plan, advance an amount not in excess of the difference between the sum of the benefits previously paid under the primary plan's sub-plan and this Fund's sub-plan and the benefits otherwise payable under this Fund's regular benefit plan. In order for such an

advance to be made, the Covered Participant must sign any documents the Trustees in their sole discretion deem necessary, including a subrogation or reimbursement agreement, an assignment of benefits or any other document necessary to effectuate recovery of the amount of the advance from the primary plan or any other source of payment, and agree to fully cooperate in obtaining such recovery. Any amount recovered for the claim from the primary plan or any other source of payment shall be forwarded to this Fund and offset against the amount of the advance.

If the primary plan pays its normal benefits for the Covered Participant's claim—that is, the benefits it would have paid if the Covered Participant was not also covered under this Fund—then the Covered Participant will be deemed covered under this Fund's regular benefit plan, and this Fund will coordinate its regular benefits as the secondary payer to the other plan.

SECTION E-5: Fund's Right To Reduction, Reimbursement And Subrogation

When the Fund pays for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to a Covered Participant (which, for purposes of this Section, shall also mean the Covered Participant's guardian or estate) by reason of their eligibility for Benefits under the Fund, the Covered Participant agrees to the following:

1. The Covered Participant will fully reimburse the Fund out of the Covered Participant's recovery—whether by suit, judgment, settlement, compromise, payment made or to be made, relating to the injury or condition or otherwise—for all Benefits paid by the Fund, without deduction for attorneys' fees or costs.

2. The Fund has first priority with respect to its right of reduction (see SECTION E-3: SUSPENSION OF BENEFITS DUE TO OVERPAYMENT OF BENEFITS AND FAILURE TO REPAY FUND BENEFITS), reimbursement and subrogation, and shall not be subject to the make-whole rule or doctrine.

3. The Fund does not pay for, nor is it responsible for, the Covered Participant's attorneys' fees or costs. Attorneys' fees and costs are to be paid solely by the Covered Participant.

4. The Fund is not subject to any state laws, including the common fund doctrine, which purport to require the Fund to reduce its recovery by any portion of a Covered Participant's attorneys' fees and costs.

5. The Fund will be reimbursed prior to the Covered Participant's receiving any payments resulting from a judgment, settlement or other payment or payments made or to be made by any person or persons considered responsible for the condition

giving rise to payments of Benefits or by their insurers or insurance, regardless of whether the payment is designated as a payment for such damages, including but not limited to pain and/or suffering, loss of income, medical benefits, or any other specified damages, or damages made or to be made by any person.

6. This Fund's reimbursement rights include, but are not necessarily limited to, a right of recovery under no-fault, personal injury protection, MedPay, financial responsibility, uninsured motorist, underinsured motorist coverage, or medical reimbursement insurances, specific risk insurance, "school" or "team" insurance, workers' compensation, and third-party liability.

7. The Fund's right of first priority shall not be reduced due to a Covered Participant's own negligence.

8. If the Covered Participant fails to reimburse the Fund in accordance with the provision for any advanced benefits, the Fund may exercise its rights of reduction under SECTION E-3: SUSPENSION OF BENEFITS DUE TO OVERPAYMENT OF BENEFITS AND FAILURE TO REPAY FUND BENEFITS.

9. In addition to the right of reduction, under SECTION E-3: SUSPENSION OF BENEFITS DUE TO OVERPAYMENT OF BENEFITS AND FAILURE TO REPAY FUND BENEFITS, if the Covered Participant fails to reimburse the Fund in accordance with the provision for any advanced Benefits and it becomes necessary for the Fund to take legal action against the Covered Participant, the Covered Participant will be liable to the Fund for all of the Fund's costs of collection, including all reasonable attorney's fees and litigation costs incurred by the Fund, plus interest at the rate of six (6%) percent per annum, compounded monthly, on the amount of the reimbursement obligation, from the date of recovery until the date of reimbursement.

10. The Fund will be subrogated to all claims, demands, actions and rights of recovery against any entity, including but not limited to third parties and insurance companies and carriers, to the fullest extent permitted by law. The amount of such subrogation will equal the total amount paid under the Fund arising out of the injury or illness for which the Covered Participant has, may have, or asserts a cause of action. In addition, the Fund will be subrogated for attorneys' fees incurred in enforcing its subrogation rights hereunder.

11. Covered Participants and their representatives shall be required to cooperate with the Fund in order to guarantee reimbursement to the Fund. In such cases, the Covered Participant is obligated to provide the Fund with whatever information, assistance and records the Fund may require to enforce the rights in this provision. Failure to do so will entitle the Fund to withhold benefits due to a Covered Participant or the Covered Participant's Dependents under the Fund.

12. Covered Participants and their representatives shall aid the Fund in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, Covered Participants and their representatives must, at the Fund's request and at its discretion, take any action, give information, and any sign documents so required by the Fund. Failure to do so will entitle the Fund to withhold benefits due to a Covered Participant or the Covered Participant's Dependents under the Fund.

13. The Fund may take legal action as it sees fit against the third party or the Covered Participant to recover the benefits the Fund has paid. The Fund's exercise of this right will not affect the Covered Participant's right to other forms of recovery, unless the Covered Participant's legal representative consents otherwise.

14. The Fund has no duty or obligation to pay a fee to the Covered Participant's attorney for services in making any recovery on behalf of the Covered Participant. The Covered Participant is obligated to inform his or her attorney of the subrogation lien, and to make no distributions from any settlement or judgment which will in any way result in the Fund receiving less than the full amount of its lien without the written approval of the Fund. Furthermore, the Covered Participant shall take no action which prejudices the Fund's subrogation right.

15. The Covered Participant shall be required to pay their own legal fees and costs and to hire only attorneys who agree to waive the common fund doctrine and to remit the gross rather than the net proceeds from litigation. The Fund shall have a lien, enforceable as a provision of this Fund, either before or after an adjudication of liens, for the full amount of benefits paid by the Fund. In the event a court awards the Fund less than the full amount of benefits, through an "adjudication of liens" or otherwise, the specific proceeds received by the participant or dependent shall be subject to a "constructive trust'' or "equitable lien" in favor of the Fund in the amount of the difference between the full amount of benefits paid by the Fund and the amount paid the Fund pursuant to the court's award and this Fund provision establishing a "constructive trust" or "equitable lien" may be enforced through any available equitable remedy to ensure that the proceeds subject to the "constructive trust'' or "equitable lien" are turned over to the Fund.

16. The Fund's right of reduction, reimbursement and subrogation is based on the Fund language and provisions in effect at the time of judgment, payment or settlement.

SECTION E-6: Advance Of Benefits

As set forth in the Benefit Exclusion provisions throughout this Summary Plan Description, the Fund does not provide payment in certain situations in which you have a right to recover, from another source, payment for the injury or condition. In such cases, however, there may be delays in your recovering the payment from the other source

because of the time it takes to process the claim or prosecute the lawsuit. If this happens, the Fund, in the sole and exclusive discretion of the Board of Trustees, may be able to help you by temporarily advancing benefits, even though such benefits would otherwise be excluded by the Benefit Exclusion provisions of the Fund.

If this is done, the Fund may require you to sign a legal document stating that the Fund will be reimbursed in full from any recovery you obtain. Regardless of whether you sign such a document, the Fund must be repaid from any recovery—whether by suit, judgment, settlement, compromise, payment made or to be made, relating to the injury or condition or otherwise—for all benefits paid by the Fund, without deduction for attorneys' fees or costs. The Fund does not pay for, nor is it responsible for, the Covered Participant's attorneys' fees or costs. Attorneys' fees and costs are to be paid solely by the Covered Participant. The Fund will be reimbursed prior to the Covered Participant's, or the Covered Participant's guardian or estate, receiving any payments resulting from a judgment, settlement or other payment or payments made or to be made by any person or persons considered responsible for the condition giving rise to payments of benefits or by their insurers or insurance, regardless of whether the payment is designated as a payment for such damages, including but not limited to pain and/or suffering, loss of income, medical benefits, or any other specified damages, or damages made or to be made by any person. The Fund may also require you to assign to the Fund your rights to recovery against the third party to the extent of the benefit advancement, and may require any attorney representing you to provide the Fund with legal assurances that the Fund's right to reimbursement of the advanced benefits will be honored. In addition, the Fund may require you to provide information to the Fund concerning your claims against or any recovery from the third party.

If you fail to reimburse the Fund in accordance with the provision for any advanced benefits and it becomes necessary for the Fund to take legal action against you, you will be liable to the Fund for all of the Fund's costs of collection, including all reasonable attorney's fees and litigation costs incurred by the Fund, plus interest at the rate of six (6%) percent per annum, compounded monthly, on the amount of the reimbursement obligation, from the date of recovery until the date of reimbursement.

PART F: BENEFIT AND COVERAGE EXCLUSIONS

SECTION F-1: General Exclusions From Coverage

Except with respect to the Benefits offered by the Fund as specifically identified in PART J through PART Q of this Summary Plan Description, you will not be provided Benefits, services, supplies or charges:

1. For injuries or conditions caused by the negligent or intentional acts of another party, except where the injury or condition is caused by an act of domestic violence.

2. For injuries or conditions for which the costs of treatment or losses concerning such injuries or conditions are recoverable through legal action or a claim settlement from another party or insurance company, except where the injury or condition is caused by an act of domestic violence. This exclusion applies whether or not the Eligible Participant makes claims for the Benefits, services, supplies or charges or compensation, and whether or not the Eligible Participant recovers losses from another party or insurance company.

3. For injuries or conditions that arise out of or in the course of any work performed in any employment or self-employment or any for-profit business or venture. This exclusion applies whether or not there is a claim for the Benefits, services, supplies or charges or compensation, and whether or not there is a recovery.

4. For injuries or conditions which are due to participation in or commission of a felony or misdemeanor.

5. For injuries or conditions caused by or related to participation in any athletic contest or demonstration, or any other type of race or contest (such as a vehicular race) that is professional or involves prizes totaling more than $50.00 in value.

6. Which are not Medically Necessary as determined by the Fund.

7. Which are not prescribed by or performed by or upon the direction of a Provider.

8. Which are not billed by and either performed by or under the supervision of a Provider.

9. Rendered by other than a Provider.

10. Rendered by a Provider who is a member of the Eligible Participant's immediate family or other relative for which, in the absence of the eligibility of the Eligible Participant under the Fund, no charge would be made.

11. Which are Experimental/Investigational in nature, as determined by the Fund, except routine costs associated with Approved Clinical Trials that have been preauthorized by the Fund.

12. Incurred prior to the Eligible Participant's effective date of eligibility under the Fund.

13. Incurred after the date of termination of the Eligible Participant's eligibility under the Fund.

14. For any illness or injury suffered after the Eligible Participant's eligibility under the Fund which resulted from an act of war, whether declared or undeclared.

15. For the cost of Benefits, services, supplies or charges received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law.

16. Which are received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

17. For the cost of Benefits, services, supplies or charges resulting from injuries or conditions arising out of a motor vehicle accident, to the extent such Benefits, services, supplies or charges are payable under any medical expense payment provision (by whatever terminology used, including such Benefits, services, supplies or charges mandated by law) of any motor vehicle insurance policy.

18. For items or services paid for by Medicare when Medicare is primary consistent with the Medicare secondary payor laws. This exclusion shall not apply when the Fund is obligated by law to offer the Eligible Participant the Benefits, services, supplies or charges as primary and the Eligible Participant so elects this Fund as primary.

19. For care of conditions that federal, state or local law requires to be treated in a public facility.

20. For court-ordered services, supplies or charges when not Medically Necessary and/or not a covered Benefit.

21. For any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services, supplies or charges are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law.

22. For telephone and electronic consultations between a Provider and an Eligible Participant.

23. For charges for failure to keep a scheduled appointment with a Provider, for completion of a claim or insurance form, or for an Eligible Participant's decision to cancel a Surgery.

24. For services performed by a Provider enrolled in an education or training program when such services are related to the education or training program, including services performed by a resident Physician under the supervision of a Provider.

25. Which are Cost-Sharing Amounts required of the Eligible Participant.

26. For which an Eligible Participant would have no legal obligation to pay.

27. For services received by an Eligible Participant in a country with which United States law prohibits transactions.

28. For Inpatient admissions which are primarily for diagnostic studies or for Inpatient services which could have been safely performed on an Outpatient basis.

29. For prophylactic blood or bone marrow storage in the event of an accident or unforeseen Surgery or transplant.

30. For Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures, convalescent care, or respite care not related to Hospice services.

31. For services related to organ donation where the Eligible Participant serves as an organ donor to an individual who is not an Eligible Participant.

32. For transplant services where human organs were sold rather than donated and for artificial organs.

33. For anesthesia when administered by the operating Physician, the assistant to the operating Physician or the attending Physician.

34. For cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the bodily part can be expected, except as otherwise required by law. This exclusion does not apply to cosmetic procedures or services related to cosmetic procedures performed to correct a deformity resulting from birth defect or accidental injury. For purposes of this exclusion, prior Surgery is not considered an accidental injury.

35. For services directly related to the care, filling, removal of teeth not needing cutting of bone (except the surgical removal of teeth that will not erupt through the gum, teeth partially or completely impacted in the bone of the jaw, and teeth that cannot

be removed without cutting into the bone), replacement of teeth, orthodontic care, treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, or for dental implants.

36. For all dental services rendered after stabilization of an Eligible Participant in an emergency following an accidental injury, including but not limited to oral Surgery for replacement teeth, oral prosthetic devices, bridges or orthodontics.

37. For maintenance therapy services.

38. For physical medicine for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities.

39. For speech therapy for the following conditions: psychological speech delay, behavior problems, mental retardation (except when disorders such as aphasia or dysarthria are present), developmental delay, stuttering and stammering, pervasive developmental disorder, attention deficit disorder/attention deficit hyperactivity disorder, and conceptual handicap.

40. For all rehabilitative therapy, including but not limited to play, music and recreational therapy.

41. For sports medicine treatment intended to primarily enhance athletic performance.

42. For travel expenses incurred in conjunction with Benefits.

43. For durable medical equipment requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home.

44. For replacement of lost or stolen durable medical equipment items within the expected useful life of the originally purchased durable medical equipment, or for continued repair of durable medical equipment after its useful life is exhausted.

45. For supportive environmental materials and equipment such as handrails, ramps, telephones and similar service appliances and devices.

46. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, diapers, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a Provider.

47. For enteral formulas administered orally and provided due to the inability to take adequate calories by regular diet, unless the enteral formula is the sole source of nutrition and except as mandated by law.

48. For blenderized baby food, regular shelf food, or special infant formula, except as specified in this Summary Plan Description.

49. For immunizations required for travel or employment.

50. For routine examination, testing, immunization, treatment and preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to pre-marital examinations, physicals for college, camp, sports or travel.

51. For treatment of temporomandibular joint syndrome (TMJ) by any and all means including, but not limited to, Surgery, intra-oral devices, splints, physical medicine, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ and except for treatment of TMJ caused by documented organic disease or physical trauma resulting from an accident.

52. For eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses and supplies, including but not limited to, refractive lenses prescribed for use with an intra-ocular lens transplant.

53. For vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients), and refraction regardless of whether it results in the prescription of glasses or contact lenses.

54. For corneal Surgery and other procedures to correct refractive errors.

55. For Infertility services if the present condition of Infertility is due, in part or in its entirety, to either party having undergone a voluntary sterilization procedure and/or an unsuccessful reversal of a voluntary sterilization procedure.

56. For donor services related to assisted fertilization.

57. For any treatment or procedure leading to or in connection with assisted fertilization such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and artificial insemination..

58. For the contraceptive therapeutic class of prescription drugs, products, or devices, including any services related to the fitting, insertion, implantation and removal of such devices. This exclusion applies even if such prescription drugs are Medically Necessary to treat an illness or medical condition unrelated to contraception as long as

there are other drugs which can be used to treat the non-contraceptive condition besides the contraceptive drug.

59. For routine foot care including, but not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone), trimming of nails (except Surgery for ingrown nails), treatment of corns, calluses and keratosis, treatment of bunions (except capsular or bone Surgery), and treatment and debridement of mycotic nails not resulting in functional impairment.

60. For supportive devices of the feet, unless otherwise mandated by law and when not an integral part of a leg brace. Supportive devices of the feet include foot supports, heel supports, shoe inserts, and all foot orthotics, whether custom fabricated or sold as-is.

61. For treatment, medicines, devices or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury.

62. For all prescription and over-the-counter drugs dispensed by a pharmacy or Provider for the Outpatient use of an Eligible Participant, whether or not billed by a Facility Provider, except for allergy serums and mandated pharmacological agents used for controlling blood sugar.

63. For all prescription and over-the-counter drugs dispensed by a Home Health Care Agency Provider, with the exception of intravenous drugs administered under a treatment plan approved by the Fund.

64. For treatment of obesity and/or morbid obesity, except for surgical treatment of morbid obesity.

65. For Inpatient stays to bring about non-surgical weight reduction.

66. For biofeedback.

67. For acupuncture.

68. For circumcisions, unless Medically Necessary.

69. For membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs or replacement of devices, equipment or parts without charge or at a reduced charge.

70. For any services related to or rendered in connection with a non-covered service, including but not limited to anesthesia, diagnostic services, etc.

71. For Inpatient admissions which are primarily for physical/occupational therapy.

72. Which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient.

73. For routine or periodic physical examinations unless specifically provided for under the Fund.

74. For well-baby care, unless specifically provided for under the Fund.

75. For screening examinations, unless specifically provided for under the Fund.

76. For immunizations, preventive care services, wellness services or programs, except as set forth in this Summary Plan Description.

77. Which are not covered by Medicare and not specifically referenced in this Summary Plan Description.

78. For the cost of benefits, services, supplies or charges where an Eligible Participant has a physical or medical complication in junction with, or as a result of, a procedure or service which is not covered by the Fund.

79. For the cost of benefits, services, supplies or charges associated with the insertion, fitting or removal of an implanted device when such device is not covered by the Fund.

80. For services, supplies or charges incurred Outside of the U.S., except as otherwise provided in this Summary Plan Description.

81. For any other service or treatment except as provided in this Summary Plan Description.

PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES

SECTION G-1: DEFINITIONS SPECIFIC TO BENEFIT CLAIMS ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES

The following terms shall have the meaning ascribed to them when used in this Part:

1. "Adverse Benefit Determination" means any determination of a Benefit Claim, either at the initial stage and/or on appeal, that results, in whole or in part, in the denial, reduction or termination of a service, or that fails to provide or pay for a claimed benefit, in whole or in part; including determinations based upon the medical necessity or experimental nature of procedures, refusal to certify an inpatient hospital admission/confinement, failure to comply with the Fund's pre-certification procedures, or rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time). A determination made by the Fund's Contract Administrator, not in the context of a Benefit Claim, that an Employee is not a Covered Participant under the Fund or that a Covered Participant is no longer an Eligible Participant under the Fund is not an Adverse Benefit Determination. (Note: Casual inquiries made to the Fund about Fund provisions unrelated to any specific Benefit Claim are not considered to be Benefit Claims for purposes of the Fund's Benefits Claim Reviews and Appeals Procedures (hereinafter "Procedures").)

2. "Adverse Eligibility Determination" means any determination that results in a denial of eligibility or termination of eligibility under the Fund.

3. "Authorized Representative" means an individual, including an attorney so designated, who you designate to act on your behalf in the pursuing of a Benefit Claim or an appeal of an Adverse Benefit Determination, and for whom you have—except as otherwise provided in the case of Urgent Care Benefit Claims—filed a Designation of Authorized Representative form with the Initial Benefit Claim Reviewer. An assignment for purposes of payment does not constitute appointment of an Authorized Representative under these Procedures. Once an Authorized Representative is appointed, the Fund shall direct all information, notifications, etc., regarding the Benefit Claim to the Authorized Representative. You will be copied on all notifications regarding decisions unless you provide specific written direction otherwise. Any reference in these Procedures to "you" is intended to include your Authorized Representative appointed in compliance with these Procedures.

4. "Benefit Claim" means a claim for Fund Benefits, including a request for certification of an inpatient hospital admission/confinement, that is filed pursuant to the provisions of this Part G. A communication regarding Benefits that is not made in ac-

cordance with these Procedures will not be treated as a Benefit Claim under these Procedures.

5. "Concurrent Care Benefit Claim" or **"Concurrent Care Decision"** means if the Fund has previously approved an ongoing course of treatment of Health Care Benefits to be provided over a period of time or for a set number of treatments, either of the following shall be considered a "Concurrent Care Benefit Claim" or "Concurrent Care Decision": (i) a decision by the Fund to reduce or terminate such previously approved course of treatment (other than by Fund amendment or a termination of the Fund) before the end of the approved period of time or course of treatment; or (ii) a determination on a request by a Covered Participant to extend the approved course of treatment that relates to an Urgent Care Benefit Claim.

6. "External Review" means a review of a final Internal Appeal Adverse Benefit Determination conducted pursuant to this Part G.

7. "Health Care Benefits" means Medical, Prescription Drug, Dental and Vision Benefits.

8. "Improper Benefit Claim" means a Benefit Claim that does not follow the Fund's Procedures for filing a Benefit Claim.

9. "Incomplete Benefit Claim" means a Benefit Claim that is missing information necessary for a determination to be made, including determinations of eligibility or medical necessity.

10. "Independent Review Organization (IRO)" means an entity that the Fund has contracted with to perform external Benefit Claim reviews.

11. "Internal Appeal" means a review of a final Internal Appeal Adverse Benefit Determination by the Fund's Board of Trustees.

12. "Initial Benefit Claim Reviewer" means the entity that the Fund has empowered to initially review and process the Benefit Claim. Who makes the initial determination depends on the type of benefit involved.

For benefits provided under the Fund's Health Care Benefits, the Contract Administrator is the Fund's Initial Benefit Claim Reviewer. For certification of inpatient hospital admissions/confinements, refer to your Fund Identification Card for the Fund's Initial Benefit Claim Reviewers. For Prescription Drug Benefits, BeneCard PBF is the Fund's Initial Benefit Claim Reviewer. For Dental Benefits, Delta Dental of Pennsylvania is the Fund's Initial Benefit Claim Reviewer. For Vision Care Benefits, National Vision Administrators, Inc., is the Fund's Initial Benefit Claim Reviewer.

13. "Initial Notice of Adverse Benefit Determination" means notification, except with Urgent Care Benefit Claims, when the notification may be orally followed by written notification within three days of the oral notification of an Adverse Benefit Determination. The Initial Benefit Claims Reviewer shall provide you with written notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by you:

a. Information sufficient to identify the Benefit Claim, including the date of service, the health care provider, the Benefit Claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

b. The specific reason or reasons for the Adverse Benefit Determination.

c. Reference to the specific Fund provisions on which the Determination was based.

d. A description of any additional material or information necessary for you to perfect the Benefit Claim, and an explanation of why such material or information is necessary.

e. A description of the Fund's Internal Appeal Procedures and the time limits applicable to such Procedures.

f. A statement that you are entitled to review your Benefit Claim file and receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Benefit Claim.

g. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided to you free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination, and that a copy will be provided to you free of charge upon request.

h. If the Adverse Benefit Determination is based upon the Medically Necessary and Appropriate, Experimental/Investigational Treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances, will be provided. If this is not practical, a statement will be included that such an explanation will be provided free of charge, upon request.

14. "Notice of Internal Appeal Adverse Benefit Determination" means that the Board of Trustees shall provide you with written notification of their determination which shall state, in a manner calculated to be understood by you:

a. Information sufficient to identify the Benefit Claim, including the date of service, the health care provider, the Benefit Claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

b. The specific reason or reasons for the Internal Appeal Adverse Benefit Determination.

c. References to the specific Fund provisions on which the Internal Appeal Adverse Benefit Determination is based.

d. A list of all documents and statements that were reviewed to make the final Internal Appeal Adverse Benefit Determination.

e. A statement that you are entitled to review your Benefit Claim file and receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Benefit Claim.

f. A description of the Fund's External Review Procedures and the time limits applicable to such Procedures.

g. A statement of your right to bring a civil action under Section 502 of ERISA following an External Review, and the time period in which you must bring such an action.

h. Any internal rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination, or a statement that a copy of this information will be provided to you free of charge upon request.

i. If the Adverse Benefit Determination is based upon the Medically Necessary and Appropriate, Experimental/Investigational Treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to your medical circumstances, will be provided. If this is not practical, a statement will be included that such an explanation will be provided free of charge, upon request.

15. "Notice of External Review Decision" means that the Independent Review Organization shall provide you with written notification of its determination, which shall state, in a manner, calculated to be understood by you:

a. A general description of the reason for the External Review request, including information sufficient to identify the Benefit Claim; this information includes the date(s) of service, the provider, Benefit Claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings), and the reason for the prior denial.

b. The date the Independent Review Organization received the assignment to conduct the External Review, and the date of the Independent Review Organization's decision.

c. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards.

d. A discussion of the principal reason(s) for the Independent Review Organization's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision.

e. A statement that the Independent Review Organization's determination is binding.

f. A statement that judicial review may be available to you.

g. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

16. "Initial Notice of Adverse Eligibility Determination" means the Contract Administrator shall provide you with written notification of any Adverse Eligibility Determination. The notice will state, in a manner calculated to be understood by you:

a. The specific reason or reasons for the Adverse Eligibility Determination.

b. Reference to the specific Fund provisions on which the Determination was based.

c. A description of any additional material or information necessary for you to establish your eligibility, and an explanation of why such material or information is necessary.

d. A description of the Fund's review Procedures and the time limits applicable to such Procedures.

e. A statement that you are entitled to review your claim file and receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the determination.

17. "Notice of Adverse Eligibility Determination on Appeal" means that the Board of Trustees shall provide you with written notification of their determination which shall state, in a manner calculated to be understood by you:

a. The specific reason or reasons for the Adverse Eligibility Determination.

b. References to the specific Fund provisions on which the Adverse Eligibility Determination is based.

c. A statement that you are entitled to review your claim file and receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the determination.

d. A statement of your right to bring an action under ERISA and the time period in which you must bring such an action.

18. "**Post-Service Benefit Claim**" means any Benefit Claim for Health Care Benefits that is neither an Urgent Care Benefit Claim nor a Pre-Service Benefit Claim.

19. "**Pre-Service Benefit Claim**" means any Benefit Claim for Health Care Benefits under the Fund for which the terms of the Fund require approval prior to obtaining care, in whole or in part, even if the approval does not guarantee that the Fund will ultimately provide the benefit to you. A request for prior approval of a benefit is not a Pre-Service Benefit Claim unless the prior approval is actually required by the Fund as a condition of receiving the benefit.

20. "**Urgent Care Benefit Claim**" means a Benefit Claim for Medical Care or treatment, to be determined by the Initial Benefit Claim Reviewer, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, for which there is such an urgent need that applying the Fund's usual time periods for making non-urgent care determinations: (i) could seriously jeopardize the life or health of you or the ability of you to regain maximum function, or (ii) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Benefit Claim. If a Physician with knowledge of your medical condition determines that the Benefit Claim is an Urgent Care Benefit Claim, the Fund shall treat it as an Urgent Care Benefit Claim for the purposes of the Benefits Claim Review and Appeals Procedures.

SECTION G-2: HEALTH CARE BENEFIT CLAIMS AND REVIEW PROCEDURES

The Benefits Claim Reviews and Appeals Procedures set forth in this Section G-2 only relate to the submission of Health Care Benefit Claims. Determinations relating solely to eligibility are governed by Section G-7.

1. CLAIMS PROCEDURES FOR HEALTH CARE BENEFITS

a. HOSPITAL, MEDICAL AND SURGICAL BENEFITS

You should refer to Part J of this Summary Plan Description for the specific rules concerning the Hospital, Medical and Surgical Benefits Claims Procedures.

b. PRE-CERTIFICATION FOR INPATIENT HOSPITAL ADMISSION/CONFINEMENT BENEFITS

You should refer to Part J of this Summary Plan Description for the specific rules concerning Pre-Certification Benefits Claims Procedures.

c. PRESCRIPTION DRUG BENEFITS

You should refer to Part L of this Summary Plan Description for the specific rules concerning the Prescription Drug Benefits Claims Procedures.

d. DENTAL BENEFITS

You should refer to Part M of this Summary Plan Description for the specific rules concerning the Dental Benefits Claims Procedures.

e. VISION BENEFITS

You should refer to Part N of this Summary Plan Description for the specific rules concerning the Vision Benefits Claims Procedures.

2. REVIEW PROCEDURES FOR HEALTH CARE BENEFIT CLAIMS

a. URGENT CARE BENEFIT CLAIMS

I. TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIM

The Initial Benefit Claim Reviewer will make an initial determination as soon as possible, taking into account the medical exigencies, but not later than 24 hours after of receipt of the Benefit Claim. Should you believe that the medical exigencies require an initial determination in less than 24 hours, you must submit information to demonstrate

that medical exigencies exist that give rise to the need for an expedited processing of the Benefit Claim.

If you file an Improper and/or Incomplete Benefit Claim, the Initial Benefit Claim Reviewer will notify you as soon as possible, but not later than 24 hours after receipt of the Benefit Claim, and advise you of the proper Procedures to be followed or the information required in order to process the Benefit Claim. Notification may be oral, unless you have requested written notification. The 24-hour deadline does not apply if the Benefit Claim fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Fund.

You must submit the additional information requested by the Initial Benefit Claim Reviewer within a reasonable amount of time (no less than 48 hours).

II. NOTIFICATION OF INITIAL BENEFIT DECISION

The Initial Benefit Claim Reviewer shall make a determination and shall notify you orally, unless written notification is requested, as soon as possible, but in no case later than 48 hours after the earlier of (i) the receipt of the specified information, or (ii) the end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time. If oral notification is provided, written confirmation shall be furnished to you not later than 3 days after the oral notification.

b. PRE-SERVICE BENEFIT CLAIMS

I. TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIM

The Initial Benefit Claim Reviewer will make an initial determination within 15 days of receipt of the Benefit Claim form.

The Initial Benefit Claim Reviewer may extend the period for the initial determination for an additional 15 days, provided you are notified of the extension within the 15-day period; the extension is required for reasons beyond the Initial Benefit Claim Reviewer's control; and you are advised of the unresolved issues that prevent any decision and the additional information needed to resolve those issues.

If any extension is necessary because you have submitted an Improper and/or Incomplete Benefit Claim to the Initial Benefit Claim Reviewer, the period for making an initial determination will be suspended from the date that the request for additional information is sent to you until the earlier of: (a) the date that you respond to the Initial Benefit Claim Reviewer, without regard to whether your response supplies all of the information necessary to decide the Benefit Claim; or (b) 45 days from the date of the request.

If you file an Improper and/or Incomplete Benefit Claim, the Initial Benefit Claim Reviewer will notify you within 5 days of the receipt of the Benefit Claim and advise you of the proper Procedures to be followed or the information required in order to process the Benefit Claim. Notification may be oral, unless written notification is requested by you.

You must submit the additional information requested by the Initial Benefit Claim Reviewer within 45 days.

II. NOTIFICATION OF INITIAL BENEFIT DECISION

If the Benefit Claim is denied in whole or in part, the Initial Benefit Claim Reviewer will provide to you a written notice of the Adverse Benefit Determination.

c. CONCURRENT CARE BENEFIT CLAIMS

I. TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIM

Should the Initial Benefit Claim Reviewer determine that it is appropriate to reduce or terminate a course of treatment before the end of such course of treatment, the Initial Benefit Claim Reviewer shall notify you by the time sufficiently in advance of the reduction or termination to allow you to appeal the Adverse Benefit Determination and to obtain a determination on appeal from the Board of Trustees.

II. NOTIFICATION OF INITIAL BENEFIT DECISION

Any Benefit Claim by you to extend the course of treatment beyond the period of time or number of treatments that has been previously approved that involves an Urgent Care Benefit Claim will be decided within 24 hours after receipt of the Benefit Claim, provided that the Benefit Claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Benefit Claim to extend the course of treatment involves other than an Urgent Care Benefit Claim you must follow the Pre-Service Benefit Claims Procedure.

d. POST-SERVICE BENEFIT CLAIMS

I. TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIM

The Initial Benefit Claim Reviewer will make an initial determination within 30 days of receipt of the disability Benefits Claim form.

The Initial Benefit Claim Reviewer may extend the period for the initial determination for an additional 15 days, provided you are notified of the extension within the 30-day period; the extension is required for reasons beyond the Initial Benefit Claim Re-

viewer's control; and you are advised of the unresolved issues that prevent any decision and the additional information needed to resolve those issues.

If an extension is necessary because you have submitted an Improper and/or Incomplete Benefit Claim to the Initial Benefit Claim Reviewer, the period for making an initial determination will be suspended from the date that the request for additional information is sent to you until the earlier of: (a) the date that you respond to the Initial Benefit Claim Reviewer, without regard to whether your response supplies all of the information necessary to decide the Benefit Claim; or (b) forty-five (45) days from the date of the request.

You must submit the additional information requested by the Initial Benefit Claim Reviewer within 45 days.

II. NOTIFICATION OF INITIAL BENEFIT DECISION

If the Benefit Claim is denied in whole or in part, the Initial Benefit Claim Reviewer will provide to you a written notice of the Adverse Benefit Determination.

SECTION G-3: DISABILITY (ACCIDENT AND SICKNESS), DEATH, AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS-OF-SIGHT BENEFIT CLAIMS AND REVIEW PROCEDURES

1. CLAIMS PROCEDURES FOR DISABILITY (ACCIDENT AND SICKNESS), DEATH, AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS

The following rules apply to Benefit Claims for Disability (Accident and Sickness) and Death, Accidental Death, Dismemberment and Loss-of-Sight Benefits under the Fund.

a. DISABILITY (ACCIDENT AND SICKNESS) CLAIMS

You should refer to Part O of this Summary Plan Description for any specific rules concerning the Disability (Accident and Sickness) Claims Procedures.

b. DEATH BENEFIT CLAIMS

You should refer to Part P of this Summary Plan Description for any specific rules concerning the Death Benefit Claims Procedures.

c. ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS-OF-SIGHT CLAIMS

You should refer to Part Q of this Summary Plan Description for any specific rules concerning the Accidental Death, Dismemberment and Loss-of-Sight Claims Procedures.

2. REVIEW PROCEDURES FOR DISABILITY (ACCIDENT AND SICKNESS), DEATH, AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS

a. TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIM

The Initial Benefit Claim Reviewer will make an initial determination within 45 days of receipt of the disability Benefits Claim form.

The Initial Benefit Claim Reviewer may extend the period for the initial determination for an additional 30 days, provided you are notified of the extension within the 45-day period; the extension is required for reasons beyond the Initial Benefit Claim Reviewer's control; and you are advised of the unresolved issues that prevent any decision, and the additional information needed to resolve those issues.

The Initial Benefit Claim Reviewer may further extend the period for the initial determination for an additional 30 days, provided you are notified of the extension within the 30-day extension period; the extension is required for reasons beyond the Initial Benefit Claim Reviewer's control; and you are advised of the unresolved issues that prevent any decision, and the additional information needed to resolve those issues.

If any extension is necessary because you have submitted an Improper and/or Incomplete Benefit Claim to the Initial Benefit Claim Reviewer, the period for making an initial determination will be suspended from the date that the request for additional information is sent to you until the earlier of: (a) the date that you respond to the Initial Benefit Claim Reviewer, without regard to whether your response supplies all of the information necessary to decide the Benefit Claim; or (b) 45 days from the date of the request.

You must submit the additional information requested by the Initial Benefit Claim Reviewer within 45 days.

b. NOTIFICATION OF INITIAL BENEFIT DECISION

If the Benefit Claim is denied in whole or in part, the Initial Benefit Claim Reviewer will provide to you a written notice of the Adverse Benefit Determination.

SECTION G-4: GENERAL CLAIMS REQUIREMENTS

1. WRITTEN BENEFIT CLAIM REQUIREMENTS

A. GENERAL RULE

If it is necessary for you to submit a Benefit Claim to the Fund, you—as opposed to the Participating Provider Health Care Provider—should request an itemized bill from the Health Care Provider. Except for Benefit Claims of the types set forth in Paragraph B below, any Benefit Claim must be made in writing on Benefit Claim forms approved by the Fund. Benefit Claim forms are available from the Initial Benefit Claim Reviewer and from the Benefit Claims Payors. All Benefit Claims submitted to the Fund must include the following:

- Patient's full name, date of birth, and address;
- Patient's identification number (as shown on the patient's identification card);
- Date each service or supply was provided;
- A description and/or procedure code for each service;
- Diagnosis, illness or injury for each service;
- Amount charged for each service;
- Number of units for each service;
- Name and address of Provider (on Provider's official bill or letterhead); and
- Location where services were provided, if other than Physician's office.

Certain services require additional information, such as medical notes from the Provider, payment or rejection notices from other insurance carriers (including workers' compensation, other health plans, Medicare, auto insurance, etc.), origin and destination points for ambulance transfers, or accident information. Delays in submitting this special information, when required, may result in a Benefit Claim processing delay.

B. EXCEPTIONS TO WRITTEN BENEFIT CLAIM REQUIREMENT

The following types of Benefit Claims do not need to be in writing:

I. PARTICIPATING PROVIDER BENEFIT CLAIMS

When you receive service from a Participating Provider, you should show the Participating Provider your benefit identification card. These Benefit Claims are handled directly between the Participating Provider and the Fund without the need for you to file a written Benefit Claim form.

II. URGENT CARE BENEFIT CLAIMS AND PRE-SERVICE BENEFIT CLAIMS

These may be handled by phone, facsimile, or similar expeditious means.

2. DEADLINE FOR FILING BENEFIT CLAIMS

The deadline for filing Benefit Claims for all types of Benefits is six (6) months—except Disability Benefits, which is ninety (90) days—from when the Benefit Claim arises (which generally is the date the service or treatment is performed or the drug or other item at issue is obtained by you). If you fail to file your Benefit Claim within the applicable period, you will lose your right to the Benefits unless, for good cause, the Board extends your time to apply. A Benefit Claim will be deemed to be "filed" (a) when it is postmarked, if properly sent by mail to the appropriate Initial Benefit Claim Reviewer, (b) when it is received by the Claims Payor or Contract Administrator, in the case of hand delivery, or (c) when deposited with a nationally operating overnight delivery service when sent to the Initial Benefit Claim Reviewer by such means.

3. IMPROPER AND INCOMPLETE BENEFIT CLAIMS

If an Improper and/or Incomplete Benefit Claim is filed, the Initial Benefit Claim Reviewer will notify you within five (5) days of the receipt of the Benefit Claim and advise you of the proper Procedures to be followed or the information required in order to process the Benefit Claim. Notification may be oral, unless you requested written notification.

4. MEDICAL EXAMINATION

In determining eligibility for any benefit, the Fund reserves the right to have you examined by a Health Care Provider designated and paid for by the Fund. Such examination may be repeated as often as may be reasonably required during the continuance of a Benefit Claim. The Fund also reserves the right to have an autopsy performed in case of death, except where it is prohibited by law.

5. DESIGNATION OF AUTHORIZED REPRESENTATIVE

Except as otherwise provided in the case of Urgent Care Benefit Claims, you may designate an Authorized Representative, which term shall include an attorney if so

designated, to act on your behalf in pursuing a Benefit Claim or an appeal of any Adverse Benefit Determination. In order for a designation of an Authorized Representative to be effective, you must submit to the Initial Benefit Claim Reviewer a Designation of Authorized Representative Form, which can be obtained from the Initial Benefit Claim Reviewer, or a letter containing the name, address and telephone number of the Authorized Representative; the statement of the extent of the Authorized Representative's authority to act; and a statement authorizing the Initial Benefit Claim Reviewer to release any information or medical records to the Authorized Representative; and signed and dated by you. In the case of an Urgent Care Benefit Claim, a Health Care Provider with knowledge of your medical condition shall be permitted to act as your Authorized Representative. When a Covered Participant designates an Authorized Representative, in the absence of a contrary direction from you, only the Authorized Representative shall receive all information and notifications to which you are otherwise entitled. In addition, the Fund shall only respond to requests for information or documents from the Authorized Representative in the absence of a contrary direction from you.

6. NOTIFICATION OF BENEFIT CLAIM APPROVAL

When a Benefit Claim—other than an Urgent Care Benefit Claim or a Pre-Service Benefit Claim—is approved, in whole or in part, you will receive written notification of the Benefit Claim approval from the Initial Benefit Claim Reviewer. When a Benefit Claim involving an Urgent Care Benefit Claim is approved in whole or in part, you shall receive notification as soon as possible, but no later than 24 hours after receipt of the Benefit Claim. When a Benefit Claim involving a Pre-Service Benefit Claim is approved in whole or in part, you will receive written notification within 15 days of the receipt of the Benefit Claim form of the Benefit Claim approval from the Initial Benefit Claim Reviewer.

7. TIME PERIODS

Except as otherwise provided in this Part G, the period of time within which an Initial Benefit Claim Determination will be made shall begin at the time the Benefit Claim is received in accordance with the Procedures for Filing Benefit Claims, without regard to whether it is an Improper and/or Incomplete Benefit Claim. The times listed are maximum times only. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

8. CALCULATION OF TIME PERIODS FOR BENEFIT CLAIM DETERMINATIONS

The time period within which an Initial Benefit Claim Determination is required to be made shall begin at the time a Benefit Claim is filed, without regard to whether all the information necessary to make a determination accompanies the filing of the Benefit Claim. However, in the event a period of time is extended, as provided for herein, due to your failure to submit information necessary to decide a Benefit Claim, the period for

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

SECTION G-5: APPEALS PROCEDURES FOR HEALTH CARE BENEFITS ADVERSE BENEFIT DETERMINATIONS

1. GENERAL

In accordance with federal law, the Fund provides for a two-step appeal/review process for Health Care, Prescription Drug Benefits, Dental Benefits and Vision Benefits. The first step is an Internal Appeal to the Fund's Board of Trustees. The second step in the appeal/review process is an External Appeal to an Independent Review Organization

The Fund has engaged the required IROs and any External Appeal shall be assigned to such IROs in accordance with federal law.

2. INTERNAL APPEALS.

a. INTERNAL APPEAL PROCEDURES.

You have 180 days following the receipt of a notification of an Adverse Benefit Determination from the Initial Benefit Claim Reviewer to appeal such determination pursuant to the rules regarding the Internal Appeal provided in this Section.

You must submit the Internal Appeal in writing to the Fund's Contract Administrator. In the case of an appeal from an Adverse Benefit Determination relating to an Urgent Benefit Claim, you may submit an oral appeal to the Fund's Contract Administrator.

You will have the opportunity to submit written comments, documents, records, and other information relating to the Benefit Claim. In the case of Urgent Benefit Claims, you can submit all necessary information by telephone, facsimile, or other available similarly expeditious method.

You will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your Benefit Claim.

A de novo review of your Internal Appeal shall be conducted by the Board of Trustees. Such review shall take into account all comments, documents, records, and other information submitted by you relating to the Benefit Claim, without regard to whether such information was submitted or considered by the Initial Benefit Claim Reviewer.

In deciding an Internal Appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the Board of Trustees shall consult with a Health Care Provider who has appropriate training and experience in the field of medicine involved in the medical judgment. Any such Health Care Provider consulted shall not be an individual who was consulted in connection with the Adverse Benefit Determination at issue nor the subordinate of any such individual.

The identification of all medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided.

You may request a hearing in person before the Board of Trustees. This request must be set forth in the written appeal filed with the Contract Administrator, or orally in the case of appeals from Urgent Care Benefit Claims or Urgent Care Concurrent Care Benefit Claims. At the hearing you may present any evidence, through documents or witnesses, to support the Benefit Claim, and may be represented by a lawyer or other Authorized Representative.

b. TIME FOR DECISION AND NOTIFICATION OF INTERNAL APPEAL

Except as hereinafter provided, the Board of Trustees shall make a decision on the Internal Appeal no later than the date of the next regularly scheduled Board of Trustees' meeting that immediately follows the Fund's receipt of the Internal Appeal, unless the Internal Appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made by no later than the date of the second meeting following the Fund's receipt of the Internal Appeal. If special circumstances require further extension of time for processing, a decision on the Internal Appeal shall be rendered not later than the third meeting of the Board of Trustees following a receipt of the appeal. If such an extension is required, the Board of Trustees shall provide you with written notice of the extension which describes the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Board of Trustees shall notify you as soon as possible but no later than 5 days after a decision is made. In the case of a Pre-service Benefit Claim, the Board of Trustees will notify you of the decision on the Internal Appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of your Internal Appeal.

c. CALCULATION OF TIME PERIODS

The time period within which a decision on the Internal Appeal is required to be made shall begin at the time an appeal is filed in accordance with the Procedures pro-

vided for in this Section, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing. However, in the event a period of time is extended as outlined in this Section, due to your failure to submit information necessary to decide an appeal, the period for making a decision on appeal shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

d. EXTENSION OF TIME

You, your Authorized Representative, the Initial Benefit Claim Reviewer, the Contract Administrator, or the Board of Trustees may agree, in writing, to extend the times set forth in this Part relating to Benefit Claims, Eligibility Determinations and Appeals. Any written agreement to extend the times must be reduced to writing prior to the expiration of the times set forth herein, and must specifically provide for the amount of the agreed-to extension.

e. NOTIFICATION OF INTERNAL APPEAL DECISION

The Board of Trustees shall provide you with written notification of the Internal Appeal decision in the form of either an acceptance of the Benefit Claim, in whole or in part, and/or a Notice of Internal Appeal Adverse Benefit Determination. In the case of an Adverse Benefit Determination, such notice shall include:

- the specific reason(s) for the adverse Internal Appeal decision;
- reference to the specific Fund provision(s) on which the denial is based;
- a statement that you are entitled to review your claim file and receive upon request, free access to and copies of documents relevant to the Benefit Claim;
- a statement that you have the right to bring a civil action under ERISA Section 502(a) following the External Review;
- if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request; and
- if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request.

f. EXPEDITED INTERNAL APPEALS FOR URGENT CARE BENEFIT CLAIMS

In the case of the Internal Appeal of an Urgent Care Benefit Claim, the Board of Trustees shall notify you of the decision on the Internal Appeal as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of your Internal Appeal.

In the event you receive an Adverse Benefit Determination that involves a medical condition for which the timeframe for completion of an Expedited Internal Appeal for Urgent Care Benefit Claims would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an Expedited Internal Appeal for Urgent Care Benefit Claims, the Fund shall waive the Internal Appeal determination and proceed to an Expedited External Review.

3. EXTERNAL REVIEW PROCEDURES

a. DEADLINE FOR EXTERNAL REVIEW

You may file a request for External Review with the Fund's Contract Administrator within four months after the date of receipt of the Notice of Internal Appeal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt (e.g., received on October 30th and there is not a February 30th), the request must be filed by the first day of the fifth month following the receipt of the Notice of Internal Appeal Adverse Benefit Determination. If the last filing date falls on a Saturday, Sunday, or federal holiday, the filing deadline is extended to the next business day.

b. PRELIMINARY REVIEW

Within five business days following the date of receipt of your External Review request, the Board of Trustees must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

- You are or were covered under the Fund at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, was covered under the Fund at the time the health care item, service, or other benefit was provided;

- The Initial Notice of Adverse Benefit Determination or Notice of Internal Appeal Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Fund;

- You have exhausted the Fund's Internal Appeal process, unless you are not required to exhaust the Internal Appeals process under the federal interim final regulations; and

- You have provided all of the information and forms required to process an External Review.

c. NOTICE OF PRELIMINARY REVIEW

Within one business day after completion of the Preliminary Review, the Fund will issue a notice in writing to you informing you of the results of the Preliminary Review. If the request for External Review is complete, but not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete and the Fund shall allow you to complete the request for External Review within the later of the four-month filing period or within 48 hours following the receipt of the Notice of Preliminary Review.

d. INDEPENDENT REVIEW ORGANIZATION

In accordance with federal law, the Board of Trustees shall assign an accredited Independent Review Organization ("IRO") to conduct the External Review. The IRO shall be assigned in accordance with the Fund's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Fund.

Upon receipt of the External Review, the IRO will:

- utilize legal experts where appropriate to make coverage determinations under the Fund;

- 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 business days following the date you receive this notice any addition information that the IRO must consider when conducting the External Review. The IRO may, but is not required, to accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment to the IRO, the Fund must provide to the IRO any documents and any information considered in making the Adverse Benefit Determination or the Internal Appeal Adverse Benefit Determination. Failure by the Fund to provide documents must not delay the External Review. If the Fund fails to timely provide the documents and information, the IRO may terminate the

External Review and make a decision to reverse the Adverse Benefit Determination or the Internal Appeal Adverse Benefit Determination. Within one business day after making such decision, the IRO must notify you and the Board of Trustees.

Upon receipt of any information submitted by you, the IRO must, within one business day, forward such information to the Trustees. Upon receipt of any such information, the Board of Trustees may reconsider its Adverse Benefit Determination or Internal Appeal Adverse Benefit Determination that is the subject of the External Review. Any reconsideration by the Board of Trustees must not delay the External Review. External Review may be terminated if the Board of Trustees determine during reconsideration to reverse the previous determination and provide coverage or payment as requested you. The Board of Trustees will provide written notice to the IRO and you of its reversal of the previous determination within one business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

The IRO will review all information and documents timely received and review the Benefit Claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

- Your medical records;
- the attending Health Care Provider's recommendation;
- reports from appropriate Health Care Providers and other documents submitted by the Fund, you, or your treating Provider
- the terms of the Fund (unless contrary to applicable law);
- appropriate medical practice guidelines, including evidence-based standards;
- any applicable clinical review criteria developed and used by the Fund (unless contrary to the Fund or applicable law);
- the opinion of the IRO's clinical reviewer;

The IRO will provide written notice of the final External Review decision to you and the Board of Trustees within 45 days after the IRO receives the request for External Review.

e. EXPEDITED EXTERNAL REVIEW

Expedited External Review shall be undertaken when you have a medical condition that necessitates Expedited External Review because the timeframe for completion of the standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the benefit claim concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which you received emergency services, but have not been discharged from a Provider's facility.

The Board of Trustees shall, immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review provided for above, and shall complete such review as soon as possible without regard to the five business days referred to therein. Upon its determination of the Preliminary Review, the Board of Trustees will immediately send the Notice of Preliminary Review.

Upon a determination that the request is eligible for External Review, the Board of Trustees shall assign an IRO, and transmit or provide all documents and information electronically or by telephone or facsimile or by any other available expeditious method.

The IRO must provide its final External Review decision and notice of such decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then, within 48 hours of the date such notice is provided, the IRO will provide written confirmation of the decision to you and the Board of Trustees in accordance with the procedures under Paragraph d. above.

4. REVERSAL OF ADVERSE BENEFIT DETERMINATION

In the event the Adverse Benefit Determination or the Internal Appeal Benefit Determination is reversed by the Board of Trustees or the IRO, respectively, the Fund will provide coverage or payment for the Benefit Claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Fund under applicable law and regulations.

SECTION G-6: APPEALS PROCEDURES FOR DISABILITY (ACCIDENT AND SICKNESS), DEATH, AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS ADVERSE BENEFIT DETERMINATION

1. GENERAL

If you disagree with the Initial Benefit Claim Reviewer's Adverse Benefit Determination, you must file a written appeal with the Board of Trustees.

The appeal must be filed within 180 days of receipt of the Adverse Benefit Determination.

If you do not appeal the adverse determination to the Board of Trustees, the determination by the Initial Benefit Claim Reviewer shall be final and binding. No legal action may be commenced or maintained by you against the Fund if you fail to appeal the denial of the Benefit Claim.

To file an appeal to the Board of Trustees, you must send to the Initial Benefit Claim Reviewer a written statement stating that you wish to appeal the Initial Benefit Claim Reviewer's Adverse Benefit Determination. The statement must be filed (postmarked or hand-delivered) within 180 days after receipt of the Adverse Benefit Determination. You or your Authorized Representative may submit with the appeal any written comments, documents, records, or other information related to the Benefit Claim which is the subject of the appeal.

2. HOW YOUR APPEAL WILL BE DECIDED AND THE TIME FRAME FOR DECIDING THE APPEAL

An appeal of an Adverse Benefit Determination by the Initial Benefit Claim Reviewer shall be decided by the Board of Trustees at their next regularly scheduled quarterly meeting that immediately follows the Board's receipt of your appeal, unless the appeal is filed within 30 days preceding the date of such regular quarterly meeting. If an appeal is filed within 30 days of a regularly scheduled meeting, the Board's determination shall be made no later than the date of the second regularly scheduled quarterly meeting following the Board's receipt of the appeal. If special circumstances require a further extension of time for processing the appeal, a determination by the Board shall be rendered no later than the third meeting of the Board following the Board's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Initial Benefit Claim Reviewer shall notify you in writing of the required extension prior to the commencement of the extension, describing the special circumstances and the date as of which the appeal determination will be made by the Board. The Initial Benefit Claim Reviewer shall notify you of the Board's appeal determination

as soon as possible, but no later than five days after the appeal determination is made by the Board.

If you do not exercise your rights under ERISA to seek review of a decision by the Board denying the Benefit Claim, in whole or in part, the decision of the Board shall be final and binding. **No legal action may be commenced or maintained by you against the Fund more than 6 months after the decision of the Board of Trustees.**

SECTION G-7: Eligibility Determinations and Appeals Procedures

1. ELIGIBILITY DETERMINATION BY THE CONTRACT ADMINISTRATOR

The Contract Administrator will make a determination relating solely to whether you are an eligible Employee or a Covered Participant. The determination shall be made as soon as administratively feasible, but no later than 45 days after receipt of all information needed to resolve the eligibility issue.

Should the Contract Administrator determine that you are not a Covered Participant, or that you are no longer a Covered Participant under the Fund, the Contract Administrator will provide to you a written notice of the eligibility determination and the reasons therefor.

2. PROCEDURE FOR APPEAL OF AN ADVERSE ELIGIBILITY DETERMINATION TO THE BOARD OF TRUSTEES

If you disagree with the Contract Administrator's Adverse Eligibility Determination, you must file a written appeal with the Board of Trustees.

The appeal must be filed within 180 days of receipt of the Adverse Eligibility Determination.

If you do not appeal the Adverse Eligibility Determination to the Board of Trustees, the determination by the Contract Administrator shall be final and binding. No legal action may be commenced or maintained by you against the Fund if you fail to appeal the denial of the Benefit Claim.

To file an appeal to the Board of Trustees, you must send to the Contract Administrator a written statement stating that you wish to appeal the Contract Administrator's Adverse Eligibility Determination. The statement must be filed (postmarked or hand-delivered) within 180 days after receipt of the Adverse Eligibility Determination. You or you Authorized Representative may submit with the appeal any written comments, documents, records, or other information related to the Benefit Claim which is the subject of the appeal.

3. HOW YOUR APPEAL WILL BE DECIDED AND THE TIME FRAME FOR DECIDING THE APPEAL

An appeal of an Adverse Eligibility Determination by the Contract Administrator shall be decided by the Board of Trustees at their next regularly scheduled quarterly meeting that immediately follows the Board's receipt of your appeal, unless the appeal is filed within 30 days preceding the date of such regular quarterly meeting. If an appeal is filed within 30 days of a regularly scheduled meeting, the Board's determination shall be made no later than the date of the second regularly scheduled quarterly meeting following the Board's receipt of the appeal. If special circumstances require a further extension of time for processing the appeal, a determination by the Board shall be rendered no later than the third meeting of the Board following the Board's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Contract Administrator shall notify you in writing of the required extension prior to the commencement of the extension, describing the special circumstances and the date as of which the appeal determination will be made by the Board. The Contract Administrator shall notify you of the Board's appeal determination as soon as possible, but no later than five days after the appeal determination is made by the Board.

If you do not exercise your rights under ERISA to seek review of a decision by the Board denying the Benefit Claim, in whole or in part, the decision of the Board shall be final and binding. **No legal action may be commenced or maintained by you against the Fund more than 6 months after the decision of the Board of Trustees.**

SECTION G-8: EXTENSION OF TIME

You, your Authorized Representative, the Initial Benefit Claim Reviewer, the Contract Administrator, or the Board of Trustees may agree, in writing, to extend the times set forth in this Part relating to Benefit Claims, Eligibility Determinations and Appeals. Any written agreement to extend the times must be reduced to writing prior to the expiration of the times set forth herein, and must specifically provide for the amount of the agreed-to extension.

SECTION G-9: YOUR RIGHTS ON APPEAL TO THE BOARD OF TRUSTEES

You may request a hearing in person before the Board of Trustees. This request must be set forth in the written appeal filed with the Initial Benefit Claim Reviewer, or orally in the case of appeals from Urgent Care Benefit Claims or Urgent Care Concurrent Care Benefit Claims. At the hearing you may present any evidence, through documents or witnesses, to support the Benefit Claim, and may be represented by a lawyer or other Authorized Representative.

You have the right to submit to the Board of Trustees along with the appeal documents, records and other information relating to the Benefit Claim.

You have the right, upon request and without charge, to reasonable access to and copies of all documents, records and other information relevant to the Benefit Claim. For this purpose, a document, record or other information is treated as "relevant" to your Benefit Claim if it:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination;
- Constitutes a statement of policy or guidance with respect to the Fund concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.

You will be provided with the names of any medical or vocational experts whose advice was obtained on behalf of the Fund by the Initial Benefit Claim Reviewer in connection with the initial Benefit Claim determination, without regard to whether the advice was relied upon in making the initial Benefit Claim determination.

The decision of the Board of Trustees will be based on its own review of the Benefit Claim, taking into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination and, where appropriate, in consultation with a Health Care Provider who has appropriate training and experience in the field of medicine involved in the Benefit Claim, and who was not consulted in connection with the initial benefit determination, and without any deference to the initial Benefit Claim determination made by the Initial Benefit Claim Reviewer.

SECTION G-10: CONSEQUENCES OF FAILING TO APPEAL AND LIMITATIONS ON ACTION AGAINST THE FUND

If you fail to seek a review through the Fund's Internal Appeals Process, the decision of the Initial Benefit Claim Reviewer or the Contract Administrator, in the case of an Adverse Eligibility Determination, shall be final and binding. No legal action may be commenced or maintained by you against the Fund if you fail to pursue an Internal Appeal.

If you fail to seek a review of an Internal Appeal Adverse Benefit Determination through the Fund's External Review Procedures, the Internal Appeal decision of the Board of Trustees shall be final and binding. No legal action may be commenced or maintained by you against the Fund if you fail to pursue an External Review.

If you do not exercise your rights under ERISA to seek review of a decision by the Board denying the Benefit Claim, in whole or in part, the decision of the Board shall be final and binding. **No legal action may be commenced or maintained by you against the Fund more than 6 months from the date of the External Review Decision.**

PART H: NOTICES

SECTION H-1: Federal Law Requirements

1. QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSO")

Under ERISA, a state court or a state administrative agency may issue a QMCSO requiring the Fund to provide Benefits to the child of a Participant. The child receiving the benefit is called an "alternate recipient."

In order for the Order to be a QMCSO, it must clearly specify:

a. The name and last-known mailing address of the Participant and the name and address of each alternate recipient covered by the Order.

b. A reasonable description of the type of coverage to be provided by the Fund to each such alternate recipient, or the manner in which such type of coverage is to be determined.

c. The period to which such Order applies.

d. The name of the plan to which the Order applies.

A QMCSO must not require the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Fund.

Upon receipt of an Order, the Contract Administrator will promptly notify the Participant and each alternate recipient or designated representative named in the Order of the receipt of the Order, and will provide to the Participant, the alternate recipient or designated representative and any attorney with a copy of the Fund's Procedures and Rules for Qualified Medical Child Support Orders and Model Order. Prior to submitting an Order or proposed Order, it is recommended that you or your attorney request a copy of the Procedures and Rules and Instructions and Model Order to assist in the preparation of the Order. The Contract Administrator will determine, within a reasonable period of time after receipt of the Order, whether the Order is a Qualified Medical Child Support Order, and will promptly notify the Participant and each alternate recipient of such determination.

Participants may obtain from the Fund's Contract Administrator, without charge, a copy of the Fund's Qualified Medical Child Support Order Procedures and Rules and the Model Qualified Medical Child Support Order.

2. RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal law that regulates group health plans and health insurance companies (the Fund is a group health plan). HIPAA restricts the use of pre-existing condition exclusions by group health plans and health insurance insurers offering group health insurance coverage.

The Fund provides a Certificate of Creditable Coverage (HIPAA Certificate) to each individual who requests one, so long as it is requested while the individual is covered under the Fund or within 24 months after the individual's coverage under the Fund ends. The request also can be made by someone else on behalf of an individual. For example, an individual who previously was covered under the Fund may authorize a new plan in which the individual enrolls to request a Certificate of the individual's creditable coverage from the Fund. An individual is entitled to receive a Certificate upon request even if the Fund has previously issued a Certificate to that individual.

Requests for Certificates should be directed to the Fund's Administrator. Telephone requests are accepted only if the Certificate is to be mailed to the address that the Fund has on file for the individual to whom the request relates. Other requests must be made in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- The last date that the individual was covered under the Fund;
- The name of the participant who enrolled the individual in the Fund; and
- A telephone number to reach the individual for whom the Certificate is requested, in case of any difficulties.

Requests that are required to be made in writing must also include:

- The name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- The address to which the Certificate should be mailed; and
- The requester's signature.

3. RIGHTS UNDER NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Please take note that under federal law, including the Newborns' and Mothers' Health Protection Act ("NMHPA") and the Employee Retirement Income Security Act, group health plans, like the Fund, and health insurance issuers generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Fund or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

4. RULES CONCERNING POST-MASTECTOMY RECONSTRUCTIVE SURGERY BENEFITS

For Covered Participants who receive Benefits in connection with a mastectomy and who elect breast reconstruction with such mastectomy, the Fund will provide coverage for:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

The amount of Benefits payable for this coverage is subject to the current Fund provisions and also subject to applicable deductibles and co-insurance provisions under the current Plan.

5. RIGHTS UNDER FAMILY AND MEDICAL LEAVE ACT

Under certain circumstances, a federal law called the Family and Medical Leave Act of 1993 ("FMLA") requires employers covered by that law to permit employees to take leaves of absence without pay in connection with the birth or placement for adoption of a child, the need to care for a serious health condition of a family member, or the inability to perform the functions of the worker's position due to a serious health condition.

In connection with leaves of absence under the FMLA, the employer may be obligated to continue making contributions to the Fund at the same rate as if you were continuing in Covered Employment in order that you may remain eligible for coverage under the Fund on the same terms as if you were still working. If Employee contributions were required of you prior to taking leave under the FMLA, you would be required to continue such Employee contributions directly to the Fund as a condition for continuing coverage.

The FMLA further provides that if you choose not to retain your health coverage during a FMLA leave and you are reinstated to your job at the end of that leave, you are entitled to be reinstated to eligibility without any new waiting period. In order to avoid any confusion regarding your coverage under this Fund, please advise the Contract Administrator whenever you are going onto, or being reinstated from, a leave under the Family and Medical Leave Act.

6. NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

The Fund complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Fund:

- Provides free aids and services to people with disabilities to communicate effectively with the Fund, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages.

If you need these services, contact BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery); Phone: 717-565-1101, Toll Free: 833-263-5750, Fax: 717-775-3434.

If you believe that the Fund has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability or sex,

you can file a grievance with BeneSys, Inc. You can file a grievance in person, or by mail, fax or e-mail. If you need help filing a grievance, BeneSys, Inc. is available to help you.

You can also file a civil rights complaint with the United States Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019, or 1-800-537-7697 (TDD).

Complaint forms are available at: *http://www.hhs.gov/ocr/office/file/index.html.*

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-717-565-1101, Toll Free: 833-263-5750.

繁體中文 (Chinese)： 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-717-565-1101, Toll Free: 833-263-5750.

Tiếng Việt (Vietnamese) : CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-717-565-1101, Toll Free: 833-263-5750.

Русский (Russian) : ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-717-565-1101, Toll Free: 833-263-5750 (телетайп: 1-717-565-1101, Toll Free: 833-263-5750).

Deitsch (Pennsylvania Dutch) : Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-717-565-1101, Toll Free: 833-263-5750.

한국어 (Korean) : 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-717-565-1101, Toll Free: 833-263-5750번으로 전화해 주십시오.

Italiano (Italian) : ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-717-565-1101, Toll Free: 833-263-5750.

العربية (Arabic) : ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. (رقم 717-565-1101, Toll Free: 833-263-5750-1) اتصل برقم هاتف الصم والبكم: 1-833-263-5750, Toll Free: 717-565-1101

Français (French) : ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-717-565-1101, Toll Free: 833-263-5750 (ATS : 1-717-565-1101, Toll Free: 833-263-5750).

Deutsch (German) : ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-717-565-1101, Toll Free: 833-263-5750.

ગુજરાતી (Gujarati) : સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-717-565-1101, Toll Free: 833-263-5750.

Polski (Polish) : UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-717-565-1101, Toll Free: 833-263-5750.

Kreyòl Ayisyen (French Creole) : ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-717-565-1101, Toll Free: 833-263-5750.

ខ្មែរ (Cambodian) : ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺមានមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ1-717-565-1101, Toll Free: 833-263-5750

Português (Portuguese) : ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-717-565-1101, Toll Free: 833-263-5750.

7. AFFORDABLE CARE ACT NONDISCRIMINATION GRIEVANCE PROCEDURE

It is the policy of the Fund not to discriminate on the basis of race, color, national origin, sex, age or disability. The Fund has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery); Phone: 717-565-1101, Toll Free: 833-263-5750, Fax: 717-775-3434, who has been designated to coordinate the efforts of the Fund to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Fund to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Grievance Procedures:

Grievances must be submitted to the Civil Rights Coordinator, % BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery), within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of the Fund relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

The Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the Fund's Board of Trustees, % BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery), within 15 days of receiving the Civil Rights Coordinator's decision. The Board of Trustees shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The Fund will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

SECTION H-2: Your Rights Under ERISA

The Fund is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). As a Participant in the Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all Fund Participants shall be entitled to:

1. RECEIVE INFORMATION ABOUT YOUR FUND AND BENEFITS

Examine, without charge, at the Contract Administrator's office, all documents governing the Fund, including Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Contract Administrator, copies of documents governing the operation of the Fund, including Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Contract Administrator may make a reasonable charge for the copies.

Receive a summary of the Fund's annual financial report. The Contract Administrator is required by law to furnish each Participant with a copy of this summary annual report.

2. CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Fund as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review of this Summary Plan Description and the documents governing the Fund on the rules governing your COBRA continuation coverage rights.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Fund, when you become entitled to elect COBRA continuation coverage, when your

COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

3. PRUDENT ACTIONS BY FUND FIDUCIARIES

In addition to creating rights for Fund Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other Fund Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Fund and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Contract Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Fund, you should contact the Contract Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Contract Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You

may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART I: PARTICIPATING PROVIDER ORGANIZATION

The Fund has entered into an agreement with a Participating Provider Organization ("PPO") as part of the Fund's ongoing effort to provide you with the best coverage at the lowest possible cost. The agreement will help control health care costs that the Fund has agreed to pay on your behalf.

By entering into the agreement, the Fund has in no way limited your freedom to choose a Health Care Provider. Each time you need medical care, you are free to decide whether to use a Participating Provider or a Non-Participating Provider.

The Participating Provider has agreed to accept the PPO Allowable Amount as its maximum charge for the services it provides. Payment in full will be made by the Fund for most benefits, but not where you are responsible for the payment of deductibles, coinsurance or co-payments.

If you choose to go to a Non-Participating Provider, the Fund will NOT PAY for the services received unless the services satisfy one of the reasons for the approved use of a Non-Participating Provider as detailed in SECTION J-3: APPROVED UTILIZATION OF NON-PARTICIPATING PROVIDERS.

The Benefits covered by the Fund which relate to the PPO and Participating Provider are set forth in PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS. PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS sets forth in detail the types of benefits covered or not covered by the Fund, any limitation on those benefits, and any deductible, coinsurance or co-payment obligations that you might have relating to these benefits.

PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS

Hospital, Medical and Surgical Benefits, which are provided on a self-insured basis by the Fund, are administered by the Fund's Contract Administrator. Such Benefits are subject to the rules in this PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS, as well as the rules in Parts A through I of this Summary Plan Description.

SECTION J-1: Eligibility

All non-Medicare-eligible Covered Participants are covered by the Hospital, Medical and Surgical Benefits of the Fund.

SECTION J-2: How Benefits Are Paid By The Fund

As described in PART I: PARTICIPATING PROVIDER ORGANIZATION, the Fund has entered into an agreement with a Participating Provider Organization. You can choose any provider you wish. If you choose a Participating Provider you will receive benefits as detailed in the Schedule of Benefits below; however, **if you choose a Non-Participating Provider you will receive no benefits at all unless you satisfy one of the requirements set forth in SECTION J-3: APPROVED UTILIZATION OF NON-PARTICIPATING PROVIDERS**

SECTION J-3: Approved Utilization Of Non-Participating Providers

In certain situations, you may not have the option of choosing a Participating Provider. Under the following circumstances the Fund will pay the Non-Participating Provider as if the Provider was a Participating Provider in your PPO. You will be responsible for any copayments, deductibles or coinsurance that you would pay if the Non-Participating Provider was a Participating Provider. The requirements for approved utilization are:

1. WHERE YOU HAVE AN EMERGENCY MEDICAL CONDITION WITHIN THE U.S. AND YOU UTILIZE THE SERVICES OF A NON-PARTICIPATING PROVIDER

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- placing your health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Medically Necessary follow-up services after the initial response to a medical emergency are not covered by the Fund unless provided by a Participating Provider.

2. WHERE A PARTICIPATING PROVIDER HAS CONCLUDED THAT YOU REQUIRE MEDICALLY NECESSARY SERVICES THAT CANNOT BE PROVIDED BY THE PARTICIPATING PROVIDER OR BY ANY OTHER PARTICIPATING PROVIDER IN YOUR PPO

The Participating Provider shall follow the applicable provisions of the PPO for certification of the referral. If there are no applicable procedures in the PPO, then either you or the Participating Provider must contact the Fund's Contract Administrator before the Medically Necessary services are provided, and submit all of the necessary documentation as requested by the Fund's Contract Administrator to justify the medical necessity for your referral to a Non-Participating Provider.

3. USE OF NON-PARTICIPATING PROFESSIONAL PROVIDERS WITHIN A PARTICIPATING FACILITY

Where you utilize a Participating Provider Facility and are required by the Participating Provider Facility to utilize the services of a Non-Participating Provider within the Participating Provider Facility for ancillary services such as anesthesia, X-ray, laboratory or pathological services.

4. UTILIZATION OF NON-PARTICIPATING CHIROPRACTORS

If you utilize a Non-Participating Chiropractor, the Fund will pay all billed charges that you incurred, less the applicable Co-Payment.

5. UTILIZATION OF NON-PARTICIPATING URGENT/IMMEDIATE CARE CENTERS

If you utilize a Non-Participating Urgent/Immediate Care Center, the Fund will pay all billed charges that you incur, less the applicable Co-payment.

You must immediately contact the Fund's Contract Administrator to inform the Fund of one of these occurrences and provide all of the necessary documentation as requested by the Fund's Contract Administrator to justify the use of a Non-Participating Provider. The Fund will then review the facts of the situation and the nature of the services provided. If the Fund determines that the services or referral satisfy one of the exceptions, the charges or referral will be paid as if the services were provided by a Participating Provider.

SECTION J-4: Schedule Of Benefits

The following is a summary of the Hospital, Medical and Surgical Benefits for Participating Providers. This is meant to be a summary of the Benefits, and does not fully describe the Hospital, Medical and Surgical Benefits. In order to fully understand these Benefits, you should review the remainder of this PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS, which contains a detailed description of the Benefits. The fact that your health care provider may prescribe, order, recommend or approve a medical service or supply does not automatically constitute coverage by the Fund. Only health care services set forth in this PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS will be covered by the Fund.

You should use this chart for quick reference when you need these services. A more detailed discussion of these services is set forth following the chart in SECTION J-7: COVERED SERVICES AND BENEFITS.

SCHEDULE OF BENEFITS		
	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS** (Refer to Part J.3. for more details)
BENEFIT PERIOD	Calendar Year	
DEDUCTIBLE PER CALENDAR YEAR		
Individual	None	N/A
Family (Aggregate)	None	N/A
COPAYMENTS		
Physician Office Visits	$20	N/A
Specialist Office Visits	$30	N/A
Urgent/Immediate Care Centers	100%	100%
Emergency Room (Copayment waived if admitted)	$200	$200
Chiropractor Visits	$20	$20
Routine Gynecological Exams	$30	N/A
Therapy (Occupational, Physical, Speech)	$30	N/A
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
Individual	$7,900	N/A
Family (Aggregate)	$15,800	N/A

SCHEDULE OF BENEFITS		
	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS** (Refer to Part J.3. for more details)
The Out-of-Pocket Maximum applies to Hospital, Medical, Surgical and Prescription Drug Benefits. For a family, the combined limit for all family members is $15,800. However, within a family there is an individual limit that cannot exceed $7,900. This means that if any one family member reaches the $7,900, there is no further cost-sharing for that individual.		
COVERED SERVICES		
Hospital Services		
Room and Board	100%	Not covered
Intensive Care Unit	100%	Not covered
Other Covered Hospital Services	100%	Not covered
Ambulatory Surgical Facility	100%	Not covered
Emergency Services (Copayment waived if admitted)	100% after $200 copayment	100% after $200 copayment
Rehabilitation Hospital	100%	Not covered
Skilled Nursing Facility – 100 day annual limit	100%	Not covered
Urgent/Immediate Care Services	100%	
Physician Services		
Surgery	100%	Not covered
Inpatient Visits	100%	Not covered
Physician Office Visits	100% after $20 copayment	Not covered
Specialty Office Visits	100% after $30 copayment	Not covered
Allergy Injections	100%	Not covered
Ambulance - emergency and non-emergency	100%	Not covered

SCHEDULE OF BENEFITS		
	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS** (Refer to Part J.3. for more details)
Asbestos Screening – active Participants only (Once every two years)	100%	Not covered
Dental Services Related to Accidental Injury	100%	Not covered
Diabetes Supplies & Education	100%	Not covered
Durable Medical Equipment	100%	Not covered
Enteral Formulae	100%	Not covered
Hearing Aids – up to $500 per hearing aid (One per ear per 24 month period)	75%	75%
Home Health Care – 90 visit annual limit	100%	Not covered
Hospice Care – includes respite care	100%	Not covered
Infertility Counseling, Testing & Treatment (Excludes assisted fertilization treatment)	100%	Not covered
Laboratory & Medical Tests	100%	100%
Maternity Services (Includes dependent daughters)	100%	Not covered
Mental Disorders/Substance Abuse		
Inpatient/Partial hospitalization	100%	Not covered
Outpatient Services	100% after $30 copayment	Not covered
Oral Surgery	100%	100%
Orthotics & Prosthetics	100%	Not covered
Outpatient Renal Dialysis Services	100%	Not covered
Private Duty Nursing – 240 hours annual limit	100%	Not covered

SCHEDULE OF BENEFITS		
	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS** (Refer to Part J.3. for more details)
Radiology Tests	100%	Not covered
Routine costs associated with Approved Clinical Trials	100%	Not covered
Spinal Manipulation Therapy - Chiropractic and Osteopathic – 20 visit annual limit	100% after $20 copayment	100% after $20 copayment
Therapy and Rehabilitation Services - Cardiac, Chemotherapy, Radiation, Infusion & Respiratory Therapy	100%	Not covered
Therapy – Occupational, Physical and Speech – due to stroke - 30 visit annual limit per type of therapy	100%	Not covered
Therapy – Occupational, Physical and Speech – due to all other disorders - 30 visit annual limit	100% after $30 copayment	Not covered
Transplant Services	100%	Not covered
PREVENTIVE CARE		
Routine Diagnostic Screening & Immunizations	100% (no copayment)	Not covered
Preventive care services available under the Fund are those required under the Patient Protection and Affordable Care Act (PPACA), as amended. The preventive care services are reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, and other applicable laws and regulations.		
ALL OTHER ELIGIBLE CHARGES	100%	Not covered

SECTION J-5: Participating Provider Organization (PPO)

For a detailed explanation of how this works and how it might affect the amount of Benefits paid by the Fund, refer to PART I: PARTICIPATING PROVIDER ORGANIZATION.

SECTION J-6: Precertification Requirements

Some providers will obtain precertification on your behalf. Be sure to verify that your provider is obtaining precertification. If your provider does not, you are responsible for obtaining precertification. The medical identification card provided to you by the Fund contains information about the precertification requirements, who to contact for precertification, and the phone number for you, your Physician and/or your family member to use to obtain precertification. If you have any questions concerning precertification, you may also contact the Fund's Contract Administrator, BeneSys, Inc., P.O. Box 1889, Troy MI 48099-1889 (mailing address), or 700 Tower Drive, Suite 300, Troy, MI 48098-2835 (for overnight delivery); Phone: 717-565-1101, Toll Free: 833-263-5750, Fax: 717-775-3434.

SECTION J-7: Covered Services And Benefits

1. ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

Benefits for room and board in an acute care Hospital include bed, board and general nursing services when an Eligible Participant occupies:

- A semi-private room (two or more beds);
- A bed in a Special Accommodations Unit; or
- A private room, if Medically Necessary or if no semi-private accommodations are available. A private room is not Medically Necessary when used solely for the comfort and/or convenience of the Eligible Participant. When a private room is selected at the Eligible Participant's option, the Eligible Participant is responsible for paying the difference between The Fund's Allowable Amount and the Hospital's private room charge.

Charges for an intensive care unit stay are payable as described in the Schedule of Benefits.

- Benefits for associated services include, but are not limited to:
- Drugs and medicines provided for use while an Inpatient;
- Use of operating or treatment rooms and equipment;
- Oxygen and administration of oxygen; and
- Medical and surgical dressings, casts and splints.

Benefits for Long-Term Acute Care Hospitals include services provided when an Eligible Participant is acutely ill and would otherwise require an extended stay in an acute care setting.

2. BLOOD AND BLOOD ADMINISTRATION

Benefits for blood and blood administration include: whole blood, the administration of blood, blood processing and blood derivatives used to treat specific medical conditions.

3. ACUTE INPATIENT REHABILITATION

Benefits for acute Inpatient rehabilitation provided in a Rehabilitation Hospital include services provided when an Eligible Participant requires an intensive level of skilled Inpatient rehabilitation services on a daily basis and these skilled rehabilitation services are provided in accordance with a Physician's order. The Fund must concur with the Physician's certification that the care and the Inpatient setting are both Medically Necessary.

4. SKILLED NURSING FACILITY

Benefits for skilled nursing facilities include services provided when an Eligible Participant requires Inpatient Skilled Nursing Services on a daily basis and these Skilled Nursing Services are provided in accordance with a Physician's order. The Fund must concur with the Physician's certification that the care and the Inpatient setting are both Medically Necessary.

5. PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) AND CONSULTATIONS (OFFICE VISITS)

Evaluation & management and consultation services involve clinical and physical exams required for the prevention, diagnosis and treatment of an illness or injury.

A. EVALUATION AND MANAGEMENT

I. INPATIENT

Benefits for Inpatient evaluation and management include medical care services provided by a Physician or other Professional Provider to an Eligible Participant who is a Hospital Inpatient. Medical care includes Inpatient visits and intensive care. Inpatient E&M services for a condition related to Surgery, maternity, Mental Health Care, or Substance Abuse care are addressed elsewhere in this Summary Plan Description.

II. OUTPATIENT

Benefits for Outpatient evaluation and management include Outpatient visits to a Professional Provider for the prevention, diagnosis, and treatment of an injury or illness. Outpatient E&M services for a condition related to Surgery, maternity, Mental Health Care, or Substance Abuse care are addressed elsewhere in this Summary Plan Description.

B. CONSULTATIONS

Consultations are distinguished from evaluation and management services because these services are provided by a Physician whose opinion or advice is usually requested by another Physician regarding a specific problem.

I. INPATIENT

Benefits for Inpatient consultations include initial and follow-up Inpatient consultation services rendered to an Eligible Participant by another Physician at the request of the attending Physician.

- Consultations that are not Benefits include:
- Staff consultations required by Hospital rules and regulations; and
- Staff consultations related to teaching interns and resident medical education programs.

II. OUTPATIENT

Benefits for Outpatient consultations include Outpatient office consultation visits.

6. RETAIL CLINIC SERVICES

Benefits for services performed in a retail clinic include those that, in the judgment of the Provider, can be treated by a duly licensed or certified associated Physician or allied health professional practicing within the scope of his/her licensure, certification or specialty. Retail clinic services are performed in an ambulatory medical clinic that provides a limited scope of services for preventive care or the treatment of minor injuries and illnesses and is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends. Benefits for retail clinic services are calculated at the same Benefit level as Professional Provider Outpatient evaluation and management (E&M) (office visits).

7. TRANSPLANT SERVICES

a. Benefits will be provided for Covered Services furnished by a Hospital which are directly and specifically related to transplantation of organs, bones or tissue in accordance with the following:

i. If a human organ, bone or tissue transplant is provided from a donor to a human transplant recipient:

(1) when both the recipient and the donor are Covered Participants, each is entitled to the Benefits of the Fund;

(2) when only the recipient is a Covered Participant, both the donor and the recipient are entitled to the Benefits of the Fund subject to the following additional limitations:

(a) the donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, other Blue Shield coverage, or any government program; and

(b) Benefits provided to the donor will be charged against the recipient's coverage under the Fund;

ii. when only the donor is a Covered Participant, the donor is entitled to the Benefits of the Fund, subject to the following additional limitations:

(1) the Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of the Fund, and

(2) no Benefits will be provided to the non-Covered-Participant transplant recipient;

iii. if any organ or tissue is sold rather than donated to the Covered Participant recipient, no Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the Covered Participant recipient's contract limit.

8. SURGICAL SERVICES

A. SURGERY

Surgery performed by a Professional Provider. Separate payment will not be made for pre- and post-operative services. If more than one surgical procedure is performed by the same Professional Provider during the same operation, the total Benefits payable will be the amount payable for the highest paying procedure, and no allowance shall be made for additional procedures except where the Fund deems that an additional allowance is warranted.

B. SPECIAL SURGERY

i. Sterilization and its reversal, regardless of medical necessity.

ii. Oral Surgery - Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary:

- Surgical removal of teeth that will not erupt through the gum, teeth partially or completely impacted in the bone of the jaw, and teeth that cannot be removed without cutting into the bone
- Extraction of teeth in preparation for radiation therapy
- Mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures
- Mandibular frenectomy
- Facility Provider and Anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Fund to be Medically Necessary due to your age and/or medical condition
- Accidental injury to the jaw or structures contiguous to the jaw
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

C. MASTECTOMY AND BREAST CANCER RECONSTRUCTION

Benefits are provided for a mastectomy performed on an inpatient or Outpatient basis for the following:

- surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;
- initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and
- physical complications of all stages of mastectomy, including lymphedemas.

Benefits are also provided for one home health care visit, as determined by the Covered Participant's Physician, when received within 48 hours after discharge, if such discharge occurred within 48 hours after an admission for a mastectomy.

D. ASSISTANT AT SURGERY

Services of a Physician who actively assists the operating surgeon in the performance of covered surgery. The condition of the Covered Participant or the type of surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

E. ANESTHESIA

Administration of Anesthesia for covered surgery when ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery.

F. SECOND SURGICAL OPINION

A consulting opinion and directly related diagnostic services to confirm the need for recommended elective surgery.

The second opinion consultant must not be the Physician who first recommended elective surgery.

Elective surgery is covered surgery that may be deferred and is not an emergency.

Use of a second surgical opinion is at the Covered Participant's option.

If the first opinion for elective surgery and the second opinion conflict, then a third opinion and directly related diagnostic services are Covered Services.

If the consulting opinion is against elective surgery and the Covered Participant decides to have the elective surgery, the surgery is a Covered Services. In such instances, the Covered Participant will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

9. MATERNITY SERVICES

Benefits for maternity services include prenatal, delivery and postpartum services provided to a female Eligible Participant for pregnancies.

A. PRENATAL SERVICES

Benefits for prenatal services include an initial examination, tests, and a series of follow-up exams to monitor the health of the mother and fetus. Prenatal services continue up to the date of delivery.

B. DELIVERY

Benefits for deliveries include facility and professional services for vaginal and cesarean section deliveries.

Group health plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain preauthorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

C. POSTPARTUM SERVICES

Benefits for postpartum services include post-delivery Hospital services and office visits.

D. INTERRUPTION OF PREGNANCY

Benefits for an interruption of pregnancy include procedures for termination of a pregnancy performed through a medical or surgical procedure, including the administra-

tion of medication in a Provider's office. Termination of the pregnancy may be non-elective or elective.

E. NEWBORN CARE

Benefits for newborn care include ordinary nursery care and physical examinations of the newborn infant while the mother is an Inpatient; prematurity services; preventive health care services; and services to treat an injury or illness, including care and treatment of medically diagnosed congenital defects and birth abnormalities.

If a Deductible applies to the Eligible Participant's coverage, only one Deductible will be applied when the mother and newborn are discharged from the Hospital together. If the newborn remains in the Hospital after the mother is discharged or if the newborn is transferred to another Hospital, another individual Deductible, this time for the newborn, must be met before eligible claims are paid for the newborn.

10. DIAGNOSTIC SERVICES

Diagnostic services are procedures ordered by a Physician because of specific symptoms to determine a definitive condition or disease, not for screening purposes. Benefits for diagnostic services include, but are not limited to: radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening, in nature.

A. RADIOLOGY TESTS

Benefits for radiology tests include X-rays, MRI's (Magnetic Resonance Imaging), CT Scans, Ultrasounds, Echography, and other radiological services performed for the purpose of diagnosing a condition due to an illness or injury.

B. LABORATORY TESTS

Benefits for laboratory tests include diagnostic pathology and laboratory tests for the diagnosis or treatment of a disease or condition.

C. MEDICAL TESTS

Benefits for diagnostic medical tests include EKG's, EEG's, and other diagnostic medical procedures performed for the purpose of diagnosing or treating a disease or condition.

Inpatient admissions that are primarily for diagnostic purposes are not covered.

11. ALLERGY SERVICES

Benefits for allergy services include immunotherapy and allergy serums.

A. IMMUNOTHERAPY

Immunotherapy refers to the treatment of disease by stimulating the body's own immune system and involves injections over a period of time in order to reduce the potential for allergic reactions.

Benefits for immunotherapy include therapy provided to individuals with a demonstrated hypersensitivity that cannot be managed by avoidance or environmental controls.

However, certain methods of treatment, which are investigational, as well as items that are for personal convenience (i.e., pillows, mattress casing, air filter, etc.) are not covered.

B. ALLERGY SERUMS

Benefits for allergy serums include the immunizing agent (serum) used in immunotherapy injections as long as the immunotherapy itself is covered.

12. THERAPY SERVICES

Benefits will be provided for the following Covered Services only when such services are ordered by a Professional Provider:

A. CARDIAC REHABILITATION

The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

B. CHEMOTHERAPY

The treatment of malignant disease by chemical or biological antineoplastic agents.

C. DIALYSIS TREATMENTS

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

D. INFUSION THERAPY

The treatment by the administration of Medically Necessary fluid or medication via a central or peripheral vein when performed, furnished and billed by a Facility Provider in accordance with accepted medical practice. A home Infusion Therapy Provider typically provides services in the home, but a patient is not required to be home-bound.

Benefits for Infusion/IV Therapy include the drugs and IV solutions, supplies and equipment to administer the drugs, and nursing visits to administer the therapy.

E. OCCUPATIONAL THERAPY

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

F. PHYSICAL THERAPY

The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.

G. RADIATION THERAPY

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

H. RESPIRATORY THERAPY

The introduction of dry or moist gases into the lungs for treatment purposes.

I. SPEECH THERAPY

The treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

J. MANIPULATION THERAPY

Treatment involving movement of the spinal or other body regions when the services rendered have a direct therapeutic relationship to the patient's condition, are performed for a musculoskeletal condition, and there is an expectation of restoring the patient's level of function lost due to this condition. Maintenance manipulation therapy is not covered.

13. EMERGENCY SERVICES

An Emergency Service is any health care service provided to an Eligible Participant after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or 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:

- Placing the health of the Eligible Participant, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Benefits for Emergency Services include the initial evaluation, treatment and related services, such as diagnostic procedures provided on the same day as the initial treatment.

Inpatient Hospital stays as a result of an emergency are reimbursed at the level of payment for Inpatient Benefits. Consultations received in the emergency room are subject to the applicable Outpatient consultation Coinsurance.

Benefits for emergency dental accident services include treatment required only to stabilize the Eligible Participant immediately following an accidental injury. Treatment of accidental injuries resulting from chewing or biting is not covered.

If The Fund, upon reviewing the emergency room records, determines that the services provided do not qualify as Emergency Services, those non-Emergency Services may not be covered or may be reduced according to the limitations of this coverage.

14. URGENT/IMMEDIATE CARE SERVICES

Benefits for services performed in an Urgent/Immediate Care center include those that, in the judgment of the Provider, are non-life threatening and urgent and can be treated on other than an Inpatient Hospital basis and are performed at a Freestanding Urgent/Immediate Care Center by a duly licensed associated Physician or allied health professional practicing within the scope of his/her licensure and specialty. Urgent/Immediate Care services are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends.

15. MEDICAL TRANSPORT

Benefits for medical transport services include the use of specially designed and equipped vehicles to transport ill or injured patients. Medical transport services may involve ground or air transports in both emergency and non- emergency situations.

Air ambulance transportation is covered only when the transport is Medically Necessary or the point of pick-up is not accessible by land, and the transport is to an acute care Hospital (whether for initial transport or subsequent transfer to another facility for special care).

Ambulance Service providing local emergency transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from a Covered Participant's home, the scene of an accident or medical emergency to a Hospital, or Skilled Nursing Facility; or
- between Hospitals; or
- between a Hospital and a Skilled Nursing Facility;
- when such Facility is the closest institution that can provide Covered Services appropriate for the Covered Participant's condition. If there is no Facility in the local area that can provide Covered Services appropriate for your condition, then Ambulance Service means transportation to the closest Facility outside the local area that can provide the necessary Covered Service.

16. MENTAL HEALTH CARE SERVICES

Benefits for Mental Health Care services include services for Mental Illness diagnoses. Substance Abuse treatment is defined under a separate Benefit.

A. INPATIENT SERVICES

Benefits for Inpatient Mental Health Care services include bed, board and general Inpatient nursing services when provided for the treatment of Mental Illness. Services provided by a Professional Provider to an Eligible Participant who is an Inpatient for Mental Health Care are also covered.

B. PARTIAL HOSPITALIZATION

Benefits for Partial Hospitalization Mental Health Care services include the treatment of a Mental Illness in a planned therapeutic program during the day only or during the night only.

The Partial Hospitalization program must be approved by The Fund or its designee. Partial Hospitalization Mental Health Care is not covered for halfway houses and residential treatment facilities.

C. OUTPATIENT SERVICES

Benefits for Outpatient Mental Health Care services include the Outpatient treatment of Mental Illness by a Hospital, a Physician or another eligible Provider.

Attention deficit/hyperactivity disorder (ADHD) is classified as a mental health condition. Treatments for ADHD are eligible under Mental Health Care Benefits, subject to any applicable Benefit Period maximums or other applicable visit limits. However, office visits for medication checks are considered medical visits and are not subject to any applicable Benefit Period maximums or other applicable visit limits for Mental Health Care.

D. SUBSTANCE ABUSE SERVICES

Substance Abuse is the use of alcohol or other drugs at dosages that place an Eligible Participant's social, economic, psychological, and physical welfare in potential hazard, or endanger public health, safety, or welfare. Benefits for the treatment of Substance Abuse includes detoxification and rehabilitation.

E. DETOXIFICATION - INPATIENT

Benefits for Inpatient detoxification include services to assist an alcohol and/or drug intoxicated or Dependent Eligible Participant in the elimination of the intoxicating alcohol or drug as well as alcohol or drug dependency factors while minimizing the physiological risk to the Eligible Participant.

Services must be performed under the supervision of a licensed Physician and in a facility licensed by the state in which it is located.

F. REHABILITATION

Benefits for Substance Abuse rehabilitation include services to assist Covered Participants with a diagnosis of Substance Abuse in overcoming their addiction. Covered Participants must be detoxified before rehabilitation will be covered. A Substance Abuse treatment program provides rehabilitation care.

I. INPATIENT

Benefits for Inpatient Substance Abuse rehabilitation include: bed, board and general Inpatient nursing services. Substance Abuse care provided by a Professional Provider to an Eligible Participant who is an Inpatient for Substance Abuse rehabilitation is also covered.

Residential treatment facilities are not covered.

II. OUTPATIENT

Benefits for Outpatient Substance Abuse rehabilitation include services that would be covered on an Inpatient basis but are otherwise provided for Outpatient or Partial Hospitalization.

To be eligible for coverage, these services must be provided by a Physician, Psychologist, or other eligible Provider employed by a Substance Abuse Treatment Facility. Otherwise, Professional Provider services for Substance Abuse treatment are not eligible for coverage nor are these services eligible under Outpatient Mental Health Care Benefits.

17. HOME HEALTH CARE SERVICES

Home Health Care is Medically Necessary skilled care provided to a homebound patient for the treatment of an acute illness, an acute exacerbation of a chronic illness, or to provide rehabilitative services.

Benefits for Home Health Care services provided to a homebound patient include:

- Professional services provided by a registered nurse or Licensed Practical Nurse;
- Physical medicine, occupational therapy and speech therapy;
- Medical and surgical supplies provided by the Home Health Care agency; and
- Medical social service consultation.

No Home Health Care Benefits are provided for:

- Drugs provided by the Home Health Care agency;
- Food or home delivered meals;
- Homemaker services such as shopping, cleaning and laundry;
- Maintenance therapy; and
- Custodial Care.

A. HOME HEALTH CARE VISITS RELATED TO MASTECTOMIES

Benefits for Home Health Care visits related to mastectomies include one (1) Home Health Care visit, as determined by the Eligible Participant's Physician, received

within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.

B. HOME HEALTH CARE VISITS RELATED TO MATERNITY

Benefits for Home Health Care visits related to maternity include one (1) Home Health Care visit within 48 hours after discharge when the discharge occurs prior to 48 hours of Inpatient care following a normal vaginal delivery or prior to 96 hours of Inpatient care following a cesarean delivery. Home Health Care visits include, but are not limited to: parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed health care Provider whose scope of practice includes postpartum care must make such Home Health Care visits. At the mother's sole discretion, the Home Health Care visit may occur at the facility of the Provider. Home Health Care visits following an Inpatient stay for maternity services are not subject to Deductibles or Coinsurance, if applicable to this coverage.

18. HOSPICE CARE

Hospice Care Services will be provided to Covered Participants with a life expectancy of 180 days or less, as certified by a Physician. Services rendered by a Home Health Care Agency or a Hospital program for hospice care for which Benefits are available as follows:

- Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services (The services of an LPN shall be made available only when the services of an RN are not available, and only when Medically Necessary. Services of an LPN are only reimbursable through a Facility Provider);
- physical therapy, occupational therapy and speech therapy;
- medical and surgical supplies provided by the Home Health Care Agency or Hospital program for hospice care;
- oxygen and its administration;
- medical social service consultations;
- health aide services to a Covered Participant who is receiving covered nursing or therapy services;
- respite care; and
- family counseling related to the Covered Participant's terminal condition.

19. DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES

Durable medical equipment consists of items that are:

- Primarily and customarily used to serve a medical purpose;
- Not useful to a person in the absence of illness or injury;
- Ordered by a Physician;
- Appropriate for use in the home;
- Reusable; and
- Can withstand repeated use.

Benefits for DME include the rental or, at the option of The Fund, the purchase of DME when prescribed by Professional Providers within the scope of their license. Rental charges cannot exceed the purchase price of the equipment. Furthermore, if the Eligible Participant purchases the DME, previous allowances for rental of the DME will be deducted from the amount allowed for the purchase of the DME.

Benefits for DME also include reasonable repairs, adjustments and certain supplies that are necessary to maintain the DME in operating condition. Examples of DME are wheelchairs, canes, walkers, nebulizers, etc. No Benefits are provided for repairs due to equipment misuse and/or abuse or for replacement of lost or stolen items. Repair costs cannot exceed the purchase price of the DME.

DME considered to be a convenience item is not covered. Examples of non-covered DME include environmental control equipment, disposable diapers and under pads, certain elastic stockings, and gluco-watches.

Medical supplies are medical goods that support the provision of therapeutic and diagnostic services but cannot withstand repeated use and are disposable or expendable in nature. Benefits for medical supplies include items such as hoses, tubes and mouthpieces for covered durable medical equipment.

20. PROSTHETIC APPLIANCES

Prosthetic appliances replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part. The prosthesis can be surgical or nonsurgical. Benefits for prosthetics include the purchase, fitting, necessary adjustment, repairs, and replacements after normal wear and tear of the most cost-effective prosthetic devices and supplies. Repair costs cannot exceed the purchase price of a prosthetic device. Prosthetics are

limited to the most cost-effective Medically Necessary device required to restore lost body function.

Wigs are covered prosthetics in certain cases and may be subject to a Benefit lifetime maximum. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered. Glasses, cataract lenses, contact lenses, and scleral shells prescribed after cataract or intra-ocular Surgery without a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

The replacement of cataract lenses (except when new cataract lenses are needed because of prescription change) and certain dental appliances are not covered.

21. ORTHOTIC DEVICES

An orthotic device is a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. Benefits for orthotic devices include the purchase, fitting, necessary adjustment, repairs, and replacement of orthotic devices. Examples of orthotic devices are: diabetic shoes; braces for arms, legs, and back; splints; and trusses.

Diabetic shoes and foot orthotics mandated by Pennsylvania state law are covered. Also, orthopedic shoes and other supportive devices of the feet are covered only when they are an integral part of a leg brace. Foot orthotics not mandated by Pennsylvania state law are covered, but a Participant is limited to one (1) pair every two (2) years.

22. DIABETIC SUPPLIES AND EDUCATION

A. DRUGS AND SUPPLIES

Unless otherwise covered under a prescription drug program, Benefits for diabetic drugs and supplies include drugs, including insulin, equipment, agents, and orthotics used for the treatment of insulin-Dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes when prescribed by a Provider legally authorized to prescribe such items.

Equipment, agents, and orthotics include:

- Injectable aids (e.g., syringes);
- Pharmacological agents for controlling blood sugar;
- Standard blood glucose monitors and related supplies;
- Insulin infusion devices; and

- Orthotics.

B. NUTRITIONAL COUNSELING, SELF-MANAGEMENT TRAINING AND EDUCATION

Benefits for nutritional counseling include counseling for medically necessary reasons and for the treatment of diabetes and for the treatment of obesity or morbid obesity only in the presence of a comorbid condition of diabetes.

Benefits for diabetes self-management training and education include participation in a diabetes self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Self-management education and education relating to diet, prescribed by a licensed Physician, includes:

- Medically Necessary visits upon the diagnosis of diabetes; and
- Visits when a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management and when a new medication or therapeutic process relating to the patient's treatment and/or management of diabetes has been identified as Medically Necessary by a licensed Physician.

For Benefits to be provided, the Eligible Participant must complete a diabetes education program that is:

- Conducted under the supervision of a licensed health care professional with expertise in diabetes;
- Approved by the American Diabetes Association; and
- Subject to the criteria determined by The Fund. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association.

23. ENTERAL NUTRITION

Enteral nutrition involves the use of special formula that is administered by mouth or through a tube placed in the gastrointestinal tract. Benefits for enteral nutrition include enteral feeding and enteral formulas.

Benefits for enteral feeding through a tube are covered for individuals with functioning gastrointestinal tracts, but for whom oral feeding is impossible and the enteral formula provides the sole source of nutrition.

Benefits for enteral formulas are covered when administered by any method for the therapeutic treatment of phenylketonuria, branch-chain ketonuria, galasctosemia,

and homocystinuria. Covered enteral formulas are exempt from any applicable Deductibles.

Lactose intolerance or other milk allergies are not indications for coverage of enteral nutrition products.

24. OTHER SERVICES

A. ORTHODONTIC TREATMENT OF CONGENITAL CLEFT PALATES

Benefits for orthodontics include orthodontic treatment of Congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

B. DIAGNOSTIC HEARING SCREENING AND HEARING AIDS

Benefits for hearing services include only hearing screenings for diagnostic purposes. Covered Participant is entitled to one hearing aid per ear during any 24-month period, including maintenance and repairs.

C. VISION CARE FOR ILLNESS OR ACCIDENTAL INJURY

Benefits for vision services include only eye care that is Medically Necessary to treat a condition arising from an illness or accidental injury to the eye. Covered services include Surgery for medical conditions, symptomatic conditions and trauma. Vision screening related to a medical diagnosis, only for diagnostic purposes, is also covered.

When cataract Surgery is performed, Benefits for vision services include lens implants, with limitations, as described in Paragraph 20, Prosthetic Appliances.

Routine eye care examinations, refractive lenses (glasses or contact lenses) and routine tests are not covered except as set forth in the Summary Plan Description. Also, replacement refractive lenses (glasses or contact lenses) prescribed for use with an intra-ocular lens transplant are not covered.

D. INFERTILITY SERVICES

Benefits for infertility services include testing to diagnose the causes of infertility and treatments and procedures for infertility.

However, treatments or procedures leading to or in connection with assisted fertilization are not covered.

E. NON-ROUTINE FOOT CARE

Benefits for non-routine foot care include surgical treatment of structural defects or anomalies such as fractures or hammertoes. Benefits also include surgical removal of ingrown toenails and bunions when provided to Covered Participants with specific medical diagnoses. An injectable local anesthetic must be used in order for a foot procedure to be considered “toenail surgery”.

Routine foot care services are not covered unless the services are Medically Necessary for an Eligible Participant with specific medical diagnoses.

F. PRIVATE DUTY NURSING SERVICES

Private duty nursing services of an actively practicing Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician, providing such nurse does not ordinarily reside in the Covered Participant’s home or is not a member of the Covered Participant’s immediate family.

For a Covered Participant who is an inpatient in a Facility Provider, only when the Fund determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.

For a Covered Participant at home, only when the Fund determines that the nursing services require the skills of a RN or of a LPN.

25. ROUTINE COSTS ASSOCIATED WITH APPROVED CLINICAL TRIALS

If a Participant is eligible to participate in an Approved Clinical Trial (according to the trial protocol) with respect to treatment of cancer or other life-threatening disease or condition, benefits shall be payable for routine costs associated with Approved Clinical Trials.

PART K: MEDICARE SUPPLEMENT BENEFITS

The Medicare Supplement Benefits are provided on a self-insured basis by the Fund. These Benefits complement the Federal Government's Medicare Program by paying the Medicare Part A Deductible and Part B Coinsurance for approved Medicare benefits. These Benefits are also subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION K-1: Eligibility

Retired Participants and their spouses are eligible for Medicare Supplement Benefits under this Part.

SECTION K-2: How Medicare Supplement Benefits are Paid

Medicare is the primary (pays first) carrier for Retired Participants and/or spouses age 65 and over who are otherwise eligible for Medicare. Retired Participants and/or their spouses who are covered by the Fund's Medicare Supplement Benefits **must** first submit their hospital and medical claims to Medicare. Upon payment by Medicare of the expenses which are listed below as "Covered Services," Medicare will electronically send your claim to the Fund, provided you have given the Fund your Health Insurance Claim (HICN) Number and the provider has the Medicare Crossover number. If the Fund receives a claim for a "Covered Services" benefit and the claim does not show that Medicare paid a portion of the claim, the Fund will not pay the "Fund Pays" portion of the claim.

The Fund's Medicare Supplement Benefits are "secondary" (pays second). The benefits provided under the Fund's Medicare Supplement Benefits—listed below in the column "Fund Pays"—will be coordinated with the benefits payable under Medicare for the same Covered Services. You are responsible for paying the Medicare Part B deductible and, if there are any unpaid covered expenses remaining after Medicare pays and your payment of the Medicare Part B deductible, the Fund will pay the remaining amount of the Medicare eligible expenses, subject to the limitations and exclusions of the Fund and provided the claim received by the Fund shows a Medicare payment. It is important to note that the benefit levels, limitations, and exclusions for Medicare Part A and B coverage are subject to change by the Federal Government. The Fund shall only reimburse under Medicare rules in effect at the time you or your spouse incurs the claim.

SECTION K-3: How To Get Medicare

1. PART A - HOSPITAL COVERAGE

If you are 65 years old and eligible for Social Security benefits, if you retire, you are automatically covered for Medicare hospital coverage, which is called "Part A" of Medicare. The Medicare card you need in order to submit claims may be obtained through your local Social Security office.

2. PART B - MEDICAL COVERAGE

To be eligible for Part B coverage, you must enroll and pay a monthly premium. Should you be entitled to Medicare benefits and not enroll for Part B coverage, the Fund will not pay any claims submitted to the Fund.

SECTION K-4: Covered Expenses

The following is a summary of the Medicare Supplement Benefits. This is meant to be a summary of the Medicare Supplement Benefits, and does not fully describe the Medicare Supplement Benefits.

COVERED SERVICES	FUND PAYS
Medicare Part A Covered Services	
Inpatient Hospital (Medicare inpatient mental health care coverage in a psychiatric facility is limited to 190 inpatient hospital days in a lifetime.)	
Days 1 – 60	Medicare Part A deductible
Days 61 – 90	Medicare Part A coinsurance
Days 91 – 150 For 60 Medicare lifetime reserve days that may be used only once	Medicare Part A coinsurance
Additional Inpatient Hospital Days	100% of Medicare eligible expenses for 365 days per benefit period after the 60 Medicare inpatient lifetime reserve days are exhausted.
Skilled Nursing Facility Care	
Days 21 to 100	Medicare Part A coinsurance

COVERED SERVICES	FUND PAYS
Day 101 and beyond	100% of Medicare eligible expenses for 365 days per benefit period after the 60 Medicare inpatient lifetime reserve days are exhausted.
Blood	First three pints per calendar year
Medicare Part B Covered Services	
Deductible	Not covered by Fund
Coinsurance	Medicare Part B coinsurance
Therapy Services	
Outpatient Physical Therapy	Medicare Part B coinsurance
Outpatient Occupational Therapy	Medicare Part B coinsurance
Outpatient Speech Therapy	Medicare Part B coinsurance
Durable Medical Equipment	Medicare Part B coinsurance
Outpatient Hospital Services (except Outpatient Psychiatric Treatment)	Medicare Part B coinsurance
Outpatient Psychiatric Treatment	Medicare Part B coinsurance
Blood	First 3 pints per calendar year
Outpatient Prescription Drugs used in Immunosuppressive Therapy	Medicare Part B coinsurance
Emergency Care	
Emergency Accident Care	Medicare Part B coinsurance
Emergency Medical Care	Medicare Part B coinsurance
Preventive Services	
Mammogram Screening (every 12 months)	Medicare Part B coinsurance (not subject to Medicare Part B deductible)
Gynecological Services (PAP tests every 2 years)	Medicare Part B coinsurance (not subject to Medicare Part B deductible)

COVERED SERVICES	FUND PAYS
Colorectal Cancer Screenings (For all Participants age 50 and over. No minimum age required for colonoscopy.)	Medicare Part B deductible and Medicare Part B coinsurance
Diabetes Monitoring	Medicare Part B deductible and Medicare Part B coinsurance
Bone Mass Measurements	Medicare Part B deductible and Medicare Part B coinsurance
Prostate Cancer Screening	Medicare Part B deductible and Medicare Part B coinsurance
Vaccinations	Medicare Part B deductible and Medicare Part B coinsurance
Glaucoma Testing	Medicare Part B coinsurance
Physical Examinations	Medicare Part B deductible and Medicare Part B coinsurance
Additional Medicare Part B Benefits	Medicare Part B coinsurance
Additional Benefits Not Covered By Medicare	
For Hearing Care Services to Retired Participants and Eligible Spouses eligible for Medicare. (See PART J: HOSPITAL, MEDICAL AND SURGICAL BENEFITS for a description of the Hearing Care Services Benefit.)	
For shingles immunizations for Retired Participants and Eligible Spouses eligible for Medicare.	
ALS Ambulance Services for Retired Participants and Eligible Spouses eligible for Medicare.	

SECTION K-5: Covered Services

1. MEDICARE PART A SERVICES

A. HOSPITAL AND RELATED BENEFITS

Benefits are provided for semi-private accommodations and all other services provided and billed for by the hospital. Coverage includes, but is not limited to, meals and special diets, general nursing care, drugs and medicines, use of operating, recovery and other specialty service rooms, anesthesia, laboratory tests, x-ray examinations, dressings, plaster casts and splints, oxygen, processing and administration of blood and blood plasma, physiotherapy and hydrotherapy, radiation therapy, EKG and EEG, basal metabolism testing, intravenous fluids and prosthetic devices surgically implanted.

B. SKILLED NURSING FACILITY CARE

Coverage is provided for a semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies when: the Eligible Participant needs daily skilled nursing or rehabilitation services; services as a practical matter can only be provided in an inpatient facility; and the care begins within 30 days of the Eligible Participant's discharge from a hospital stay of at least three days.

C. BLOOD

Coverage is provided for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) per calendar year, unless replaced in accordance with Federal regulations.

2. MEDICARE PART B SERVICES

A. MEDICAL AND SURGICAL BENEFITS

Coverage of Medicare Part B coinsurance is provided for physician services and inpatient and outpatient medical and surgical supplies.

Generally, Medicare Part B coverage includes, but is not limited to the following:

- X-ray, radium and radioactive isotope therapy, including material and services of technicians
- Diagnostic x-ray, diagnostic laboratory and other diagnostic tests performed or ordered by a professional provider
- Rental or purchase of durable medical equipment for use in your home, when prescribed by a provider

- Surgical dressings, splints and casts
- Ambulance services when an ambulance is needed to transport you to or from a hospital or skilled nursing facility because any other method of transportation would be dangerous to your health
- Surgical services performed by a professional provider, including services involving surgery of the jaw or related structures or setting of fractures of the jaw or facial bones
- Transplant services performed for an Eligible Participant including the services for the removal of an organ from a donor when the donor is not an Eligible Participant
- Medical services performed by a professional provider
- Services and supplies furnished as part of a professional provider's professional care and which are commonly included in the charge
- Obstetrical delivery including pre- and post-natal care for a female Eligible Participant
- Devices (other than dental) which replace all or part of an internal body organ, including replacement of the devices
- Leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements, if required, because of a change in the Eligible Participant's physical condition

B. THERAPY SERVICES

Coverage is provided for the following services, when ordered by a physician:

- Outpatient physical therapy
- Outpatient occupational therapy
- Outpatient speech therapy

C. OUTPATIENT HOSPITAL SERVICES

Coverage is provided for services for the diagnosis or treatment of an illness or injury.

D. OUTPATIENT PSYCHIATRIC TREATMENT

Coverage is provided for the outpatient treatment of mental illness when services are rendered in a hospital or psychiatric facility.

Generally, coverage includes, but is not limited to, the following:

- Individual and group therapy with physicians, psychologists or other mental health professionals authorized by the state
- Services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients
- Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered
- Activity therapies, but only those that are individualized and essential for the treatment of your condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into your treatment
- Family counseling service. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of your condition
- Patient education programs, but only where the educational activities are closely related to your care and treatment
- Diagnostic services for the purpose of diagnosing you when extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan

E. BLOOD

Coverage is provided for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) per calendar year.

F. OUTPATIENT PRESCRIPTION DRUGS

Coverage is provided only for prescription drugs used in immunosuppressive therapy.

G. EMERGENCY CARE

Coverage is provided for the following Medicare eligible expenses:

I. EMERGENCY ACCIDENT

The initial treatment of bodily injuries resulting from an accident and any follow-up care.

II. EMERGENCY MEDICAL

The initial treatment after the sudden onset of a medical condition manifesting itself by acute symptoms that require immediate medical attention and any follow-up care.

H. PREVENTIVE SERVICES

Coverage is provided for the following Medicare eligible expenses:

I. MAMMOGRAM SCREENING

Benefits are provided once every 12 months for all female Eligible Participants age 40 and over, and one baseline mammogram for female Eligible Participants age 35-39.

II. GYNECOLOGICAL SERVICES

Benefits are provided to all female Eligible Participants for pelvic exams to check for cervical and vaginal cancer once every two years. If the Eligible Participant is of child bearing age and has had an abnormal Pap smear within three years, or has a high risk for cervical or vaginal cancer, coverage is provided for a pelvic exam every year. In addition to the pelvic exam, a clinical breast exam is also covered to check for breast cancer.

III. COLORECTAL CANCER SCREENINGS

Benefits are provided for tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer to Eligible Participants age 50 and older (no minimum age required for colonoscopy) as follows:

- Fecal occult blood test once every 12 months
- Flexible sigmoidoscopy once every 48 months
- Colonoscopy once every 24 months if the Eligible Participant is at high risk for colon cancer, otherwise once every 10 years
- Barium enema (physician can substitute for flexible sigmoidoscopy or colonoscopy) once every 24 months if the Eligible Participant is at high risk for colon cancer, otherwise once every 48 months

IV. DIABETES MONITORING

Benefits are provided to all Eligible Participants with diabetes (insulin users and non-users) for glucose monitors, test strips, lancets and self-management training.

V. BONE MASS MEASUREMENTS

Benefits are provided to certain Eligible Participants at risk for losing bone mass once every 24 months.

VI. PROSTATE CANCER SCREENING

Benefits are provided to all male Eligible Participants age 50 and older for a digital rectal examination once every 12 months and a Prostate Specific Antigen (PSA) test once every 12 months.

VII. VACCINATIONS

Benefits are provided to all Eligible Participants on an outpatient basis for the following:

- Hepatitis B vaccine immunization for individuals at a high or intermediate risk for Hepatitis B
- Flu shots every 12 months
- Pneumococcal (pneumonia) shot upon the recommendation of a professional provider

VIII. GLAUCOMA TESTING

Benefits are provided to all Eligible Participants at high risk for glaucoma once every 12 months.

SECTION K-6: Medicare Coverage Outside the U.S. is Limited

Medicare will not pay for health care or supplies you receive Outside the U.S.

SECTION K-7: When does Medicare Cover Health Care Services in a Foreign Hospital?

There are three situations when Medicare may pay for certain types of health care services you receive Outside the U.S.:

- You are in the U.S. when you have a medical emergency and the foreign hospital is closer than the nearest U.S. hospital that can treat your illness or injury.

- You are traveling through Canada **without unreasonable delay** by the most direct route to or from Alaska or another state when an emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat your illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis.

- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether it is an emergency.

In these situations, Medicare will pay only for the Medicare-covered services you receive in a foreign hospital.

SECTION K-8: Appeal Of Adverse Benefit Determination

If you disagree with a claim denial or other determination by the Contract Administrator, you have a right to file an appeal with the Board of Trustees. For information concerning the Appeal procedures, please refer to PART G: Benefit Claims, Eligibility Determinations and Appeals Procedures.

PART L: PRESCRIPTION DRUG BENEFITS

The Fund helps pay for Prescription Drug needs by paying on a self-insured basis for part of the cost of covered Prescription Drugs for eligible Covered Participants. The processing and administration of the Fund's Prescription Drug Benefit Program is done by BeneCard PBF. Such Benefits are subject to the rules in this PART L: PRESCRIPTION DRUG BENEFITS, as well as being subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION L-1: Eligibility

All non-Medicare-eligible Covered Participants are covered by the Prescription Drug Benefits of the Fund. If a Covered Participant enrolls in Medicare Part D, the Participant's Prescription Drug coverage under the Fund will be terminated. Thereafter, Covered Participants will not be permitted to reinstate the Fund's Prescription Drug Coverage.

SECTION L-2: Schedule Of Co-Pay Levels

The co-pay levels are:

Type of Drug	At BeneCard PBF * Participating Pharmacy	Through Mail Program
Generic Drugs	20% of the discounted Rx price	$10.00
Preferred Brand-Name Drugs when no Generic Equivalent is Available	20% of the discounted Rx price	$30.00
Preferred Brand-Name Drugs when Generic Equivalent **is** Available**	20% of the discounted Rx price plus difference between cost of Generic equivalent and Brand-Name Drug	$30.00 plus difference between cost of Generic equivalent and Non-Preferred Brand-Name Drug
Non-Preferred Brand-Name Drugs when no Generic Equivalent is Available	40% of the discounted Rx price	$60.00
Non-Preferred Brand-Name Drugs when Generic Equivalent **is** Available**	40% of the discounted Rx price plus difference between cost of Generic equivalent and Non-Preferred Brand-Name Drug	$60.00 plus difference between cost of Generic equivalent and Non-Preferred Brand-Name Drug

The Out-of-Pocket Maximum applies to Hospital, Medical, Surgical and Prescription Drug Benefits. For a family, the combined limit for all family members is $15,800. However, within a family there is an individual limit that cannot exceed $7,900. This means that if any one family member reaches the $7,900, there is no further cost-sharing for that individual.

* There is a limit to the number of Prescriptions you may receive for the same drug. To ensure the lowest cost to you and to the Fund, you are only permitted to have the original Prescription and two (2) refills filled at the BeneCard PBF Participating Retail Pharmacy. After this has occurred, you will be required to utilize the Mail Order program.

** Where a Participant has been granted a Prior Authorization to be permitted to take the Preferred Brand-Name Drug or the Non-Preferred Brand-Name Drug in lieu of the Generic, the Participant will not be required to pay the difference between the cost of the Generic Equivalent and the Brand-Name/Non-Preferred Brand-Name Drug.

SECTION L-3: Overview Of Prescription Drug Benefits

You may purchase either Brand-Name Drugs or their Generic equivalent. You will be responsible for paying a Retail or Mail Order Pharmacy co-pay as stated in the Schedule of Co-Pay Levels. To ensure the lowest cost to you, it is important that you purchase your Prescription Drugs at a BeneCard PBF Participating Pharmacy (explained in SECTION L-7: BENECARD PBF PARTICIPATING PHARMACY NETWORK AND PHARMACY BENEFIT) or through the Fund's Mail Order Program (explained in SECTION L-8: MAIL ORDER PHARMACY BENEFITS). When you use a BeneCard PBF Participating Retail Pharmacy, you will be charged the lower of the BeneCard PBF discounted price or the pharmacy's regular price for any Prescription Drugs that you purchase. As with virtually all Prescription Drug plans, there are certain exclusions from coverage and limitations, which are explained in SECTION L-13: EXCLUSIONS.

SECTION L-4: What Are "Covered Drugs" Under The Fund?

Unless subject to a specific exclusion or limitation, including those explained in SECTION L-13: EXCLUSIONS, the Fund's Prescription Drug Benefit program generally covers Medically Necessary outpatient drugs that require a Prescription under either State or Federal law, and that are prescribed by a licensed practitioner. (Drugs requiring a Prescription under federal law generally bear the legend "Caution: Federal law prohibits dispensing without a Prescription," and are therefore sometimes called "Legend Drugs.")

Under appropriate circumstances, the Fund also specifically treats the following items, with a Prescription, as "Covered Drugs":

- Federal Legend drugs, except those specifically excluded below or limited by the Fund (see SECTION L-13: EXCLUSIONS)

- Preventative Care Drugs and Vaccinations mandated by the Affordable Care Act

If an item is considered to be a "Covered Drug," the actual amount of the benefit, if any, a Covered Person will receive depends upon the rules explained throughout this PART L: PRESCRIPTION DRUG BENEFITS.

SECTION L-5: Generic Drug Rules

1. RULE CONCERNING USE OF GENERIC DRUGS WHEN AVAILABLE

Although the Fund—unlike many other group employee prescription benefit plans—does not completely exclude all benefits if you choose to use a Brand-Name Drug when an FDA-equivalent Generic Drug is available, in order for you to ensure that you have the lowest out-of-pocket cost, you must use the Generic version of the drug unless a Prior Authorization is obtained as described in SECTION L-10: DRUGS REQUIRING PRIOR AUTHORIZATIONS.

Under the rules of the Fund, when an FDA-approved Generic Drug is available for a specific Brand-Name Drug, the Fund will not pay any more in benefits than what the Fund would have paid for the Generic equivalent, unless there is a Prior Authorization for you to take a Brand-Name version of the drug. Consequently, if you choose the more expensive Brand-Name Drug, you will be responsible for paying the difference between the cost of the Brand-Name Drug and the equivalent Generic Drug in addition to paying the applicable Co-Pay unless a Prior Authorization is obtained as described in SECTION L-10: DRUGS REQUIRING PRIOR AUTHORIZATIONS.

Be sure to make your Physician or other medical provider aware of this rule when you are having a drug prescribed.

2. A WORD ABOUT GENERIC DRUGS

A Generic Drug is a drug that is chemically equivalent to the original Brand-Name Drug. Generic Drugs must meet the same FDA standards for purity, strength and safety as the original Brand-Name Drug. Generic Drugs also must produce the same effect in the body and have the same active ingredients, strength and absorption rate as Brand-Name Drugs.

Generic-Drug equivalents for Brand-Name Drugs generally become available as the result of the patent expiring on the Brand-Name Drug, allowing it to be produced as a Generic. The only significant difference between the Generic Drug and the Brand-Name version of the drug is the cost. The majority of Generic Drugs are actually manu-

factured by the same companies that produce the Brand-Name Drugs. According to the FDA, Brand-Name manufacturers account for almost 75% of all Generic Drug production. Many manufacturers actually make duplicate versions of their own, as well as other companies', Brand-Name Drugs, but sell them without the Brand-Name.

By using Generic Drugs where available, you immediately save money directly, and the Fund also saves money, which will help to keep the cost of Fund coverage affordable in the long range.

SECTION L-6: Preferred vs. Non-Preferred Brand-Name Program

As detailed in SECTION L-2: SCHEDULE OF CO-PAY LEVELS, the Fund, in an effort to reduce costs to you and the Fund, adopted a Preferred Brand-Name Program. The Preferred Brand-Name Program is nothing more than a list of Brand-Name Drugs where the manufacturers of the drugs on the list have agreed to reduce their cost to BeneCard PBF.

1. PREFERRED BRAND-NAME DRUGS

Preferred Brand-Name Drugs are medications clinically equivalent to Non-Preferred Brand-Name Drugs, but are usually less expensive. Your Prescription Drug program packet contains a list of drugs that qualify for this category.

2. NON-PREFERRED BRAND-NAME DRUGS

Non-Preferred Brand-Name Drugs usually cost more than other clinically equivalent drugs. Your co-payment will be highest when you use these drugs, unless your Physician provides BeneCard PBF with information that there is a Medically Necessary reason for you to take a Non-Preferred Brand-Name version of the drug. Your Physician must follow the Prior Authorization process described in SECTION L-10: DRUGS REQUIRING PRIOR AUTHORIZATIONS, for Preferred Brand-Name/Non-Preferred Brand-Name substitutions.

If there is a Medically Necessary reason for you to take a Non-Preferred Brand-Name version of the drug, you must obtain a Prior Authorization. Be sure to make your Physician or other medical provider aware of this rule when you are having a drug prescribed.

3. HOW BRAND-NAME DRUGS MAKE THE PREFERRED LIST

A team of Physicians and pharmacists selects the Preferred Brand-Name Drugs based first on drug effectiveness and then on cost. These healthcare experts meet regularly to discuss new drugs and trends in therapy, and the list of Preferred Brand-Name Drugs includes hundreds of medications. The list of Preferred Brand-Name Drugs

along with Generic Drugs is known as a Formulary, which all participating pharmacists receive. So, ask your pharmacist to check whether your prescribed drug is on the Formulary.

You may request a list of medications on the Formulary List by calling BeneCard PBF Customer Service at 1-888-907-0070. You may review the Formulary list on the BeneCard PBF website, www.benecardpbf.com. You will first have to register as a member on the website, then you can view the Fund's Formulary list.

SECTION L-7: BeneCard PBF Participating Pharmacy Network And Pharmacy Benefit

For outpatient drugs that are not purchased through the Fund's Mail Order Program (described in SECTION L-8: MAIL ORDER PHARMACY BENEFITS), you generally must have your Prescriptions filled at a pharmacy that participates in the BeneCard PBF Network in order to make sure you have the lowest out-of-pocket costs. Virtually all pharmacies—including most major national chain stores—participate in the BeneCard PBF Network. For detailed information about the names and locations of pharmacies participating in the BeneCard PBF Network, you can either contact BeneCard PBF at 1-888-907-0070, or you can search the list of Network Pharmacies by visiting the BeneCard PBF website at www.benecardpbf.com.

The extensive BeneCard PBF Participating Pharmacy network covers all 50 states, Puerto Rico, and the U.S. Virgin Islands. The Fund has special rules regarding the handling of Prescriptions obtained by Covered Persons while traveling outside of the country. For more detailed information regarding these special rules, please feel free to contact the BeneCard PBF Customer Service department.

When purchasing Prescriptions at a BeneCard PBF Participating Pharmacy, you should identify yourself as a Participant of the Fund with coverage under the BeneCard PBF Program, and you should present your Identification Card, along with your Prescription, to the participating pharmacist. If you go to a participating BeneCard PBF pharmacy, you will generally realize a cost savings for each Prescription, and will be responsible for paying the pharmacy the appropriate co-pay and, if applicable, the difference between the cost of the Generic equivalent and the cost of the Brand-Name Drug.

There is no limit to the number of Prescriptions allowable through your Prescription Drug program. However, the amount of a drug that may be supplied per Prescription or refill is the prescribed quantity, up to and including a MAXIMUM OF A 34-DAY SUPPLY ACCORDING TO DIRECTIONS. In addition, there is a limit to the number of Prescriptions you may receive for the same drug. To ensure the lowest cost to you and to the Fund, you are only permitted to have the original Prescription and two (2) refills filled at the BeneCard PBF Participating Retail Pharmacy. After this has occurred, you will be required to utilize the Mail Order program.

If you choose to have a Prescription for a Covered Drug filled at a pharmacy that does not participate in the BeneCard PBF Network, you will not receive the benefit of the discounted price and will have to pay the entire cost of the drug.

SECTION L-8: Mail Order Pharmacy Benefits

For those prescriptions you will be taking for a long term, sometimes referred to as maintenance drugs, the Fund has a Mail Order Program which you may be able to use for a more cost effective and more convenient way of obtaining those drugs.

The Fund's Mail Order Program is designed to allow you to receive, in a more convenient way and for less money, longer-term quantities of maintenance drugs (e.g., heart medication, blood pressure medication, diabetic medication, etc.). The Mail Order Program is also handled through BeneCard PBF. Mail forms and envelopes are available from the Fund's Contract Administrator, and filing instructions are printed on each mailer.

You can obtain up to a **90-day supply** of a Prescription through the Fund's Mail Order Program. All of the same rules—including those concerning exclusions and concerning limitations (except for the 34-day supply limitation at the local Pharmacy)—apply the same way with respect to Prescriptions purchased through the Mail Order Program as Prescriptions purchased at the local BeneCard PBF Participating Pharmacy.

You can purchase Prescriptions through the Fund's BeneCard PBF Mail Order Program in one of three different ways: (1) you can use the Mail Order forms from the Fund referred to above; (2) you can do so by phone using the Interactive Voice Recovery System, which enables you to renew Prescriptions at any time of the day or night by calling 1-888-907-0070 and following the instructions that are given to you over the phone; or (3) you can place orders over the internet at www.benecardpbf.com, and following the directions at that website.

Your physician may submit a prescription on your behalf by faxing the information to BeneCard at 1-888-907-0040. The prescription should include your Identification Number (ID#) shown on your Medical card.

If you have any questions regarding the Mail Order Program, you should feel free to call the BeneCard PBF Mail Order Program Customer Service line at 1-888-907-0070.

SECTION L-9: Drug Quantity Management

Drug Quantity Management is a program that is designed to make the use of Prescription Drugs safer and more affordable. It provides you with drugs you need for

your good health and the health of your family, while making sure you receive them in the amount—or quantity—considered safe.

Certain drugs are included in this program. For these drugs, you can receive an amount to last you a certain number of days. For instance, the program could provide a maximum of 30 pills for a drug you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the U.S. Food & Drug Administration.

Drug Quantity Management also helps save money in two different ways. First, if your drug is available in different strengths, sometimes you could take one dose of a higher strength instead of two or more of a lower strength—which saves money over time. For example:

> You might be taking two 20 mg pills once a day. To last you a month, you need 60 pills. But Drug Quantity Management would provide just 30 pills at a time. You would need to get two supplies—and pay two co-payments—every month.
>
> With your doctor's approval, you could get a higher strength pill. For instance, you could take a 40 mg pill once a day (instead of two 20 mg pills). One supply lasts you a month—and you have just one co-payment.
>
> Taking your prescribed dose in a higher strength pill also helps the Fund save money, because the Fund pays for fewer pills. By saving on drug costs, the Fund can continue to control the rising cost of Prescription Drugs for everyone in the Fund.

Secondly, the program also controls the cost of "extra" supplies that could go to waste in your medicine cabinet.

1. WHAT DRUGS ARE INCLUDED IN THE DRUG QUANTITY MANAGEMENT PROGRAM?

The Drug Quantity Management program includes drugs that could have safety issues for you if the quantity is larger than the guidelines recommend. For instance, it includes drugs that aren't easily measured out, like nose sprays or inhalers. Drugs that come in several strengths are also included.

A list of drugs in the Drug Quantity Management program is available, if you'd like a copy. You can obtain a copy of the list by calling BeneCard PBF Customer Service at 1-888-907-0070. We recommend that you show this list to your doctor.

2. HOW DOES THE DRUG QUANTITY MANAGEMENT PROGRAM WORK?

Here is what occurs at the BeneCard PBF pharmacy when a drug is included in the Drug Quantity Management program:

a. When you hand in your Prescription, your pharmacist sees a note on the computer system indicating that your drug is not covered for the amount prescribed. This could mean:

You have asked for a refill too soon; that is, you should still have some of the drug left from your last supply. Just ask your pharmacist when it will be time to get a refill.

OR

Your doctor wrote you a Prescription for a quantity larger than the Fund covers.

b. If the quantity on your Prescription is too large, here is what you can do:

Have your pharmacist fill your Prescription as it's written, for the amount that the Fund covers. You pay the appropriate co-payment. Please note to obtain the full prescription as written by the physician you will require a Prior Authorization and it must be reviewed clinically.

OR

Ask your pharmacist to call your doctor. If applicable, they can discuss changing your Prescription to a higher strength, where one is available. In most cases, if your doctor approves this change you'll have fewer co-payments because you'll receive your drugs just once a month. And you can get the approved amount covered by the Fund.

OR

Ask your pharmacist to contact your doctor about getting a "Prior Authorization," as described in SECTION L-10: DRUGS REQUIRING PRIOR AUTHORIZATIONS. That is, your doctor can call BeneCard PBF to request that you receive the original amount and strength he/she prescribed. During this call, your doctor and a BeneCard PBF representative may discuss how your medical problem requires a drug in larger quantities than the Fund usually covers. They may consider safety issues about the amount of a drug you're going to receive. The BeneCard PBF representa-

tive will check the Fund's guidelines to see if your drug can be covered for a larger quantity. BeneCard PBF's Prior Authorization phone lines are open 24 hours a day, seven days a week, to make this request. Please note the approval process depends on BeneCard PBF getting in touch with your doctor in order for a determination to be made right away.

3. WHAT HAPPENS WHEN YOU SEND IN A PRESCRIPTION FOR MAIL-ORDER DELIVERY, BUT ARE CONTACTED AND TOLD THE DRUG IS IN A DRUG QUANTITY MANAGEMENT PROGRAM?

The Mail Order Pharmacy will try to contact your doctor to suggest either 1) changing your Prescription to a higher strength, or 2) asking for a Prior Authorization or fill for up to the quantity limit allowed by the Fund. If the Mail Order Pharmacy doesn't hear back from your doctor within two days, they will fill your Prescription for the quantity covered by the Fund. To save time, you may want to let your doctor know that the BeneCard PBF Mail Order Pharmacy may be calling.

SECTION L-10: Drugs Requiring Prior Authorizations

Prior Authorization is the process of obtaining approval to receive certain drugs. Certain drugs—including all Specialty Drugs—have been selected for Prior Authorization because there is a high potential for inappropriate use or a safety concern. Inappropriate use can lead to a situation where the prescribed drug is not effective for your specific medical condition.

1. WHAT IS PRIOR AUTHORIZATION?

Prior Authorization is a program that helps you get Prescription Drugs you need with safety, savings and—most importantly—your good health in mind.

The program monitors designated Prescription Drugs and their costs, so you can get the right drug at the right cost. The drugs requiring Prior Authorization may change from time to time. You can find the current list of drugs at www.benecardpbf.com to check for any additions or deletions. Prior Authorization makes sure you are getting a cost-effective drug that works for you.

For instance, Prior Authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

For example: A medicine may be in the program because it treats a serious skin condition, but it could also be used for cosmetic purposes, such as reducing wrinkles. To make sure your medicine is used to treat a medical condition and to promote your health and wellness, the Fund covers it only when a doctor prescribes it for a medical problem.

When your pharmacist tells you that your Prescription needs a Prior Authorization, it simply means that more information is needed to see if the Fund can cover the drug. Only your doctor (or sometimes a pharmacist) can provide this information requested to process a Prior Authorization.

2. HOW PRIOR AUTHORIZATION WORKS

Here's what occurs when a Prescription Drug needs a Prior Authorization:

a. When you hand in your Prescription, your pharmacist sees a note on the computer system indicating "Prior Authorization required." Your pharmacist lets you know that your Prescription needs a Prior Authorization—which simply means that more information is needed to determine if the Fund can cover the drug.

b. What you can do:

You can ask your doctor to call BeneCard PBF. Only your doctor (or sometimes a pharmacist) can give BeneCard PBF the information needed to see if your drug can be covered. The Prior Authorization phone lines are open 24 hours a day, seven days a week, so that a determination can be made as soon as the doctor responds.

Your doctor or pharmacist will be asked questions about your specific condition. If the information provided meets the Fund's requirements, you pay the Fund's appropriate co-payment at the pharmacy.

A Prior Authorization will be considered by BeneCard PBF if/when your Physician faxes the appropriate documentation to the BeneCard PBF Prior Authorization Department:

Dr. Fax Line: 609-219-0208 or 609-219-1078

Your physician may also call BeneCard PBF to discuss a Prior Authorization or obtain clinical information at 609-219-0400.

Documentation will be reviewed by a clinical team. If it meets the required criteria, a Prior Authorization will be entered in the system to allow you to just pay the co-pay and not the cost difference. Clinical review may take up to 72 hours from receipt of the fax. Prior Authorization expires after one year.

OR

You can ask your doctor if you could use another medication that is covered by the Fund.

OR

You can ask your pharmacist to fill a small supply of your Prescription right away. You will have to pay full price for this drug.

OR

You can simply pay full price for the entire Prescription at your pharmacy.

c. If your doctor (or pharmacist) calls for a Prior Authorization, a BeneCard PBF licensed pharmacist will:

- check the Fund's guidelines to see if your Prescription Drug can be covered, and
- note whether the Fund will cover the drug only when it's used for treating specific medical conditions, rather than for other purposes.

To obtain additional information regarding the procedures for Prior Authorization by BeneCard PBF, please call Member Services at 1-888-907-0070.

SECTION L-11: Specialty Pharmacy

1. WHAT IS A SPECIALTY PHARMACY?

The Specialty Pharmacy not only supplies the prescribed drug and related supplies (such as needles and syringes), but also provides clinical support to you to help improve compliance with taking the Specialty Drug as well as convenient delivery. All prescriptions for Specialty Drugs are subject to Prior Authorization as described in Section 10 of this Part L.

Specialty Drugs are medications that require special handling, personalized care, monitoring or special delivery needs. These products, whether injectable or non-injectable medications, require specialized clinical management, patient education and training, as well as specific packing, handling and shipping requirements.

Examples of common disease states for Specialty Drugs (this list not all-inclusive): Cancer, Anemia, Respiratory Syncytial Virus, Multiple Sclerosis, Crohn's Disease, Transplant, Growth Hormone Deficiency, Anticoagulation, HIV/AIDS, Hepatitis, Infertility, Rheumatoid Arthritis, Cystic Fibrosis.

2. HOW WILL YOUR SPECIALTY DRUGS BE FILLED BY THE SPECIALTY PHARMACY, AND WHAT IS THE APPLICABLE CO-PAY?

When you submit a Prescription for a Specialty Drug to a participating BeneCard PBF Retail Pharmacy, the Prescription will be forwarded to the Specialty Pharmacy for Prior Authorization if BeneCard determines that it is medically necessary that the Specialty Drug be filled immediately. You will be informed that you are permitted to have the initial Prescription for the Specialty Drug filled at the Retail Pharmacy, but that you will have to have any future refills filled by the Specialty Pharmacy. After you receive your initial Specialty Drug Prescription at the Retail Pharmacy, you will be contacted by a representative of the Specialty Pharmacy who will help you process future refills of the Prescription through the Specialty Pharmacy. . If BeneCard determines that it is not medically necessary that the Specialty Drug be filled immediately at the Retail Pharmacy, you will be contacted by a representative of the Specialty Pharmacy who will help you process the prescription through the Specialty Pharmacy for the first fill.

Specialty medications that are filled through the BeneCard Specialty Pharmacy can be called or faxed in by a healthcare professional. Prior to dispensing, the prescription will be verified to ensure accuracy including dosing, diagnosis, and that the prescription follows the manufacturer's recommendations and clinical guidelines. A review of your profile will be conducted to identify any potential issues such as: inappropriate drug therapy, therapeutic duplication, under- or over-utilization, drug-drug interactions, drug-allergy interactions, drug-disease contraindications, and drug-gender contraindications for all your medications. The Specialty Pharmacy staff will then contact you and obtain any other pertinent information needed prior to dispensing the medication, and will counsel you on all important information regarding your medications and their disease states. Education is a key component to products that require special handling, personalized care, monitoring and special delivery needs. These counseling sessions will occur with each prescription fill, and are customized to the specific medication and your specific needs to ensure the special needs of each medication and disease state are met. Your compliance and appropriate administration is important with these medications to ensure positive outcomes. Since these products require special counseling, monitoring and follow up, they are filled through our Specialty Pharmacy.

All Specialty Drug Prescriptions will be subject to a $30.00 co-pay, and you will obtain up to a 30-day supply per Prescription.

3. HOW DOES THE SPECIALTY PHARMACY PROCESS THE PRESCRIPTION?

When a Prescription is received by the Specialty Pharmacy, you will be contacted by telephone by a representative of the Specialty Pharmacy. During this telephone call, the representative obtains information from you concerning allergies, medical history and additional drugs that you are taking. For every Prescription dispensed at the Specialty Pharmacy, you will receive a minimum of three clinical consultations from a

representative at the Specialty Pharmacy. Consultations will include patient and physician outreach to assess appropriate dose and use of the medication. The representative will counsel you on appropriate administration, management of potential side effects, and proper dosing of the prescribed medication.

4. HOW CAN YOU CONTACT THE SPECIALTY PHARMACY?

You can contact the Specialty Pharmacy at 1-888-907-0070.

SECTION L-12: Step Therapy Program

1. WHAT IS A STEP THERAPY PROGRAM?

The Program is a two-step approach to provide pharmacy and mail order pharmacy benefits for clinically appropriate and cost-effective drugs to be the first step ("Step-One Drugs") to treat a specific condition before alternate, more costly drugs in the same class ("Step-Two Drugs") are tried. The Step Therapy Program is also utilized for Specialty Drugs. The goal of using Step Therapy is to utilize less expensive Step-One alternatives, and have the more costly Step-Two medications available when necessary.

The first time you have a Prescription filled for one of these classes of drugs, or if it has been 180 days since you had a Prescription filled for one of these classes of drugs, Step Therapy requires trial of a Step-One drug before a Step-Two drug will be covered under the Fund. Step-One drugs are less expensive (usually Generic) drugs known to be safe and effective for most people. These drugs should be tried first because they can provide the same health benefits as more expensive drugs, at a lower price. If a Step-One drug does not provide the therapeutic benefit required, a Step-Two drug is the next option. Step-Two drugs (according to BeneCard PBF clinical criteria) are covered by the Fund only after an equally appropriate, cost-effective Step-One drug is tried. Step-Two drugs are Brand-Name Drugs, such as those you see advertised on TV.

A Generic Step-One medication will cost the Fund, on average, between 30% and 80% less than the equivalent Brand-Name Step-Two drug.

The Drug Categories and Conditions included in the Step Therapy Program may change from time to time, and if they do, you will receive a notification of any additions or deletions.

A. HOW DOES STEP THERAPY WORK?

When writing a Prescription, your doctor may be able to choose from many drugs that provide the same therapeutic benefit. Ask your doctor to prescribe a Step-One drug whenever possible. You will pay the Generic co-pay for Step-One drugs.

If you present a Prescription for a Step-Two drug to the pharmacy, the pharmacy will search BeneCard PBF's online computer records to see if you have used a Step-One drug in the past 180 days. If the system finds record of a Step-One drug, your Prescription will be processed. You will pay the Formulary co-pay for Formulary Step-Two drugs and the non-Formulary co-pay for non-Formulary Step-Two drugs.

If the BeneCard PBF system does not find a record of a Step-One drug filled in the past 180 days, your claim for the Step-Two drug will be denied. You or the pharmacist must then contact your Physician to change the Prescription to a Step-One drug, or obtain a Prior Authorization from BeneCard PBF's Prior Authorization Department (as described in SECTION L-10: DRUGS REQUIRING PRIOR AUTHORIZATIONS) for use of the Step-Two drug, or you may obtain the Prescription by paying the full cost of the Step-Two drug.

In certain situations, Prior Authorization for a Step-Two drug will be granted without trial of a Step-One drug if special medical criteria have been met. Your doctor can contact the BeneCard PBF Prior Authorization Department to provide supporting medical necessity information when requesting coverage of a Step-Two drug.

If the BeneCard PBF system shows you have been using a Step-Two medication, you will continue to have coverage for that medication at the appropriate Formulary or non-Formulary co-pay.

The Step Therapy Program also applies to Prescriptions submitted through the BeneCard PBF Mail Order Pharmacy. The guidelines for the Step Therapy Program discussed above for BeneCard PBF Participating Pharmacies also apply to the BeneCard PBF Mail Order Pharmacy.

B. WHY DID THE FUND IMPLEMENT A STEP THERAPY PROGRAM?

A Step Therapy Program helps to ensure that Participants receive the most appropriate drug while helping to manage Prescription costs for you and the Fund.

SECTION L-13: Exclusions

In addition to the Exclusions set forth in PART F: BENEFIT AND COVERAGE EXCLUSIONS that are applicable to all types of benefits, there are also some special exclusions, and some special limitations, that apply specifically to Prescription Drug Benefits.

1. COMPLETE EXCLUSION:

- Physician-administered Injectables

- Unit Dose
- Biologics Minus ACA
- DESI Medications
- IV Medications
- Implants
- OTC
- Repackaged
- Vaccines Not Mandated by the Affordable Care Act
- Allergy Serum
- Alternative Medications
- Anabolic Steroids
- Biologicals
- Blood and Blood Plasma
- Cosmetics
- Diagnostic (Non-Diabetic)
- Fluoride Preparations
- Glucometer
- Hair Growth
- Homeopathic
- Medical Supplies
- Nutritional and Dietary
- OTC – Special
- Rhogam
- Vaginal Contraceptive Devices

- Weight Loss
- Yohimbine

2. PARTIAL LIMITATION APPLICABLE TO ON-DEMAND MALE SEXUAL DYSFUNCTION DRUGS:

The number of dosages and/or units of drugs utilized to treat On-Demand Male Sexual Dysfunction (MSD) will be limited to six (6) doses and/or units of medication per thirty (30) days at retail, or eighteen (18) doses and/or units of medication per ninety (90) days at Mail Order. There is no limitation for daily dosing Male Sexual Dysfunction drugs.

SECTION L-14: Delegation Of Benefit Claim And Appeal Procedures

The Fund has delegated to BeneCard PBF the authority and responsibility to initially determine the extent of benefits to which any Participant is entitled under the Fund.

SECTION L-15: Procedures For Appeal To The Board Of Trustees For Denial Of Pre-Authorization

1. If your request for Prior Authorization was not approved because there was insufficient information, you will be given fifteen (15) days to submit the additional information requested by BeneCard PBF. If this additional information is not submitted, or your request for Prior Authorization is denied, you may do one of the following:

a. You or your doctor may request to speak with the clinical department to determine the applicable criteria by calling the clinical department or submitting a request for more information regarding the clinical nature of the product and its approved uses.

b. You may choose to contact your Physician.

i. Your Physician may choose to initiate different drug therapy to meet both your clinical needs and the Fund's coverage criteria.

ii. If BeneCard PBF was unable to approve your request because of insufficient information, or if either you or your Physician believe additional information should have been considered in connection with your Prior Authorization request, your Physician may submit additional information for BeneCard PBF's review by phone at 609-219-0400, or in writing by sending a letter to the BeneCard PBF Prior Authorization Department, 5040 Ritter Road, Mechanicsburg, PA 17055. If coverage is

justified based on the additional information submitted by your Physician, the Prescription will be processed under the terms of the Fund.

iii. As an alternative, or in addition, to having your Physician contact the BeneCard PBF Prior Authorization Department as described in the preceding paragraph, your denied request may be appealed in accordance with the procedures described below in Paragraph 3.

2. You may Choose to Continue Therapy with the Denied Drug.

If, after discussion with your Physician, you and your doctor decide to continue therapy with the denied drug, you will be responsible for all charges, or you can appeal the decision.

3. If your request was denied, you may choose to immediately appeal this denial.

See PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES for procedures for appealing to the Board of Trustees.

PART M: DENTAL BENEFITS

Dental Benefits, which are provided on a self-insured basis by the Fund, are administered by Delta Dental of Pennsylvania. Such benefits are subject to the Rules in this PART M: DENTAL BENEFITS, as well as being subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION M-1: Eligibility

All Covered Participants are covered by the Dental Benefits of the Fund.

SECTION M-2: Deductible

All Retired Participants and their Dependents are required to pay the first $25.00 of covered benefits per Contract Year. The Contract Year is November 1 through October 31.

SECTION M-3: Payment Of Covered Expenses

Claims for dental benefits under the Fund are handled by the following private Claims Payor, which has been hired by the Fund:

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500
(Toll Free in PA) 800-932-0783
(Toll Free Outside PA) 800-233-0323
Web: www.deltadentalins.com

The Group Number assigned by Delta Dental to the dental program covering participants of the Fund is **10009**. You will need to know this Group Number when filing a claim for dental benefits under the Fund.

1. PARTICIPATING DENTISTS

There are licensed Dentists who have entered into an agreement with Delta to abide by Delta's policies regarding services, your portion of the charged fees, and other matters. These Dentists are known as Participating Providers. The Fund has provided you with a booklet setting forth a current list of Delta Dental Participating Dentists. If for some reason the Participating Dentists Booklet was not supplied or given to you, please notify the Contract Administrator or Delta Dental at the phone numbers listed above, immediately and one will be promptly provided to you. Periodically updated Participating Dentists Booklets will be forwarded to you by the Fund as the list of Participating

Dentists changes. In the event that you lose your Participating Dentists Booklet or desire an update to the Booklet, please contact Delta Dental and a replacement Booklet will be promptly provided to you without cost. Names of Participating Dentists can be obtained upon request by calling Delta at the phone numbers listed above, or from the Delta internet website at www.deltadentalins.com

2. PAYMENT FOR SERVICES

Payment for services performed for you by Participating Dentists is calculated by Delta on a Usual, Customary, and Reasonable or the fee charged, whichever is less ("UCR Allowance" or "Maximum Allowable Fee") basis. Participating Dentists have agreed to accept the UCR Allowance as full payment for services covered by the Fund. Delta calculates its share of the UCR Allowance using the previously described Co-payment Schedule ("Delta Payment") and sends it to the Participating Dentist. Delta advises you of any charges not payable by Delta for which you are responsible ("Patient Payment"). These are generally your share of the UCR Allowance, the co-payments, deductibles, charges where maximums have been exceeded, or charges for services not covered by the Fund.

Payment for services performed for you by a Non-Participating Dentist is also calculated by Delta on a UCR Allowance basis using the previously described Co-payment Schedule, but Delta pays its Delta Payment to you. You are responsible for payment of the Non-Participating Dentist's total fee, which may include amounts in addition to your share of the UCR Allowance and services not covered by the Fund.

3. PREDETERMINATION OF BENEFITS

If total charges for a treatment plan exceed $300.00, predetermination is a condition of approval of the charges for payment. The dentist is requested to submit the claim form in advance of performing services. Delta will act promptly in returning a predetermination voucher to the dentist and you with verification of Patient eligibility Scope of benefits Definition of 60-day period for completion of services.

The notification shall also state the amount which will be paid by you and Delta provided the Covered Participant to be treated is eligible on the date when each respective procedure is commenced, the procedures are completed within a sixty (60) day period following the date of the predetermination notice, the claim is submitted not more than six months after the date of service and the benefits continue to be within applicable benefit maximums and frequency of procedure limitations. Subject to the continuing eligibility of the Covered Participant to be treated, applicable benefit maximums not being exhausted and the continuing inapplicability of frequency of procedure limitations, Delta will grant extensions of a benefit predetermination period upon request from the attending dentist or Covered Participant to be treated.

SECTION M-4: Covered Expenses

1. COVERED BENEFITS

A. DIAGNOSTIC

Procedures to assist dentists in evaluating existing conditions and to determine the required dental treatment, including but not limited to visits, exams, diagnosis and X-rays.

B. PREVENTIVE

Procedures to prevent the occurrence of all disease, including prophylaxis (cleaning), topical application of fluoride solutions (limited to age 19), space maintainers, when used to maintain existing space.

C. BASIC RESTORATIVE

Amalgam, composite, Synthetic porcelain and plastic restorations for treatment of carious lesions.

D. MAJOR RESTORATIVE

Single crowns, inlays and onlays, gold or cast restorations, when teeth cannot be restored with amalgam, synthetic porcelain or plastic restorations.

E. ORAL SURGERY

Extraction and oral surgery procedures, including pre- and post-operative care and general anesthesia when administered by a dentist for a covered oral surgery procedure.

F. ENDODONTIC

Procedures for pulpal therapy and root canal filling.

G. PERIODONTIC

Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth. Post-treatment periodontal prophylaxis is benefited four times in any twelve consecutive months. This number shall be reduced by the number of routine prophylaxes received during that twelve-month period so that the total number of prophylaxes, including routine and periodontal, shall not exceed four.

H. PROSTHODONTIC

Procedures for construction or repair of fixed bridges, partial or complete dentures; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

I. ORTHODONTIC

Procedures for straightening teeth (for Dependent children to age 19).

Payment Schedule

	Paid by Benefit Fund	Paid by You
Diagnostic	100%	0%
Preventive	100%	0%
Basic Restorative	100%	0%
Oral Surgery	80%	20%
Endodontic	80%	20%
Periodontic	80%	20%
Major Restorative	60%	40%
Prosthodontic	60%	40%
Orthodontic	60%	40%

The above-covered percentages are payable to participating dentists or you, and are subject to the following limitations: Maximum benefit is $2,000.00 per person based on a contract year. The contract year is from November 1 of a given year to October 31 of the following year. The orthodontic maximum is $2,000.00 lifetime per patient. For Covered Participants age fourteen (14) and under, Diagnostic, Preventive and Basic Restorative services shall not be applied against the contract year maximum benefit of $2,000.00. All other covered services shall be applied against the contract year maximum benefit of $2,000.00

This schedule is applied according to the payment for services criteria explained under “Payment for Services,” above.

SECTION M-5: Benefit Limitations

The above-described benefits shall be limited as follows:

1. LIMITATION ON OPTIONAL TREATMENT PLAN

In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a

professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the Eligible Participant. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

2. LIMITATION ON MAJOR RESTORATIVE BENEFITS

If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the Eligible Participant and the dentist select another type of restoration, the obligation of Delta shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage of the dental care program.

Replacement of crowns, inlays and onlays shall be provided no more often than once in any five-year period, and then only in the event that the existing crown, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of the Fund, under any prior dental care contract, or by the Eligible Participant.

3. LIMITATION ON DIAGNOSTIC AIDS

Full mouth X-rays and Panorex X-rays accompanied by bitewing X-rays are limited to once in any three-year period. Bitewing X-rays are limited to once in any six-month period. Periodic examinations of the full mouth are limited on once in any six-month period. When an Enrollee is pregnant, one additional oral examination shall be permitted during any 12-month period.

4. LIMITATION ON FLUORIDE AND PROPHYLAXES

Fluoride applications as a benefit are limited to once in any six- (6) month period up to age 19. Prophylaxes and fluoride application may be performed either together or separately. Prophylaxes are limited to one in any six-month period. When an Eligible Participant is pregnant, the Eligible Participant shall receive an additional pregnancy benefit which includes either one (1) additional routine prophylaxis during the twelve- (12) month period, or one (1) additional periodontal scaling and root planning per quadrant in any twelve- (12) month period, subject to the normal periodontal reporting guidelines. Written confirmation of the pregnancy must be provided by the Eligible Participant when the claim is submitted.

5. LIMITATION ON PROSTHODONTIC BENEFITS

Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the Fund. Prosthodontic appliances and abutment crowns will be replaced only after five (5) years have elapsed following any prior provision of such appliances and abutment crowns under any Fund procedure. Implants provided under any Delta Dental plan will be replaced only after five (5) years have passed. Replacement of an implant-supported prosthesis not provided under a Delta Dental program will be covered if it is unsatisfactory and cannot be made satisfactory, but only after five (5) years have passed. Implant removal is limited to once for each tooth during the Enrollee's lifetime.

6. LIMITATION ON ORTHODONTIC BENEFITS

Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of Dependents up to age 19 or to the date eligibility terminates, whichever occurs first. The obligation of the Fund to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any reason prior to completion of the procedure. The Fund will not make any payment for repair or replacement of orthodontic appliances furnished pursuant to the Fund.

7. LIMITATION ON PERIODONTAL SURGERY

Benefits for periodontal surgery in the same quadrant are limited to once in any five- (5) year period. The five- (5) year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this Plan or by the Eligible Participant.

SECTION M-6: Exclusions From Coverage For Dental Benefits

In addition to the general rules concerning exclusions from coverage in PART F: BENEFIT AND COVERAGE EXCLUSIONS, the following specific exclusions apply to dental benefits. No benefits are payable under this PART M: DENTAL BENEFITS for:

1. Treatment or materials with respect to congenital skeletal malformation or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not affect eligible newborn children.

2. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion or otherwise.

3. Treatment or materials primarily for cosmetic purposes, including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes.

4. Periodontal splinting, equilibration, gnathological records and associated treatment and extra-oral grafts.

5. Preventive plaque control programs, including oral hygiene and dietary instruction programs.

6. Fissure sealants.

7. Temporomandibular joint dysfunction.

8. Prescription drugs, including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except for oral surgery.

9. Experimental procedures which have not been accepted by the American Dental Association.

10. Charges for hospitalizations, including hospital visits.

11. Dental practice administrative services, including but not limited to preparation of claims; any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control; or any ancillary materials used during the routine course of providing treatment, such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

12. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

13. Personalization or characterization, such as jewels or lettering.

14. Adult orthodontics.

SECTION M-7: Coordination Of Benefits

If separate dental benefits are available to the member, spouse or Dependents under other programs, there are specific conditions applicable to determination of payment. The ratio of each carrier's liability to total cost incurred is reviewed. Payment is made according to the "birthday" rule adopted by most insurance carriers, but in no case does Delta pay in excess of its total contractual obligation if it were the only carrier involved. If the other carrier determines its benefits first, Delta will pay any difference between the amount paid by the other carrier and the charge for the covered service, to the extent of Delta's benefit for the given procedure.

SECTION M-8: Delegation Of Benefit Claim And Appeal Procedures

The Fund has delegated to Delta the authority and responsibility to initially determine the extent of benefits to which any Participant is entitled under the Fund, and to receive and determine any appeals relating to benefit determinations.

SECTION M-9: Claims Procedure

Attending Dentist's Statement (claim form) will be sent to you to replace each claim form submitted to Delta. For your convenience, these claim forms have been preprinted with your group number and the name of the Fund. When you use the form, please fill in Sections 1 through 9, and sections 13 through 15. Blank claim forms are also available at dental offices. Covered Participant Social Security Number and group number (10009) are very important. Your dentist will complete an examination and recommend needed treatment. If treatment is to be extensive, your dentist may send the claim form to Delta in advance (see above, Predetermination).

When services are completed, you will be asked to sign the form, and your dentist will submit it to Delta. The claim form may also be submitted by you, if desired.

Timely submission of claims is important. Claims submitted six months or more beyond the date of service will not be eligible for payment.

If your child is currently receiving orthodontic treatments or is about to receive orthodontic treatments, you should complete the following information on a claim form and submit it to Delta:

- Patient's name, relationship to Employee, date of birth, and whether a full-time student.
- Covered Employee's name, Social Security number, address, trust Fund name, whether other family members are employed and if they have dental coverage.

Ask your dental office to complete the area marked for the dentist's name, address, dental license number, Social Security number or tax identification number, and telephone number.

Your dental office can also complete the following information on the claim form:

- the type of treatment;
- the date the bands were placed;

- the initial case fee;
- the cost for diagnostic work-up;
- the monthly payment due;
- the total case fee; and
- the previous carrier's payment to date (if applicable).

Sign the claim and ask the dentist performing the treatment to sign the claim.

Delta will calculate the Fund's monthly payment based upon the above information. Delta sends the Fund's payments automatically on a quarterly basis (covering three months with each payment) directly to the offices of Participating Dentists or to you if the dental office does not participate with Delta. Therefore, you and the dental office do not need to re-submit the claim for periodic payments. However, you are expected to notify Delta if treatment ceases early.

Delta attempts to process all claims within a reasonable processing time. If a claim will be delayed more than 60 days, Delta will notify you in writing stating the reason for the delay.

Routine claims questions can be handled by writing to Delta or calling Delta at (717) 766-8500 or toll-free at (800) 932-0783.

Any dissatisfaction with adjustments made or denials of payment should be brought to the attention of the Contract Administrator. The Contract Administrator will advise you of your rights of appeal or other recourse.

SECTION M-10: How To Have A Claim Denial Reviewed:

If a claim is denied in whole or in part, Delta shall notify you and your attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fourteen (14) days, for processing. If there is an extension, you and your attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either you or your attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. You or your attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract

provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta's claim review and appeal process and the time limits applicable to such process, including a statement of your right to bring a civil action under ERISA. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Contract, an explanation is available free of charge upon request by either you or your attending dentist.

If you or your attending dentist want the denial of benefits reviewed, you or your attending dentist must write to Delta within one hundred and eighty (180) days of the date on the denial letter. The letter should state why the claim should not have been denied. Also any other documents, data information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If you do not appeal the denial of benefits, the determination shall be final and binding.

The review shall be conducted for Delta by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental Consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental Consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta will not afford deference to the initial adverse benefit determination.

If after review, Delta continues to deny the claim, Delta shall notify you and your attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta shall send you or your attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the claim for benefits. The notice shall also state that you have a right to bring an action under ERISA. **No legal action may be commenced or maintained**

by you against the Fund more than six (6) months after the receipt of the decision.

If in the opinion of you or your attending dentist, the matter warrants further consideration, you or your attending dentist should advise Delta in writing as soon as possible. The matter shall be immediately referred to Delta's Dental Affairs Committee. This appeal procedure is not mandatory, but is voluntary. This stage can include a clinical examination, if not done previously, and a hearing before the Delta's Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will render a decision within sixty (60) days of your initial request for review described in the previous Paragraph (initial sixty (60) day period). The decision of the Dental Affairs Committee shall be final insofar as Delta is concerned.

At any time during the review process, Delta may determine that an extension of time is required. In unusual cases, such as those which require review by a dental specialist of technical records, the review may take longer than the initial sixty (60) day period. In such cases, written notice of the extension shall be furnished to you prior to the termination of that period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial sixty (60) day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which Delta expects to render the determination on review.

In the case of a claim involving urgent care, Delta shall notify you of its benefit determination, whether adverse or not, as soon as possible, but not later than seventy-two (72) hours after receipt of the request for review. Delta shall include in its notification a description of the expedited appeal process applicable to urgent care claims review. If you fail to provide sufficient information, Delta shall notify you as soon as possible, but not later than twenty-four (24) hours after receipt of the claim of the specific information necessary to complete the claim. Delta shall notify you of the determination as soon as possible, but no later than forty-eight (48) hours after the earlier of Delta's receipt of the specified information, or the end of the period you were afforded to provide the specified additional information.

PART N: VISION CARE BENEFITS

Vision Care Benefits, which are provided on a self-insured basis by the Fund, are administered by the Fund's Contract Administrator. Such benefits are subject to the Rules in this PART N: VISION CARE BENEFITS, as well as being subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION N-1: Eligibility

Covered Participants are covered by the Fund for benefits as specifically provided below in Covered Expenses and Materials and Schedule of Vision Care Services and Materials.

SECTION N-2: Covered Expenses And Materials

Vision care expense benefits are payable for each service or supply listed in the Schedule of Vision Care Services and Materials. Benefits are payable up to the maximum allowance that applies to each service or material. Such services or materials must be rendered by or recommended and approved by a licensed Optometrist, Ophthalmologist or Optician.

SECTION N-3: Schedule Of Vision Care Services And Materials

1. LENSES AND FRAMES

When a correction is prescribed by an ophthalmologist or optometrist, the Fund provides benefits for the necessary materials and professional services connected with the ordering, fitting and adjusting of such materials for all participants. Spectacle lenses, contact lenses and frames are covered up to the aggregate materials allowance under the Fund.

A. SPECTACLE LENSES

the Fund provides benefits for any necessary lenses, including single vision, bifocal, trifocal or other complex lenses necessary for the patient's visual welfare.

B. CONTACT LENSES

Contact lenses are covered under your Fund.

C. FRAMES

The Fund has no restrictions on the type of frames which are covered.

2. PRESCRIPTION SAFETY LENSES AND FRAMES

The Fund provides a benefit to Active Employees only for prescription safety glasses with fixed side shields.

SECTION N-4: SCHEDULE OF BENEFITS

Claims for reimbursement of Covered Expenses and materials will be paid in accordance with the following schedule:

	Customary and Reasonable Charges up to a Maximum of:
Examination (analysis, including tonometry)	$85.00
Materials	
Spectacle Lenses:	
Single Vision (pair)	$90.00
Bifocal (pair)	$120.00
Trifocal (pair)	$150.00
Contact Lenses: If medically required due to cataract surgery or other conditions to correct visual acuity not correctable to 20/70 with spectacle lenses (includes examination and requires Prior Authorization)	Customary and Reasonable, up to a maximum of $300.00
Cosmetic contact lenses	$150.00, separate from exam
Frames	$100.00 maximum
Prescription Safety Eyeglasses	$50.00 maximum

SECTION N-5: Discounts For Vision Care Services And Materials

The Fund has entered into an agreement with National Vision Administrators (NVA) to make available to you discounted vision care services and materials. NVA has entered into agreements with Ophthalmologists, Optometrists and Opticians (Participating Providers) where the Participating Providers have agreed to provide you with discounted vision care services and materials. By entering into the agreement with NVA, the Fund has in no way limited your freedom to choose a vision care services and/or materials provider. The Fund has given you the NVA booklet entitled “Opti-Vision, Vision Care Brochure,” which describes in detail how the program works and its details. You may contact the Contract Administrator, or contact NVA at 800-672-7723, to determine whether a vision care provider is a Participating NVA Provider. You can also

visit NVA's website at www.e-nva.com to determine whether a vision care provider is a Participating NVA Provider. If you choose a Participating NVA Provider, all you have to do is present the card to the Participating Provider and you pay at a discounted rate for exams and materials (lens, contacts, frames). The discounted rates are available for as many services or materials as you choose. You are not limited by the Schedule of Vision Care Services and Materials in SECTION N-3: SCHEDULE OF VISION CARE SERVICES AND MATERIALS. For example, while the Fund will only reimburse you for one set of frames in any eighteen (18) month period, you can purchase as many frames as you choose at the discounted rate. The same is true for contact lenses—except for disposable lenses, which are limited to a "one-time-only" discount—and examinations.

SECTION N-6: CFI Mail Order Contact Lens Service

The Fund has entered into an agreement with Contact Fill-CFI to make available to you discounted mail order contact lenses. To obtain mail order contact lenses through Contact Fill-CFI, you can send the prescription form obtained from your eye doctor to CFI using a mail order form, or you may have your eye doctor contact CFI by phone at 1-866-234-1393 to provide the prescription. Mail order forms may be obtained from the Contract Administrator at 1-800-636-7632, or through CFI at 1-866-234-1393. To reorder your contact lenses, you can do so by phone at 1-866-234-1393; by mail, mailed to P.O. Box 61197, Harrisburg, PA 17106-1197; by faxing the order form to 1-866-589-6969 (you must include credit card information); or by e-mail to cservices@contactfill.com (you must include in the e-mail all the information on the order form plus credit card information).

SECTION N-7: Limitations And Exclusions

1. LIMITATIONS

Payment for Covered Expenses and materials will be limited in the following manner:

- All Covered Participants are entitled to one vision examination and one pair of glasses (frames and lenses, or contact lenses) once in every 18 month period; however Dependents under age 18 shall be entitled to a vision examination and change of lenses, including contacts, once in every 12 month period, if prescribed by the optometrist or ophthalmologist. Frames are allowed once in any 18 month period.

- All Active Employees are entitled to obtain one pair of approved prescription safety eyeglasses with fixed side shields once in every 18 month period. Non-prescription safety eyeglasses are not covered by the Fund. While you may obtain prescription safety eyeglasses at a different 18-month interval than

your regular eyeglasses, the Fund still only provides coverage for one vision examination in an 18-month period.

- In addition, the Fund may approve benefits for additional services if medically required. An example of medical necessity would be a change of lenses required as a result of cataract surgery.

The time periods describe above will begin on the first date of service for such item that is eligible under this Benefit.

2. EXCLUSIONS

In addition to the general rules concerning exclusions from coverage in PART F: BENEFIT AND COVERAGE EXCLUSIONS, the following specific exclusions apply to Vision Care Benefits:

1. Orthoptics or vision training, plano (non-prescription) lenses or frames for nonprescription lenses, sunglasses or glasses secured when there is no prescription change.

2. Lenses and frames furnished under this program which are lost, scratched or broken, will not be replaced except at the normal intervals when services are otherwise available.

3. Medical or surgical treatment of the eyes, drugs or medications.

4. Services or materials provided as a result of any workers' compensation law or similar legislation, or obtained through or required by any government agency or program, whether federal, state, or any subdivision thereof.

5. Loss from war or while in military service.

6. Any eye examination required by an employer as a condition of employment; or any service or material provided by any other vision care plan, or group benefit plan containing benefits for vision care.

7. Examinations or materials not listed above as a covered service.

SECTION N-8: Overages

Charges for materials and services not covered under the Fund provisions and schedule of benefits described above will be the sole responsibility of the Covered Participant.

SECTION N-9: Claims Procedures

In addition to the general rules concerning how to make a claim for benefits set forth in PART G, the following rules apply to Vision Benefits.

Vision care benefits under the Health and Welfare Fund are obtained by submitting a vision benefits claim form to the Contract Administrator. To claim vision care benefits under the Fund, you should do the following:

- Obtain a vision claim form from the Contract Administrator. Be sure to specify that it is a vision claim which you would like to file.
- Be sure you and your provider (optometrist, ophthalmologist or optician) have fully completed the form.
- Claims must be filed within six (6) months following the date on which charges were incurred.

SECTION N-10: Appeal Of An Adverse Benefit Determination

If you disagree with a claim denial or other determination by the Contract Administrator, you have the right to file an appeal with the Board of Trustees. For information concerning the appeal procedures, please refer to PART G: Benefit Claims, Eligibility Determinations and Appeals Procedures.

PART O: DISABILITY (ACCIDENT AND SICKNESS) BENEFITS

Disability (Accident and Sickness) Benefits, which are provided on a self-insured basis by the Fund, are administered by the Fund's Contract Administrator. Such benefits are subject to the Rules in this PART O: DISABILITY (ACCIDENT AND SICKNESS) BENEFITS, as well as being subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION O-1: ELIGIBILITY

Active Employees are covered by Disability Benefits of the Fund. There is no disability benefits coverage for Dependents.

SECTION O-2: SCHEDULE OF BENEFITS

Basic Weekly Benefits:	$450.00*
• Date Benefits Commence:	
○ Accident	First Day
○ Sickness	Eighth Day
• Maximum Benefit	26 Weeks
Extended Weekly Benefits:	$450.00*
• Maximum Benefit	26 Weeks

* The Fund also withholds and remits the FICA Tax and the Pennsylvania Unemployment Compensation Tax, if any, on the amount of disability benefits subject to such taxation. If you so elect, the Fund will also withhold and remit Federal Income Tax from your disability benefits.

SECTION O-3: DESCRIPTION OF BENEFITS

1. Basic Weekly Benefits

A weekly benefit is payable to an Active Employee, in addition to any other benefits that are payable under an individual policy of insurance (such as automobile), who becomes disabled as a result of a non-occupational injury, sickness or illness. Benefits begin on the first day of disability due to injury, accident or hospital confinement, and the eighth day of disability due to sickness or illness. For the purposes of disability benefits under the Fund, the term "disability" means an inability because of an injury or illness to perform any work as a pipefitter in the construction and service industries.

2. EXTENDED WEEKLY BENEFITS

If you continue to be totally disabled due to a non-occupational injury, sickness or illness after you have been paid your 26 weeks of Basic Weekly Benefits, you may be eligible for up to an additional 26 weeks of benefits, if approved by the Board of Trustees.

SECTION O-4: Duration of Disability Income Benefits

3. BASIC WEEKLY BENEFITS

An Active Employee shall receive the amount stated in the Schedule of Benefits above per week for each week of total disability, or during partial weeks of disability a daily rate of one-seventh of the weekly rate for up to 26 weeks.

4. EXTENDED WEEKLY BENEFITS

An Active Participant shall receive the amount stated in the Schedule of Benefits above per week for each week of total disability, or during a partial week of disability a daily rate of one-seventh of the weekly rate, for up to an additional 26 weeks of benefits after all Basic Weekly Benefits are paid.

SECTION O-5: How To Claim Disability Benefits

In addition to following all of the rules in PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES, concerning how to claim all types of benefits under the Fund, you must follow the rules set forth below when making a claim for disability benefits:

- If you become disabled, you should promptly submit a Disability Claim Form to the Fund's Contract Administrator.

SECTION O-6: Appeal Of An Adverse Benefit Determination

If you disagree with a claim denial or other determination by the Contract Administrator, you have the right to file an appeal with the Board of Trustees. For information concerning the appeal procedures, please refer to PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES

PART P: DEATH BENEFITS

Death Benefits, which are provided on a self-insured basis by the Fund, are administered by the Fund's Contract Administrator. Such benefits are subject to the Rules in this PART P: DEATH BENEFITS, as well as being subject to all the rules in Parts A through I of this Summary Plan Description.

SECTION P-1: Eligibility

A benefit is payable upon the death from any cause, including work-related injury and illness, of

- an eligible Active Employee;
- all Retired Employees receiving pensions from the Local 520 Pension Fund who were eligible for benefits under this Fund on the effective date of pension benefits

SECTION P-2: Schedule Of Benefits

- Active Employees and Disabled Participants under age 70: $5,000.00.
- Eligible Retired Participants: $2,000.00.

Under the terms of the Merger Agreement between the Fund and the Plumbers and Steamfitters Local No. 810 Health and Welfare Fund, Active Employees who are former participants in the Local No. 810 Fund and who were Active Employees or available for work under the Local No. 810 collective bargaining agreement on the date of the merger are eligible for an additional death benefit of $2,000.00, provided they are Active Employees or available for work under the Local 520 collective bargaining agreement on the date of death.

SECTION P-3: Beneficiary Designation

Each Active Participant should designate a beneficiary to whom the death benefit and any other benefit that would have been payable to or on behalf of a deceased Active Participant may be paid. This may be done by filling out a beneficiary designation card which you can obtain from the Contract Administrator. A beneficiary may be changed at any time by completing a new beneficiary designation card. No change in beneficiary will take effect until the new beneficiary designation is received by the Contract Administrator. If a Participant fails to designate a beneficiary, the Death Benefits shall be paid in the following order: (1) to the Participant's spouse, if living; otherwise to (2) any surviving children, (3) otherwise to any surviving parents, (4) otherwise to the Participant's estate.

SECTION P-4: Exclusions From Coverage For Death Benefits

In addition to general rules concerning exclusions from coverage in PART F: BENEFIT AND COVERAGE EXCLUSIONS, the following specific exclusions apply to Death Benefits.

1. No benefits are payable under this PART P: DEATH BENEFITS if death results in whole or in part from any of the following:

2. Suicide or intentionally self-inflicted injury while sane or insane.

3. Participation in the commission of a felony or misdemeanor other than a felony or misdemeanor arising under a Motor Vehicle Code or Fish and Game Laws.

4. War or act of war or service in the armed forces of any nation.

5. Use of illegal drugs.

SECTION P-5: Claims Procedure

The claim form must be accompanied by a death certificate.

SECTION P-6: Appeal Of An Adverse Benefit Determination

If you disagree with a claim denial or other determination by the Contract Administrator, you have the right to file an appeal with the Board of Trustees. For information concerning the appeal procedures, please refer to PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES.

PART Q: ACCIDENTAL DEATH AND DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS

Accidental Death and Dismemberment and Loss-of-Sight Benefits, which are provided on a self-insured basis by the Fund, are administered by the Fund's Contract Administrator. Such benefits are subject to the Rules in this PART Q: ACCIDENTAL DEATH AND DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS, as well as being subject to all the General Rules in Parts A through I of this Summary Plan Description.

SECTION Q-1: Eligibility

In addition to any other benefits payable under the Fund, a benefit of $5,000.00 is payable upon the accidental death or loss of a limb or loss of sight by an Active Employee, including work-related death or injury, in accordance with the following:

- Death or loss must be through external, violent and accidental means and must occur within one year from the date of the accident.
- Loss of a limb means dismemberment by severance at or above the wrist or ankle joint.
- Loss of sight means total and irrevocable loss of sight of both eyes.
- If more than one limb is lost or if a limb is lost and death results from any one incident, only one benefit shall be payable.

SECTION Q-2: Beneficiary Designation

Each Active Participant should designate a beneficiary to whom the death benefit and any other benefit that would have been payable to or on behalf of a deceased Active Participant may be paid. This may be done by filling out a beneficiary designation card which you can obtain from the Contract Administrator. A beneficiary may be changed at any time by completing a new beneficiary designation card. No change in beneficiary will take effect until the new beneficiary designation is received by the Contract Administrator.

SECTION Q-3: Exclusions From Coverage For Accidental Death And Dismemberment Benefits

In addition to general rules concerning exclusions from coverage in PART F: BENEFIT AND COVERAGE EXCLUSIONS, the following specific exclusions apply to death benefits. No benefits are payable under this PART Q: ACCIDENTAL DEATH AND DISMEMBERMENT AND LOSS-OF-SIGHT BENEFITS if death results in whole or in part from any of the following:

1. Suicide or intentionally self-inflicted injury while sane or insane.

2. Participation in the commission of a felony or misdemeanor other than a felony or misdemeanor arising under a Motor Vehicle Code or Fish and Game Laws.

3. War or act of war or service in the armed forces of any nation.

4. Use of illegal drugs.

5. No accidental death or dismemberment benefit is payable when death or loss results in whole or in part from bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections by pyogenic organisms that occur with and through an accidental cut or wound), disease, or illness of any kind.

SECTION Q-4: Claims Procedure

For the accidental death benefit, the claim form must be accompanied by the death certificate and such proof of accidental death as the Fund may require. For dismemberment and loss of sight, the claim form must be accompanied by such proof of loss as the Fund may require.

SECTION Q-5: Appeal Of An Adverse Benefit Determination

If you disagree with a claim denial or other determination by the Contract Administrator, you have the right to file an appeal with the Board of Trustees. For information concerning the appeal procedures, please refer to PART G: BENEFIT CLAIMS, ELIGIBILITY DETERMINATIONS AND APPEALS PROCEDURES**.**