TEAMSTERS LOCAL UNION 966

HEALTH FUND

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

(Premier Plan)

(January 1, 2010)

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ADOPTION

The Trustees of the Teamsters Local Union 966 Health Fund ***(Trustees)*** have caused this restated Teamsters Local Union 966 Health Plan ***(Plan)*** to take effect as of the first day of January 2009. This is a revision of the Plan previously adopted June 1, 2003. We have read the document herein and certify the document reflects the terms and conditions of the Employee welfare benefit Plan as established by the ***Trustees***.

Union Trustees

_____
James R. Anderson

_____
Gerard Covello

DATE:_____

Employer Trustee

_____
Herbert R. Ricklin

SUMMARY PLAN DESCRIPTION

Name of Plan:

Teamsters Local Union 966 Health Fund

Name, Address and Phone Number of Plan Sponsor:

Trustees of the Teamsters Local Union 966 Health Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(888) 490-8800

Employer Identification Number:

13-1911036

Plan Number:

501

Type of Plan:

Welfare Benefit Plan: life insurance, accidental death and dismemberment, burial, medical, dental, prescription drug and vision benefits.

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***Trustees*** and shall hereinafter be referred to as the ***Plan Administrator or claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:

Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(888) 490-8800

Legal process may be served upon the ***Plan Administrator*** or the ***Trustees***.

Name, Title, Address and Principal Place of Business for the *Trustees*:

Union Trustees

James R. Anderson
Teamsters Local Union 966
300 Knickerbocker Road
Cresskill, NJ 07626

Gerard Covello
Teamsters Local Union 966
300 Knickerbocker Road
Cresskill, NJ 07626

Employer Trustee

Herbert R. Ricklin
Herbert R. Ricklin & Associates
374 Millburn Ave.
Millburn, NJ 07041

Health Fund:

This Health Fund has been established pursuant to collective bargaining agreements between Local Union 966 of the International Brotherhood of Teamsters and several ***Employers***. The Health Fund provides benefits for all ***Employees*** covered under the collective bargaining agreements. In addition, certain non-bargaining ***Employees*** of the Union and the ***Employers*** are also provided benefits by the Health Fund. ***Employees*** have a right to obtain a copy of the collective bargaining agreement. A written request for such copy should be submitted to the ***Plan Administrator.*** The collective bargaining agreement is available for examination in the ***Plan Administrator's*** office.

Reservation of Rights:

Plan benefits for participants are not guaranteed. The ***Trustees*** reserve the right to change or discontinue (1) the types and amounts of benefits under this ***Plan*** and (2) the eligibility rules, including those rules providing extended or accumulated eligibility even if extended eligibility has already been accumulated. The nature and amount of plan benefits and eligibility rules are always subject to the actual terms of the ***Plan*** as it exists at the time the claim occurs. The ***Trustees*** have the sole and exclusive right and discretion to interpret the ***Plan***, its rules and regulations, as to eligibility, the types and extent of benefits provided, administrative procedures and all other provisions set forth herein.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels or ***termination of coverage,*** refer to the following sections:

Schedule of Benefits
Effective Date of Coverage
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***Employers*** and from the covered ***Employees*** and their covered ***dependents.*** The ***Trustees,*** working with the ***Plan Administrator*** and their advisors**,** evaluate the costs of the ***Plan*** based on projected ***Plan*** expenses and they determine the recommended amount to be contributed by the ***Employers*** and the amount to be contributed by the covered ***Employees***, if any**.**

Funding Method:

The ***Trustees*** will maintain a trust for the receipt of money and property to fund the ***Plan,*** for the management and investment of such funds and for the payment of ***Plan*** benefits and expenses from such funds.

The ***Trustees*** shall deliver, from time to time to the trust, amounts of money and property as shall be necessary to provide the trust with sufficient funds to pay all ***Plan*** benefits and reasonable expenses of administering the ***Plan*** as the same shall be due and payable. The ***Trustees*** may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose and may pay the premiums, therefore, directly or by funds deposited in the trust.

All funds received by the trust and all earnings of the trust shall be applied toward payment of ***Plan*** benefits and reasonable expenses of administration of the ***Plan*** except to the extent otherwise provided by the ***Plan*** documents. The ***Trustees*** may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the ***Plan.***

Covered persons shall look only to the funds in the Trust for payment of ***Plan*** benefits and expenses.

Ending Date of Plan Year:

December 31st

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedures.*

The designated ***claims processors*** are:

Carday Associates, Inc.
CIGNA HealthCare
Envision RxOptions
Self-Insured Dental Services
Amalgamated Life Insurance Company

Statement of ERISA Rights:

As a participant in the Teamsters Local Union 966 Health Fund, the participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About The Plan and Benefits

Examine, without charge, at the ***Plan Administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** 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 ***Plan Administrator***, copies of documents governing the operation of the ***Plan,*** including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The ***Plan Administrator*** may make a reasonable charge for the copies.

Receive a summary of the ***Plan's*** annual financial report. The ***Plan Administrator*** is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the ***Employee***, spouse or ***dependents*** if there is a loss of coverage under the ***Plan*** as a result of a qualifying event. The ***Employee*** or his or her

dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing the COBRA continuation coverage rights.

A reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health ***Plan***, if the ***covered person*** has creditable coverage from another Plan. The ***covered person*** should be provided a certificate of creditable coverage, free of charge, from their group health Plan or health insurance issuer when they lose coverage under the Plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if they request it before losing coverage, or if they request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, the ***covered person*** may be subject to a ***preexisting condition*** exclusion for twelve (12) months (eighteen (18) months for ***late enrollees***) after the ***covered person's*** enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for ***Plan*** participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate this ***Plan,*** called "fiduciaries" of the ***Plan,*** have a duty to do so prudently and in the interest of ***Plan*** participants and beneficiaries. No one, including the ***Employer***, a union, or any other person, may fire the ***Employee*** or otherwise discriminate against the ***Employee*** in any way to prevent the ***Employee*** from obtaining a health benefit or exercising his or her rights under ERISA.

Enforce The Rights

If a claim for a health benefit is denied or ignored, in whole or in part, the ***covered person*** has 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 a ***covered person*** can take to enforce the above rights. For instance, if the ***covered person*** requests a copy of ***Plan*** documents or the latest annual report from the ***Plan*** and does not receive them within thirty (30) days, the ***covered person*** may file suit in a Federal court. In such a case, the court may require the ***Plan Administrator*** to provide the materials and pay the ***covered person*** up to one hundred ten dollars ($110) a day until the ***covered person*** receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the ***covered person*** has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court. In addition, if the ***covered person*** disagrees with the ***Plan's*** decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the ***covered person*** may file suit in Federal court. If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if the ***covered person*** is

discriminated against for asserting his or her rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the ***covered person*** is successful, the court may order the person they have sued to pay these costs and fees. If the ***covered person*** loses, the court may order them to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If the ***covered person*** has any questions about this ***Plan***, they should contact the ***Plan Administrator***. If the ***covered person*** has any questions about this statement or about their rights under ERISA, or if they need assistance in obtaining documents from the ***Plan Administrator***, they should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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. The ***covered person*** may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Conformity With Applicable Laws

This ***Plan*** shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this ***Plan,*** including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the ***Plan Administrator*** to pay claims which are otherwise limited or excluded under this ***Plan,*** such payments will be considered as being in accordance with the terms of this ***Plan*** document. It is intended that the ***Plan*** will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable laws.

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The ***Plan*** will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the ***Plan*** will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the ***Plan*** to obtain premiums or determine or fulfill its responsibility for coverage and provision of ***Plan*** benefits that relate to a ***covered person*** to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or ***Plan*** maximums as determined for a ***covered person's*** claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing ***Employee*** contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the ***Plan.***

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and ***Plan*** performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business Planning and development, such as conducting cost-management and Planning-related analyses related to managing and operating the ***Plan,*** including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the ***Plan***, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
  (b) customer service, including the provision of data analysis for policyholders, Plan sponsors or other customers;
- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the ***Plan*** will disclose PHI to other health benefit Plans, health insurance issuers or HMOs for purposes related to the administration of these Plans.

The ***Plan*** will disclose PHI to the ***Plan Administrator*** only upon receipt of a certification from the ***Plan Administrator*** that the ***Plan*** documents have been amended to incorporate the following provisions. With respect to PHI, the ***Plan Administrator*** agrees to certain conditions.

The ***Plan Administrator*** agrees to:

- Not use or further disclose PHI other than as permitted or required by the ***Plan*** document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the ***Plan Administrator*** provides PHI received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***Plan Administrator*** with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a ***covered person;***
- Not use or disclose PHI in connection with any other benefit or Employee Benefit Plan of the ***Plan Administrator*** unless authorized by the ***covered person;***
- Report to the ***Plan*** any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a ***covered person*** in accordance with HIPAA's access requirements***;***
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the ***Plan*** available to the Health and Human Services Secretary for the purpose of determining the ***Plan's*** compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the ***Plan*** that the ***Plan Administrator*** still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the ***Plan Administrator*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:
  - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the ***Plan Administrator*** creates, receives, maintains or transmits on behalf of the ***Plan****;*
  - Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20)(iii) is supported by reasonable and appropriate security measures;
  - Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
  - Report to the ***Plan*** any security incident of which it becomes aware**.**

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review*, *Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Vision Expense Benefit, Plan Exclusions* and *Preferred Provider Organization.*

MEDICAL BENEFITS:

Maximum Benefit Per Covered Person While Covered By This Plan:

Medical	$300,000
Inpatient and Outpatient Chemical Dependency	$40,000

Maximum Benefit Per Covered Person Per Calendar Year For:

Home Health Care	120 visits
Chiropractic Treatment	10 visits
Physical Therapy	30 visits
Routine Physical Examination (employee only)	$125
Inpatient and Outpatient Chemical Dependency	$8,000
Outpatient Mental and Nervous Disorders	40 visits
Private Duty Nursing (8 hours per shift)	15 shifts
Ambulance	$500
Vision Services	$200
Hearing Aid	$650
Dental Treatment	$1,500
Prescription Drugs	$8,000

Calendar Year Deductible: (applies to *non-preferred providers*)

Individual Deductible (Per Person)	$500
Family Deductible (Aggregate)	$1,000

Co-pays Per Occurrence: (Refer to *Medical Expense Benefit, Co-pay)*

Inpatient Hospital Admission	$250
Emergency Room or Outpatient Hospital Visit (waived if admitted)	$100
Preferred Provider Physician Office Visit	$25
CT Scan or MRI	$75

Out-of-Pocket Medical Expense Limit Per Calendar Year: (applies only to *preferred providers*)

Individual (Per Person)	$5,000

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket Medical Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year and, for the services of ***preferred providers*** and ***non-preferred providers,*** after the individual or family deductible has been satisfied and until the individual out-of-pocket medical expense limit has been reached. Thereafter, for the services of ***preferred providers*** the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Medical Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

Benefit Description	***Preferred Provider***	***Non-preferred Provider***
Inpatient Hospital	100% after $250 c***o-pay*** for 1st 31 days, 75% thereafter	50% no deductible
Emergency Room Services	100% after $100 ***co-pay***	50% no deductible
(***Co-pay*** waived if admitted – charges must be incurred within 48 hours of ***injury*** or ***illness***)		
Outpatient Hospital Services	100% after $100 ***co-pay***	50% after deductible
Physician's Services		
Home and Office Visit (including x-rays and lab)	100% after $25 ***co-pay***	50% after deductible
Inpatient Visit	100% after $25 ***co-pa***	50% after deductible
Surgery	100% after $25 ***co-pay***	50% after deductible
Second Surgical Opinion	100% after $25 ***co-pay***	50% after deductible

Benefit Description	***Preferred Provider***	***Non-preferred Provider***
Anesthesiology	100% after $25 ***co-pay***	50% after deductible
Diagnostic X-rays & Lab		
Inpatient	100%	50% after deductible
Outpatient	100% $75 ***co-pay*** CT Scan or MRI	50% after deductible
Durable Medical Equipment	80%	50% after deductible
Well Child Care & Immunizations Limitation: through age 2 (age 18 for immunizations)	100% no ***co-pay***	100% no deductible
Routine Physical Examination (employee only) Limitation: $125 ***maximum benefit*** per calendar year	100% no ***co-pay***	no coverage
Routine Mammograms	100% after $25 ***co-pay***	50% after deductible
Extended Care Facility Limitation: 120 days ***maximum benefit*** per confinement	100%	50% after deductible
Home Health Care Limitation: 120 visits ***maximum benefit*** per calendar year	100% after $25 ***co-pay***	50% after deductible
Mental and Nervous Disorders		
Inpatient Services Limitation: 21 days ***maximum benefit*** per confinement	100% after $25 ***co-pay***	50% after deductible

Benefit Description	***Preferred Provider***	***Non-preferred Provider***
Outpatient Services	100% after $25 ***co-pay***	50% after deductible
Limitation: 40 visits ***maximum benefit*** per calendar year		
Chemical Dependency		
Inpatient Services	100% after $25 ***co-pay***	50% after deductible
Outpatient Services	100% after $25 ***co-pay***	50% after deductible
Limitation: $8,000 calendar year, $40,000 lifetime ***maximum benefit*** for all inpatient and outpatient services		
Chiropractic Care		
Office Visits	100% after $25 ***co-pay***	50% after deductible
Limitation: 10 visits ***maximum benefit*** per calendar year per person, $25 maximum covered charge per visit for ***non-preferred providers***		
Physical Therapy		
Office Visits	100% after $25 ***co-pay***	50% after deductible
Limitation: 30 visits ***maximum benefit*** per calendar year $25 maximum covered charge per visit for ***non-preferred providers***		per person,
Hearing Aid and Examination Limitation: $650 ***maximum benefit*** per calendar year	100%	100% no deductible
All Other Covered Expenses	100%	50% after deductible

PRESCRIPTION DRUG PROGRAM:

Participating Pharmacy - Prescription Drug Card 100% after ***co-pay***;

Co-pay Generic: $10 ***co-pay***
Preferred Brand Name: $25 ***co-pay***
Non-Preferred Brand Name: $50 ***co-pay***
Brand Name PPI Medications: 50% ***co-pay***

Limitations: 30-day supply; $8,000 ***maximum benefit*** per person, per calendar year (combined with Mail Order).

If the ***covered person*** purchases a brand name drug for which there is a generic bio-equivalent, the ***covered person*** will be required to pay the difference between the cost of the ***generic*** drug and the brand name requested, plus the usual ***generic co-pay.***

Mail Order Prescriptions 100% after ***co-pay***;

Co-pay Generic: $20 ***co-pay***
Preferred Brand Name: $50 ***co-pay***
Non-Preferred Brand Name: $100 ***co-pay***

Limitations: 90-day supply; $8,000 ***maximum benefit*** per person, per calendar year (combined with Prescription Drug Card).

If the ***covered person*** purchases a brand name drug for which there is a generic bio-equivalent, the ***covered person*** will be required to pay the difference between the cost of the ***generic*** drug and the brand name requested, plus the usual ***generic co-pay.***

DENTAL BENEFITS

Calendar Year Deductible:
Individual Deductible (Per Person) $100

Maximum Benefit Per Covered Person:
Covered Dental Allowances, per calendar year (other than Orthodontics)
Per Person $1,500

Customary and Reasonable Amount Payable For:

Covered Dental Allowances	per schedule
Orthodontic Services	no coverage provided

VISION BENEFITS:

Examination, Lenses and Frames

Maximum benefit per person per calendar year	$200

BURIAL BENEFITS:

Gravesite at Forest Park Green Cemetery, Morganville, NJ

For Employee and Spouse (parent or child if unmarried)

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

The ***Plan*** requires pre-certification of certain services, supplies or treatment, as specified below. Under this ***Plan's*** claim filing procedures, the pre-certification call is considered to be filing a ***pre-service claim*** for benefits. Please see *Claim Filing Procedures* for details regarding a ***covered person's*** rights regarding ***pre-service claim*** determinations and appeals.

PRE-CERTIFICATION

Hospital

All ***hospital*** admissions are to be certified in advance of the proposed ***confinement*** (pre-certification) by the ***Utilization Review Organization,*** except for ***emergencies***. The ***covered person*** or their representative should call the ***Utilization Review Organization*** at least twenty-four (24) hours prior to admission.

Covered persons should contact the Utilization Review Organization by calling:

CareAllies at 1-800-768-4695

Emergency hospital admissions are to be reported to the ***Utilization Review Organization*** within seventy-two (72) hours following admission.

Group health Plans 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, Plans may not, under Federal law require that a provider obtain authorization from the* ***Plan*** *for prescribing a length of stay not in excess of the above periods.*

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be precertified.

Benefits payable for *hospital confinement* shall be reduced by one hundred dollars ($100) if pre-certification is not obtained.

After admission to the ***hospital***, the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the pre-certification been completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

Pre-certification from the ***Utilization Review Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during the ***pre-existing condition*** waiting period.

PRE-CERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. See *Claim Filing Procedures* for more information concerning the appeal process.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the Trustees may arrange for review and/or case management services from a professional qualified to perform such services. The Trustees shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the ***covered person;*** however, the ***Plan*** will generally provide a greater benefit to the ***covered person*** by participating in the program.

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

MENTAL AND NERVOUS DISORDERS OR CHEMICAL DEPENDENCY

CareAllies will manage all ***inpatient*** and ***outpatient*** treatment for ***mental and nervous disorders*** or ***chemical dependency.*** In order for the ***covered person*** to receive benefits from the ***Plan*** for treatment of ***mental and nervous disorders*** or ***chemical dependency,*** such treatment must be authorized and supervised by **CareAllies**.

If the ***covered person*** needs assistance with ***chemical dependency*** or ***mental and nervous disorders,*** the ***covered person*** must first call **CareAllies** before seeking treatment at ***1-800-768-4695.*** **No benefits will be paid for treatment that is not pre-certified by CareAllies.**

PREFERRED PROVIDER OR NON-PREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***non-preferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***non-preferred provider. Covered persons*** should contact the ***Preferred Provider Organization*** for a current listing of ***preferred providers.***

NON-PREFERRED PROVIDERS

A ***non-preferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***non-preferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

REFERRALS

Referrals to a ***non-preferred provider*** are covered as ***non-preferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***non-preferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. ***Non-preferred*** emergency room physician if the treatment is rendered in a preferred facility.

2. ***Non-preferred*** anesthesiologist if the operating ***facility*** is a ***preferred provider.***

3. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***non-preferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***co-pay, coinsurance*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.** The ***covered expenses*** for services, supplies or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.*** Specified preventive care expenses will be covered by this ***Plan.***

CO-PAY

The ***co-pay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment. The service and applicable ***co-pay*** are shown on the *Schedule of Benefits.* The ***co-pay*** must be paid each time a treatment or service is rendered. The ***co-pay*** will not be applied toward the following:

1. The calendar year deductible.

2. The maximum out-of-pocket expense.

3. The deductible carry-over.

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Deductible Carry-Over

Amounts ***incurred*** during October, November and December and applied toward the deductible of any ***covered person,*** will also be applied to the deductible of that ***covered person*** in the next calendar year.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***non-preferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***non-preferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

CALENDAR YEAR OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** for the services of ***preferred providers*** (after satisfaction of any applicable ***co-pays***), the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the services of ***preferred providers*** for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount,*** as applicable***.***

2. Deductible(s).

3. ***Co-pays.***

4. Expense ***incurred*** as a result of failure to obtain pre-certification.

MAXIMUM BENEFIT

The ***maximum benefit*** payable on behalf of a ***covered person*** is shown on the *Schedule of Benefits*. The ***maximum benefit*** applies to the entire time the ***covered person*** is covered under the ***Plan,*** either as an ***Employee, dependent, alternate recipient*** or under COBRA. If the ***covered person's*** coverage under the ***Plan*** terminates and at a later date he again becomes covered under the ***Plan,*** the ***maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered person*** during any period of coverage.

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.*** All separate ***maximum benefits*** are part of, and not in addition to, the ***maximum benefit.*** No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan.***

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits; refer to *Utilization Review.*

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable***.***

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   a. Admission fees and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an Employee of the ***hospital;***
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   g. X-ray and diagnostic laboratory procedures and services;

h. Oxygen and other gas therapy and the administration thereof;
i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility.***

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an ***elective surgical procedure*** (non-emergency surgery) is recommended by the ***physician***.

The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

TRANSPLANT

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant. If the recipient is also a ***covered person, covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government Plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan.*** The donor's expense shall be applied to the recipient's ***maximum benefit.*** In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

   If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Benefits for organ or tissue transplants are subject to the ***maximum benefit*** shown on the *Schedule of Benefits.*

WILMS TUMOR

Covered expenses shall include charges for treatment of Wilms Tumor, including charges for autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***Employee,*** and the covered female spouse of a covered ***Employee***.

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** does not cover services, supplies and treatments for elective abortions or complications from an abortion.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***Employee*** or covered spouse. Reversal of sterilization is not a ***covered expense.***

INFERTILITY

Covered expenses for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be a ***covered expense***.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care while the mother is confined for delivery for a period not to exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours following a Cesarean Section. However, if a different length of stay is provided in accordance with the guidelines established by the:

1. American College of Obstetricians and Gynecologists, and

2. American Academy of Pediatrics;

then, benefits will be paid in accordance with such guidelines.

WELL CHILD CARE

Covered expenses shall include charges for routine physical examinations for covered ***dependent*** children through age two (2). Also covered are charges for lead poisoning screening as mandated by New Jersey state law. ***Covered expenses*** shall include charges for immunizations for covered ***dependent*** children through age eighteen (18).

ROUTINE PHYSICAL EXAMINATION

Covered expenses shall include charges for routine examinations, including any accompanying x-rays and diagnostic lab tests (not required as the result of an ***illness*** or ***injury***), subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

ROUTINE MAMMOGRAMS

Covered expenses shall include charges for routine mammograms, payable as specified on the *Schedule of Benefits.*

ROUTINE PSA TESTING

Covered expenses shall include charges for routine prostate cancer screening, subject to the ***maximum benefit*** specified on the *Schedule of Benefits* for Routine Physical Examination.

THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy.

2. Services of a ***professional provider*** for speech therapy that supplements speech therapy services required to be provided by local school boards under applicable law, subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

3. Radiation therapy and chemotherapy.

4. Dialysis therapy or treatment.

5. Home infusion therapy.

6. Services of a ***professional provider*** for occupational or respiratory therapy.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital*** for at least three (3) consecutive days;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The extended care ***confinement*** begins within fourteen (14) days after discharge from that ***hospital confinement,*** or within fourteen (14) days after a related extended care ***confinement;*** and

4. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown in the *Schedule of Benefits*.

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility,*** provided:

1. The ***home health care*** is being provided for the same or related condition for which the patient has been hospitalized for at least three (3) days;

2. The ***home health care*** is being provided in accordance with a ***home health care*** Plan which is established within fourteen (14) days following the beginning of ***home health care.***

Covered expenses shall include:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse. If full-time or twenty-four (24) hour nursing care is required on a short-term basis, such care will be covered for a maximum of three (3) days.

2. Physical, respiratory, occupational or speech therapy.

3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services. If full-time or twenty-four (24) hour services are required on a short-term basis, such care will be covered for a maximum of three (3) days.

4. Medical social service consultations.

5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary.***

6. Medical supplies, appliances and equipment.

7. Drugs and medicines that can be obtained only upon the written prescription of a ***physician.***

8. Laboratory services.

9. Special meals.

10. Diagnostic and therapeutic services, including surgical services, performed in a ***hospital outpatient*** department, a ***physician's*** office or any other licensed health care ***facility,*** but only to the extent that such charges would have been covered had the patient been hospitalized.

A visit by a member of a ***home health care*** team and four (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit.

Covered expenses shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

No ***home health care*** benefits will be provided for:

1. Services or supplies not included in the ***home health care*** Plan;

2. Services of an individual who is a member of the patient's family or a member of the patient's spouse's family;

3. ***Custodial care;***

4. Transportation services; or

5. Any period during which the patient is not under the continuing care of a ***physician.***

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of necessary ***durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage.

Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage.

Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall also include charges for the surgical extraction of teeth and the treatment of tumors or cysts.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; crutches; electronic pacemakers; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; blood and blood plasma that is not donated or replaced;
surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC SURGERY

Cosmetic surgery shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result requires surgery. ***Cosmetic surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

3. It is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part.

4. It is for reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

MASTECTOMY

Covered expenses shall include the following:

1. ***Medically necessary*** mastectomy, including complications from a mastectomy, including lymphedemas.

2. Reconstructive breast surgery necessary because of a mastectomy.

3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

4. External breast prosthesis and permanent internal breast prosthesis.

MENTAL AND NERVOUS DISORDERS

Inpatient

Subject to the pre-certification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance,*** up to the ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders.***
Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient

The ***Plan*** will pay the applicable ***coinsurance,*** up to a ***maximum benefit*** as defined in the *Schedule of Benefits,* for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders.***

CHEMICAL DEPENDENCY

The ***Plan*** will pay for the treatment of ***chemical dependency*** as shown on the *Schedule of Benefits.* Benefits shall be payable for ***inpatient*** or ***outpatient*** treatment in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider.***

ACUPUNCTURE

Acupuncture to induce surgical anesthesia or for therapeutic purposes shall be a ***covered expense.***

PRIVATE DUTY NURSING

Services of a Registered Nurse for private duty ***nursing*** shall be a ***covered expense.***

CHIROPRACTIC CARE

Covered expense includes initial consultation, x-rays and treatment (but not maintenance care), subject to the ***maximum benefits*** shown on the *Schedule of Benefits.*

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a ***professional provider; physician; hospital; facility*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan.***

REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified cardiac/pulmonary rehabilitation programs***.***

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.

2. Charges for or in connection with: treatment of disease of the teeth; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

3. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses; dispensing optician's services.

4. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery.*

5. Charges for ***custodial care,*** domiciliary care or rest cures.

6. Charges for recreational or leisure therapy.

7. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

8. Charges for travel or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

9. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

10. Charges for expenses related to hypnosis.

11. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug ***co-pay*** applicable thereto.

12. Charges for any services, supplies or treatment not specifically provided herein.

13. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an Employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

14. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

15. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

16. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

17. Charges for treatment or surgery for sexual dysfunction or inadequacy, unless related to organic ***illness.***

18. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

19. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

20. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

21. Charges for marital counseling.

22. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

23. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

24. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

25. Charges for chelation therapy, except as treatment of heavy metal poisoning.

26. Charges for sex therapy, diversional therapy or recreational therapy.

27. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

28. Charges for holistic medicines or providers or naturopathy.

29. Charges for or related to the following types of treatment:
    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

30. Charges for structural changes to a house or vehicle.

31. Charges for maternity/pregnancy for dependent children.

32. Charges for services, supplies and treatments for elective abortions or complications from an abortion.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with Envision RxOptions to charge the ***Plan*** and ***covered persons*** reduced fees for covered prescription drugs.

CO-PAY

The ***co-pay*** is applied to each covered pharmacy drug charge and is shown on the S*chedule of Benefits*. The ***co-pay*** amount is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***co-pay,*** and then submit the receipt to the ***Pharmacy Organization*** for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***co-pay,*** plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy.***

If the ***covered person*** purchases a brand name drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the usual generic ***co-pay.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the usual generic ***co-pay.***

CO-PAY

The ***co-pay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* It is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin when prescribed by a ***physician*** and the following diabetic supplies: insulin syringes and needles; urine testing strips for glucose; lancets and lancet devices; alcohol swabs; ketone testing strips; blood testing strips for glucose; and ketose tablets.

4. Allergy medications including Claritin OTC and generic Allegra (Fexofenadine) except injectable medications.

5. Tretinoin, all dosage forms (e.g. Retin-A), for treatment of acne only, for ***covered persons*** under age twenty-six (26).

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

3. Claritin OTC and generic Allegra; all other similar low and non-sedating antihistamine medications with prior authorization.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or Claritin OTC.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera; blood or blood plasma.

4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”

5. Experimental drugs and medicines, even though a charge is made to the ***covered person.***

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A drug or medicine which is provided under the *Home Health Care* benefit of this ***Plan.***

10. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

11. A charge for hypodermic syringes and/or needles (other than insulin), insulin pens and cartridges.

12. A charge for infertility medication.

13. A charge for contraceptives, oral or other medication or device, Levonorgestrel (NorPlant).

14. A charge for any drug used for cosmetic purposes, including, but not limited to:
    a. Drugs whose sole purpose is to stimulate or promote hair growth (e.g. Minoxidil); and
    b. Tretinoin, all dosage forms (e.g. Retin-A) for ***covered persons*** age twenty-six and older.

15. A charge for growth hormones and all analogs.

16. A charge for appetite suppressants or drugs used for the purpose of weight loss, unless ***medically necessary*** for the treatment of Attention Deficit Disorder (ADD) and Narcolepsy.

17. All vitamins.

18. A charge for erectile dysfunction medication.

19. Smoking deterrents.

DENTAL EXPENSE BENEFIT

HOW DENTAL COVERAGE WORKS

The ***Fund*** provides dental coverage through Self-Insured Dental Services (SIDS), a panel of ***dentists*** who accept the ***Plan's*** payment as payment in full. Coverage is also provided when a ***covered person*** uses a dentist who is not on the panel. Coverage is as follows:

If a Panel Dentist is used: The ***Fund's*** payment for each dental service is based on the schedule on pages 30-35. Panel dentists accept the ***Fund's*** payment as payment-in-full. The maximum payment on behalf of any ***covered person*** is $1,500 per year, inclusive of any payments made to a ***dentist*** who is not a panel ***dentist***. The patient is responsible for full payment of services after the limit has been reached. However, the panel ***dentists*** will charge no more than the discounted rates in the schedule.

If a dentist who is not a Panel Dentist is used: The ***Fund's*** payment for each dental service is on the schedule on pages 30-35. The ***dentist*** may charge more than the amount paid by the ***Fund***, in which case the patient will be responsible for paying any amount above the ***Fund's*** allowance. The maximum annual ***Plan*** payment on behalf of any ***covered person*** is $1,500, inclusive of payments made to panel ***dentists***. The patient is responsible for full payment of services after the limit has been reached. The fees of non-panel ***dentists*** may be higher than the amounts charged by panel ***dentists***.

In case of an emergency, call SIDS immediately at (516) 396-5500 or (718) 204-7172 to arrange for a panel dentist to provide treatment at no cost, subject to the ***Plan's*** dental maximum.

Orthodontics is a branch of dentistry which attempts to correct irregularities of the teeth through the installation of braces. There is **no orthodontic benefit** payable by the ***Fund***. However, participating orthodontists agree to limit their fees to those listed in the schedule. ***Employees*** and their ***dependents*** using this program will be responsible to pay these fees directly to the participating orthodontist.

SCHEDULE OF COVERED DENTAL ALLOWANCES

Covered expenses include charges incurred for the performance of dental services provided for in the Schedule of Covered Dental Allowances when the dental service is performed by or under the direction of a duly licensed ***dentist***, is essential dental care, and begins and is completed while the individual is covered for benefits. The schedule below shows the maximum the ***Fund*** will pay for any particular dental service, and the maximum a panel ***dentist*** will charge for that service.

Plan Pays

Diagnostic and Preventive

ORAL EXAMINATION $20.00
maximum of two in a calendar year

FULL MOUTH SERIES X-RAYS OR PANORAMIC FILM
10 to 14 periapical and bitewing films 25.00

INTRAORAL FILM
periapical, per film 3.00
bitewing, per film 3.00
$40 X-ray maximum in a calendar year

OCCLUSAL FILM. 10.00

EXTRAORAL FILM. 20.00

PROPHYLAXIS, including scaling and polishing 28.00
maximum of two in a calendar year

FLUORIDE TREATMENT, excluding prophylaxis 10.00
to age 19, 1 application per year

SPACE MAINTAINER 100.00

Basic Restorative

SILVER AMALGAM FILLINGS
one surface 25.00
two surfaces 35.00
three surfaces 42.00
four or more surfaces 53.00

COMPOSITE RESIN
one surface 35.00
two surfaces 45.00
three or more surfaces 55.00

RESIN-INSICAL ANGLE 60.00

Plan Pays

METALLIC INLAY
one surface 150.00
two surfaces 175.00
three or more surfaces 200.00

METALLIC ONLAY 70.00

Major Restorative

CROWNS
acrylic jacket 150.00
porcelain jacket 275.00
plastic with metal 275.00
porcelain with metal 300.00
full or 3/4 cast 250.00

LABIAL VENEER-lab processed 175.00

STAINLESS STEEL CROWN, primary tooth 75.00

PIN RETENTION-per tooth 15.00

POST AND CORE, prefabricated 65.00

CAST POST AND CORE 95.00

Endodontics
x-ray evidence of satisfactory completion required

PULP CAP, direct 11.00

VITAL PULPOTOMY 35.00

ROOT THERAPY
one canal 195.00
two canals 250.00
three canals 340.00
four or more canals 380.00

APICOECTOMY, 1st root 120.00

Plan Pays

APICOECTOMY, maximum per tooth 240.00
RETROGRADE FILLING-per tooth 40.00

Prosthodontic Repairs

DENTURE RELINE
office procedure-complete 75.00
office procedure-partial 60.00
laboratory procedure-complete 125.00
laboratory procedure-partial 100.00

DENTURE REPAIRS
repair partial acrylic saddle/base 60.00
repair cast framework 60.00
broken denture base 60.00
replace tooth in denture 60.00
replace broken facing 50.00
replace broken clasp 60.00
add tooth to existing partial denture 60.00
add clasp to existing partial 60.00

RECEMENTATION
crown or inlay 25.00
bridge 35.00

Prosthodontics

COMPLETE DENTURE
immediate or permanent 425.00

PARTIAL DENTURE-unilateral 150.00

PARTIAL DENTURE-bilateral
acrylic base with clasps and rests 330.00
cast metal base 450.00

Plan Pays

BRIDGE ABUTMENT
crown-plastic with metal 275.00
crown-porcelain fused to metal 300.00
crown-full cast 250.00

BRIDGE PONTIC
full cast 250.00
plastic with metal 275.00
porcelain with metal 300.00

CAST METAL RETNR-ACID ETCH BRIDGE 150.00

Oral Surgery

ROUTINE EXTRACTION 35.00

SURGICAL EXTRACTION
must be demonstrated by x-ray
erupted tooth 60.00
retained root 45.00
impaction-soft tissue 88.00
impaction-partial bony 110.00
impaction-complete bony 185.00

SURGICAL EXPOSURE IMPACTED OR
UNERUPTED TOOTH 60.00

ALVEOLOPLASTY-per jaw 75.00

BIOPSY OF ORAL TISSUE 80.00

REMOVAL OF CYST OR TUMOR
less than 1.25 cm 40.00
greater than 1.25 cm 90.00

INCISION AND DRAINAGE 55.00
no other treatment that visit

FRENULECTOMY 65.00

Plan Pays

HEMISECTION 75.00

ROOT RESECTION 75.00

Periodontics

Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, ***payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.***

Plan Pays

ROOT SCALING AND GINGIVAL CURETTAGE, including prophylaxis
per visit 33.00
full mouth 33.00
periodontal maintenance following periodontal surgery 33.00
maximum payment-$140 in a calendar year

Periodontal Surgery

confirmation by charting and/or x-rays required per quadrant of at least 5 teeth

gingivectomy, gingivoplasty and mucogingival surgery
per quadrant 150.00
osseous graft, per site 50.00
osseous graft, maximum per quadrant 200.00
pedicle soft tissue graft, osseous surgery, including
gingivectomy-per quadrant 300.00

Adjunctive Services

SPECIALIST CONSULTATION, including exam 35.00
maximum of one in a calendar year

PALLIATIVE TREATMENT 15.00
no other treatment that visit

Plan Pays

GENERAL ANESTHESIA/IV SEDATION 60.00
first 30 minutes only

Orthodontics

There is **no orthodontic benefit** payable by the ***Fund***. However, participating orthodontists agree to limit their fees to those listed in the schedule. ***Employees*** and their ***dependents*** using this program will be responsible to pay these fees directly to the participating orthodontist.

You Pay

MINOR TOOTH GUIDANCE /INTERCEPT
removable appliance 225.00
fixed appliance 250.00
active treatment, per month of treatment 50.00

Maximum Charge Per Case **650.00**

COMPREHENSIVE TREATMENT
removable appliance 225.00
harmful habit appliance 225.00
fixed appliance 400.00
active treatment, per month 50.00
passive treatment, per 3 months 50.00
POST-TREATMENT STABILIZATION DEVICE 100.00
Maximum Charge Per Case 2,100.00

HOW TO FILE A DENTAL CLAIM

Each claim for dental benefits must be made in writing on a form provided by Self-Insured Dental Services. **Contact Self Insured Dental Services, Department 77, P.O. Box 9005, Lynbrook, NY 11563-9005, (516) 396-5500 or (718) 204-7172, to obtain the proper forms**. If a panel dentist is used, the dentist will submit the claim directly to Self-Insured Dental Services. Dental claims must be filed within twelve months after the date of service. Claims filed later than twelve months from the date of service will not be reimbursed.

If dental care has been received from more than one ***dentist***, use two claim forms or one claim form with an itemized bill from each ***dentist***. Claim forms and/or bills must show the

dentist or provider's name and federal employer identification number, the name of the patient, a diagnosis, dates and type of service rendered, amount charged for each service, and any amounts paid by other insurance.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan.***

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred,*** except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;

2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;

3. For endodontic treatment, on the date the pulp chamber is opened.

EXTENSION OF BENEFITS

An expense incurred in connection with a dental service that is completed after the termination of a ***covered person's*** eligibility will be deemed to be incurred while that person was eligible if,

1. For crown, fixed bridgework and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while the ***covered person*** was eligible and the device was installed or delivered within one month after the ***covered person's*** eligibility terminated.

2. For root canal therapy, the pulp chamber of the tooth was opened while the ***covered person*** was eligible and the treatment was completed within one month after the ***covered person's*** eligibility terminated.

PRE-TREATMENT REVIEW

This process is intended to the ***covered person*** and ***dentist***, in advance of treatment, what dental will be provided under the ***Plan***. A claim form for pre-treatment review should be filed by the ***dentist*** if the course of treatment prescribed is expected to cost more than $300 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery. The ***dentist*** should complete the claim form describing the planned treatment and the intended charges before starting treatment. Mail the completed form, together with the necessary x-rays and other supporting documentation, to Self Insured Dental Services, Dept. 77, PO Box 9005, Lynbrook, NY 11563-9005.

Self Insured Dental Services will review the proposed treatment and apply the appropriate Plan provisions. The ***covered person*** and ***dentist*** will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. A pre-treatment authorization for a proposed course of treatment that was submitted by one ***dentist***, will remain valid if some or all of the work is done by another ***dentist***. The pre-treatment authorization will be honored for one year after issuance.

A pre-treatment authorization is not a promise of payment. Work must be done while the ***covered person*** is still eligible under the ***Plan*** (except where there is an extension of benefits) and no significant change occurred in the condition of the ***covered person's*** mouth after the pre-treatment estimate was issued. Payment will be made in accordance with ***Plan*** allowances and limitations in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. In these instances, although the ***covered person*** may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive alternate course of treatment. This should in no way be considered a reflection on the treating ***dentist's*** recommendations. By using the pre-treatment review and authorization procedures, the ***covered person*** and ***dentist*** can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a pre-treatment authorization estimate, the benefits paid by the ***Plan*** may be based on the less expensive treatment.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Treatment that is solely for the purpose of cosmetic improvement.

2. Replacement of lost, or stolen appliances.

3. Replacement of a bridge, crown or denture within two years after the date it was originally installed.

4. Replacement of a bridge, crown or denture which is or can be made usable according to common dental standards.

5. Multiple bridge abutments.

6. Procedures, appliances or restorations (except full dentures) whose main purpose is to:
   a. change vertical dimension; or
   b. diagnose or treat conditions of dysfunctions of the temporomandibular joint; or
   c. stabilize periodontally involved teeth.

7. A surgical implant of any type, including any prosthetic device attached to it.

8. Dental services that do not meet common dental standards.

9. Services not included as Covered Dental Expenses in the Dental Schedule.

10. Orthodontic services.

11. Services for which benefits are not payable according to the "Plan Exclusions" section.

VISION EXPENSE BENEFIT

Vision benefits will be paid for the charges for covered vision expenses for ***covered persons*** as shown on the *Schedule of Benefits*. The benefits will apply when charges are ***incurred*** for vision care by a legally licensed ***physician*** or ***professional provider.***

COVERED VISION EXPENSE

The ***Plan*** provides coverage for services, supplies and treatment for the following:

1. Examinations and refractions performed by a licensed Optometrist or Ophthalmologist.

2. Lenses or contacts prescribed by such Optometrist or Ophthalmologist.

3. Frames purchased in conjunction with lenses newly prescribed.

VISION EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for vision expenses ***incurred*** by a ***covered person*** for the following:

1. Services or supplies required as a condition of employment or by any governmental body.

2. Medical or surgical care of the eye.

3. Artificial eyes.

4. Any service performed or supplies provided for special procedures such as orthoptics or any aids for sub-normal vision.

BURIAL BENEFITS

The ***Fund*** has made arrangements with the Forest Park Green Cemetery in Morganville, New Jersey to reserve burial plots for the use of Local 966 members. This particular cemetery was selected because it is well maintained and is an association of separate cemeteries of different religious preferences.

Employees and their spouse (parent or child if unmarried) are entitled to free side-by-side gravesites. If a ***Fund*** gravesite is used for the ***Employee*** or the ***Employee's*** spouse, the adjoining gravesite is automatically reserved.

If the ***Employee*** has no spouse, one gravesite may be used by the ***Employee's*** mother, father or child. Any unmarried dependent child who dies before age 23 (or at any age if physically handicapped or mentally handicapped and incapable of gainful employment) shall also receive a free adjoining gravesite. In such case, however, the ***Employee*** shall be required to pay for the perpetual care.

Contact the ***Plan Administrator*** for full details about the cemetery's location and other provisions relating to this benefit.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies or treatment for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Worker's Compensation law, employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount*** or exceed the ***negotiated rate*** as applicable.

6. To the extent that payment under this ***Plan*** is prohibited by any law of the jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

7. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage, except as specifically provided herein.

8. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

9. Charges for services, supplies or treatment that is considered ***experimental/investigational.***

10. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

11. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider.***

12. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation.*

13. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

14. Benefits which are payable under any one section of this ***Plan*** shall not be payable as a benefit under any other section of this ***Plan.*** For example, if a benefit is eligible under both the *Medical Expense Benefit* section and the *Dental Expense Benefit* section, and is paid under the *Medical Expense Benefit,* the remaining balance will **not** be paid under the *Dental Expense Benefit.*

15. Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.

16. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

17. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony, except that those resulting from a medical condition (such as mental illness) or incurred by the victim of an act of domestic violence shall be covered. Claims shall be denied if the ***Plan Administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person***.

18. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll. Refer to *Enrollment* and *Effective Date of Coverage* for more information.

ACTIVE EMPLOYEE ELIGIBILITY

Collective Bargaining Employees

All ***Employees*** of ***contributing Employers,*** whose employment is covered by the Collective Bargaining Agreement by and between Local Union 966 of the International Brotherhood of Teamsters and their Employer, shall be eligible to enroll for coverage under this ***Plan.***

Non-Bargaining Employees

All full-time non-bargaining ***Employees*** of ***Employers*** who are regularly scheduled to work at least twenty (20) hours per work week shall be eligible to enroll for coverage under this ***Plan.*** This does not include temporary or seasonal ***Employees.*** An ***Employer*** may contribute to the Health Fund on behalf of its full-time non-bargaining ***Employees.*** Contributions for non-bargaining ***Employees*** are permitted provided the Employer maintains its principal place of business within the geographic jurisdiction of Local Union 966 and the Employer has elected to contribute on behalf of all of its full-time non-bargaining ***Employees*** beginning with the month in which they are first employed.

Contributions will not be accepted from an Employer on behalf of its non-bargaining ***Employees*** if that Employer has failed to make the required contributions for its bargaining ***Employees*** pursuant to a Participation Agreement with the Plan.

All full-time employees of Local Union 966, International Brotherhood of Teamsters shall be eligible to enroll for coverage under this Plan.

RETIREE ELIGIBILITY

No coverage is provided for ***Retired Employees*** or their dependents.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***Trustees*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***Employee*** under a legally valid existing marriage between person's of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***Employee's*** natural child, stepchild, legally adopted child or foster child, provided:
   a. The child has not reached the end of the calendar year in which he or she attains age nineteen (19), and;
   b. The child is unmarried, and;
   c. The child is dependent upon the ***Employee*** for more than fifty percent (50%) of his or her support and maintenance.

3. An eligible child shall also include any other child of an ***Employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***Employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***Employee*** elects coverage for himself. An application for enrollment must be submitted to the ***Trustees*** for coverage under this ***Plan***. The ***Trustees/Plan Administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***Trustees/Plan Administrator*** shall determine whether such order is a Qualified Medical Child Support Order (as defined in Section 609 of ERISA) or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***Trustees/Plan Administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption. "Placed for adoption"*** means the date the ***Employee*** assumes legal obligation for the total or partial financial support of the child during the adoption process.

5. Upon written notice to the ***Fund,*** a child who has reached the end of the calendar year of his or her nineteenth (19th) birthday, is attending school or college as a full-time student or has a physical or mental impairment that prevents self-sustaining employment, and is dependent upon the ***Employee*** for more than fifty percent (50%) of his or her support and maintenance, may also be included herein as an eligible ***dependent*** until the end of the calendar year in which the child attains age twenty-three (23).

6. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***Employee*** for support due to a mental retardation and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***Trustees*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental retardation and/or physical disability;

   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An ***Employee*** must file a written application with the ***Plan Administrator*** for coverage hereunder for himself and his eligible ***dependents*** within sixty (60) days of becoming eligible for coverage; and within sixty (60) days of marriage or the acquiring of children or birth of a child. The ***Employee*** shall have the responsibility of timely forwarding to the ***Plan Administrator*** all applications for enrollment hereunder.

The ***Trustees*** must be notified of any change in eligibility of ***dependents,*** including the birth of a child that is to be covered and adding or deleting any other ***dependents.*** Forms are available from the ***Plan Administrator*** for reporting changes in ***dependents'*** eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***Employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)

2. Cessation of Employer contributions toward the other coverage

3. Legal separation or divorce

4. Termination of other employment or reduction in number of hours of other employment

5. Death of ***covered person.***

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***Employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***Plan Administrator's*** receipt of the completed enrollment form.

Special enrollment rights may arise if an individual declines coverage due to other coverage and then subsequently loses that coverage. The circumstances causing a loss of other coverage have been expanded:

Examples:

- Moving out of an HMO service area
- A child losing *dependent* status
- Losing coverage because of the exhaustion of another Plans' maximum lifetime benefit.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***Employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***Employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the first day of the first calendar month following the ***Plan Administrator's*** receipt of the completed enrollment form;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible ***Employees,*** as described in *Eligibility,* are covered under the ***Plan*** on the date they become eligible.

1. *Collective Bargaining Employees*

   Unless specified otherwise by the collective bargaining agreement, a collective bargaining ***Employee*** becomes eligible on the first day of the month in which the sixth (6^{th}) monthly ***Employer*** contribution to the Health Fund is required on the ***Employee's*** behalf. The six (6) months of ***Employer*** contributions do not have to be consecutive, but must be within a consecutive twenty-four (24) month period.

   Continuing Eligibility For Collective Bargaining Employees

   To continue eligibility after satisfying the initial requirements, the ***Employee*** must have continuing ***Employer*** contributions required to be made on his or her behalf to the Health Fund. An ***Employee's*** eligibility will terminate on the last day of the month for which an ***Employer*** contributes to the Health Fund on his or her behalf.

   If an ***Employer*** continuously fails to make required contributions and/or is excessively delinquent in making contributions on behalf and ***Employee***, the ***Trustees*** have the right to terminate coverage.

   If a collective bargaining agreement requires an ***Employer*** to pay contributions on behalf of an ***Employee*** when he becomes unemployed, coverage will remain in effect for up to 12 consecutive months while those contributions are received.

   If an ***Employee*** is out of covered employment because of a non-work related illness or injury, the ***Employee's*** benefit coverage for treatment of that illness or injury will continue for up to 12 months, while the ***Employee*** is totally disabled (unable to work at any job) due to that illness or injury. To be eligible for this extended coverage, the ***Employee*** must be receiving statutory disability benefits.

   If, at the time coverage would usually terminate, a ***dependent*** is totally disabled (unable to perform the normal activities of a person of the same age and sex) due to illness or injury, benefit coverage for that illness or injury will continue for up to 12 months while the ***dependent*** remains totally disabled.

Reinstatement

Should an ***Employee's*** eligibility terminate, it will be reinstated on the first day of the month following the ***Employee's*** return to covered employment provided the ***Employee*** returns within twenty-four (24) consecutive months after being last employed in covered employment. If the ***Employee*** does not return to covered employment within twenty-four (24) consecutive months, the ***Employee*** will be treated as a new ***Employee*** and will be subject to the requirements for initial eligibility outlined above.

2. *Non-Bargaining Employees*

Eligible non-bargaining ***Employees,*** as described in *Eligibility*, are covered under the ***Plan*** the first day of the month in which the sixth (6^{th}) monthly ***Employer*** contribution to the Health Fund is required on the ***Employee's*** behalf. The six (6) months of ***Employer*** contributions do not have to be consecutive, but must be within a consecutive twenty-four (24) month period.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility*, will become covered under the ***Plan*** on the later of the dates listed below, provided the ***Employee*** has enrolled them in the ***Plan*** within thirty (30) days of meeting the ***Plan's*** eligibility requirements.

1. The date the ***Employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***Employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children will be considered a ***dependent*** under this ***Plan*** for thirty (30) days immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***Employee*** must submit an application for enrollment within thirty (30) days of birth.

4. Coverage for a newly adopted child shall be effective on the date the child is ***placed for adoption.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) or *Extension of Benefits* provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

Collective Bargaining Employees

1. The date the ***Plan*** terminates.

2. The date the ***Employee*** is no longer a member of an eligible class.

3. The date a change is made in this ***Plan*** to terminate coverage for an ***Employee's*** class.

4. The date contributions on the ***Employee's*** behalf cease.

5. The date the ***Employee*** fails to pay any required contribution when due.

6. The date the ***Employee*** enters into full-time active duty with the Armed Forces of any country.

7. The last day of the month for which an ***Employer*** is required to contribute to the Health Fund on an ***Employee's*** behalf.

Non-Bargaining Employees

1. The date the ***Plan*** terminates.

2. The date the ***Employee*** is no longer a member of an eligible class.

3. The date a change is made in this ***Plan*** to terminate coverage for an ***Employee's*** class.

4. The date contributions on the ***Employee's*** behalf cease.

5. The date the ***Employee*** fails to pay any required contribution when due.

6. The date the ***Employee*** enters into full-time active duty with the Armed Forces of any country.

7. The last day of the month for which an ***Employer*** is required to contribute to the Health Fund on an ***Employee's*** behalf.

DEPENDENT(S) TERMINATION DATE

1. The date the ***Employer*** terminates the ***Plan*** and offers no other group health Plan.

2. The date the ***Employee's*** coverage terminates. However, if the ***Employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***

3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***Employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a full-time***,*** active member of the Armed Forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

7. The date the ***dependent*** becomes eligible as an ***Employee.***

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If, on the date an ***Employee's*** coverage under this ***Plan*** terminates because the ***Plan*** itself terminates in its entirety or terminates with respect to an ***Employer*** or because medical expense benefits are terminated for all ***covered persons*** or the class of ***covered persons*** to which the ***Employee*** belongs, and an ***Employee*** or ***dependent*** is ***totally disabled,*** benefits will be extended only for the condition causing such ***total disability*** and only during the uninterrupted continuance of that disability. This extended benefit will terminate on the earlier of the following:

1. The date the person is no longer ***totally disabled;***

2. The date the person becomes eligible for ***Medicare;***

3. The date the ***maximum benefits*** under this ***Plan*** have been paid;

4. Twelve (12) months following the date coverage terminated.

If COBRA continuation of coverage is elected by the ***covered person,*** this provision for coverage shall apply after the COBRA continuation of coverage period ends.

SURVIVOR'S BENEFITS

If an ***Employee*** dies while covered under this ***Plan,*** coverage will be continued for his surviving covered ***dependents,*** until the last day of the month following the date of the ***Employee's*** death.

CERTIFICATES OF COVERAGE

The ***Plan Administrator*** shall provide each terminating ***covered person*** with a Certificate of Coverage, certifying the period of time the individual was covered under this ***Plan.*** For ***Employees*** with ***dependent*** coverage, the certificate provided may include information on all covered ***dependents.*** You or your ***dependent*** may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the ***Plan*** and for 24 months following termination of coverage. You may also need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the ***Plan Administrator***, Carday Associates Inc. at 7130 Columbia Gateway Drive, Suite A, Columbia, MD 20146 (telephone 888-490-8800).

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***Employee.***

2. The ***Employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***Employee.***

4. The ***Employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***Employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***Employee,*** or a child's loss of ***dependent*** status, the ***Employee*** or ***dependent*** must notify the ***Trustees/Plan Administrator,*** in writing, of that event within **sixty (60)** days of the event**.** The ***Employee*** or ***dependent*** must advise the

date and nature of the qualifying event and the name, address and Social Security number of the affected individual. **Failure to provide such notice to the *Trustees/Plan Administrator* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the ***Employee*** or ***dependent*** will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***Employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***Employee*** or ***dependent*** chooses to have continued coverage, he must advise the ***Trustees/Plan Administrator*** in writing of this choice. The ***Trustees/Plan Administrator*** must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or
   b. The date the person receives the notice from the ***Trustees/Plan Administrator*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***Trustees/Plan Administrator*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***Employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***Trustees*** require that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***Trustees*** or the ***Trustee's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***Employee*** or as a spouse will pay the rate applicable to an ***Employee*** if

coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***Employee.***

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***Employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***Employee.***

2. Divorce or legal separation from an ***Employee.***

3. ***Employee's*** entitlement to ***Medicare*** if it results in a loss of coverage under this ***Plan.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***Employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***Employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***Employee,*** divorce or legal separation from the ***Employee,*** or the child's loss of ***dependent*** status. However, if the spouse of an Employee loses eligibility because of the death of the Employee, continuation coverage is available for an indefinite period of time.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***Trustees.***

4. The date coverage under this ***Plan*** ends and the ***Employer*** offers no other group health benefit Plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the date of election of COBRA continuation coverage.

6. The date the ***covered person*** first becomes covered under any other group health Plan after the date of election of COBRA continuation coverage, with exception of the ***pre-existing*** provision below.

PRE-EXISTING CONDITIONS

In the event that a ***covered person*** becomes eligible for coverage under another employer-sponsored group health Plan, and that group health Plan has an exclusion or ***pre-existing*** limitation on a condition that is covered by this ***Plan,*** the ***covered person*** may remain covered under this ***Plan*** with continuation of coverage and elect coverage under the other employer's group health Plan. This ***Plan*** shall be primary payor for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health Plan and secondary payor for all other expenses.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***Trustees*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The ***Trustees*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

If an ***Employee*** or an ***Employee's dependent*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the ***Employee*** or the ***Employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***Employee*** or ***Employee's dependent*** may not be required to pay more than the ***Employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***Trustees*** may require the ***Employee*** or ***Employee's dependent*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***Employee*** fails to return to employment within the time allowed.

The ***Employee*** or the ***Employee's dependent*** coverage will be reinstated without exclusions or a waiting period.

TRADE ADJUSTMENT ASSISTANCE

If a ***covered person's*** coverage under this ***Plan*** terminates due to circumstances which would qualify that ***covered person*** for trade adjustment assistance (TAA) under the terms of the Trade Act of 1974 (19 U.S.C. 2101 *et seq.*) which covers workers whose employment has been adversely affected by international trade – increased imports or a shift in production to another country, and that ***covered person*** did not elect to continue coverage under the *Continuation of Coverage* provisions of this ***Plan*** during his or her initial sixty

(60) day election period as specified herein, a second sixty (60) day election period will be granted. This second sixty (60) day election period shall begin on the first day of the month in which the ***covered person*** is determined to be a TAA-eligible individual. However, the election to continue coverage under this provision of the ***Plan*** cannot be made more than six (6) months after the date of the TAA-related loss of coverage.

If continued coverage is elected under this provision of the ***Plan,*** such coverage shall begin on and any applicable COBRA time frames shall be measured from the first day of the second election period and not on the date of the original qualifying event. All other requirements for continued coverage under the COBRA provisions of this ***Plan*** shall apply.

Any time between the date of the original qualifying event and the first day of the second election period shall NOT count towards any determination of whether the individual has experienced a "break in coverage" (See *Effective Date of Coverage, Pre-existing Conditions*).

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit which is provided by this ***Plan*** made by a ***covered person*** or the ***authorized representative*** of a ***covered person*** which complies with the ***Plan's*** procedures for making claims. Claims for health care benefits are one of two types: ***pre-service claims*** or ***post-service*** claims.

Pre-service claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims***).

If the ***covered person*** would like the ***Plan Administrator/claims processor*** to deal with someone other than them regarding a claim for benefits then the ***covered person*** must provide the ***Plan Administrator*** with a written authorization in order for an ***authorized representative*** (other than the ***Employee***) to represent and act on behalf of the ***covered person.*** The ***covered person*** must consent to release information related to the claim to the ***authorized representative.***

FILING A PRE-SERVICE CLAIM

A ***pre-service claim*** begins when the ***covered person,*** provider, or the ***covered person's authorized representative*** makes a call to the ***Utilization Review Organization*** to precertify specified services, supplies or treatment. See *Utilization Review* for specific details regarding the services which require pre-certification, the number to call, and time frames for making the pre-certification call.

If a call is made to the ***Utilization Review Organization*** that fails to follow the pre-certification procedure as specified in *Utilization Review,* but at least identifies the name of the patient, a specific medical condition or symptom and the specific treatment, service or product for which pre-certification is being requested, the ***covered person*** or the ***covered person's authorized representative*** will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.

Pre-service claims fall into three categories: Pre-certification Claims, Urgent Care Claims or Concurrent Care Claims.

A. A Pre-certification Claim is a claim for any services for which the ***Plan*** requires pre-certification, however the services which are required are not services which would qualify as Urgent Care Claims, as defined below.

B. Urgent Care Claims are claims for services which require pre-certification, however, the services are of such a nature such that the application of the longer time periods for making Pre-certification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a ***physician*** with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

C. Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a ***pre-service claim*** has been submitted to the ***Plan*** (call made to the ***Utilization Review Organization***) and no additional information is required, the ***Plan*** will generally complete its determination of the claim within the following timeframes:

1. Pre-certification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;

2. Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;

3. Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:

    a. If the request for additional care is of an urgent care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;

    b. For non-urgent care, the determination must be made within fifteen (15) calendar days after the request is received.

When a ***pre-service claim*** has been submitted to the ***Plan*** and additional information is needed in order to determine whether and to what extent, services are covered or benefits are payable by the ***Plan,*** then the ***Plan Administrator*** or its designee (***Utilization Review Organization***), shall notify the ***covered person*** as follows:

1. If the ***pre-service*** claim is for care of an urgent care nature, the ***Plan Administrator*** or its designee shall notify the ***covered person*** as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The ***covered person*** or ***authorized representative*** will have forty-eight (48) hours to provide the requested information and the ***Plan Administrator*** or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the ***covered person*** to respond in a timely and complete manner will result in a denial of the pre-certification request.

2. If the ***pre-service claim*** is for non-urgent care or if an extension of time is required due to reasons beyond the control of the ***Plan Administrator*** or its designee***,*** the ***Plan Administrator*** or its ***designee*** will, within fifteen (15) calendar days from the date of the initial call, provide the ***covered person*** or the ***covered person's authorized representative*** with a notice detailing the circumstances and the date by which the ***Plan Administrator,*** or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the ***covered person*** will have forty-five (45) days to provide the requested information. The ***Plan Administrator,*** or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the pre-certification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the ***pre-service claim*** for benefits is denied, the ***Plan Administrator*** or its designee shall provide the ***covered person*** or authorized representative with a written notice of benefit denial within the timeframes listed above.

The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based;
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
4. A description of the ***Plan's*** review procedure and applicable time limits;
5. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

C. If denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

The Named Fiduciary for purposes of an appeal of a ***pre-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 is the ***Board of Trustees***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written (for any claim involving urgent care, the request may be verbal) request to the Named Fiduciary within sixty (60) calendar days from receipt of notification of the denial. The written request should state the reasons the ***covered person*** feels the claim should not have been denied. The following describes the review process:

1. The ***covered person*** has a right to submit documents, information and comments.

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:

   a. Relied on in making the benefit determination; or
   b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
   c. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or
   d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review shall take into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If the original denial was, in whole or in part, based on medical judgment:

   a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the Named Fiduciary will be neither
      (1) An individual who was considered in connection with the original denial of the claim, nor
      (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
   c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Named Fiduciary shall provide the ***covered person*** or authorized representative with a written notice of the appeal decision within the following timeframes:

1. Urgent Care Claims or Concurrent Care Claims involving urgent care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;

2. Pre-certification Claims or Concurrent Care Claims involving non-urgent care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

A. Explanation of the denial including:

1. The specific reasons for the denial
2. Reference to specific ***Plan*** provisions on which the denial is based
3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the Notice will supply either:

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

FILING A POST-SERVICE CLAIM

1. A claim form is to be completed on each covered family member at the beginning of the calendar year and for each claim involving an ***injury***. Appropriate claim forms are available from the ***claims processor***.

   Claims should be submitted to the address shown on their identification card.

2. All bills submitted for benefits must contain the following:
   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***Employee.***
   d. Address of ***Employee.***
   e. Name of ***Employer.***
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Social Security number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident***, injury*** or ***illness*** being treated.

3. Properly completed claims not submitted within twelve (12) months of the date of incurred liability will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the ***claims processor*** and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the ***Plan's*** control.

When a completed claim has been submitted to the ***claims processor*** and additional information is required for determination of the claim, the ***claims processor*** will provide the ***covered person*** or ***authorized representative*** with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim

and will indicate the date when the ***claims processor*** expects to make a decision, if the requested information is received. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***claims processor*** will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information**.** Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the ***post-service*** claim for benefits is denied, the ***Plan Administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the ***Plan*** had requested additional information from the ***covered person*** or ***authorized representative***, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

A. Explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the ***Plan*** provisions on which the denial is based.
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary.
4. A description of the ***Plan's*** review procedure and applicable time limits.
5. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Claim" below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either

1. A copy of that criterion, or
2. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED POST-SERVICE CLAIM

The "Named Fiduciary" for purposes of an appeal of a ***post-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is the ***Board of Trustees***.

A ***covered person,*** or the ***covered person's authorized representative***, may request a review of a denied claim by making written request to the "Named Fiduciary" within sixty (60) calendar days from receipt of notification of the denial. The request for review should state the reasons the ***covered person*** feels the claim should not have been denied.

The review process is as follows:

1. The ***covered person*** has a right to submit documents, information and comments.

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:

    a. Relied on in making the benefit determination, OR
    b. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, OR
    c. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions, OR
    d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment,

   a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the Named Fiduciary will be neither
      (1) An individual who was considered in connection with the original denial of the claim, nor
      (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
   c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The ***Plan Administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

A. An explanation of the denial including:

   1. The specific reasons for the denial.
   2. Reference to specific ***Plan*** provisions on which the denial is based.
   3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
   4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

B. If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:

   1. A copy of that criterion, or
   2. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

C. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the patient's medical circumstances, or
2. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one Plan normally pays its benefits in full, referred to as the primary Plan. The Other Plan(s), referred to as secondary Plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all Plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another Plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall <u>not</u> include any amount that is not payable under the primary Plan as a result of a contract between the primary Plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any Plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type Plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment Plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any Plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trusteed, union welfare, employer organization, or Employee benefit organization Plans.

"This ***Plan"*** shall mean that portion of the ***Employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all Plans does not exceed one hundred percent (100%) of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan.***

AUTOMOBILE-RELATED INJURIES

The ***Plan*** will not provide primary coverage for medical expenses arising due to an automobile-related ***injury.*** In addition, the ***Plan*** allows only the ***maximum benefit*** specified on the *Schedule of Benefits* for medical expenses arising due to an automobile or other motor or recreational vehicle-related accident (e.g. automobiles, motorcycles, jet skis, all-terrain vehicles, etc.).

A ***covered person*** **should not** advise his or her automobile insurance carrier that he or she has alternative coverage under this ***Plan*** for medical claims arising from an accident. The ***Plan*** will pay these claims only on a secondary payor basis.

ORDER OF BENEFIT DETERMINATION

Each Plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The Plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a Plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The Plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the Plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the Plan of that parent pays first. The Plan of the stepparent married to that parent, if any, pays second. The Plan of the other natural parent pays third. The Plan of the spouse of the other natural parent pays fourth.
   b. In the absence of such a court decree, the Plan of the parent with custody pays first. The Plan of the stepparent married to the parent with custody, if any, pays second. The Plan of the parent without custody pays third. The Plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The Plan covering a person as an active (not laid off or retired) ***Employee,*** or as that person's ***dependent*** pays first. The Plan covering that person as a laid off or retired ***Employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage
   If a person is covered under another group health Plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the ***pre-existing condition*** or exclusions. This ***Plan*** shall be primary for the ***pre-existing condition*** only.

7. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***Trustees*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***Trustees*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***Trustees*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***Trustees*** shall be fully discharged from liability.

SUBROGATION

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health Plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of

recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***Plan Administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***Plan Administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***Plan Administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***Plan Administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***Plan Administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***Employee*** becomes entitled to ***Medicare*** coverage and is still actively at work, the ***Employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***Employee*** is still actively at work***,*** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***Employee*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary Plan. ***Medicare*** will pay as secondary Plan.

4. If the ***Employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan. Medicare*** will be the only payor.

5. No benefits are provided to ***retirees*** under this ***Plan.***

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Fund Office**.** The ***Trustees*** shall have full charge of the operation and management of the ***Plan.*** The ***Trustees*** have retained the services of an independent ***Plan Administrator*** and ***claims processors*** experienced in claims review.

The ***Plan Administrator*** is the named fiduciary of the ***Plan*** for all purposes except claim appeals, as specified in *Claim Filing Procedure.* As fiduciary, the ***Plan Administrator*** maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the ***Plan,*** and determining eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan;*** any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***Employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a qualified medical child support order or national medical support notice.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***Plan Sponsor*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***Employee*** or any ***dependent(s)***

hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was January 1, 1985. The ***effective date*** of the modifications contained herein is January 1, 2010.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***non-preferred provider.***

INCAPACITY

If, in the opinion of the ***Plan Administrator,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***Plan Administrator*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***Plan Administrator*** or by the ***Employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***Plan Administrator*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***Plan Administrator*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***Plan Administrator*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their Employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Plan Administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State Plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this ***Plan*** null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***Plan Administrator*** or ***Employer*** and any ***Employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***Employee.*** Nothing in the ***Plan*** shall be deemed to give any ***Employee*** the right to be retained in the service of the ***Plan Administrator*** or ***Employer*** or to interfere with the right of the ***Plan Administrator*** or ***Employer*** to terminate the employment of any ***Employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***Board of Trustees*** may modify or amend the ***Plan*** from time to time in accordance with the provision of the collective bargaining agreement, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***Board of Trustees'*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***Plan Administrator,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.*** Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***Plan Administrator.***

PLAN TERMINATION

The ***Board of Trustees*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***Plan Administrator*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***Employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***Employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***pre-existing condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Plan Administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Alternate Recipient

Any child of an ***Employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan.***

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Authorized Representative

An individual who the ***covered person*** has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an ***authorized representative*** of a ***covered person.***

Birthing Center

A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more ***physicians*** or a specialized ***facility*** other than a ***birthing center.***

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

The company contracted by the ***Plan Sponsor*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***Plan Sponsor.***

Close Relative

The ***Employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***Employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy.***
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review

A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility, hospice,*** or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay. With respect to an ***Employee,*** if the ***Employee*** has returned to work for at least one (1) full working day, additional ***confinements*** will not be considered part of the original ***confinement***. With respect to a ***dependent*** only, if ***hospital confinements*** are separated by a period of ninety (90) days, each ***confinement*** will be considered a new ***confinement***.

Co-pay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury. 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. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury.*** Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dentist

A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents

For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility*.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency

The sudden onset of an ***illness*** or ***injury*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Employee

A person covered by a collective bargaining agreement between the ***Union*** and the ***Employer***, or by any other agreement which requires contributions on their behalf to the ***Fund***.

Employer

Any employer who now or hereafter has a collective bargaining agreement with the ***Union*** requiring periodic contributions to the ***Fund*** and who is accepted into participation by the

Trustees; or any employer who now or hereafter has a written agreement with the ***Fund*** requiring periodic contributions to the ***Fund***; or the ***Union*** for all its full-time salaried Employees.

Experimental/Investigational

Services, supplies, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor,*** Named Fiduciary, ***Plan Administrator*** or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The ***claims processor,*** Named Fiduciary, ***Plan Administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor,*** Named Fiduciary, ***Plan Administrator*** or their designee will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment

or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center or an outpatient-imaging center.

Fund

The ***Fund*** is the Teamsters Local Union 966 Health Fund.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Home Health Aide Services

Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person.***

Incurred or Incurred Date

With respect to a ***covered expense,*** the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound***.***

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room.

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan.***

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

    a. The entire time the ***covered person*** is covered under this ***Plan,*** or
    b. A specified period of time, such as a calendar year.

3. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

    a. Treatments during a specified period of time, or
    b. Days of ***confinement,*** or
    c. Visits by a ***home health care agency.***

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***claims processor,*** Named Fiduciary, ***Plan Administrator*** or their designee, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of good medical practice within the United States***;*** and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider;*** and

4. Is an appropriate supply or level of service that safely can be provided; and

5. It is recommended or approved by the attending ***professional provider.***

The fact that a ***professional provider*** may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was

medically necessary, the ***claims processor, Plan Administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***claims processor, Board of Trustees*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs and Part D – Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Non-preferred Provider

A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient;***

2. A ***physician's*** office, laboratory or x-ray ***facility;*** or

3. An ***ambulatory surgical facility;*** and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental and nervous disorders.***

3. ***Chemical dependency*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the ***Pharmacy Organization***.

Pharmacy Organization

An organization who selects and contracts with certain pharmacies to provide ***covered persons*** prescription medications at a ***negotiated rate.*** The ***Pharmacy Organization*** is Envision RxOptions.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.

Placed For Adoption

The date the ***Employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***Plan Administrator*** is designated by the ***Trustees*** and is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan Administrator*** is Carday Associates, Inc.

Plan Sponsor

The ***Plan Sponsor*** is the Board of Trustees of the Teamsters Local Union 966 Health Fund.

Post-service Claim

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims*****).**

Pre-existing Conditions

An ***illness*** or ***injury*** which existed within six (6) months before the ***covered person's*** enrollment date for coverage under this ***Plan.*** An ***illness*** or ***injury*** is considered to have existed when the ***covered person:***

1. Sought or received professional advice for that ***illness*** or ***injury,*** or

2. Received medical care or treatment for that ***illness*** or ***injury,*** or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury.***

Preferred Provider

A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate.*** The ***Preferred Provider Organization*** is CIGNA HealthCare Network.

Pregnancy

The physical state which results in childbirth or miscarriage.

Pre-service Claim

A ***pre-service claim*** is a claim for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Acupuncturist

Certified Addictions Counselor

Certified Registered Nurse Anesthetist

Certified Registered Nurse Practitioner

Chiropractor

Clinical Laboratory

Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)

Dental Hygienist

Dentist

Dietician

Dispensing optician

Nurse (R.N., L.P.N., L.V.N.)

Occupational Therapist

Optician

Optometrist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

Retiree

A former ***Employee*** who retired from service of the ***Employer***. Retirees are not eligible for coverage under this ***Plan.***

Retrospective Review

A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board

Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in it's ***semiprivate*** rooms containing two (2) or more beds.

Total Disability or Totally Disabled

The ***Employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency*** or ***mental and nervous disorders,*** and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician.***
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    d. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Trustees

The ***Trustees*** are the Trustees of the Teamsters Local Union 966 Health Fund.

Utilization Review

A process of evaluating if services, supplies or treatment are ***medically necessary*** to help ensure cost-effective care.

Union

The ***Union*** is Local Union 966 of the International Brotherhood of Teamsters.

Utilization Review Organization

The individual or organization designated by the ***Trustees*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.*** The ***Utilization Review Organization*** is CareAllies.

Well Child Care

Preventive care rendered to ***dependent*** children through the age of two (2).