

SUMMARY PLAN DESCRIPTION

OF THE

LOCAL 73 HEALTH AND WELFARE FUND

January 1, 2014

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LOCAL 73 HEALTH AND WELFARE FUND

P.O. BOX 911

OSWEGO, NEW YORK 13126

Telephone: (315) 343-1808

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EMPLOYER IDENTIFICATION NUMBER

23-7112893

PLAN NUMBER

501

**LOCAL 73 HEALTH AND WELFARE FUND
P.O. BOX 911
OSWEGO, NEW YORK 13126
Telephone: (315) 343-1808**

Dear Participant:

This Booklet, known as a “Summary Plan Description”, describes the requirements you must satisfy in order for you and your eligible dependents to become and remain eligible for benefits from this Fund. It also summarizes the benefits you are eligible for and the conditions governing the payment of benefits. The procedure you must follow in filing a claim for benefits is also explained, as well as the procedure for making an appeal if your claim is denied.

If you have any questions concerning the Plan, or this Booklet, or if you would like to receive more information about Plan eligibility, coverage and/or benefits, you should contact the Fund Administrator at the Fund Office. The location of the Fund Office and its telephone number are set forth at the top of this page.

Sincerely,

THE BOARD OF TRUSTEES OF THE
LOCAL 73 HEALTH AND WELFARE FUND

UNION TRUSTEES

Timothy Donovan
Patrick Carroll
Bernard Finnegan

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CAUTION

This booklet and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Plan **have not empowered anyone else** to speak for them with regard to the Health and Welfare Fund. No employer, Union representative, supervisor, or shop steward is in a position to discuss your rights under this Plan with authority.

IMPORTANT INFORMATION

- Familiarize yourself with the entire booklet.
- Application must be made for all the Benefits.
- The Fund Office should be made aware of all your dependents and your current address.
- Keep your death benefit beneficiary designation up to date.
- All claim forms must be submitted in a timely manner and completely filled in; incomplete or late forms will be denied or returned.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Fund Administrator or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each Payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such Payment is not so excludable.

Grandfathered Health Plan

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ARTICLE 1 – DEFINITIONS

For the purposes of this Plan, the following terms have the following definitions:

Section 1.1 Accident or Accidental Injury

An “Accident” or an “Accidental Injury” shall only be determined to have occurred when the facts and circumstances establish an unanticipated, unexpected, unforeseen, or unplanned event. The Trustees have the sole and exclusive authority to determine whether or not the facts and circumstances establish an accident or accidental injury.

Section 1.2 Benefits

“Benefits” are payments from the Local 73 Health and Welfare Fund made for the value of covered services rendered to Participants and their Eligible Dependents.

Section 1.3 Contributing Employer

A “Contributing Employer” is an employer who makes contributions to the Local 73 Health and Welfare Fund pursuant to a Collective Bargaining Agreement with the U.A. Local Union No. 73, or pursuant to a written Participation Agreement with the Board of Trustees of the Local 73 Health and Welfare Fund.

Section 1.4 Convalescent/Skilled Nursing Facility

“Convalescent/Skilled Nursing Facility” means only an institution (or a distinct part thereof) that meets all the following requirements:

- It meets any licensing or certification standards, and
- It provides inpatient skilled nursing and physical restoration services for patients convalescing from a Sickness or Injury, and
- It is under the full-time supervision of a physician or registered professional nurse who is regularly on the premises at least 40 hours per week, and
- It provides skilled nursing services on a 24-hour basis under the direction of a full-time registered professional nurse, with licensed nursing personnel on duty at all times, and
- It maintains a complete medical record on each patient, and
- It has a utilization review plan in effect for all of its patients, and

- It must have a written agreement or arrangement with a physician to provide emergency care, and
- If not an integral part of a Hospital, it must have a written agreement with one or more Hospitals to provide for the transfer of patients and medical information between the Hospital and the Convalescent/Skilled Nursing Facility, and
- With respect to covered family members who are entitled to Medicare, it is an approved provider of services under Medicare, and
- It is accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

The term Convalescent/Skilled Nursing Facility will not include any institution which is, other than incidentally, a place for the aged, the blind, the deaf, the mentally ill or handicapped, a place for rest, custodial care or educational care, drug addicts or alcoholics.

Section 1.5 Covered Employment

“Covered Employment” is work for which your employer is required to contribute, on your behalf, to the Local 73 Health and Welfare Fund, either pursuant to a Collective Bargaining Agreement with the U.A. Local Union No. 73, or pursuant to a written Participation Agreement with the Board of Trustees of the Local 73 Health and Welfare Fund.

Section 1.6 Doctor

A “Doctor” is a legally qualified: doctor of medicine (MD), doctor of osteopathy (DO), chiropractor (DC), podiatrist (POD), or dentist (DDS). Also a licensed qualified psychologist and/or a certified social worker operating within the scope of their license.

Section 1.7 Eligible Dependent

An “Eligible Dependent” is a dependent spouse or child of a Participant, who qualifies for benefits for Eligible Dependents from this Plan pursuant to the provisions of Sections 3.5, 3.9A, 3.9B, 3.9C or 3.9D.

Section 1.8 Hospital

A “Hospital” is a legally constituted and operated institution which:

- Is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient’s expense, and which maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of doctors; and

- Provides nursing service by registered graduate nurses at all times, and is operated continuously with organized facilities for operative surgery; and
- Is not an institution, or a part of an institution, which is a convalescent hospital or which is used principally as a rest facility, nursing facility or facility for the aged or for the care and treatment of drug addicts or alcoholics.

Section 1.9 Intensive Care Unit

An “Intensive Care Unit” is an accommodation or a part of a hospital other than a post-operative recovery room which, in addition to providing room and board:

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

Section 1.10 Medically Necessary or Medical Necessity

“Medically Necessary” or “Medical Necessity” means health care services, supplies or treatment that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
- not primarily for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient’s illness, injury or disease.

“Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer review medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the

view of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

Medical necessity may not necessarily be established based solely on the opinion of a physician. The Board of Trustees, or their designee, has the discretion and authority to evaluate credible scientific evidence or make factual determinations based on the opinions provided by health care professionals, peer reviewed medical literature and Physician Specialty Society recommendations in determining whether a health care service, supply or treatment is medically necessary, including but not limited to, prudent clinical judgment, generally accepted standards of medical practice, clinically appropriate, not primarily for the convenience of the patient and alternative services.

Section 1.11 Participant and Spouse

You are considered a “Participant” in the Local 73 Health and Welfare Fund if you work in Covered Employment for a Contributing Employer, provided you have satisfied the eligibility requirements specified in Section 3.2 or Section 3.3, whichever is applicable to you. You will cease to be considered a Participant in this Plan once your eligibility for benefits has terminated pursuant to Section 3.6.

A “Spouse” means a person to whom an Employee is legally married under the laws of the state of New York. Couples who are legally separated by court order are not legally married under state law.

Section 1.12 Plan

This “Plan” is the Local 73 Health and Welfare Fund.

Section 1.13 Trustees

“Trustees” means the Board of Trustees of the Local 73 Health and Welfare Fund.

Section 1.14 Usual, Customary and Reasonable Charge (“UCR”)

“Usual, Customary and Reasonable Charge” (“UCR”) means the charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other physicians. Any amounts that exceed usual and customary and reasonable are not recognized by the plan for any purpose.

Section 1.15 Union

The “Union” is the U.A. Local Union No. 73.

ARTICLE 2 – GENERAL

Section 2.1 About This Plan

The name of this Plan is the Local 73 Health and Welfare Fund. This is a welfare type plan under ERISA, subject to HIPAA, providing medical, death, accidental death & dismemberment, and disability benefits. The purpose of this Plan, which is self-administered and self-insured, (except for the below-referenced life insurance benefit) is to provide the benefits summarized in this Booklet to Participants and their Eligible Dependents. An insurer provides life insurance coverage and its name and address follows:

Union Labor Life Insurance Company
8403 Colesville Road
Silver Spring, MD 20910
Phone: (866) 795-0680

The benefits available from the Fund's Retiree-Only Plan are described in a separate Summary Plan Description. To receive a copy of that document, contact the Fund Administrator.

Section 2.2 About This Booklet

This Summary Plan Description summarizes the benefits that are available from this Plan. This Booklet also describes the eligibility requirements for participation in this Plan, the limitations on the benefits, the procedure for claiming your benefits, and other information of which you should be aware.

Except as otherwise required by the context, use of the masculine or feminine gender herein shall include both the masculine and feminine genders.

The terms "you" or "your", as used in this Booklet, may refer to different individuals in different Articles. Please refer to the Note at the beginning of each of the following Articles in order to determine to whom that Article is addressed.

Section 2.3 Plan Funding

This Plan is a multi-employer plan that provides benefits to Participants and their Eligible Dependents. Participants are represented by the Union in collective bargaining with the Contributing Employers.

You may obtain a complete list of all of the Contributing Employers, upon written request to the Fund Administrator, or you may examine the list at the Fund Office. You may also receive from the Fund Administrator, upon written request, information as to whether a particular employer is a Contributing Employer, and, if the employer is, the employer's address.

The Contributing Employers and the Union negotiate collective bargaining agreements, pursuant to which this Plan is maintained. These agreements specify the amounts that Contributing Employers will contribute to this Plan on behalf of the Participants they employ.

The employer contributions are combined with the earnings from investments made by the Trustees on behalf of this Plan, and are accumulated in a trust fund. Money in the trust fund is then used to provide benefits to Participants and their Eligible Dependents, and to defray the reasonable administrative expenses incurred in operating this Plan.

A copy of the Collective Bargaining Agreement may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries at the Fund Office.

Section 2.4 Plan Administrator

Your Plan is administered by a Board of Trustees on which the Union and the Contributing Employers are equally represented. Thus, the Board as a whole is the Plan Administrator.

As such, the Trustees are responsible for making decisions regarding, for example the: rules of eligibility, types of benefits offered, administrative policies, management of Plan assets, and interpretation of Plan provisions. The Trustees are also the sponsor of this Plan.

If you have any questions about this Plan, you may contact the Trustees by writing to: The Board of Trustees, Local 73 Health and Welfare Fund, P.O. Box 911, 705 E. Seneca St. Rd., Oswego, New York 13126. The telephone number is (315) 343-1808.

Section 2.5 Plan Trustees

The names, titles and business addresses of the Trustees are as follows:

UNION TRUSTEES

Timothy Donovan
P.O. Box 911
Oswego, New York 13126

Patrick Carroll
P.O. Box 911
Oswego, New York 13126

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Section 2.6 Fund Administrator

The Trustees have designated James P. Gaffney as Fund Administrator. As Fund Administrator he is responsible for carrying out the Trustees' decisions and for overseeing the daily operation of this Plan and the Fund Office. If you have any questions about your Plan, you may contact the Fund Administrator by writing to: Fund Administrator, Local 73 Health and Welfare Fund, P.O. Box 911, Oswego, New York 13126. The telephone number is (315) 343-1808.

Section 2.7 Service of Legal Process

The Trustees have designated James P. Gaffney this Plan's Fund Administrator as agent for service of legal process. The address at which process may be served on James P. Gaffney is as follows: James P. Gaffney, Fund Administrator, Local 73 Health and Welfare Fund, P.O. Box 911, Oswego, New York 13126.

Service of legal process upon James P. Gaffney will be deemed to be service upon the Trustees. However, service of legal process may also be made upon any Trustee.

Section 2.8 Plan Year

For the purpose of maintaining this Plan's fiscal records this Plan's year begins on May 1 and ends on April 30.

Section 2.9 Statement of ERISA Rights

As a Participant in the Local 73 Health and Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites 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 this 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, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of this 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 yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Prior to January 1, 2015 reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan, you should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. After December 31, 2014, no group health plan will be permitted to impose a preexisting condition limitation regardless of whether you have creditable coverage. Consequently, effective May 1, 2014, this Plan will no longer apply any preexisting condition exclusions, but the Plan will provide the certificate of creditable coverage through December 31, 2014 to reduce any preexisting condition limitation that may be imposed by another group health plan.

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 your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

- If you have any questions about your plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, listed in your telephone directory, or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone numbers of the Regional and District EBSA Offices are available through EBSA's website). The information contained in this Section is subject to change based upon future guidance that may be issued by the Internal Revenue Service or Department of Labor.

Section 2.10 Plan and Benefit Terminations and Changes

Although it is not currently anticipated that the Trustees will terminate this Plan, the Trustees necessarily reserve the right to terminate it at an indefinite point in the future. The continuation of this Plan is also contingent upon the continuation of employer contributions to this Plan. However if all or a portion of this Plan is terminated, it will be so terminated only with respect to claims which have not yet been incurred.

If this Plan is terminated for any reason, the assets remaining in the Trust Fund will be utilized to pay necessary administration costs and remaining benefits until such assets are depleted. If all assets are so expended, no further benefits would be provided by this Plan. Upon termination of this Plan, Participants and Eligible Dependents would have no further rights or vested interests in this Plan.

The Trustees also reserve the right to amend modify or terminate: (1) this Plan; (2) the types and/or amounts of benefits provided under this Plan; and/or (3) the eligibility rules concerning extended or accumulated eligibility even if such extended eligibility has already been accumulated. Furthermore, the benefits provided by this Plan are not guaranteed, are not vested upon retirement and are not deferred income. Additionally, the benefits provided by this Plan are subject to modification or termination by the Trustees even if such action is not financially necessary.

Thus, the continuation of benefits for all Participants and Eligible Dependents and the eligibility rules for benefits under this Plan are subject to modification and revision by the Trustees. No Participant or Eligible Dependent has a vested right or contractual interest in the benefits provided. The provision of benefits to individuals under this Plan will be reviewed periodically by the Trustees.

2.11 Benefits Cover Specific Claims Only

Notwithstanding any other provision of this Plan, benefits available under this Plan provide only for the payment of certain specific expenses. Benefits do NOT cover illnesses, conditions, diseases, injuries, etc. Thus, while the Plan will make payments for certain expenses you incur with respect to certain illnesses, conditions, diseases, injuries, etc., the Plan does not provide for the payment of all of the expenses you incur with respect to a particular illness, condition, disease, injury, etc. For example, if you sustain an injury which requires surgery, the surgeon's fee may be covered by our Surgical Expense Benefits. However, if the Plan were later amended to eliminate Surgical Expense Benefits and you subsequently required a second surgery with respect to the same injury, then the surgeon's fee for the second surgery would NOT be covered. Even though the Surgical Expense Benefits were available when you sustained the injury, the expenses of the second surgery are not covered because Surgical Expense Benefits were NOT available when you incurred the specific claim for the second surgery.

ARTICLE 3 – ELIGIBILITY FOR BENEFITS

NOTE: The terms “you” and “your” as used in this Article refer only to Participants.

Section 3.1 General

This Article summarizes how you and your Eligible Dependents may become and remain eligible for the benefits offered by this Plan. Remember that you will not receive any benefits for any expenses you incur before you become eligible. Also you are only eligible for covered expenses which the Trustees determine are Medically Necessary and appropriate and which meet professionally recognized standards of treatment.

Section 3.2 Initial Eligibility

Effective January 1, 2014, you will become eligible for benefits when you work a sufficient number of hours in Covered Employment for a Contributing Employer to accumulate the contributions in your personal account necessary to purchase three (3) months of family coverage at the rate in effect when the Fund receives the contributions from your employer. Your eligibility will be effective on the first day of the month that follows the month after you accumulate the necessary contributions, and you will have no access to your personal account until you have first accumulated the contributions necessary to purchase the family coverage. You will remain eligible for benefits for the three (3) month period following the effective date of your coverage. Thereafter, you will remain eligible based on the Continuing Eligibility provisions provided in Section 3.3 of the Summary Plan Description.

The Administrative Manager will determine your hours worked and contributions by utilization of the Contributing Employer Remittance Reports, pay stubs, or other documents satisfactory to the Administrative Manager. In the event that you became eligible for benefits as indicated above and your contributions have not been received, you will not have monies allocated into your individual account plan until such contributions have been received.

Once you satisfy the eligibility criteria and complete the enrollment forms, your coverage will be implemented in accordance with the Fund’s procedures. For instance, if you satisfy the eligibility criteria after six (6) months of employment with a participating employer, your coverage with the Fund will start the first day of the seventh (7th) month after your start date with that participating employer. If your start date is not the first day of a calendar month, the waiting period may be extended until the first day of the next calendar month in this example.

Effective January 1, 2014, the Fund will permit you to waive or “opt-out” of medical coverage only if you confirm that you have coverage with another employer-sponsored, group health plan that provides minimum value. An employer-sponsored, group health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. If your spouse or children are covered under some other health insurance plan, including coverage through your spouse’s employer, individual

insurance, or some other product, you may elect not to provide the Fund's medical coverage for them as well.

If you fail to enroll in another form of coverage, the Fund will automatically enroll you in Family Coverage. If you elect to "opt out" of the Fund's medical coverage, you will continue to accumulate contributions in your personal account for so long as you remain "opted out" provided you have completed and returned the enrollment forms provided by the Fund Office. You will also be given the option at least annually or at the termination of your employment to irrevocably "drop out" of all medical coverage for the applicable time period offered through the Fund and to waive all future reimbursements from your personal accounts. Although "dropping out" of all Fund coverage is not recommended, because you will be choosing to permanently forego all medical coverage for the applicable period and personal account reimbursements despite the fact that contributions will continue to be made to the Fund for your work in covered employment, the Fund is required to provide this option to you. Once such an election is made, it must be irrevocable. You should carefully consider the consequences of "dropping out" of all medical and personal account plan benefits, and you should discuss any such decision with your tax adviser.

The Fund Office will provide you with enrollment forms including requests for information about other group coverage available to you and/or your dependents. You must complete these forms and return them to the Fund Office regardless of whether you choose to waive Fund coverage for yourself or your dependents. If you fail to complete the required forms, your account may be charged for Family Coverage with the Fund taking the appropriate action concerning the coordination of benefits. Although automatically enrolled in the Fund's medical coverage, the Fund will not process your claims until the Fund receives the necessary enrollment forms. Until all the completed forms are received by the Fund Office, the Fund's Trustees reserve the rights to hold claims in abeyance and even terminate coverage retroactively.

Section 3.3 Continuing Eligibility

You will remain eligible for benefits for subsequent periods of Covered Employment provided the Fund continues to receive sufficient contributions for you to pay the applicable premiums for the type of coverage for which you are enrolled. Once your account contains insufficient allocations to pay the applicable premiums for one month of coverage, you will lose coverage with the Fund effective the first of the month after your account has insufficient monies. If you anticipate that your account will have insufficient amounts, you should consider the self-pay options described in this Summary Plan Description.

Section 3.4 Credited Hours for Disabled Participants

If you become totally disabled while you are a Participant in this Plan and are unable to work, then, while you remain disabled, you will be credited under this Plan as having coverage for any full month(s) you are disabled, subject to having sufficient assets in your personal account.

Section 3.5 Eligibility for Dependents

NOTE: For the purposes of this Section, the terms “child” and “dependent” refer to your natural children, your step-children, your lawfully adopted children, children lawfully placed with you for adoption by an authorized placement agency, foster children lawfully placed with you by an authorized agency or by judgment, decree, or other order of any court of competent jurisdiction, and/or your dependent children as defined by IRS. The Plan will provide benefits to a dependent child pursuant to the requirements of any court order (including a National Medical Child Support Notice) that the Plan Administrator determines meets the requirements of a qualified medical support order as defined in Section 609 of ERISA.

While you are eligible for benefits as a Participant, your eligible dependents will be entitled to benefits as eligible dependents. Your eligible dependents, provided they qualify as your dependents and enroll with the Fund, are: (1) your legal spouse provided you are not legally separated; and (2) your children who have not attained the age twenty six (26). However, coverage will cease for your child, if your child becomes insured by a group health plan before May 1, 2014, except for coverage under your spouse’s employer-sponsored health plan.

If you have an unmarried child who is unable to work and support himself because of a permanent and total disability and who qualified as your dependent under federal income tax rules, then that child’s eligibility for benefits will be extended past age 26 provided that the child is an eligible dependent and is permanently and totally disabled at such time. The child will remain eligible for benefits indefinitely provided the child’s condition remains the same and you remain a Participant. You must notify the Fund Administrator about such child prior to the beginning of the taxable calendar year in which the child will attain the age at which his coverage would otherwise cease.

Your newborn child becomes an eligible dependent at birth. However, if you are adding a dependent, you must notify the Fund Administrator at once of the change.

If both you and your spouse are Participants, then both you and your spouse may cover your children as eligible dependents. However, in no event will the payments for such children exceed 100% of their claims.

NOTE: The following proof when applicable must be submitted to the Fund Administrator upon request:

- Your marriage certificate must be submitted in order to prove that you are currently legally married to your spouse. Common law spouses are not considered eligible dependents under the Plan.
- A copy of your child’s birth certificate must be submitted in order to prove that your child qualifies as your dependent.

- Proof of disability must be submitted no later than 31 days before the beginning of the taxable calendar year in which your child attains age 26 for any child eligible for coverage beyond these age limits due to the child's permanent and total disability. Additionally, proof of the continued existence of this child's disability must be provided periodically as requested by the Fund Administrator.

If such proof is not submitted, as requested, then the Trustees reserve the right to assume that the affected individuals do not qualify as your Eligible Dependents under this Plan.

Open Enrollment: Please note that there is an open enrollment period for a period of 60 days commencing January 1 each year for dependents who became eligible to participate in the Fund as a result of changed circumstances.

Section 3.6 Termination of Eligibility

Your eligibility for medical coverage will terminate when your account has insufficient assets to pay the applicable premium for the next month of coverage for which you are enrolled. You will cease to receive medical coverage effective the first of the next month. When your account has zero dollars, you will cease to be considered a Participant.

If your spouse is eligible as a dependent and you become divorced or legally separated or your marriage is annulled, then your spouse's eligibility will automatically terminate on the date this occurs, and your spouse will cease to be considered an Eligible Dependent. However, your spouse may elect continuation coverage (on a self-pay basis) when her eligibility terminates. (Refer to Article 19 for the details about this continuation coverage.)

Your dependent's eligibility will terminate if you die or if he or she ceases to qualify as an eligible dependent pursuant to Section 3.5. At such time your dependent will cease to be considered an eligible dependent. You must notify the Fund Administrator if any of these things occur. Article 19 describes how your dependent may continue his or her coverage (on a self-pay basis) after his or her eligibility terminates. In any event, the Fund will comply with the provisions of a Qualified Medical Child Support Order.

Section 3.7 Re-Establishment of Eligibility

If your eligibility terminates, then you must again satisfy the requirements specified in Section 3.2 to re-establish your eligibility with one exception. If you lose medical coverage because of an insufficient account balance, you may re-establish medical coverage during the twelve (12) month period after you lost the coverage by working a sufficient number of hours in Covered Employment and by your employer remitting a sufficient amount of contributions for payment of the applicable premiums for the type of coverage for which you were previously enrolled. Twelve (12) months after eligibility ceased, you must re-establish eligibility in accordance with Section 3.2.

Section 3.8 Additional Conditions

This Plan has become a party to Reciprocity Agreements with other Health and Welfare Funds. These agreements were established in order to preserve eligibility and provide benefits for a Participant and his eligible dependents in his home Fund when he works outside the jurisdiction of this Plan. Thus, you may be eligible for benefits based upon the provisions of one of these Agreements.

Section 3.9 Eligibility Rules Regarding Retirees

The benefits for Retirees and their Eligible Dependents are explained in a separate Summary Plan Description for the Retiree-Only Plan. To receive a copy of that document, contact the Fund Administrator.

3.10 Leave for Qualified Military Service

If you leave employment for full-time Qualified Military Service, as defined by Federal Law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage, subject to the rules of the Plan, must, for elections to continue health care coverage made on or after December 10, 2004, last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four-month period if you enter Qualified Military Service and are discharged earlier and you fail to make a timely application for reemployment upon discharge. You will not forfeit any period of coverage for which you had previously qualified under the Eligibility for Benefits Rules.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the average cost that the Plan incurs annually per Participant plus a two percent (2%) administrative charge.

3.11 Special Enrollment Rights

COVERAGE UNDER THIS PLAN IS AUTOMATIC UPON YOUR ELIGIBILITY. BY LAW, THE PLAN MUST PROVIDE THE FOLLOWING DESCRIPTION OF ITS SPECIAL ENROLLMENT RIGHTS TO ANYONE WHO BECOMES ELIGIBLE FOR COVERAGE:

If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for

adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

You and your dependent may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

ARTICLE 4 – HOSPITAL BENEFITS

NOTE: The terms “you” and “your” as used in this Article refer to Participants and their Eligible Dependents.

Section 4.1 Inpatient Benefits

A. General

This Section summarizes the benefits you are eligible for if you are confined as a registered bed patient in a Hospital for care or treatment for a non-occupational accident or sickness other than maternity. (Maternity Benefits are summarized in Article 7.) Your benefit coverage includes charges incurred by a Participant or Beneficiary in connection with a mastectomy covered by the Plan, in a manner determined in consultation with the attending physician and the Participant or Beneficiary, for (1) reconstruction of the breast on which a mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomies, including lymphedemas.

The Plan utilizes a network service supplied by a preferred provider organization.

B. Room and Board Expenses

You are eligible for an allowance for room and board expenses equal to the actual charge for such accommodations if you are staying in a ward or a semi-private room. If you are staying in a private room, you are eligible for an allowance of up to the Hospital's average semi-private room and board rate. If you are confined in the Intensive Care Unit, however, then you will receive an allowance for room and board of up to double the Hospital's average semi-private room and board rate. All other necessary medical services will be paid at the negotiated rate as determined by the Fund's Managed Care provider. The Plan utilizes the network services of EBS-RMSCO which is

located in Liverpool, New York. The EBS-RMSCO list of network providers will be given to you at no charge. Room and board expenses will only be covered for a maximum of 31 days per Benefit Period with a maximum allowance per Benefit Period equal to 31 times the Hospital's average semi-private room and board rate. These benefits are only payable for expenses you incur during a period in which you are eligible for room and board allowance.

C. Convalescent/Skilled Nursing Facility

You are eligible for 80% coverage for the Usual, Customary and Reasonable ("UCR") charges for a stay at a convalescent/skilled nursing facility for up to a 60-day stay.

D. Benefit Period

The benefits summarized in this Section will be provided to you for each Benefit Period.

A "Benefit Period" consists of any one continuous period of confinement or of all Related Confinements. "Related Confinements" are two or more periods of confinement resulting from the same illness or injury or from related illnesses or injuries provided:

- In the case of a Participant, the confinements are not separated by a period in which the Participant returns to active full-time work for at least 5 consecutive scheduled working days; and
- With respect to eligible dependents, the confinements are not separated by at least 2 consecutive months.

E. Extended Eligibility for Inpatient Benefits

If you are totally disabled on the date your eligibility terminates (due to an injury or sickness which you sustained before the date of termination) and if you enter a hospital within 29 months from that date, then Inpatient Benefits will be provided as though you were still eligible for benefits from this Plan provided you remain totally disabled from the date your eligibility terminated until the date you were hospitalized.

Section 4.2 Outpatient Benefits

A. General

You are eligible for up to \$3,000 to cover expenses related to:

- Outpatient medical treatment rendered in a hospital in connection with a surgical operation performed as a part of the outpatient treatment and resulting from accidental bodily injuries or sickness excluding pregnancy provided such treatment is rendered within 72 hours after the operation is performed.

Following exhaustion of the \$3,000.00 basic benefit described in this Section, outpatient medical treatment expenses are covered at the coinsurance rates described in Section 9.1(C).

B. Covered Outpatient Expenses

Outpatient Benefits cover expenses for:

- Necessary medical services and supplies furnished by a hospital other than room and board;
- Anesthesia and its administration whether furnished by a hospital or not; and
- Diagnostic services rendered in connection with emergency outpatient medical treatment in a Hospital within 72 hours after the time of an accident.

Section 4.3 Exclusions

No hospital benefits will be paid to cover charges for:

- The services of private nurses, special nurses or doctors;
- An ambulance from the hospital to your home or any other means of transportation;
- Anything excluded under Article 11; and
- Transfers from one hospital to another that are not deemed Medically Necessary.

ARTICLE 5 – SURGICAL BENEFITS

NOTE: The terms “you” and “your” as used in this Article refer to Participants and their Eligible Dependents.

Section 5.1 General

Surgical Benefits are provided for surgical care, including the usual care provided by your Doctor before and after surgery. Surgery is an operation or procedure, which requires cutting. Surgical benefits also cover the setting of fractured or dislocated bones.

The maximum surgical benefit for any one surgical procedure will be the amount charged by the attending doctor up to the maximum specified in Section 5.2.

If two or more surgical procedures are performed through the same incision or through the same natural body orifice or in the same operative field, payment will be made for each procedure.

The maximum for each procedure includes normal follow-up care for the customary period of time as determined by the Trustees.

Section 5.2 Schedule of Covered Surgical Procedures

Surgical benefits are provided to you for the procedures and amounts as defined by either EBS-RMSCO's negotiated fee or the usual, customary, and reasonable charge. Assistant surgeon charges will receive the EBS-RMSCO negotiated fee. If providers are non-participating, they will be paid at twenty percent (20%) of the usual, customary, and reasonable charge.

Section 5.3 Separate Surgical Periods

Successive operations will be considered to have been performed during one surgical period unless the subsequent operation:

- Results from causes entirely unrelated to the causes of the previous operation; or
- If you are a Participant, is performed after you have returned to work for your employer for at least 5 consecutive scheduled working days; or
- If you are an eligible dependent, is performed at least 2 consecutive months after the date of your previous operation.

Section 5.4 Extended Eligibility for Surgical Benefits

Surgical benefits will be provided to you to cover a surgical procedure which is performed on you within 29 months after the date your eligibility terminates, provided:

- The procedure results from injuries sustained or sickness contracted prior to the date your eligibility terminated; and
- You are totally disabled by the injuries or sickness on the date your eligibility terminates and you remain continuously so disabled until the date of the procedure.

Section 5.5 Second Surgical Opinion Benefits

Surgical benefits of up to the reasonable and customary rate are provided if you wish to obtain a second surgical opinion when your doctor recommends elective surgery. This surgery must be of a non-emergency nature, but must require hospitalization. The second surgical opinion must be given by a board certified specialist who is competent to consider the proposed surgery.

ARTICLE 6 – MEDICAL BENEFITS

NOTE: The terms “you” and “your”, as used in this Article, refer to Participants and their Eligible Dependents.

Section 6.1 The Benefits

If you are treated by a Doctor, for an off-the-job illness or accident, whether you are confined to a hospital or not, you are entitled to coverage for that service. (Not a well care visit). The benefits are paid according to the Major Medical Section of this Plan.

Section 6.2 Extended Eligibility for Medical Benefits

Subject to the provisions of this Article, Medical Benefits will be provided to you during a period of hospital confinement that commences within 29 months after your eligibility terminates, provided the confinement results from an injury or sickness which you sustained before the date your eligibility terminated and which resulted in your becoming totally disabled continuously from the date your eligibility terminated until the date your confinement commenced.

ARTICLE 7 – MATERNITY BENEFITS

NOTE: The terms “you” and “your”, as used in this Article, refer only to female Participants and the eligible dependent spouses of male Participants.

Section 7.1 Covered Maternity Expenses

If you are confined in a hospital because of a pregnancy, you are eligible to receive Maternity Benefits to cover expenses for:

- Room and board charges;
- Necessary medical services and supplies furnished by a hospital;
- Services of a doctor for an obstetrical procedure (in or out of the hospital);
- Hospital nursery care for the newborn child; and
- Transfers from primary hospital to a secondary hospital will not be covered unless deemed Medically Necessary; no transfers are allowed merely for convenience.

The services of a private duty nurse will not be covered.

Section 7.2 Length of Maternity Hospitalization

In accordance with Federal law, the Plan may not 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 normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

ARTICLE 8 – OTHER BENEFITS

Section 8.1 Diagnostic Laboratory and X-Ray Benefits

Participants and their eligible dependents are entitled to up to \$1,000.00 for all of the expenses incurred for diagnostic laboratory and x-ray services for one calendar year. However, no benefits are payable under this Article to cover expenses incurred for: x-ray examinations made without film; services for which you are entitled to benefits under Article 4; or anything excluded under Article 11.

Following exhaustion of the \$1,000.00 basic benefit described in this Section, expenses for diagnostic laboratory and x-ray services are covered at the co-insurance rates described in Section 9.1(C).

Section 8.2 Physical Examination Benefits

Participants and their spouses are eligible to receive an annual physical check-up examination. The maximum yearly benefit is \$300.00 for the Participant and \$150.00 for the spouse.

Following the exhaustion of the \$300.00 or \$150.00 basic benefit described in this Section, expenses for physical examinations are covered at the coinsurance rates described in Section 9.1(C).

ARTICLE 9 – MAJOR MEDICAL BENEFITS

NOTE: The terms “you” and “your”, as used in this Article, refer to Participants and their eligible dependents.

Section 9.1 The Benefits

- A. You must pay the first \$400.00 of covered expenses that you incur each calendar year. This is the individual deductible. However, the maximum deductible per family is

\$400.00 per person for three individuals. This family deductible is decreased to \$400.00 with respect to all family members involved in a single accident.

- B. If you incur and pay the first \$400.00 of covered expenses in the last quarter of the calendar year, you will not be required to pay the \$400.00 deductible for the coming calendar year.
- C. Once you have satisfied your deductible in a calendar year, you are eligible to receive Major Medical Benefits equal to 80% of the covered expenses you incur during the remainder of that calendar year, provided such expenses are not covered under other Articles of this Plan. You must pay the remaining 20% of such expenses, up to a maximum of \$1,600.00 per calendar year. This is the co-insurance amount.
- D. After you pay \$1,600.00 in co-insurance in a calendar year, you are eligible to receive Major Medical Benefits equal to 100% of the covered expenses you incur during the remainder of that calendar year.
- E. Effective May 1, 2011, benefits for covered chiropractic treatments are limited to fifty treatments per calendar year and are covered at the co-insurance rates described in Section 9.1(C). You must pay the remaining 20% of the remaining expenses, and you are responsible to pay 100% of all additional expenses, including costs of all treatments over fifty per calendar year.
- F. Effective May 1, 2011, benefits for physical therapy are limited to fifty treatments per calendar year and are covered at the co-insurance rates described in Section 9.1(C). You must pay the remaining 20% of the remaining expenses, and you are responsible to pay 100% of all additional expenses, including costs of all treatments over fifty per calendar year.
- G. Effective June 1, 2010, you no longer need to pay the entire cost of a medication after the third purchase. Beginning with the fourth purchase at a participating retail pharmacy, your retail coinsurance for long-term drugs is: 25 percent for generic drugs, 35 percent for preferred brand-name drugs, and 55 percent for nonpreferred brand-name drugs. See your coinsurance payments in the chart below. Although you have the option to get your long-term drugs at a retail pharmacy, you may pay less by getting long-term drugs by mail from Express Scripts. You'll get up to a 90-day supply delivered right to you, at a cost that will help the Health and Welfare Fund save money and continue providing you with an affordable prescription drug benefit.

Two easy ways to get your long-term drugs through mail order:

1. By mail:

- (a) Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate).
 - (b) Print a mail-order form from Express Script's website, www.express-scripts.com, and mail that and your new prescription directly to Express Scripts.
2. By fax:
- (a) Ask your doctor for a new long-term prescription as described above.
 - (b) Give your doctor your member ID number (shown on your prescription drug ID card) and ask him or her to call 1-888-327-9791 for instructions on how to use Express Script's fax service to send prescriptions. (Only your doctor can fax your prescriptions.)
3. Ask your doctor for a new long-term prescription as described above.
4. Give your doctor your member ID number (shown on your prescription drug ID card) and ask him or her to call 1-888-327-9791 for instructions on how to use Express Script's fax service to send prescriptions. (Only your doctor can fax your prescriptions.)

A note about insulin coinsurance payments:

Also effective June 1, 2010, coinsurance for insulin decreased from 30 percent to 20 percent, whether purchased at a participating retail pharmacy or through mail order.

The chart below shows your prescription drug coinsurance payments, effective June 1, 2010. Please discuss cost-saving opportunities, such as using generics or mail order, with your doctor.

	The first three purchases at a participating retail pharmacy (up to a 30-day supply)	Beginning with the fourth purchase at a participating retail pharmacy (up to a 30-day supply)	Any purchase through mail from the Express Scripts Pharmacy (up to a 90-day supply)
Generic drugs	20% of the medication's cost	25% of the medication's cost	20% of the medication's cost
Preferred brand-name drugs	30% of the medication's cost*	35% of the medication's cost*	30% of the medication's cost*
Nonpreferred brand-name drugs	50% of the medication's cost*	55% of the medication's cost*	50% of the medication's cost*
Insulin	20% of the medication's cost	25% of the medication's cost	20% of the medication's cost*

*** If you purchase a brand-name drug when a generic equivalent is available, you will pay the brand-name coinsurance plus the difference in cost between the brand, and the generic. This**

additional cost will apply even if your doctor has indicated “DAW” (dispense as written) on the prescription.

If you have any questions or need assistance, visit Express Scripts online at www.express-scripts.com or call Express Scripts Member Services toll-free at 1-866-544-2926. Have your member ID number and a recent prescription drug number handy.

Section 9.2

Covered Major Medical Expenses

No portion of an expense is considered a covered expense to the extent it is covered under another Article of this Plan. Covered Major Medical expenses are the reasonable expenses incurred for necessary Hospital, surgical and medical services and supplies which have been prescribed by the attending Doctor, and which have been directly furnished for the sole purpose of treatment of your non-work related illness or injury. The following expenses are covered:

A. Hospital Expenses

Major Medical Benefits are provided to cover expenses for:

- Hospital room and board;
- Necessary medical services and supplies furnished by a hospital;
- Anesthesia and its administration, furnished during inpatient hospital confinement or Hospital outpatient medical treatment;
- Local ambulance service, furnished in connection with hospital inpatient or outpatient medical treatment, by an organization which normally provides this type of service;
- Emergency medical treatment rendered within 72 hours after the time of accident and resulting from a disability caused by accidental bodily injuries, provided such services are furnished on a day when you receive hospital inpatient or outpatient treatment; and
- Medical treatment furnished in connection with a surgical operation.

B. Surgical Expenses

Major Medical Benefits are provided to you to cover expenses for the surgical services of a doctor, rendered for the performance of a surgical procedure, including post-operative care and treatment rendered by such doctor in connection with such operation.

C. Medical Service Expenses

Major Medical Benefits are available to cover expenses for medical treatment, services and supplies (other than hospitalization or surgical services), subject to the following:

- Expenses for any type of nursing service will be covered only if the person rendering the service is a registered graduate nurse;
- Expenses for the rental of a wheelchair, hospital-type bed, iron lung or other durable equipment for medical or surgical treatment, or for purchase if adjudged more economical by the Trustees. However, coverage of rental equipment is subject to the following conditions:
 1. With respect to equipment which may be rented, you must contact the Fund Office immediately when you find out that you require the use of such equipment. The Fund Office will then determine in their sole discretion, whether the equipment should be rented or purchased for your use, on the basis of the cost of the equipment and the period of time during which you will be required to use it.
 2. Repair costs and disposable supplies are NOT covered.
 3. The equipment must be primarily and customarily used for medical purposes.
 4. The equipment must be generally not useful to a person in the absence of injury or illness. For example, equipment that may be enjoyed by the entire family, such as air conditioners, exercise bicycles, etc. are NOT covered.
- Expenses for ambulance service will be covered only if they are for local ambulance service and are furnished by an organization which normally provides this type of service; and
- Expenses for transportation (other than by ambulance) will be covered only if they are for transportation within the continental limits of the United States and Canada via public conveyance:
 - From the place of legal residence or local Hospital to a specialized Hospital or specialized clinic, and return; or
 - From the area where an illness or injury commences to the place of legal residence or local hospital.

- Laboratory and X-ray services above Section 8.1 limit.
- Effective May 1, 2013 through April 30, 2014, the Plan will cover the durable medical equipment known as the continuous positive airway pressure (CPAP) devices at the rate of 80% of the Usual, Customary and Reasonable (UCR) charge. You must pay the remaining 20% of the charge.

D. Dental Expenses and Cosmetic Surgery Expenses

Major Medical Benefits will be provided to you to cover expenses for dental work or cosmetic surgery only if the work or surgery is necessary for the repair or alleviation of damage caused solely by accidental bodily injury sustained while you were eligible for benefits. The term “dental work” means treatment of the teeth or gums, and any supplies furnished in connection with such treatment, provided the treatment is performed or the supplies are furnished by a person authorized by license to perform such treatment or furnish such supplies.

E. Expenses Related to Complications Incident to Pregnancy

Maternity benefits are provided to cover expenses for:

- Charges for surgical procedures in connection with the pregnancy, and related charges incurred thereafter in connection with the pregnancy, if the procedure is:
 - For extrauterine pregnancy; or
 - For complications requiring intra-abdominal surgery after termination of pregnancy.
- Charges incurred during confinement in a hospital which are directly related to the following complications of pregnancy:
 - Pernicious vomiting;
 - Toxemia with convulsions;
 - Rheumatic heart disease causing cardiac decompensation; or
 - Ureteral obstruction due to pressure of the gravid uterus.

F. Professional Psychiatric and/or Psychological Service Expenses

The following will apply to the coverage of expenses for professional psychiatric and/or psychological services furnished on any day you are not confined as an inpatient in a hospital:

Benefits under this Plan cover 80% of psychiatric and/or psychological service expenses. You are responsible for the remaining 20%.

G. Extended Eligibility for Major Medical Benefits

If your eligibility terminates while you are totally disabled, then benefits will continue to be payable for the covered expenses you incur during the period beginning with the date of such termination and ending on the earliest of the following dates:

- The date your total disability terminates;
- The last day of the 29th consecutive month following the month in which your eligibility terminates;
- The date on which you become eligible for similar benefits under another plan providing group coverage; or
- The date on which the maximum benefit has been paid.

H. Expenses Related to a Mastectomy

Charges incurred by a Participant or Beneficiary in connection with a mastectomy covered by the Plan, in a manner determined in consultation with the attending physician and the Participant or Beneficiary, for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and the treatment of physical complications at all stages of a mastectomy including lymphedemas.

The above coverages are subject to any deductibles and co-insurance limitations consistent with those established for other benefits under the Plan.

I. Well Child Care

The following preventive services for children are covered under the Plan's Major Medical Benefit as indicated below:

- Autism screening for children at 18 and 24 months
- Behavioral assessments for children up to 17 years of age
- Blood pressure screening for children up to 17 years of age
- Cervical dysplasia screening for sexually active females

- Congenital hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders up to 17 years of age
- Hearing screening for all newborns
- Height, weight, and body mass index measurements for children up to 17 years
- Hematocrit of hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations may vary in accordance with the US Preventative Task Force Recommendations:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenza type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
- Lead screening for children at risk of exposure
- Medical history for all children throughout development up to 17 years of age
- Phenylketonuria (PKU) screening in newborns
- Tuberculin testing for children at higher risk of tuberculosis up to 17 years of age.

J. Benefits for Organ and Bone Marrow Transplants

The Plan covers Medically Necessary organ and bone marrow transplants, including Medically Necessary stem cell transplants, that are not Experimental or Investigative as determined by the Trustees in their discretion. The Plan will also cover the expenses of the donor who is not a Participant or Dependent under this Plan when the recipient is a Participant or Dependent under this Plan provided there is no other coverage available. The expenses incurred by the recipient and donor are subject to the co-insurance rates described in Section 9.1(C). If other coverage is available to the donor, this Plan will be the secondary payer in accordance with the coordination of benefits rules.

The following conditions must apply to such procedures:

- (A) The procedure must be performed at a facility known for having an effective program for doing such procedures, and
- (B) The Covered Family Member must be a likely candidate for the successful outcome of such a procedure, and
- (C) Medical expenses for the donor and the recipient must be considered Allowable Expenses under this Plan.

Benefits are payable for the following:

- (A) The cost of registering the recipient with a transplant registry.
- (B) Pre-transplant services provided to donors in anticipation of a transplant. Covered Services include laboratory tests (including tissue typing), and general medical evaluations.
- (C) Acquisition services for an organ or bone marrow from a living donor or from a cadaver. Organ transplant expenses to include transportation of the organ to the place of transplantation, including the cost of a technician, packing and preservation, and injections of antibodies, but not charges for lodging or meals of a courier, or finder's fees.
- (D) Charges for transportation of the recipient from one facility to another facility where the procedure will be performed.
- (E) Routine post-operative care for both the recipient and donor as well as for complications that result from the procedure.

Organ and Bone Marrow Transplants Limitations and Exclusions: The Plan does not cover:

- (A) Legal fees, finder fees, and any other fee paid to or on behalf of the donor for the organ, tissue, or bone marrow.
- (B) Charges incurred for mechanical devices designed to replace human organs (except for charges for a kidney dialysis machine or use of a mechanical heart to keep a patient alive until a human heart donor becomes available).

- (C) Charges incurred for keeping a donor alive for transplant purposes.
- (D) Travel expenses (including meals and lodging) incurred by a live donor, travel companion or the recipient to travel to any transplant center.

ARTICLE 10 – INDIVIDUAL REIMBURSEMENT ACCOUNTS

Effective May 1, 2002, each active participant has an individual account established and funded by a portion of existing Contributing Employer contributions. As of October 1, 2002, this account may be used for the payment of unreimbursed medical expenses. The portion of the amount of the employer contributions that will be credited to your personal account will be determined by the Trustees of the Plan, from time to time, and will be based upon the financial requirements of the Plan. This benefit, like others in this Plan, is not vested.

These unreimbursed expenses include expenses for Covered Medical Services described in Articles 4 through 9 that were not paid by the Plan, such as Plan deductibles, coinsurance, or co-payments, as well as optical, dental, and other non-covered medical items. Claims for reimbursement from this account should be accumulated and submitted, and will be reimbursed once a quarter. Forms will be made available in the Fund office to apply for reimbursement.

Your individual account will grow as contributions are made to it. Your individual account will be decreased by any reimbursement or premiums paid from it. Additionally, regardless of whether you decline medical coverage, the Fund will automatically deduct a coverage fee from all accounts. Active employees must maintain an account balance of at least \$3,000.00 before using the account for unreimbursed medical expenses. Retirees and separated participants may deplete their accounts completely. You and your beneficiaries may not receive more from your individual account than has been contributed to it.

If there is not enough money in your individual account when you apply for reimbursement, you may wait until enough money has been contributed. However, you must submit your request within 12 months of incurring the expense to receive reimbursement.

ARTICLE 11 – EXCLUSIONS

NOTE: This Article applies to Participants and their eligible Dependents. Thus, the terms “you” and “your”, as used in this Article, refer to Participants and their eligible dependents. Also, these exclusions only apply to the benefits summarized in Articles 4, 5, 6, 7, 8, and 9.

Section 11.1 Excluded Items

- A. Notwithstanding any other provision of this Plan, you are not eligible to receive any benefits to cover expenses or charges for any “item”:

1. Payable under any Federal, state or local government program or law, provided you would be eligible to receive payment for the “item” if you applied for it or enrolled in the program [this exclusion is not applicable with respect to Medicaid, or Medicare (when Federal law requires this Plan to pay benefits before Medicare)];
2. Payable under a Workers’ Compensation law or similar law, provided you would be eligible to receive payment for the “item” if you applied for it or claimed it;
3. Provided to you without charge;
4. Which would have been provided to you without charge if you were not eligible for benefits from this Plan;
5. Provided by a member of your family, or by a corporation or partnership participated in by a member of your family;
6. Covered by mandatory automobile no-fault insurance, provided you would be eligible to receive payment for the “item” if you applied for it or claimed it [refer to Article 18];
7. Which the Trustees, in their sole discretion, deem to be custodial, domiciliary, intermediary, or rest care [an “item” you receive because of your age or mental or physical condition, primarily to assist you in the activities of daily living shall be deemed custodial care; additionally, this exclusion shall apply even if you are concurrently receiving a medical item which is merely maintenance care that cannot reasonably be expected to contribute substantially to the improvement of your medical condition];
8. Which the Trustees, in their sole discretion, determine is not medically necessary, or is unnecessarily repetitious [this exclusion is not applicable with respect to the Annual Physical Checkup Examination Benefit];
9. Which the Trustees, in their sole discretion, consider experimental or investigative in nature, or of no proven medical value;
10. Provided to you at a cost in excess of the reasonable and customary cost for that “item” in the locality in which it was provided to you [the excess cost is excluded];
11. Provided to you at a cost in excess of the provider’s usual charge for that “item” [thus, if the provider’s usual charge is less than this Plan’s maximum allowance for that “item”, then you will not receive a benefit that exceeds the provider’s usual charge];

12. Provided to you because of an occupational accidental bodily injury or illness, or incurred while you were doing any act related to your occupation or employment, or any act you did for profit or remuneration;
13. Necessitated or caused by any act of war, declared or undeclared, including armed aggression;
14. Incurred while you were in the service of any military, or naval or air force of any country, while such country is engaged in war, declared or undeclared, or while you were performing police duty as a member of any military or naval organization;
15. Incurred while you were committing or engaged in an illegal act. No benefits or Plan assets will be paid or expended from this Plan to cover expenses related to an injury, condition, or disease resulting from directly or indirectly being engaged in, or incurred while committing, an Illegal Act. For the purpose of this exclusion, the term "Illegal Act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether an action or omission is an Illegal Act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the term "Illegal Act" shall not be interpreted to exclude Coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness;
16. Incurred as a result of an accident which occurred while you or a member of your family was driving while intoxicated, or with ability impaired;
17. Not provided by a hospital or a doctor;
18. Which is Red Cross blood or blood plasma;
19. Incurred before you became eligible for benefits from this Plan, or after your eligibility for benefits from this Plan terminated, unless your eligibility was being extended pursuant to the provisions of this Plan;
20. Caused by intentionally self-inflicted injuries or suicide, unless caused by a medical condition such as depression in accordance with the exclusions permitted by the regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

21. resulting from an injury or illness related to the engagement in hazardous recreational activity in accordance with the exclusions permitted by the regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including but not limited to (i) skydiving; (ii) bungee jumping; (iii) professional or amateur motor vehicle or vessel racing (including, but not limited to, the racing of cars, motorcycles, dirt bikes, power boats, etc.); or (iv) professional boxing or other fighting for a fee;
22. Which is a hearing aid, or which is related to the fitting of hearing aids;
23. Which is not specifically specified as a covered “item” in this Plan;
24. Which is a cosmetic device, or a dental care, procedure, or appliance, unless such “item” is necessitated by an accidental injury;
25. In connection with cosmetic or reconstructive surgery, unless such “item” is necessary for the prompt repair of a non-occupational injury; is incidental to or following surgery caused by trauma, infection, or other diseases of the involved part; or is related to congenital disease or anomaly of an eligible dependent child which has resulted in a functional defect.

However, charges incurred by a Participant or Beneficiary in conjunction with a mastectomy are covered by the Plan, in a manner determined in consultation with the attending physician and the Participant or Beneficiary, for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses and the treatment of physical complications at all stages of mastectomy including lymphedemas.

26. Which is a pair of eyeglasses or contact lenses, or which is related to their fitting or prescription, or which is for an eye refraction;
27. In connection with travel, even if it is prescribed by a Doctor, except as specified in Section 9.2C;
28. Provided without charge by or in a hospital operated by a federal or state government or agency (other than a hospital operated by the Veterans’ Administration) a nursing home; or a skilled nursing facility;
29. Provided in an institution, or a part of one, which is primarily a nursing, convalescent or rest facility, or a facility for the aged;
30. In connection with telephone consultations; the completion of Claim Forms or other medical reports; sales taxes; or acupuncture;

31. Caused by or resulting from alcohol or drug abuse to the extent this exclusion is permitted by the regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as well as other applicable laws;
 32. Which should be paid by another Health Care Plan, in accordance with the provisions of Article 18;
 33. In connection with palliative or cosmetic foot care; orthotics; artificial insemination; in-vitro fertilization; transsexual surgery; or sexual dysfunction unrelated to organic disease;
 34. Related to obesity, except for the surgical treatment of morbid obesity;
 35. Amounts in excess of the medical benefits limitations set forth in Section 6.1; or
 37. Incurred for which some other third party is responsible.
- B. The term “item”, as used in this Article, refers to any of the following, including a portion of any of the following, or more than one of any of the following: service, care, surgery, condition, pregnancy, injury, sickness, Hospital confinement, nursing service, room and board, treatment, institutional service, procedures, surgical procedure, or supply.

ARTICLE 12 – DEATH BENEFITS

NOTE: Death Benefits are only provided to and for Participants. Thus, the terms “you” and “your”, as used in this Article, refer only to Participants.

Section 12.1 Death Benefits For Participants

In the event of your death from any cause, and if you are working in Covered Employment at the time of your death, a Death Benefit of \$10,000.00 will be paid to your Designated Beneficiary. Death Benefits are only available for the beneficiaries of participants who were paying premiums from their personal account for coverage at the time of their death.

Section 12.2 Designated Beneficiary

When you become eligible for benefits, be sure to fill out a Designation of Beneficiary form, and submit it to the Fund Administrator. If you have not already filled out such a form, then you should fill out one now. These forms are available at the Fund Office. You may change your Designated Beneficiary at any time you desire. However, if you attempt to change your Designated Beneficiary, but the form is not submitted to the Fund Administrator prior to your

death, then this Plan will pay your Death Benefit in accordance with the form then on file at the Fund Office.

If you do not name a Designated Beneficiary, or if the person you named dies before you, your Death Benefit will be paid as follows:

- First - To your widowed spouse; or if your widowed spouse is not living, then
- Second - To your children in equal shares; or if you do not have any children, then
- Third - To the object of your natural bounty, as determined in the sole discretion of the Trustees

If your Designated Beneficiary is a minor, then his share may be paid, at the option of the Trustees, in one sum or in installments, to such person as is, in the opinion of the Trustees, caring for and supporting him.

Any attempted assignment by the Designated Beneficiary will be considered null and void. In such case, the money will be held by the Trustees for such purposes as they, in their sole discretion, deem proper.

Section 12.3 Disabled Participants

If you become totally and permanently disabled before age 60, and you are a Participant at such time, then your Death Benefit coverage will be continued, while you remain so disabled, until the second anniversary of the commencement of your disability. Proof of continued total disability must be submitted to the Fund Administrator as required. If that proof is accepted by the Trustees, the Death Benefit will be payable upon your death. "Total disability", as used in this Article, means disability due to bodily injury or disease, which totally and permanently prevents you from engaging in any occupation or employment for compensation or profit.

If you die while your coverage is being continued in this manner, written notice of your death and proof of your continuous total disability to the date of your death must be received by the Fund Administrator within 12 months. Should your death occur before fulfillment of the requirements as to proof of total disability, but within the time allowed for furnishing such proof, your Death Benefit will still be paid if the proof required in such circumstances is furnished to the Fund Administrator.

All coverage under this Section will cease immediately on the earliest of:

- The date you cease to be totally disabled;
- The end of the period for which your coverage has been continued, if there is a failure to furnish the required proof; or

- The date you refuse to be examined as requested by the Trustees.

Section 12.4 Death Benefits to Participants

If you have been married to your spouse for at least 1 year, and your spouse dies from any cause, you will be paid a Death Benefit of \$5,000.00.

ARTICLE 13 – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

NOTE: Accidental Death and Dismemberment Benefits are only provided to Participants. Thus, the terms “you” and “your”, as used in this Article, refer only to Participants.

Section 13.1 The Benefits

A benefit will be payable in a lump sum if you sustain an accidental bodily injury on or off the job which results in loss of your life or your hand, foot or eyesight. Loss of life benefits are payable to your Designated Beneficiary (refer to Section 12.2 as to how to designate your beneficiary). All other benefits under this Article are payable directly to you. The benefits payable under this Article are as follows:

Loss of Life (In addition to Death Benefits)	\$20,000.00
Loss of one hand, one foot, or the sight in one eye	\$10,000.00

No more than \$20,000.00 will be paid for all losses combined resulting from the same accident.

Loss of a hand or a foot means dismemberment through or above the wrist or ankle joint. Loss of eyesight means loss of the entire and irrevocable sight of the eye. Accidental Death and Dismemberment Benefits are only available for the participants or their beneficiaries who were paying premiums from their personal account for coverage at the time of the accident.

Section 13.2 Exclusions

No Accidental Death and Dismemberment Benefits are payable for any losses:

- Occurring more than 90 days after the accident;
- Resulting from sickness or disease, or medical or surgical treatment for such sickness or disease;
- Resulting from war or an act of war, whether or not war is declared;

- Resulting from sickness or injury sustained while in the Armed Forces or engaged in armed conflict; or
- Resulting from intentionally self-inflicted injuries or suicide.

ARTICLE 14 – WEEKLY DISABILITY BENEFITS

NOTE: Weekly Disability Benefits are only available to Participants. Thus, the term “you” and “your”, when used in this Article, refers only to Participants.

Section 14.1 The Benefits

If you become totally and continuously disabled by accidental bodily injury or sickness and are thereby prevented from performing the duties of your occupation, then you will be entitled to benefits as follows:

- Benefits will begin on the first day of a disability caused by an accident, and the eighth day of a disability caused by sickness.
- Benefits are only payable for a maximum of 26 weeks.
- The maximum Weekly Disability Benefit is \$240.00 per week.

Successive periods of disability will be considered one period, unless the subsequent period:

- Results from causes entirely unrelated to the causes of the previous disability; or
- Commences after you have returned to active full-time work for your employer for at least 2 consecutive weeks.

Weekly Disability benefits are only available for the participants who were paying premiums from their personal account for coverage at the time of the injury or sickness.

ARTICLE 15 – APPLYING FOR BENEFITS

Section 15.1 How to Apply For Benefits

To receive the benefits you are eligible for from this Plan, you must fill out a claim form and submit it, along with an itemized copy of your bill, to the Fund Administrator within 180 days after the date of your first treatment or your first visit to your doctor, or the first day of your hospital confinement. To receive the proper claim form, you must notify the Fund Administrator immediately upon the happening of an event which entitles you to benefits from this Plan.

You will forfeit any benefits you would otherwise be eligible to receive if a completed claim form, along with the itemized bill, is not filed with the Fund Administrator on time. Thus, you must make sure that your claim form is forwarded to your doctor or your hospital early enough so that the claim form can be completed and returned to the fund administrator within 180 days.

With respect to Death Benefits, the Fund Administrator should be notified of the death at once. The designated beneficiary will then be sent an application for a Death Benefit. This form must be completed and returned to the Fund Administrator, with a certified copy of your death certificate, within 90 days from the date of death.

Section 15.2 Claims for Incapacitated Individuals

If the Trustees (or their designee) determine that a person entitled to benefits from the Plan is unable to care for his affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees (or their designee), be made to that person's spouse, child or such person who shall have care and custody of that person, as the Trustees will determine in their sole discretion.

Section 15.3 Review of Claim Forms

After you submit a completed claim form, the Fund Administrator will review it to determine your eligibility for the benefits claimed. The Fund Administrator will first determine whether the benefits you are applying for are offered by this Plan. If they are, then the Fund Administrator will determine whether you are eligible for such benefits pursuant to this Plan's rules of eligibility.

You should be aware that the benefits provided by this Plan and the rules of eligibility for such benefits may be changed by the Trustees from time to time. All provisions in this Booklet are subject to any rules and regulations the Trustees may adopt and to the Trust Agreement which established and governs the Fund's operations.

If the Fund Administrator determines that you are applying for benefits that are offered by this Plan and that you are eligible for such benefits, then the Fund Administrator will determine the amount of benefits you are entitled to under the applicable Plan provisions. The Fund Administrator's decision regarding your eligibility for, and entitlement to the benefits you claimed is subject to review only by the Trustees.

If your application for benefits is denied, in whole or in part, then the Fund Administrator will notify you in writing regarding: (1) the specific reason for the denial; (2) the particular Plan provision upon which the denial is based; and (3) an explanation of this Plan's Appeal Procedure.

If additional information or documentation is required to review a claim, you will be so notified and an explanation given as to why such additional material is necessary.

ARTICLE 16 – CLAIMS REVIEW AND APPEAL PROCEDURES

Initial Decisions

Time Frames

Hospital, Surgical, Medical, Maternity, Major Medical, Diagnostic Laboratory and X-Ray, Physical Exam, Supplemental Accident Expense, and Individual Reimbursement Account Benefits

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service, Urgent, or Concurrent Claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant. Pre-Service, Urgent and Concurrent claims are not Post-Service Claims.

Pre-Service Claims

The receipt of some medical benefits may be conditioned on advance approval from the Plan. Claims for such benefits are considered Pre-Service Claims, as described above. For Pre-Service Claims, you will be notified of the benefit determination (whether adverse or not) within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the third-party administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the third-party administrator will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the plan regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the Plan's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Post-Service Claims

For Post-Service Claims (claims not requiring pre-approval), you will be notified of any adverse benefit determination by the Plan within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the Plan notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Weekly Disability Benefit

If your claim for a Weekly Disability Benefit is denied in whole or in part for any reason, then within 45 days after this Plan receives your claim, this Plan will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the

control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable).

Death Benefit and Accidental Death and Dismemberment Benefit

If your claim for Death Benefit and Accidental Death and Dismemberment Benefit is denied in whole or in part for any reason, then within 90 days after the plan (or the insurance company, if applicable) receives your claim, the plan (or the insurance company, if applicable) will send you written notice of its decision, unless special circumstances require an extension, in which case the plan (or the insurance company, if applicable) will send you written notice of the decision no later than 180 days after the plan (or the insurance company) receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by plan (or the insurance company) expects to render the benefit determination. However, any decision regarding life insurance coverage that is based on a finding of total and permanent disability is subject to the same rules that apply to Disability Benefit claims.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;
2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;
5. In a case of an adverse determination involving a claim for urgent care, a description of the expedited review process applicable to such claims;
6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a

copy of it will be provided free of charge upon request; and

7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

To appeal an adverse benefit determination of a Hospital, Surgical, Medical, Maternity, Major Medical, Diagnostic Laboratory and X-Ray, Physical Exam, Supplemental Accident Expense, and Individual Reimbursement Account Benefit you must write to the Trustees within 180 days after you receive this Plan's initial determination. Your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will

consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims: If urgent care claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the plan's benefit determination on review, shall be transmitted between you and the third-party administrator by telephone, facsimile, or other similarly expeditious method.

Determinations on Appeal

Time Frames

Pre-Service Claims for Major Medical Benefits: The Plan will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the request for review (except if the Plan provides two (2) levels of the appeal, the decision has to be made within 15 days at each level.)

Urgent Care Claims: The Plan will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

Post-Service Claims for Benefits: The Plan will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but no later than 60 days after receipt of the request for review (except if the Plan provides two (2) levels of appeal, the decision has to be within 30 days of each level).

Weekly Disability, Death, and Accidental Death and Dismemberment Benefit Claims: Appeals of adverse Weekly Disability Benefit determinations must be determined by the plan within 45 days after receipt of the request for review (plus a possible 45-day extension, if necessary). Appeals of adverse Death and Accidental Death and Dismemberment Benefit determinations must be determined by the plan (or the insurance company, if applicable) within 60 days after receipt of the request for review (plus a possible 60-day extension, if necessary).

All Other Claims: The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made.

The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;
2. Reference to specific plan provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The Trustees' Decision is Final and Binding

The Trustees' final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan. Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

ARTICLE 17 – COORDINATION OF BENEFITS

NOTE: As used in this Article, the terms “you” and “your” refer only to Participants.

Section 17.1 Coordination Rules

Quite frequently, because both the husband and wife are working, family members are covered under more than one “Health Care Plan”. Thus, in some instances, the combined benefits received under the two Plans could exceed the medical bill. Therefore, if you and/or any of your Eligible Dependents are covered under this Plan as well as another plan providing medical benefits, then these coordination of benefits rules apply. If you or your dependents could have coverage under another Plan but did not claim benefits from the other Plan, these coordination of benefits rules may apply as if you had claimed such benefits. Since the purpose of a benefit program is to cover medical expenses and not to make a “profit” from being sick, these rules determine the portion of your expenses that will be paid by each plan. The rules determine how the benefits payable under one of the two plans in such cases will be reduced so that the total benefits payable under all plans will not exceed the “Allowable Expenses” incurred during any calendar year.

Under these rules, one plan is determined to be the “Primary Plan”. That plan pays its benefits first, as if there are no coordination of benefits rules. The other plan, the “Secondary Plan”, determines its benefits only after the Primary Plan has made its determination as to what it will pay.

“Allowable Expenses” are any necessary, reasonable and customary item of expense for medical care or treatment covered under at least one of the plans under which you are eligible for benefits.

A “Health Care Plan” is any plan or program, or group or group-type coverage providing health care coverage on an insured or uninsured basis. The following are considered “Health Care Plans”:

- Any Blue Cross or Blue Shield coverage or plan;
- Any self-insured or non-insured plan, or any other plan arranged through any employer, trustee, union, employer organization or employee benefit organization;
- Any prepayment arrangement;
- Any group or blanket insurance;
- Any group type contracts other than individual insurance issued on a franchise basis;
- Any coverage under governmental programs (except Medicaid), or any coverage required or provided by any law, to the extent permitted by applicable law;

- Student insurance plans;
- Medical benefits coverage and group, or group-type, and individual automobile “no fault” and traditional automobile “fault” type contracts.

Medicare is not considered a “Health Care Plan” with respect to any Participant over age 64 or any spouse of a Participant, or any disabled Participant who is still eligible for benefits from this Plan. Additionally, school accident coverages which cover grammar, high school or college students for accidents only, including athletic injuries, are not considered Health Care Plans.

If the other plan which may be liable for benefits does not contain a coordination of benefits provision, this Plan will be the Secondary Plan. If the other plan does contain such provisions, this Plan will be the Primary Plan with respect to your covered expenses. However, if you are covered under this Plan and another plan because you maintain two jobs, then the plan which has covered you for the longer period of time will be the Primary Plan.

This Plan will be the Secondary Plan with respect to any expenses incurred by an Eligible Dependent, if the other plan covers the Eligible Dependent as a covered employee, regardless of provisions in the other plan to the contrary.

If you are married, then the Primary Plan with respect to expenses incurred by your Eligible Dependent children will be determined by reference to your and your spouse’s birthday. If your children are eligible for coverage under both this Plan and your spouse’s plan (and you and your spouse are not legally separated or divorced), then the plan covering the parent whose birthday falls earlier in the year will be the Primary Plan. If both parents have the same birthday, then the plan which covered a parent longer is the Primary Plan. If neither of these rules applies, and if your spouse’s plan determines liability based on the gender of you and your spouse, then the rules of this Plan will govern. As used in this Article, the word “birthday” only refers to the month and day in a calendar year, not the year in which the person was born.

If the expenses are for a child whose parents are divorced or legally separated, then the plan covering the parent with custody is the Primary Plan. If the parent with custody remarries, then the order of payment is as follows:

- First - The plan covering the natural parent with whom the child resides;
- Second - The plan covering the step-parent with whom the child resides; and
- Third - The plan covering the natural parent not having custody of the child.

If the divorce decree makes one parent liable for the expenses of the child’s medical care, then the plan covering that parent will be the Primary Plan regardless of these rules, provided that the plan has actual knowledge of those terms. This paragraph does not apply with respect to any

period during which any benefits are actually paid or provided before the plan has such actual knowledge. This Plan will comply with the terms of a Qualified Medical Child Support Order.

The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). However, if the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, then this paragraph is ignored.

If, for some reason, the proper coordination of benefits cannot be determined under the rules described above, then the plan that covered the patient for the longest time is the Primary Plan. The other plan is the Secondary Plan.

If this Plan is the Secondary Plan, then benefits from this Plan will be reduced when the sum of the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this coordination of benefits Article, and the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this Article, whether or not claim is made, exceeds those Allowable Expenses in a period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

It is your obligation to notify the Fund Administrator if you, your spouse or any of your Eligible Dependents is covered by another Health Care Plan. If you fail to do so, any amount by which this Plan overpays benefits will be recovered from you, either directly or through a reduction in future benefits.

Without your permission and without notice to you, this Plan may release to, or obtain from, any person, company or organization information which this Plan believes is necessary to carry out the purposes of this Article. This Plan will not be legally responsible to anyone for releasing or obtaining information. You must furnish to this Plan any information it requests concerning this Article. If you do not submit requested information, then this Plan may deny you benefits until you do.

A "payment made" by another plan may include an amount which should have been paid by this Plan. If it does, we may pay that amount to the organization which made such payment. This amount will be treated as though it were a benefit paid to you. This Plan will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services. Thus, this Plan may repay to any other Health Care Plan the amount which you are eligible to receive under this Plan. These payments are the same as benefits paid to you, and they satisfy this Plan's obligations to you.

If the “amount of the payments made” by this Plan exceeds the amount payable under this Article, then this Plan may recover the excess from one or more of the persons we have paid or for whom we have paid, including insurance companies or other organizations. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services. If, after benefits have been paid under this Plan for services, supplies or treatment received by you or your Eligible Dependents, it is established that you or your dependent did not pay the charges for such services, supplies or treatment or were reimbursed for such charges (other than by an individual insurance policy), then this Plan shall be entitled to be reimbursed by you and/or your Eligible Dependent to the extent that the benefits paid exceed those that would have been payable based on the charges which were actually incurred and paid by you or your dependent.

NOTE: In case of automobile accident cases involving no-fault or fault insurance, this Plan will always be the Secondary Plan and will only pay unpaid balances and rejected charges, up to the maximum allowable under this Plan.

ARTICLE 18 – CLAIMS INVOLVING THIRD PARTY LIABILITY

Please Note: This provision applies to all participants, spouses, and dependent children, with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms “you” and “your” refer to all participants, spouses, and dependent children.

Section 18.1 General

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or otherwise responsible for your medical bills. The Trustees, in their discretion, may determine not to provide benefits under the Plan for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party’s responsibility to you. The rules in this Section govern how the Plan pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits may be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules may permit the Plan to pay your covered expenses until your dispute with a third party is resolved.

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party may be liable in any way for the injuries giving rise to these expenses, the Plan has provided benefits, this Plan must be reimbursed for the benefits it has advanced to you. That reimbursement must come out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

Section 18.2 Rights to Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to so advise the Welfare Fund Office. By law, the Plan automatically acquires any and all rights which you may have against the third party.

The Trustees may, in their sole discretion, require the execution of this Plan's Subrogation Agreement by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. The Plan's Subrogation Agreement must be signed and returned to the Fund Office within forty-five (45) days of the date of the cover letter forwarding the Subrogation Agreement. If the Trustees have required execution of the Plan's Subrogation Agreement, no benefits will be provided unless you, your spouse (if any) and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney, since that attorney must also execute the Subrogation Agreement.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE SUBROGATION AGREEMENTS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to the following information:

1. The details of your accident or injury;
2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and
3. The name and address of your attorney.

You must also:

1. Sign the Fund's Subrogation Agreement;
2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;
3. Provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees have the right to disregard any findings, determinations, conclusions, or judgments regarding a third party action relating to your obligation to reimburse the Fund. The Trustees have the right to independently determine whether reimbursement is required and/or how the Fund receives the appropriate reimbursement or credit, including reduction of future benefits for you, your spouse or dependents.

Section 18.3 Right of Future Subrogation and Reimbursement

In addition to satisfaction of the existing lien from any recovery by you, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

"Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fund's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been covered by the Plan until the amount of said proceeds is exhausted.

It is only at that point that your further related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

Section 18.4 Assignment of Claim

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the attorneys' fees, costs and expenses incurred in making the recovery, then the excess will be paid to you.

Section 18.5 Failure to Cooperate with Plan

You will be personally liable to the Plan for reimbursement owed to the Plan as well as for the Plan's attorney's fees and costs and we will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;
2. You fail to assign your claim against the third party to this Plan when required to do so;
3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;
4. You fail to require any attorney you subsequently retain to sign the Plan's Subrogation Agreement;
5. You and/or your attorney fail to reimburse the Plan;
6. You fail to provide the Plan with medical or other authorization to obtain the necessary information; or
7. You or your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries, or, if necessary, take legal action against you. The Plan may also recover the amount you owe from your Personal Account Plan. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.

ARTICLE 19 – CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. The Fund’s COBRA Continuation Coverage is administered by the Fund Office. Unlike Regular Self-Pay Coverage, your spouse and your dependent children may elect COBRA Continuation Coverage even if you do not.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law take effect in 2014, you’ll be able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse’s plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: healthbenefitexchange.ny.gov.

There are two parts to your coverage under the Plan: (1) your self- insured health benefits; and (2) your Individual Reimbursement Account benefits. You, your spouse, and your dependents may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the Individual Reimbursement Account benefits. If you lose coverage in this active’s plan because of retirement, you may elect COBRA coverage in the active’s plan or coverage under the Retire-Only Plan. However, election of one type of coverage is rejection of the other.

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Local 73 Health and Welfare Fund (“Welfare Fund”) due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Welfare Fund due to a reduction in hours worked, including a strike, walkout or layoff. You may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the Individual Reimbursement Account benefits. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Reimbursement Account. You will continue to have access to your

Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account so long as the account balance is sufficient to cover your claims. In fact your Individual Reimbursement Account can be used to pay the required COBRA premiums for health insurance benefits.

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.
2. Your spouse's loss of health insurance coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.
3. Divorce or judicial order of legal separation.
4. Your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your spouse may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the Individual Reimbursement Account benefits. In this case, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Reimbursement Account. Your spouse will continue to have access to your Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account so long as the account balance is sufficient to cover the claims.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, to continue to have access to your Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account, your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.
2. Your dependent child's loss of health insurance coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.

3. Divorce or judicial order of legal separation of the child's parents.
4. Your enrollment in Part A or Part B of Medicare.
5. The child ceases to qualify as an "eligible dependent" as described in Section 3.5.

If your dependent child has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your dependent child may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the Individual Reimbursement Account benefits. In this case, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Reimbursement Account. Your dependent child will continue to have access to your Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account so long as the account balance is sufficient to cover the claims.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an "eligible" dependent, to continue to have access to your Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account, your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

You or your beneficiaries have the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund in the event that the Social Security Administration has determined you or one of your

qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

After the Fund office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Office will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverages has terminated.

The employee, spouse and dependent children each has independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation coverage will begin on the date of delivery.

You may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the Individual Reimbursement Account benefits. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Reimbursement Account. You will continue to have access to your Individual Reimbursement Account and to receive reimbursements from your Individual Reimbursement Account so long as the account balance is sufficient to cover your claims. In fact your Individual Reimbursement Account can be used to pay the required COBRA premiums for health insurance benefits.

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits) or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you

before December 31, 2014 by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies before December 31, 2014 that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.
2. Failure to pay the monthly premium on time.
3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.
4. The individual enrolls in Part A or Part B of Medicare.
5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

Anyone who becomes eligible for COBRA continuation coverage, but who is also eligible for extended coverage as described in Section 3.3, or any other type of extended benefit as described in Section 3.5, will not begin his or her period of COBRA coverage until after using up all other extended coverage available under the Plan to that individual.

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan. The monthly COBRA premium will usually be more than the monthly premium charged to self-pay participants described at Article 20.

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Administrative Manager.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

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

ARTICLE 20 – SELF-PAY

If your coverage would otherwise terminate due to your account having insufficient monies to pay the premiums for a full month of your medical coverage, and

- (1) you are available for covered employment with a signatory employer within the Local 73 geographic jurisdiction; or
- (2) are disabled (unable to perform bargaining unit work under a Collective Bargaining Agreement requiring contributions to the Fund and Disabled past the normal 24 months of coverage)

then you will be allowed to continue your coverage by making a self-payment to the Fund Office. The amount of such payment will be determined by the Trustees and communicated to any participant who would otherwise have the coverage terminated. The self-payment must cover a full month of benefits. Self-payment will not be allowed for a period of more than eighteen (18) consecutive months. Payments for this self-pay benefit must be received at the Fund Office no later than one month after the individual's loss of eligibility due to the above-referenced insufficient account balance. In the event UA Local 73 provides assets to be allocated into specific individual accounts of participants, and the Local 73 Health and Welfare

Fund receives such assets, the Fund is authorized to allocate such assets into the specific accounts and the participants are entitled to access such accounts.

Self-Pay Option for Dependents (Other than COBRA)

For the purpose of maintaining eligibility, and not for establishing initial eligibility, you will be entitled to purchase coverage for your dependents provided that your dependents were eligible as a dependent (including spouses and children, but excluding ex-spouses) of an active participant at the time the dependent would otherwise lose coverage with the Fund. The Trustees will determine the dollar amounts necessary for the self-payments.

When the dependent's coverage would end for a reason other than a participant's death, the spouse and/or children will be allowed to self-pay for up to 36 months. The widows, widowers, and children of active participants who lose coverage because of the death of the participant are entitled to either COBRA continuation coverage under this active's plan or coverage under the Retiree-Only Plan. In this case, the spouses will be allowed to participate in the Retiree-Only Plan until they reach Medicare eligibility or until they are no longer married to the participant. The children will be offered this coverage for up to 36 months.

Selecting the self-pay option for a dependent under this Article is a rejection of COBRA continuation coverage although the dependent will have the ability to reconsider the rejection during the COBRA election period described in the COBRA Section of this Summary Plan Description.

Duration of Self-Pay/COBRA Coverage

The time you elect to self-pay will be subtracted from the number of months you would otherwise be entitled to opt for your COBRA benefits. Therefore, you will not be allowed eighteen months of self-pay and then an additional eighteen months of COBRA benefits.

**ARTICLE 21 - PLAN INTERPRETATIONS, DETERMINATIONS
AND AMENDMENTS**

Section 21.1 Plan Interpretations and Determinations

- A. The Trustees, and/or their designees, are responsible for interpreting this Plan and for making determinations under this Plan. In order to carry out their responsibility, they shall have full and exclusive authority and discretion:
- to determine whether an individual is eligible for any benefits under the Plan;
 - to determine the amount of benefits, if any, an individual is entitled to from the Plan;
 - to determine or find facts that are relevant to any claim for benefits from the Plan;
 - to interpret all of the Plan's provisions;
 - to interpret all of the provisions of this Summary Plan Description;
 - to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting the Plan;
 - to interpret the provisions of the Trust Agreement governing the operation of the Plan;
 - to interpret all of the provisions of any other document or instrument involving or impacting the Plan; and,
 - to interpret all of the terms used in the Plan, the Summary Plan Description, and all of the other previously mentioned Agreements, documents, and instruments.
- B. All such determinations and interpretations made by the Trustees, or their designee:
- shall be final and binding upon any individual claiming benefits under the Plan and upon all Employees, all Employers, the Union, and any party who has executed any agreement with the Trustees or the Union;
 - shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and,
 - shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

- C. The Trustees reserve the right to change the terms of this Plan, to change or terminate any or all benefits provided by this Plan, and to terminate part or all of this Plan.

Benefits under this Plan will be paid only if the Trustees decide in their discretion that you are entitled to them.

ARTICLE 22 – MISCELLANEOUS

Section 22.1 Right to Reclaim Overpayment And To Offset

In the event that a participant or a third party is paid benefits from the Fund in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter “overpayments” or “mistaken payments”), the Trustees have the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to a claimant (you) or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Fund with interest at 18% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of you or your spouse or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant, third party, or other individual or entity shall reimburse the Fund for attorneys’ fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Funds in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

Section 22.2 Cooperation

You must submit to the Trustees, in writing, all such information as they may reasonably request for the purpose of maintaining or administering this Plan. Your failure to comply with such request in good faith will be sufficient grounds for this Plan to delay payment of your benefits. The Trustees will be the sole judges of the standard of proof required in any case, and they may, from time to time, adopt such methods and procedures as they consider advisable.

For example, in order to process a claim under this Plan, it may be necessary for the Trustees to obtain your medical records. By becoming eligible for benefits from this Plan, you give permission to the Trustees to obtain your medical records from any provider, doctor, nurse, hospital or other health care personnel or institution.

Section 22.3 Your Address

If you fail to inform the Trustees of a change in your address, and the Trustees are unable to communicate with you at the address last recorded by the Trustees, then any payments due you will be held without interest until payment can be successfully made.

Section 22.4 Date Expenses are Incurred

An expense is considered to be incurred on the date the service or treatment is received, or the purchase is made, rather than on the date the bill is received.

Section 22.5 Change in Family Status

After your eligibility begins, you must notify the Fund Administrator of any change in your family status by reason of marriage, birth of a child, death, divorce or legal separation. You must also notify the Fund Administrator if your child reaches age 26, or if you or your spouse will soon be 65 years of age. In the event that you are planning to retire, please notify the Fund Administrator of your expected retirement date. This will enable the Fund Administrator to more quickly process records concerning your retirement.

Section 22.6 Medicare Coverage for Participants

When you become eligible for Medicare, you will be considered to be insured under Part A. and B. of Medicare. This is regardless of whether or not you have registered for Part A. or enrolled for Part B. You and your dependents have the option to retain Medicare as your primary plan regardless of coverage under this Plan.

We suggest that at least 3 months before you reach age 65, or 3 months before you receive your 24th Social Security Disability Pension Payment, you contact your local Social Security Office.

This is necessary in order to ensure that, as soon as you are eligible, you are adequately covered by Medicare, which includes both Part A for Hospital Coverage and Part B for Medical expenses.

If Medicare is your primary Plan and there are Covered Charges remaining unpaid (that is, after Medicare has paid or would have paid), you will be reimbursed by the Plan up to the maximum amount approved by Medicare. However, the total amount received from Medicare and the Welfare Plan will never be more than 100% of your "Allowable Expenses". "Allowable Expenses" means any necessary, reasonable, and customary item of expense for medical care and Treatment of this type and kind Covered under this Welfare Plan.

This Plan will be primary and Medicare will be secondary for 30 months for eligible individuals under age 65 with Medicare solely because of permanent kidney failure. Thereafter, Medicare will be primary. If you are age 65 and older with end stage renal disease, Medicare will be primary in accordance with applicable law. If you suffer from end stage renal disease before age 65,

Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

It must be stressed that if you are nearing age 65 you may suffer a loss of Benefits if you fail to enroll in Medicare because, even if you don't enroll in Medicare, claims will be paid as if you had.

Section 22.7 Qualified Medical Child Support Order

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders (QMCSO's). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent's group health plan as alternative recipients. Both you and your beneficiaries can obtain, without charge, a copy of the Plan's QMCSO's procedures from the Fund Administrator.

ARTICLE 23 – FAMILY AND MEDICAL LEAVE CONTINUATION COVERAGE

NOTE: Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

- To care for your newly born or adopted child;
- To care for your spouse, child or parent who has a serious health problem; or
- If you have a serious health problem which prevents you from performing your job.

Section 23.1 Eligibility

In order for you to be eligible for such a leave, your employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that employer for at least twelve (12) months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an employer must have at least fifty (50) employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year. Additionally, you must:

- Work at a location where the employer has at least 50 employees; or
- Work within 75 miles of one or more work sites where the employer has 50 or more employees.

Section 23.2 Contributions

Your employer must notify the Fund that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance report to the Fund, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act for a leave of absence.

Section 23.3 Benefits

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, *unless your employer fails to make the required contributions for you.*

Section 23.4 Termination of Eligibility

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

- Your employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or
- You exhaust the twelve (12) weeks of leave which you are entitled to under federal law; or
- You or your employer notify the Fund that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave.)

In the event your employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with the provisions of the section of the Summary Plan Description entitled CONTINUATION COVERAGE.

ARTICLE 24 – CONFIDENTIALITY OF PROTECTED INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective April 14, 2004. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, James P. Gaffney.

This Plan and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the Local 73 Health and Welfare Fund), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

“Payment” includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

- (a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant’s claim);
- (b) coordination of benefits;
- (c) adjudication of health benefit claims (including appeals and other payment disputes);
- (d) subrogation of health benefit claims;
- (e) COBRA contributions;
- (f) risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (g) billing, collection activities and related health care data processing;
- (h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- (i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- (j) medical necessity reviews or reviews of appropriateness of care or justification of charges;
- (k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- (l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

- (m) reimbursement to the plan.

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

- (a) quality assessment;
- (b) population-based activities relating 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;
- (c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- (d) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- (e) 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;
- (f) business management and general administrative activities of the Plan, including, but not limited to:
 - (1) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements
- (g) resolution of internal grievances; and
- (h) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Local 73 Health and Welfare Fund who assist in the Plan’s administration and the Board of Trustees of the Local 73 Health and Welfare Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not to use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not to use or disclose the information for employment related actions and decisions unless authorized by you; (d) not to use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact James P. Gaffney, the Fund's Privacy Official, if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

The Plan Sponsor will:

- (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

- (b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;
- (c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information;
- (d) report to Plan any security incident of which it becomes aware concerning electronic protected health information; and
- (e) appoint James P. Gaffney as the HIPAA Security Official.

(mgg/L73/SPD/WF-SPDRestatement)