TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA

HEALTH & WELFARE FUND

RETIREE HEALTH BENEFITS

PLAN DOCUMENT

Amended and Restated
Effective June 1, 2023

Introduction

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

Until January 1, 2011, benefits for active and retired employees were provided pursuant to a single Plan Document. However, effective January 1, 2011, the Joint Council created a separate Plan Document covering Retirees. The separate Plans for active employees and Retirees are both administered pursuant to a single Agreement and Declaration of Trust. The Plan and the Trust Agreement are intended to meet the requirements of Sections 401(a) and 501(a) of the Internal Revenue Code of 1986 (the "Code"), as amended and the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The Plan has been established for the exclusive benefit of Retirees and their Beneficiaries.

Pursuant to the authority derived from Article IV, Section 18 and Article VI, Sections 1 and 6 of the Reaffirmation and Restatement of Agreement and Declaration of Trust, the Board of Trustees of the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund hereby amends and restates, effective June 1, 2023, the following rules and regulations and plan of benefits applicable to Retired Participants of the Plan. These rules and regulations and this plan of benefits shall remain in effect until changed by future action of the Board. No one speaking on behalf of the Plan or the Fund can alter the terms of the Plan. If any statement made to a Retiree or his or her Beneficiary conflicts with the Plan, the Plan's written terms as set forth herein will prevail. In addition, Retirees and their Beneficiaries cannot rely on any oral statements made by a representative of the Fund as evidence that benefits are available or payments will be made for a particular service or supply.

Article 1. Definitions

Section 1.1 Accidental Bodily Injury or Injury

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

Section 1.2 Adverse Benefit Determination

The term "Adverse Benefit Determination" is defined as any of the following: a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for, a benefit, that is based on a determination of a Participant's, Dependent's or Beneficiary's eligibility to participate in a Plan, or for a benefit resulting from the application of any utilization review, as well as a

failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational, or not Medically Necessary or appropriate.

Section 1.3 Allowable Charge

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

Section 1.4 Ambulatory Surgical Facility

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

Section 1.5 Annual Maximum

The term "Annual Maximum" is defined as the maximum benefit paid by the Fund on behalf of a Participant or Dependent per calendar year for certain benefit categories as identified in the applicable Schedule of Benefits.

Section 1.6 Beneficiary

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

Section 1.7 Coinsurance

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

Section 1.8 Co-payment

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

Section 1.9 Contributions

The term "Contributions" is defined as the amount paid by an Employer to the Fund on behalf of its Retirees, on a weekly or monthly basis, pursuant to the terms of an applicable Collective Bargaining Agreement or Participation Agreement. The term "Contributions" shall also mean the amounts paid to the Fund on behalf of its Retirees by the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund and Pension Fund, the Teamsters Joint Council No. 83, and Teamsters Local Unions that constitute "Employers" within the meaning of Section 1.17. When, pursuant to the terms of a Collective Bargaining Agreement or Participation Agreement,

Contributions are paid to the Fund on a monthly basis, one (1) month of Contributions will be deemed the equivalent of four (4) weeks of Contributions.

Section 1.10 Custodial Care

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

Section 1.11 Deductible

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

Section 1.12 Dentist

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

Section 1.13 Dependent

A. The Participant's Dependent Spouse is defined as the Participant's lawful Spouse who is eligible for benefits on the Participant's pension effective date, as that term is described in Section 2.1.A.4.a, or retirement date, as that term is described in 2.1.A.4.b and 2.1.A.4.c.

B. The Participant's Qualifying Child, defined as a natural child, an adopted child (including a child placed for adoption), a stepchild, and a child for whom the Participant has legal custody and who is living with the Participant in a normal parent-child relationship and is not a Qualifying Child of any other taxpayer during the calendar year. A Qualifying Child must (1) be under the age of nineteen, (2) be unmarried; (3) have the same principal residence as the Participant for more than one-half the calendar year; and (4) not have provided more than one-half of his or her own support during the calendar year.

   For purposes of this Plan Document, a "stepchild" is defined as the natural child or adopted child (including a child placed for adoption) of the Participant's lawful Spouse or a child for whom the lawful Spouse has legal custody.

C. A Qualifying Child who reaches age nineteen (19) remains a Qualifying Child under the following conditions:
   1. The Qualifying Child was eligible for benefits under Section 1.13.B and
      1. has not obtained the age of twenty-three (23); and
      2. is regularly attending school as a full-time student seeking a degree or certification such as, but not limited to, an Associates Degree, a

Bachelors Degree, a Masters Degree, a Doctoral Degree, or any other certification as approved by the Board of Trustees in an accredited secondary school, junior college, college or university or other educational institution approved by the Board of Trustees; or

3. would have attended school as described in Section 1.13.C.1.b (as supported by school supplied proof such as a completed application, tuition payment receipt, etc.) but for a non-permanent Injury or Illness as documented by a physician that prevented the child from attending or;
4. is attending part-time but is unable to attend full time as documented by a physician.

2. The Qualifying Child was eligible for benefits under either Section 1.13.B or Section 1.13.C.1 and is and continues to be both:
   1. incapable of self-sustaining employment by reason of mental retardation or physical handicap as determined by the appropriate state, federal regulatory agencies, or Fund's Medical Consultant; and
   2. chiefly dependent upon the Participant for support and maintenance as confirmed by a Physician in writing;
   3. such incapacity commenced while the child was eligible for benefits under this Plan and before the child would otherwise have ceased to be a Dependent; and
   4. proof of such incapacity is submitted to the Fund Office as soon as possible after the date that the child would otherwise have ceased to be a Dependent; and subsequently, as may be required by the Fund, but not more often than annually after the two-year period following the date initial proof is received.
3. The Qualifying Child was not eligible for benefits under Section 1.13.B or Section 1.13.C.1, but who meets all the conditions of Section 1.13.C.2 except that the disability commenced before the child was eligible for benefits under this Plan.

D. Divorce.
   1. A Qualifying Child whose coverage is determined by the terms of a divorce decree or a Qualified Medical Child Support Order will be considered a Dependent without regard to the Qualifying Child's principal residence and without regard to whether the Participant is responsible for more than one-half the Qualifying Child's support.

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

Section 1.14 Durable Medical Equipment ("DME")

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

in nature or solely for convenience, or equipment to be used in the home, such as humidifiers, vacuum cleaners, waterbeds, etc.

Section 1.15 Emergency Services

The term "Emergency Services" is defined as (a) anything a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care; (b) an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or "Independent Freestanding Emergency Department" (as defined under the No Surprises Act), including "Ancillary Services" (also as defined under the No Surprises Act) routinely available to the emergency department to evaluate such Emergency Medical Condition; (c) such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and (d) services provided by an Out-of-Network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until:

1. The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation;

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

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

Section 1.16 Employer

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

Section 1.17 Experimental or Investigational

The term "Experimental or Investigational" is defined as treatments, procedures, devices, or drugs which the Trustees determine, in the exercise of their discretion, are Experimental, Investigational,

or done primarily for research. Treatments, procedures, devices, or drugs are excluded under this Plan unless:

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

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

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

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

Section 1.18 Fee Allowance

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

Section 1.19 Hospital

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

Section 1.20 Hospital Confinement or Confined in a Hospital

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

Section 1.21 Illness

The term "Illness" is defined to include physical illness, mental illness, functional nervous disorders, and pregnancy.

Section 1.22 In-Network
The term "In-Network" is defined as the use of a provider that is a member of the Fund's appointed Preferred Provider Organization such that all claims incurred by such a provider will be processed under the "In-Network" benefit level as described in the applicable Schedule of Benefits.

Section 1.23 Lifetime Maximum
The term "Lifetime Maximum" is defined as the maximum collective payment by the Fund on behalf of a Participant or Dependent over their lifetime for certain benefit categories as identified in the applicable Schedule of Benefits.

Section 1.24 Medical Benefits
The term "Medical Benefits" is defined as all benefits provided under Article 3 of this Plan.

Section 1.25 Medical Consultant
The term "Medical Consultant" is defined as an entity appointed by the Trustees to provide selected consulting and management services as defined in the general medical community.

Section 1.26 Medically Necessary
The term "Medically Necessary" is defined as services or supplies which the Trustees or their authorized delegate determine, in the exercise of their discretion, are generally acceptable by the national medical professional community as being safe and effective in treating a covered Illness or Injury, consistent with the symptoms or diagnoses, furnished at the most appropriate medical level and not primarily for the convenience of the patient, a health care provider, or anyone else. Because a health care provider has prescribed, ordered, or recommended a service or supply does not, by itself, mean that it is Medically Necessary.

Section 1.27 Necessary Services and Supplies
The term "Necessary Services and Supplies" is defined as any charges, other than charges for Room and Board, made by a Hospital on its own behalf for Necessary Medical Services and Supplies actually administered during Hospital Confinement. Necessary Services and Supplies shall also include any charges for the administration of anesthesia, radiology and pathology during Hospital Confinement, and charges for professional ambulance service (as described in Section 3.9.B.7), but shall not include any charges for special nursing fees, dental fees, or medical fees. Necessary Services and Supplies shall also mean charges made by a Hospital, Ambulatory Surgical Facility or physician surgery site on its own behalf for necessary medical services and supplies actually administered for outpatient surgery.

Section 1.28 No Surprises Act
The term "No Surprises Act" is defined to mean the surprise billing legislation enacted as part of the Consolidated Appropriations Act of 2021, and any applicable regulations promulgated thereunder.

Section 1.29 No Surprises Services
The term "No Surprises Services" is defined to include the following services, to the extent covered under the Plan: (a) Out-of-Network provider services to treat an Emergency Medical Condition; (b) Out-of-Network provider air ambulance services; (c) ancillary services as defined under the

No Surprises Act and its implementing regulations (including anesthesiology, pathology, radiology, neonatology and diagnostic services) when performed by Out-of-Network providers at In-Network facilities; and (d) other services to treat a condition that is not an Emergency Medical Condition performed by an Out-of-Network provider at In-Network health care facilities with respect to which the provider does not comply with the notice and consent requirements under the No Surprises Act and its implementing regulations.

Section 1.30 Out-of-Network

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

Section 1.31 Participant

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

Section 1.32 Physician

The term "Physician" is defined as an individual who is licensed to prescribe and administer drugs or to perform surgery and is operating within the scope of a current license. Licensed psychologists and midwives are also included in the definition of Physician.

Section 1.33 Plan

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

Section 1.34 Preferred Provider Organization

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

Section 1.35 Qualified Beneficiary

The term "Qualified Beneficiary" is defined as:

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

B. Any covered Participant who had retired before the date of termination of benefits caused by the bankruptcy of his last regular Employer, his Dependent Spouse or surviving Spouse, and Qualifying Children.

Section 1.36 Registered Nurse/Licensed Practical Nurse

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

Section 1.37 Retiree

The term "Retiree" is defined as an individual who satisfies the eligibility requirements under the Plan, as set forth in Section 2.1.A.

Section 1.38 Room and Board

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

Section 1.39 Schedule of Benefits

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

Section 1.40 Spouse

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

Section 1.41 Trust Agreement

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

Section 1.42 Trust Fund or Fund

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

Section 1.43 Trustees

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

Section 1.44 Union

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

Article 2. Eligibility

Section 2.1 General Provisions

A. Participant's Eligibility.

1. A Participant shall be eligible to participate in retirement benefits, provided that the participant:

    a. Is retired as evidenced by a letter of retirement from his employer and/or the pension fund under which he retired, and
    b. Is not eligible for Medicare, and
    c. Has at least 35 weeks of contributions into Plan 12 in five (5) of the last seven (7) years immediately preceding retirement, and
    d. Be at least 57 years of age and have at least 20.0 years of vesting service in the Teamsters Joint Council No. 83 of Virginia Pension Fund, or
    e. Be any age and have at least 25.0 years of vesting service in the Teamsters Joint Council No. 83 of Virginia Pension Fund, or
    f. Be any age and have at least 30.0 years of vesting service in the Teamsters Joint Council No. 83 of Virginia Pension Fund.

If eligible by reason of either Section 2.1.A.d or e above, the Participant will have access to a maximum of 96 months of coverage unless terminated earlier by Section 2.5. If eligible by reason of Section 2.1.A.f above, the Participant will have access to coverage until such coverage is terminated by Section 2.5.

2. <u>For Participants who are not Participants in the Teamsters Joint Council No. 83 of Virginia Pension Plan.</u> A Participant in the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund shall be eligible to participate in retirement benefits provided that the Participant:
    a. Is retired as evidenced by a letter of retirement from his Employer and/or the pension plan under which he retired;
    b. Is at least age fifty-seven (57) but under age sixty-five (65) at retirement; and
    c. Has had Contributions paid on his behalf into the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund under a Schedule of Benefits providing retirement health benefits for at least five (5) out of the last seven (7) Years of Contributions immediately prior to his retirement; or
        (i) Was employed by his Employer on the date the Employer commenced making payments to the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund under a Schedule of Benefits providing retirement health benefits and who retired within five (5) years of said commencement date, provided the employer agrees in writing to pay the COBRA rate monthly to the Fund on behalf of all such Participants for as long as such Participant remains under retirement health coverage. The COBRA rate shall be determined annually by the Fund's appointed actuary and approved by the Board of Trustees; and
    d. Is not eligible for health benefits from Medicare

3. Premium Payments. With respect to Section 2.5.A.4, and other than the initial premium payment, monthly premiums shall be due by the first (1st) day of the calendar month that is two (2) months in advance of the month coverage is purchased; provided however, that a monthly premium for any particular month shall be deemed to have been made by the premium due date so long as such premium is received by the Fund Office by the tenth (10th) day of such month ("grace period"). Premiums may be automatically deducted from the monthly benefits provided by the Teamsters Joint Council No. 83 of Virginia Pension Plan upon written request of the Participant.

4. Benefits Effective Date. Except as provided in Section 2.1.A.4.d, benefits under Section 2.1.A.4 will become effective on the first (1st) day of the month that is two (2) months after the Participant's:
   a. pension effective date, for a Participant retiring with a pension from the Teamsters Joint Council No. 83 of Virginia Pension Fund unless deferred due to the continuation of "active" benefits as provided for in the Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund Active Employee Plan (the "Active Plan");
   b. retirement date as evidenced by a written statement from the plan under which the Participant retires, for a Participant retiring pursuant to any other pension plan; or
   c. retirement date as evidenced by a letter from his Employer, for a Participant not retiring pursuant to any pension plan or fund.
   d. notwithstanding the foregoing:
      (i) benefits payable on behalf of a Participant under the Extension of Benefits provisions set forth in the Active Plan shall not be payable under the health benefits provisions of this Plan;
      (ii) a Participant who is eligible for benefits under the Continuation of Medical Benefits during Periods of Short Term Disability provisions set forth in the Active Plan shall become eligible for health benefits under the Plan immediately following the date on which all such benefits terminate.

5. Years of Contributions. With respect to eligibility for the retirement health benefit plan, a Participant will be deemed to have earned a "Year of Contributions" if his Employer pays health and welfare Contributions which provide for health benefits to this Fund on his behalf for at least thirty-five (35) weeks out of a fifty-two (52) consecutive week period.

B. Dependent Eligibility Requirements.
   1. A Participant's Dependent Spouse will become eligible for this Plan provided that:
      a. the Dependent Spouse is younger than age sixty-five (65); and
      b. the Dependent Spouse is not eligible for Medicare;
   2. A Participant's Qualifying Child will become eligible for benefits under the Plan provided the Participant retires before August 1, 2019 and:

a. at least one (1) of the Qualifying Child's parents, (i.e., the Participant or his Dependent Spouse), is covered under this Plan;
b. the Qualifying Child met the definition of a Dependent as described in Section 1.13 of this Plan immediately prior to the Participant's pension effective date or retirement date; and
c. the Qualifying Child is not eligible for health benefits from Medicare.

3. Premium Payments. With respect to Section 2.6.A.6 and Section 2.6.B.5, monthly premiums shall be due on the first (1st) day of the calendar month that is two (2) months in advance of the month coverage is purchased; provided, however, that a monthly premium for any particular month shall be deemed to have been made by the premium due date so long as such premium is received by the Fund Office by the tenth (10th) of such month ("grace period"). Premiums may be automatically deducted from the monthly benefits provided by the Teamsters Joint Council No. 83 of Virginia Pension Plan upon written request of the Participant.

4. Benefits Effective Date. If meeting the eligibility requirements of Section 2.1.B and except as provided in Sections 2.1.B.4.a and 2.1.B.4.b, the effective date of a Participant's Dependents' benefits under the Plan shall be the same as the Participant.
   a. If a Participant never becomes eligible for health benefits under the Plan solely because he retires at or after age sixty-five (65), then his Dependent's Plan benefits effective date shall be the date on which the Participant's Plan benefits would have commenced unless postponed at the election of the Participant's Dependent;
   b. If a Participant never becomes eligible for benefits under the Plan solely because he dies before the effective date of his retirement, then his Dependents' effective date shall be the first (1st) of the month following the Participant's death unless postponed at the election of the Participant's Dependent. This provision shall not apply unless the Participant would have met the requirements set forth in Section 2.1.A, but for his death.

C. Plan coverage is provided only to those Participants and their Dependents who meet the eligibility requirements of this Article 2. Such benefits are payable only if the expense in question is incurred:
   1. while the Participant and/or his Dependent is eligible for benefits under this Plan, subject to the limitations contained herein; or
   2. in cases where a particular benefit is extended under the Plan, during the period of such extension.

D. A Spouse who receives health benefits from his or her own employer may waive, in writing, the right to receive benefits under the Plan. Any such waiver must include the notarized signature of the Spouse and will be effective on the first day of the month after the month in which the waiver is received.

Section 2.2 Extension of Dental Expense Benefits

In General. If a Participant's eligibility for benefits under this Plan terminates, Dental Expense Benefits under Section 3.8, for which the Participant or Dependent is otherwise eligible will be extended beyond the termination date, subject to the following limitations:

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

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

C. Termination.

1. The extension will end on the date that is three (3) months after the termination date; or
2. The date the Participant's past Employer ceases to be a participating Employer.

Section 2.3 COBRA/USERRA Continuation Coverage

This Section describes the procedures for continuing health coverage, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Unless stated otherwise, "COBRA Continuation Coverage" includes the coverage required by USERRA.

A. In General. The Participant's Dependent Spouse and other eligible Dependents may continue eligibility for benefits for specified periods set forth in Section 2.3.D, by making self-payments at the rates determined by the Trustees where eligibility would have otherwise terminated as a result of a "Qualifying Event."

B. Benefits Provided. An individual electing COBRA Continuation Coverage will be eligible for the same benefits provided under the Schedule of Benefits that he was covered by on the date coverage otherwise would have terminated as a result of the Qualifying Event.

1. Core and Non-Core Benefits — If an individual is covered under a Schedule of Benefits which provides Dental Expense Benefits (Non-Core Benefits), he may reject coverage for such and elect coverage only for medical coverage (Core Benefits).
2. Non-Medical Benefits Not Covered — COBRA Continuation Coverage does not provide coverage for non-Medical Benefits.

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

1. Retiree's Dependent Spouse Qualifying Event.
   a. Divorce from the Retiree.
2. Retiree's Dependent Qualifying Event.
   a. Retiree's Dependent Spouse's death;
   b. Retiree's Dependent Spouse's entitlement to Medicare;
   c. Loss of Dependent status
3. For Retirees, and the Dependent Spouse, surviving Spouse and Dependent of a Retiree eligible for benefits pursuant to Section 2.1.A and 2.1.B and not protected by Section 2.9 and Section 4.3, the date of termination of benefits caused by the bankruptcy of his last regular Employer.

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

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

E. Termination Events. No other self-pay coverage is available from the Plan once an individual's COBRA coverage ceases as a result of a Terminating Event. A Terminating Event occurs on the earliest of the following dates:

1. The conclusion of the Applicable Continuation Period;
2. The date on which all health care coverage offered by the Fund terminates;
3. The date on which the individual becomes covered by another group health plan;
4. The date on which the individual becomes entitled to Medicare coverage; or
5. The last day of the period preceding any period for which a premium is not timely paid;

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

1. Timeliness. A Qualified Beneficiary must notify the Fund Office in writing of each Qualifying Event within sixty (60) days after the later of:
    a. the date of the Qualifying Event; or
    b. the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.
2. Fund Notification. Within thirty (30) days of receipt of notice that a Qualifying Event has occurred, the Fund Office will notify the Qualified Beneficiary not living with the Participant (whose address is known to the Fund) whose coverage is affected by the Qualifying Event of the right to elect COBRA Continuation Coverage. The Fund Office also will provide notice of the applicable premiums, and instructions for electing COBRA Continuation Coverage;
3. Election of COBRA Continuation Coverage. To elect COBRA Continuation Coverage, the Qualified Beneficiary must complete the COBRA election form provided by the Fund and must pay the premium for such coverage. The completed election form must be postmarked more than sixty (60) days after the later of the following dates:

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

b. the date of the notice of his right to elect COBRA Continuation Coverage sent out by the Fund Office;

If the completed form is submitted by email, the email must be date stamped no later than sixty (60) days after the later of the dates above. Failure to timely elect COBRA Continuation Coverage will result in the loss of eligibility for such coverage.

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

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

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

H. Amount of Premium.

1. The Fund will charge a monthly premium for COBRA Continuation Coverage. The Board of Trustees, on an annual basis, will establish the monthly premiums to be charged for such coverage for each Schedule of Benefits offered by the Fund. The amount of the premium shall be based on individual and family coverage and shall not exceed one hundred two percent (102%) of the Fund's actual cost for providing benefits to similarly situated individuals, as determined by the Fund's actuary.

I. Types of Premiums. Core coverage, or if eligible, core and non-core coverage, shall be offered under Section 2.3.

Section 2.4 Coverage Pursuant to Qualified Medical Child Support Orders

A. In General. The Fund shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order. A Qualified Medical Child Support Order with respect to any Participant or Beneficiary shall apply to the Fund when it has received such an order with respect to a Participant or Beneficiary who is eligible to receive such benefits, and with the respect to which the requirements of Section 2.4.D are met. For avoidance of doubt, if Medical Child Support Order is deemed a Qualified Medical Child Support Order, the Plan shall provide coverage for the Alternate Recipient only to the extent required pursuant to the Qualified Medical Child Support Order; provided, however, no payment under the Plan will be made to any person(s) named in any Qualified Medical Child Support Order unless such benefits are otherwise properly payable to such person(s) under the terms of the Plan.

B. Definitions. For purposes of this subsection:

1. Qualified Medical Child Support Order. The term "Qualified Medical Child Support Order" means a Medical Child Support Order:
   a. which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Beneficiary is eligible under the Fund's Plan of Benefits; and
   b. with respect to which the requirements of Section 2.4.C and Section 2.4.D are met.
2. Medical Child Support Order. The term "Medical Child Support Order" means any judgment, decree, or order (including approval of a settlement agreement) which:
   a. provides for child support with respect to a Qualifying Child of a Participant or provides for health benefit coverage to such a Qualifying Child, is made pursuant to a State domestic relations law (including community property law), and relates to benefits under the Plan; or
   b. is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, if such judgment, decree, or order:
      (i) is issued by a court of competent jurisdiction; or
      (ii) is issued through an administrative process established under State Law and has the force and effect of law under applicable State law. For purposes of this Section 2.4.B.2.b.ii, an administrative notice which is issued pursuant to an administrative process referred to in Section 2.4.B.2.b.ii of the preceding sentence and which has the effect of an order described in Section 2.4.B.2.a or Section 2.4.B.2.b of the preceding sentence shall be treated as such an order.
3. Alternate Recipient. The term "Alternate Recipient" means any Qualifying Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such Participant;
4. Qualifying Child. The term "Qualifying Child" includes any Qualifying Child adopted by, or placed for adoption with, a Participant of the Plan.

C. Information to be included in qualified order. A Medical Child Support Order meets the requirements of Section 2.4 only if such order clearly specifies:

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

2. a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. the period to which such order applies.

D. Restriction on new types or forms of benefits. A Medical Child Support Order meets the requirements of Section 2.4 only if such order does not require the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

E. Procedural Requirements.

1. Timely notifications and determinations. In the case of any Medical Child Support Order received by the Fund,
   a. within five (5) business days after the receipt of such order, the Fund shall promptly notify the Participant and each Alternate Recipient of the receipt of such order and the Fund's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and
   b. within fifteen (15) business days after receipt of such order, the Fund shall determine whether such order is a Qualified Medical Child Support Order or if additional information is necessary to make a determination. The Fund shall notify the Participant and each Alternate Recipient of either the determination or the need for additional information.
2. Requirement for additional information. In the event that it cannot be determined from the face of the judgment, decree or order, based on the ready knowledge of the Fund, that such judgment, decree, or order meets the requirements set forth in Section 2.4.F.1, the Fund shall promptly request in writing from the Participant, the Participant's representative, and/or the Alternate Recipient's designated representative such additional information as is deemed necessary to make a determination.
   a. If the information requested is not received within thirty (30) days of its request, the judgment, decree, or order shall be considered as not constituting a QMCSO (Qualified Medical Child Support Order), and the Fund shall within five (5) business days so notify in writing all persons who received initial notification of receipt of the judgment, decree or order by the Fund.
      (i) Any appropriate party aggrieved by such decision may exercise the right of appeal to the Trustees of the Fund as provided in Section 6.2.D of the Plan Document.
3. Establishment of procedures for determining qualified status of orders. The Fund shall establish and maintain reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of benefits under such qualified orders. Such procedures:
   a. shall be in writing;

b. shall provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the Plan (at the address included in the Medical Child Support Order) of such procedures within five (5) business days after receipt by the Fund of the Medical Child Support Order; and

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

F. National Medical Support Notice deemed to be a Qualified Medical Child Support Order.

1. In general. If the Participant or Beneficiary of the Plan is a non-custodial parent of a Qualifying Child and the Fund receives an appropriately completed National Medical Support Notice promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such Qualifying Child, and the Notice meets the requirements of Sections 2.4.C and 2.4.D, the Notice shall be deemed to be a Qualified Medical Child Support Order in the case of such Qualifying Child.

2. Enrollment of Child in Plan. In any case in which an appropriately completed National Medical Support Notice is issued in the case of a Qualifying Child of a Participant under the Plan who is a non-custodial parent of the Qualifying Child, and the Notice is deemed under Section 2.4.F.1 to be a Qualified Medical Child Support Order, the Fund, within (forty) 40 business days after the date of the Notice, shall:

a. notify the State agency issuing the Notice with respect to such Qualifying Child whether coverage of the Qualifying Child is available under the terms of the Plan and, if so, whether such Qualifying Child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision thereof substituted for the name of such Qualifying Child pursuant to Section 2.4.C.1 to effectuate the coverage; and

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

3. Rule of construction. Nothing in Section 2.4.F shall be construed as requiring the Fund, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.

G. Actions taken by fiduciaries. If a Fund fiduciary acts in accordance with his fiduciary responsibilities as established in ERISA in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Fund's obligation to a Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

H. Treatment of Alternate Recipients.

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

I. Direct provision of benefits provided to Alternate Recipients. Any payment for benefits made by the Fund pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

J. Payment to State official treated as satisfaction of obligation to make payment to Alternate Recipient. Payment of benefits by the Fund to an official of a State or a political subdivision thereof whose name and address have been substituted for the address of an Alternate Recipient in a Qualified Medical Child Support Order, pursuant to Section 2.4.C.1, shall be treated, for purposes of Section 2.4.J, as payment of benefits to the Alternate Recipient.

K. Rights of Payment where Participants or Beneficiaries are eligible for Medicaid benefits.
1. Assignment of rights. Payment for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by on or behalf of such Participant or a Beneficiary of the Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912 (a)(1)(A) of such Act.
2. Enrollment and provision of benefits without regard to Medicaid eligibility. In enrolling an individual as a Participant or Beneficiary or in determining or making any payments for benefits of an individual as a Participant or Beneficiary, the fact that the individual is eligible for, or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act, will not be taken into account.
3. Acquisition by States of rights of third parties. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Fund has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

L. Coverage of Qualifying Children in cases of adoption, except in cases where a Qualifying Child does not meet the conditions of Section 2.1.B.2.b.
1. Coverage effective upon Placement for Adoption. In any case in which the applicable Schedule of Benefits provides coverage for Qualifying Children of Participants or Beneficiaries, the Fund shall provide benefits to Qualifying Children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Qualifying

Children who are natural children of Participants or Beneficiaries under the Plan, irrespective of whether the adoption has become final.

2. Restrictions based on pre-existing conditions at the time of Placement for Adoption prohibited. The Fund will not restrict coverage under the Plan of any Qualifying Child adopted by a Participant or Beneficiary or placed with a Participant or Beneficiary for adoption, solely on the basis of a pre-existing condition of such Qualifying Child at the time that such Qualifying Child would otherwise become eligible under the Plan, if the adoption or Placement for Adoption occurs while the Participant or Beneficiary is eligible for coverage under the Plan.
3. Definitions. For purposes of this Section 2.4.L:
   a. Qualifying Child. The term "Qualifying Child" means, in connection with any adoption, or placement for adoption, of the Qualifying Child, an individual who has not attained the age eighteen (18) as of the date of such adoption or Placement for Adoption.
   b. Placement for Adoption. The term "placement", or being "placed", for adoption, in connection with any Placement for Adoption of a Qualifying Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such person of a legal obligation for a total or partial support of such Qualifying Child in anticipation of adoption of such Qualifying Child. The Qualifying Child's placement with such person terminates upon the termination of such legal obligation.

Section 2.5 Termination of Participant's Eligibility for Plan Benefits

A. Termination of Eligibility. All of a Participant's health benefits will terminate on the earliest of the following dates:
   1. The date the Participant attains age sixty-five (65);
   2. The date the Participant first becomes eligible for Medicare;
   3. The date of the Participant's death;
   4. The last day of the month two (2) months following the month for which the premium is not received in a timely manner;
   5. The date of termination of group coverage as defined in Section 2.9;
   6. Effective June 1, 2003 and only as primary insurance, the day before the day in which a Participant is eligible for other comprehensive medical coverage from his employer for which the monthly premium is less expensive to the Participant than the current premium charged by the Fund for benefits as determined by a comparison between the Fund's monthly charge for single coverage to the new Employer's monthly premium for single coverage, or the Fund's monthly charge for family coverage to the new Employer's monthly premium for family coverage, whichever is applicable. At the election of the Participant, benefits may be continued in a secondary capacity unless any other provision of this subsection would terminate benefits.
   7. For a Participant who retires after January 1, 2009 under a Special Early Pension with less than thirty (30) years of health and welfare Contributions,

the date on which the Participant has received eight (8) years of health coverage.

Section 2.6 Dependents — Termination of Eligibility for Benefits

Except as provided in Section 2.3, all benefits of a Participant's Dependents will automatically terminate on the earliest of the following dates:

A. Dependent Spouse.
   1. The date the Dependent Spouse attains age sixty-five (65);
   2. The date the Dependent Spouse becomes eligible for Medicare;
   3. The date three (3) years after the Participant's termination date;
   4. If the Dependent Spouse became eligible pursuant to Section 2.1.B.4.a or 2.1.B.4.b, the date three (3) years after the commencement of benefits;
   5. If Section 2.6.A.4 above, does not apply, the date the Participant's benefits terminate;
   6. The last day of any month for which the premium is not received in a timely manner;
   7. The date on which the Dependent Spouse and Retiree are legally divorced;
   8. The date of the Dependent Spouse's death; or
   9. The date of termination of group coverage as defined in Section 2.9.

B. Qualifying Child.
   1. The date that the Qualifying Child no longer meets the definition of a Dependent as set forth in the Plan;
   2. The date that is the later of the termination dates of the Participant and the Dependent Spouse, as set forth in Section 2.5.A or 2.6.A, respectively;
   3. The date that the Qualifying Child becomes eligible for Medicare;
   4. The date of the Qualifying Child's death;
   5. The last day of the month two (2) months following the month for which the premium is not received in a timely manner; or
   6. The date of termination of Group Coverage as defined in Section 2.9.

Section 2.7 Participant and Dependents – Reinstatement of Eligibility for Benefits

A. Reinstatement. If the Participant and/or Dependent defers election of coverage when offered, if the Participant's and/or Dependent's coverage terminates or never becomes effective in accordance with Section 2.1.A, or 2.1.B, or if the Participant is unable to elect coverage as primary insurance due to the provisions of Section 2.5.A.6, coverage will become effective or be reinstated provided:
   1. all other qualifications set forth under the Plan are met;
   2. the Participant and/or Dependent continuously maintained comprehensive medical coverage from the later of:
      a. the date of termination with this Plan, or
      b. the Participant's retirement date under the Teamsters Joint Council No. 83 of Virginia Pension Fund to the date of reinstatement under this Plan; and
   3. the Fund Office is notified of the termination date in advance of the desired reinstatement date.

B. Reinstatement Procedure. To become reinstated, the Participant or Dependent must submit a statement from the other health insurance carrier providing proof of the coverage period as described in 2.7.A.2.

C. Failure to Pay Premium. In no event will benefits be reinstated for any Participant or Dependent when such termination occurs due to failure to pay the required premium in a timely manner.

Section 2.8 Election of Retirement Health Plan Coverage

A. To elect coverage for benefits under the Plan, an election form provided by the Fund Office must be completed. This completed election form must be received by the Fund Office at least thirty (30) days prior to the Participant's retirement date. If coverage is being elected solely for the Dependent Spouse, with or without other Dependents, the election form must be received by the Fund Office at least thirty (30) days prior to the Dependent Spouse's (and, if applicable, Qualifying Child's) effective date for benefits under the Plan.

B. Failure to timely elect benefits coverage under the Plan may result in the loss of eligibility for such coverage.

Section 2.9 Termination of Group Coverage

To the extent not prohibited by federal laws and regulations, including COBRA, notwithstanding any other provision contained herein, for Participants and Dependents whose Employer became a Contributing Employer on or after January 1, 1994, benefits will not be provided after the date on which coverage for active Participants of such Employer ceases due to termination of group coverage.

Article 3. Benefits

Section 3.1 Pre-certification Requirement

The following procedures require pre-certification:

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

B. Transplant. Transplants (which may only be performed at a transplant facility approved by the Fund's Medical Consultant).

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

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

E. Non-Compliance with Pre-Certification Requirements. Failure to contact the Fund's Medical Consultant or Trustees, as applicable, for pre-certification as described in this Section 3.1 will result in a denial of coverage and no benefit payments for services listed in Sections 3.1.

F. Limitations.

1. No benefit payment will be made for weekend admissions, unless they are certified as being medical emergencies;
2. No benefit payment will be made for inpatient Hospital care on the day prior to surgery, unless the early admission is pre-certified as being Medically Necessary;
3. No benefit payment will be made for charges associated with days of inpatient Hospital care determined not Medically Necessary, whether or not the Fund's Medical Consultant was contacted as specified above;
4. Limitations set forth in Article 4 of this Plan ("General Limitations").

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

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

I. Appeals Procedure. If a Participant disagrees with the initial conclusion of the Fund's Medical Consultant regarding Medical Necessity, he must appeal the decision as provided in the Medical Consultant's internal regulations. If, upon the decision of the Medical Consultant's appeal body, the Participant is still in disagreement, he may file an appeal with the Fund's Board of Trustees as outlined in Section 6.2.D.

Section 3.2 Disease Management Program

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

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

Section 3.3 Inpatient Hospital Expense Benefit

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

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

2. Necessary Services and Supplies for each day of Hospital Confinement.

B. Limitations. No payment will be made under this section for:
   1. drugs provided by the Hospital for use at home;
   2. personal comfort items;
   3. expenses which are not payable under the limitations set forth in Article 4 of this Plan Document ("General Limitations"); or
   4. any Room and Board or Necessary Supplies received on days of Hospital Confinement that are deemed uncertified by the Fund's Medical Consultant.

Section 3.4 Emergency Room Benefit

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

2. Limitations. No payment will be made under Section 3.7 for:

   1. charges made for professional ambulance service; or

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

Section 3.5 Surgical Expense Benefit

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

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

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

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

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

E. Ambulatory Surgery. The Surgical Expense Benefits provided under Section 3.5 will be equally available for surgery performed at a Hospital or at a certified Ambulatory Surgical Facility.

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

Section 3.6 Diagnostic X-ray and Laboratory Expense Benefit

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

B. Limitations. No payment shall be made under this Section for:

1. charges incurred during a Hospital Confinement;
2. dental x-rays, except in connection with an accident;
3. examinations that are not recommended and approved by a legally qualified Physician;
4. radium, chemotherapy, radioactive-isotope therapy;
5. diagnostic x-ray or laboratory procedures performed within the confines of a doctor's office or ambulatory care center;
6. diagnostic x-ray or laboratory procedures performed in connection with an emergency room visit; and
7. expenses which are not payable under the Plan according to Article 4, "General Limitations."

Section 3.7 Prescription Drug Expense Benefit

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

B. Allowable Drugs. As used in this Section 3.7, "Allowable Drugs" shall include the following non-Hospital items:
   1. Drugs and Medicines lawfully obtainable upon the written prescription of a licensed Physician;
   2. Insulin and supplies, including syringes, needles and test materials considered necessary items in cases of a diabetic individual. This definition shall not include glucometers or similar types of blood sugar testing devices.

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

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

E. Limitations. No payment shall be made under Section 3.7 for:
   1. drugs or medicines dispensed by a licensed Hospital or convalescent facility during confinements;
   2. dietary supplements, vitamins (except vitamins covered under the Fund's appointed prescription benefit manager) and immunization agents, as well as appliances and other non-drug items;
   3. drugs or medicines lawfully obtainable without a written prescription, except as specifically provided under the definition of Allowable Drugs;
   4. patent medicines, biologicals, allergens, sickroom supplies, nose drops or other nasal preparations;
   5. drugs or medicines supplied or administered in a Physician's Office, other than specialty medicines filled by the Fund's prescription benefit manager;
   6. fertility drugs when prescribed as a means of promoting pregnancy;
   7. drugs or medicines dispensed for cosmetic purposes ;
   8. drugs or medicines, which are not payable under the Plan according to Article 4, "General Limitation;"
   9. drugs not approved by the Fund's prescription benefit manager according to the Fund's pre-certification requirements.
   10. drugs appearing on the Fund's prescription benefit manager Exclusion List;
   11. drugs under the "Exclude at Launch Program" as defined by the Fund's prescription benefit manager;
   12. Spinraza; and
   13. Zolgensma.

Section 3.8 Dental Expense Benefit

A. In General. The Fund shall pay expenses incurred by a Participant or Dependent for eligible dental services, if such benefits are provided under the Participant's Schedule of Benefits and not to exceed the maximums provided in the Participant's Schedule of Benefits.

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

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

D. Jaw Joint Dental Benefits. Charges in connection with treatment of jaw joint problems, including temporomandibular joint (TMJ) syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and complex of muscles, nerves, and other tissues related to that joint, shall be covered solely under the Dental Expense Benefit provisions of the Plan, except TMJ surgery and TMJ related diagnostic tests, x-rays, therapy, treatment and other procedures for which an American Dental Association charge code does not apply which shall be considered under the Fund's Medical Benefits, and subject to the maximums, conditions, and requirements applicable to other Medical Benefits.

E. Limitations.

1. No payment shall be made under Section 3.8 for:
    a. expenses incurred for dental services rendered for cosmetic purposes including but not limited to bleaching;
    b. charges for special, non-standard, techniques in denture construction to the extent the cost exceeds the cost of standard techniques;
    c. charges for replacing lost or stolen appliances or repairing appliances damaged when not in the mouth;
    d. expenses incurred for the replacement of any prosthetic appliance, gold restoration, crown, or bridge within five (5) years following the date of the last placement of such appliance, gold restoration, crown or bridge;
    e. expenses incurred for the replacement of any prosthesis by a different type of prosthesis within five (5) years, except for those expenses that result from the difference in cost of a second (2^{nd}) prosthesis minus the cost of the first (1^{st}) prosthesis;
    f. expenses for any crown, other than a stainless steel crown, for Qualifying Children less than fourteen (14) years of age unless teeth involved are permanent;
    g. charges for supplies normally used at home including, but not limited to toothpaste, toothbrushes, waterpiks and mouth washes;
    h. expenses incurred for a dental service that is not performed by or under the supervision of a Physician or Dentist;
    i. temporary restorations or prosthesis except when necessary to replace tooth numbers 6 (six), 7 (seven), 8 (eight), 9 (nine), 10 (ten), and 11 (eleven), or tooth numbers 22 (twenty-two), 23 (twenty-three), 24 (twenty-four), 25 (twenty-five), 26 (twenty-six) and 27 (twenty-seven) in preparation for an implant;
    j. expenses incurred for more than two (2) examinations during any calendar year;

k. expenses incurred for more than two (2) prophylaxes during any calendar year;
l. expenses incurred for more than one (1) full mouth x-ray and panorex x-ray during any three (3) year period and two (2) sets of bite wing x-rays in a calendar year;
m. expenses incurred for adjustments and relines of dentures during the six (6) month period following installation;
n. any charges for or related to orthodontic services; or
o. expenses which are not payable according to Article 4, "General Limitations."

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

Section 3.9 Major Medical Expense Benefit

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

B. Allowable Major Medical Expenses. For the purposes of Section 3.9, the term "Allowable Major Medical Expenses" means those expenses actually incurred by a Participant or his Dependent for the charges listed below, but only if the expenses are incurred while such Participant or Dependent is eligible for benefits, and only to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of the Injury or Illness suffered:

1. Charges made by a Hospital, not to exceed the amount shown in the applicable Schedule of Benefits;
2. Charges made by a Physician, psychologist, psychiatrist or ophthalmologist in accordance with his license for professional services;
3. Charges made by a licensed counselor or social worker;
4. Charges made by a Registered Nurse or a Licensed Practical Nurse, other than a member of the Participant's or his Dependent's family, for professional services;
5. Charges made for anesthesia and its administration; radium, and radioactive isotope treatment, chemotherapy, blood transfusions; oxygen and other gases and their administration; use of any Durable Medical Equipment; physical therapy, speech therapy or occupational therapy, prosthetic appliances and dressings, artificial limbs or artificial eyes. If any of these items over $1,000 are approved by the Fund's Medical Consultant for services in the patient's home, the maximum amount payable shall be determined by the Fund's Allowable Charge.

6. Charges made for drugs lawfully obtainable only upon the written prescription of a Physician by a Participant or Dependent for whom the Fund is the secondary Plan;
7. Charges made for professional ambulance service, only when medically necessary and not merely for the convenience of the patient, used to transport a Participant or his Dependent:
    a. directly from the place where such Participant or Dependent is injured in an accident or stricken by Illness to the nearest Hospital where necessary care and treatment can be given;
    b. from one Hospital to another Hospital when medically necessary; or
    c. from a Hospital to the patient's home when medically necessary;
8. Charges made for contact lenses or cataract glasses and lenses when cataract surgery has been performed and for contact lenses when contact lenses are used as a prosthetic appliance for other medically necessary reasons;
9. Charges for braces, crutches, or the rental of a wheel chair, Hospital-type bed, or artificial respirator. If any of these items over $1,000 are approved by the Fund's Medical Consultant for home use, the maximum amount payable shall be determined by the Fund's Allowable Charge;
10. Charges made by a Dentist or dental surgeon for repair of damage to the jaw and/or natural teeth as the direct result of an Injury, osseous surgery not connected with dental implants, or medical procedures relating to the treatment of the lips, tongue or cheeks;
11. Charges made by a nursing home or a skilled nursing facility for skilled care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care and rehabilitation services as well as other related health services. The skilled nursing care can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled rehabilitation services received must be under the general direction of a Physician. Eligible charges will not include convalescent or Custodial Care;
12. Charges for the administration of allergy injections, without regard to the place of service;
13. Outpatient cardiac rehabilitation;
14. Charges made by a Hospital for Room and Board or necessary services and supplies related to dental treatment, if approved by the Fund's Medical Consultant, as described in Section 1.35.
15. Charges related to prescription drugs administered in an outpatient setting.
16. Charges related to urgent care centers.
17. Charges related to mental health and substance abuse treatment in residential and intensive outpatient treatment settings.

C. Limitations. Allowable Major Medical Expenses will not include, and no payment will be made for expenses incurred:
1. to the extent that the Participant or his Dependent receives or is entitled to receive any other benefits under the Plan for such expenses;

2. for or in connection with cosmetic surgery unless the Participant or his Dependent receives an Injury as a result of an accident while eligible for Major Medical Expense Benefits, which results in damage to the person requiring the cosmetic surgery;
3. for eyeglasses, or examination for the prescription, or fitting of eyeglasses or for hearing aids;
4. for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for:
    a. charges made for, or in connection with dental work necessitated by Injury to natural teeth sustained while the Participant or his Dependent is eligible for benefits; and
    b. Hospital charges for Room and Board or Necessary Services and Supplies, if approved by the Fund's Medical Consultant;
5. for marriage counseling, by whomever charged;
6. for charges for treatment related to Hospital days that exceed the maximum number of days specified in the applicable Schedule of Benefits;
7. for charges for treatment in connection with treatment of jaw joint problems, including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jaw bone and skull and complex of muscles, nerves, and other tissues related to that joint except for charges for TMJ surgery and TMJ related diagnostic tests, x-rays, therapy, treatment and other procedures for which an American Dental Association charge code does not apply;
8. in connection with weight loss programs;
9. for charges related to the treatment of learning disabilities;
10. for which benefits are not payable under the Plan according to Article 4 of this Plan Document ("General Limitations");
11. for Spinraza.

Section 3.10 Physician Office Visit Benefit

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

B. Allowable Physician Office Visit Charges. As used in Section 3.10, "Allowable Physician Office Visit Charges" shall include the office visit charge, related network charges and fees, as well as all lab, x-ray, drugs (i.e. chemotherapy, allergy), administration charges (i.e. vaccines) and all other products or services provided within the confines of and charged by a Physician's office. In addition to charges from a Physician, benefits under Section 3.10 will be provided for charges submitted by a licensed psychologist, licensed physician's assistant, licensed nurse practitioner, licensed optometrist or ophthalmologist, licensed counselor or social worker, and Registered or Licensed Practical Nurse (other than a member of the Participant's or his Dependent's family).

C. Limitations.
   1. Charges for the administration of allergy injections; and
   2. The payment of Physician Office Visit benefits is subject to the limitations set forth in Article 4 of this Plan Document ("General Limitations").

Section 3.11 Out-of-Pocket Expense Benefit

A. General Rule. The Fund will pay 100% of Allowable Out-of-Pocket Expense Charges after a Participant, a Dependent, or the Participant's family satisfies the out-of-pocket limit specified in the applicable Schedule of Benefits.

B. Allowable Out-of-pocket Expense Charges. As used in Section 3.11, "Allowable Out-of-pocket Expense Charges" shall mean all expenses incurred that require payment of Coinsurance other than those listed in Section 3.11.C.

C. Limitations. Benefits under this section are not payable with respect to:
   1. Dental Benefits;
   2. any expenses incurred prior to the date the Participant or Dependent becomes eligible for benefits;
   3. charges that exceed the Allowable Charge;
   4. charges that are the result of reduction of benefit payment due to non-compliance with pre-certification guidelines set forth in Section 1.36.A, Section 3.1.A and Section 3.1.E;
   5. charges that are for services and supplies that are not covered by the Plan;
   6. charges that are in excess of Schedule of Benefits maximums;
   7. charges incurred under the Plan's Prescription Drug Expense Benefit;
   8. co-payment when utilizing a doctor or emergency room;
   9. charges that are applied to the annual Deductible;
   10. Benefits that are not payable according to Article 4 of this Plan Document ("General Limitations"); or
   11. charges that are in connection with follow-up care related to the Organ Transplant Expense Benefit.

Section 3.12 Comprehensive Rehabilitation Program Expense Benefit

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

B. Allowable Rehabilitative Expenses. For the purposes of Section 3.12, the term "Allowable Rehabilitative Expenses" means those expenses actually incurred by a Participant or his Dependent for the charges listed in Section 3.12.B.1 through Section 3.12.B.5, but only if the expenses are incurred while such Participant or Dependent is eligible for benefits, and only to the extent that the services or supplies provided are recommended by a Physician or a qualified Rehabilitation Program

Specialist, and are essential for the necessary care and treatment of the Injury or Illness suffered:

1. Charges for the services of a registered physical therapist, registered occupational therapist or registered speech therapist;
2. Treatment in an extended care or skilled nursing facility, i.e., specially qualified facilities which provide skilled nursing care and rehabilitative services;
3. Charges made by a Registered Nurse or a Licensed Practical Nurse, other than a member of the Participant's or his Dependents' family, for medically required professional services;
4. Charges made by a Physician for professional services;
5. Charges for medically necessary Durable Medical Equipment (DME rentals and purchases exceeding $1,000 must be approved by the Fund's Medical Consultant), prosthetic appliances, dressings, and drugs and medicines lawfully obtainable only upon the written prescription of a Physician, that are not otherwise payable under the Plan.

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

1. Custodial Care in any extended care facility, skilled nursing facility or "nursing home;"
2. expenses no longer recommended for coverage under the rehabilitation program by the Fund whether or not these expenses are otherwise payable under the Plan; and
3. benefits which are not payable under the Plan according to Article 4 of this Plan Document ("General Limitations").

Section 3.13 Organ Transplant Expense Benefit

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

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

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

C. Limitations. No payment shall be made under this section for:
   1. any transplant that is considered Experimental or Investigational as determined by the Fund's Medical Consultant;
   2. expenses for transportation of surgeons or family members;
   3. expenses related to any transplant not performed at a transplant facility approved by the Fund's Medical Consultant; or
   4. limitations set forth in Article 4 of this Plan Document ("General Limitations").

Article 4. General Limitations

Section 4.1 Limitations

A. Employment Related Injury or Illness. No payment will be made for expenses for or in connection with an Injury or Illness for which a Participant or Dependent is entitled to benefits under any Workers' Compensation or similar law.
   1. Payment of Benefits Pending Appeal. If a Participant or Dependent is denied Worker's Compensation benefits after providing his Employer's Worker's Compensation carrier a timely and valid application for benefits, the Fund may pay benefits after receipt of an initial administrative agency determination that no benefits are available under a Worker's Compensation law, provided the Participant or Dependent continues to promptly and timely exhaust his remedies through the agency appeals process as required in Section 4.1.A.2 and executes a Subrogation and Reimbursement Agreement as required in Section 6.6 providing that if the appeal is successful, the Participant or Dependent will pay the Fund the lesser of the amount previously paid by the Fund or the amount received in Worker's Compensation benefits.
   2. Exhaustion of Remedies. The Fund shall require a Participant or Dependent to promptly and timely exhaust his remedies under the Workers' Compensation law as a condition for obtaining coverage under the Plan. Except as may result from an appeal to a court as provided in Section 4.1.A.3, below, the decision of the tribunal of last resort within the agency administering the Workers' Compensation law will be considered final and binding on all issues under its jurisdiction which affect this limitation.
   3. Appeals to Court. If the Fund has paid benefits and after the tribunal of last resort of the appropriate administrative agency determines that no benefits are available under a Workers' Compensation law, the Participant or Dependent shall, if requested by the Fund, execute a written authorization to the Fund to appeal the decision to court at the Fund's expense on behalf of the Participant or Dependent. The Participant or Dependent shall also execute a written assignment providing that if the appeal is successful, the Participant or Dependent will pay the Fund the lesser of the amount previously paid by the Fund including applicable fees paid by the Fund Office to the Fund's Preferred Provider Organization directly attributable to

benefit payments or the amount received in Worker's Compensation benefits.

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

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

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

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

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

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

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

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

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

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

K. Pre-certification. No payment will be made for expenses for any charges that are the result of reduction of benefit payment due to noncompliance of the pre-certification requirements as described in Section 1.35 and Section 3.1.

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

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

N. Custodial Care. No payment will be made for expenses for charges for Custodial Care.

O. Endosseous Surgery. No payment will be made for expenses for or in connection with endosseous surgery in preparation of and including dental implants except as set forth in Section 3.8.C.

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

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

R. Illegal Act. No benefit coverage will be provided for charges incurred for any Injury or Illness arising from the commission of an illegal act. An Illegal Act is defined as an action taken which violates any federal, state or local law, regardless of whether the Participant or Dependent is prosecuted or convicted for such Illegal Act.

S. Unnecessary Treatment. No payment will be made for any unnecessary procedures, treatment or supplies as determined by the Fund's Medical Consultant.

T. Pre-existing Condition Clause. No benefits shall be paid for charges in connection with a pre-existing Injury, Illness, or condition for which medical advice and/or treatment was sought under the provisions of Section 4.1.T.1 and 4.1.T.2.

1. The pre-existing condition clause shall apply to:
    a. Participants covered by Retiree health benefits who were not covered under the Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund for the ninety (90) day period immediately prior to the effective date of coverage for such Retiree health benefits; and
    b. Dependents and Qualified Beneficiaries of Section 4.1.T.1 .a.
2. The pre-existing condition exclusion set forth in Section 4.1.T shall apply only if:
    a. the exclusion relates to a condition (whether physical or mental), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within ninety (90) days of the effective date of coverage; and
    b. the exclusion does not extend for more than six (6) months from the effective date of coverage; and
3. The six (6) month period of exclusion is reduced by the total of any Creditable Coverage applicable to the Retiree or Dependent as of the first (1st) day for which Contributions are received. For this Section only, "Creditable Coverage" shall mean the period of time the Retiree or Dependent was covered under any other health benefit plan including group health benefit plans, health insurance plans, Medicare, Medicaid, COBRA, and any other government mandated or available health benefits. Creditable Coverage is not counted if there was a sixty-three (63) immediately preceding the enrollment date that the individual was not covered under any Creditable Coverage. Any time an individual is in a waiting period for

coverage under a group health plan, the time will not be considered a break in continuous coverage. The Retiree or Dependent must supply proof of Creditable Coverage.

4. The pre-existing condition clause does not apply to:
   a. pregnancy;
   b. individuals who are covered under Creditable Coverage or who are enrolled as a result of birth or adoption. The Participant or Beneficiary must supply proof of Creditable Coverage, birth or adoption; or

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

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

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

Section 4.2 Non-duplication

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

Section 4.3 Termination of Group Coverage

To the extent not prohibited by federal laws and regulations, including COBRA, notwithstanding any other provision contained herein, for Participants and Dependents whose employer became a Contributing Employer on or after January 1, 1994, benefits will not be provided after the date on which coverage for active Participants of such Employer ceases due to termination of group coverage.

Section 4.4 Limitations on Uses and Disclosures of Health Information

USES AND DISCLOSURES OF HEALTH INFORMATION

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

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

Protected Health Information is information that is identifiable to a particular Individual. An Individual's Protected Health Information may be disclosed by the Fund to the Board of Trustees, the Plan Sponsor for the Plan. Disclosure to the Board of Trustees is dependent upon the Board of Trustees' certification that it will not use or disclose information other than as set out in these plan documents, or as otherwise permitted by law. The Board of Trustees' certification may be

found in Section 4.5. Additionally, Section 4.4.B.16.d. describes the classes of employees of the Fund who have access to Protected Health Information. These employees use Protected Health Information to perform plan administration functions. Employees of the Fund may not use or disclose Protected Health Information except as described in the plan documents, or as otherwise permitted by law. Employees who violate their duties with respect to Protected Health Information shall be sanctioned up to and including discharge from their employment.

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

A. Required Disclosures.
   1. All Protected Health Information must be disclosed when required by the Secretary of Health and Human Services or any other officer or employee of Department of Health and Human Services to whom the authority involved has been delegated;
   2. All records contained in a designated record set must be disclosed to the Individual, when requested in writing, except for
      a. psychotherapy notes; or
      b. information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

B. Permitted Disclosures. The Board of Trustees may make the following uses or disclosures without obtaining the Individual's prior consent, either oral or written:
   1. The Board of Trustees may make disclosures to the Individual;
   2. The Board of Trustees may disclose Protected Health Information for the treatment activities of a health care provider;
   3. The Board of Trustees may use or disclose Protected Health Information to any person or entity for the purposes of carrying out the Fund's payment, or health operations;
   4. The Board of Trustees may disclose Protected Health Information to another covered entity or health care provider for the payment activities of the entity that receives the information;
   5. The Board of Trustees may disclose Protected Health Information to another covered entity for the health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the Individual who is the subject of the Protected Health Information being requested, the Protected Health Information pertains to such relationship, and the disclosure is:
      a. for a purpose of conducting quality assessment and improvement activities, including outcomes, evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of heath care providers and patients with information about treatment alternatives; and related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance,

conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; or

b. for the purpose of health care fraud and abuse detection or compliance;

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

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

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

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

8. The Board of Trustees may use Protected Health Information to create a limited data set, or it may disclose Protected Health Information to a business associate for such purpose, whether or not the limited data set will be used by the Board of Trustees. The Board of Trustees may also use or disclose a limited data set, only for the purpose of research, public health, or health care operations, if the Board of Trustees has entered into a data use agreement with the limited data set recipient;

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

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

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

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

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

b. the disclosure is to:

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

(ii) an attorney retained by or on behalf of the Trustee or business associate for the purpose of determining the legal options of the member or business associate with regard to the conduct described in Section 4.4.A;

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

a. the health care system;

b. government benefit programs for which health information is relevant to Beneficiary eligibility;

c. entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

d. entities subject to civil rights laws for which health information is necessary for determining compliance.

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

a. the receipt of health care;

b. a claim for public benefits related to health; or

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

12. The Board of Trustees may disclose Protected Health Information for a law enforcement purpose to a law enforcement official:
    a. as required by law including laws that require the reporting of certain types of wounds or their physical injuries, except for laws subject to Section 4.4.B.12.b and about victims of domestic abuse; or
    b. in compliance with and as limited by the relevant requirements of:
        (i) a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;
        (ii) a grand jury subpoena; or
        (iii) an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
            (1) the information sought is relevant and material to a legitimate law enforcement inquiry;
            (2) the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
            (3) de-identified information could not reasonably be used;
13. The Board of Trustees may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related Injuries or Illness without regard to fault;
14. The Board of Trustees may make uses or disclosures of Protected Health Information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Uses or disclosures under this paragraph must also comply with Section 4.4.B.12 and Section 4.4.B.16.
15. Oral Agreement Required Prior to Use or Disclosure. The Board of Trustees may disclose to a family member, other relative, or a close personal friend of the Individual, or any other person identified by the Individual, the Protected Health Information directly relevant to such person's involvement with the Individual's care or payment related to the individual's health care.
    a. if the Individual is present for, or otherwise available prior to, a use or disclosure described above and has the capacity to make health care decisions, the Board of Trustees may use or disclose the Protected Health Information if it:
        (i) obtains the Individual's agreement;
        (ii) provides the Individual with the opportunity to object to the disclosure, and the individual does not express an objection; or,
        (iii) reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

b. If the Individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the Individual's incapacity or an emergency circumstance, the Board of Trustees may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the Individual and, if so, disclose only the Protected Health Information that is directly relevant to the person's involvement with the Individual's health care.

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

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

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

(i) the Board receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the Individual who is the subject of the Protected Health Information that has been requested has been given notice of the request. For purposes of this Section 4.4.B.16.b.(i), satisfactory assurances from a party seeking Protected Health Information means that the Board must receive from such party a written statement and accompanying documentation demonstrating that:

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

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

(3) the time for the Individual to raise objections to the court or administrative tribunal has elapsed, and:

(I) no objections were filed; or

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

(ii) the Board receives satisfactory assurance from the party seeking the information that reasonable efforts have been

made by such party to secure a qualified protective order. For purposes of Section 4.4.B.16.b.(ii), satisfactory assurance means that the Board will receive from such party seeking information a written statement and accompanying documentation demonstrating that:

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

(2) the party seeking the Protected Health Information has requested a qualified protective order from such court or administrative tribunal;

(iii) for purposes of this Section, a qualified protective order means, with respect to Protected Health Information requested under Section 4.4.B.16, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

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

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

(iv) notwithstanding Section 4.4.B.16.b, the Board may disclose Protected Health Information in response to lawful process described in Section 4.4.B.16.b above without receiving satisfactory assurance if the Board makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of Section 4.4.B.16.b.i or Section 4.4.B.16.b.ii of this paragraph.

c. Written Authorization From Individual Required. Except for the uses and disclosures above, or as otherwise required or permitted by law, the Board of Trustees will make no uses or disclosures of Protected Health Information unless the Individual has given their written authorization to the Board permitting it to use or disclose the information. Furthermore, the Individual may revoke the written authorization given to the Board at any time, provided that the revocation is also in writing. There are certain circumstances under which the Individual may not revoke the written authorization. Those circumstances are:

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

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

d. Classes of Health and Welfare Fund Employees and their access to Protected Health Information:

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

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

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

(iv) Claim Coordinators. The Claim Coordinators interact, via the toll free phone system, with Participants and family

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

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

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

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

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

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

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

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

D. The Board of Trustees will report to the Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided, for which it becomes aware;

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

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

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

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

I. The Board of Trustees will, if feasible, return or destroy all Protected Health Information received from the Fund that the Board still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

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

Article 5. Coordination of Benefits

Section 5.1 Coordination of Benefits

All benefit provisions of this Plan are subject to Article 5.

Section 5.2 Definitions

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

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

1. group or blanket insurance coverage (excluding blanket school accident coverage, youth sports accident coverage, or a single policy affording multiparty coverage at the individual's expense);
2. any coverage under prepaid group plans, labor-management Trusteed plans, union welfare plans, employer organization plans, employee organization benefits plans, or any other arrangements of benefits for individuals of a group; or

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

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

C. Benefits. The term "Benefits" means that portion of this Plan which provides benefits that are subject to this Article 5.

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

Section 5.3 Order of Determination for Retiree Coverage

When a Participant or Dependent is eligible for benefits under the Fund and eligible for coverage from any other plan, the order of plan priority will be determined as follows:

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

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

1. The plan which covers the Participant as an employee or as the certificate holder will be the primary plan and the plan covering the Participant as a Dependent will be the secondary plan;
2. For a Qualifying Child:
   a. Except as set forth in Section 5.3.B.2.b, the primary plan for a Qualifying Child will be the plan of the parent whose birthday month and day (excluding year of birth) occurs earlier in a calendar year. (Example: If the father's birthday is September 15, 1940, and the mother's birthday is January 30, 1942, the mother's Plan will be primary.);
   b. When the parents are separated or divorced: If there is a court order which establishes financial responsibility for the medical, dental, or other health care expenses with respect to the Qualifying Child, the benefits for a Qualifying Child will be determined in accordance with the court order. Otherwise, the plan of the parent with custody

will be primary; if the parent with custody has remarried, the plan of the parent with custody will be primary, the stepparent's plan will be secondary, and the plan of the parent without custody will pay third (3rd). If the parents have joint custody, the parent who claims the Qualifying Child for tax purposes will be primary;

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

3. If the foregoing provisions of this Section 5.3.B., do not establish an order of benefit determination, the plan which has covered the person for the longer period of time shall be primary.

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

For any claim received in which the Plan is not the primary plan, the Plan will pay the difference between the primary plan's reimbursement and 100% of the Allowable Charge, provided this amount does not exceed the benefits payable under the Plan in the absence of duplicate coverage. For purposes of this Section 5.4, Allowable Charge is defined as the billed charges less the greater of the discounts allowed under the primary plan or the Fund's plan, any reduction necessary to limit the billed charge to the applicable fee schedule for Out-Of-Network claims, or if required by contract with the Fund's Preferred Provider Organization, the billed charge reduced by the primary Plan's Preferred Provider Organization's discount. Notwithstanding the foregoing, to the extent permitted by the No Surprises Act, any calculation of benefits payable where the Plan is not primary will be determined by the Fund on a reasonable and consistent basis in its sole discretion.

Article 6. Payment of Benefits and Miscellaneous

Section 6.1 Payment of Benefits

A. Persons to Whom Benefits are Payable. The proceeds of any benefits shall be paid solely to:

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

B. Facility of Payment of Benefits. If a Participant is a minor or, in the opinion of the Trustees, otherwise not competent to give a valid receipt for any benefit due him, and if no request for payment has been received by the Fund from a duly appointed guardian or other legally appointed representative of the Participant, the Fund may, at its option, make direct payment to the Individual or institution appearing to the Fund to have assumed the custody of or the principal support of the Participant. If the Participant dies while benefits for Hospital, nursing, medical, surgical, dental, or other services remain unpaid, the Fund may at its option, make direct payment to the Individual or institution on whose charges claim is based or to any of the

following surviving relatives of the Participant: wife, husband, mother, father, child or children, brothers or sisters, or to the executors or administrators of the Participant. Any payment by the Fund in accordance with Section 6.1 will discharge the Fund from all further liability to the extent of the payment made.

Section 6.2 Claims Procedures

A. Notice of Claim.

1. Written Notice of Claim must be given to the Fund Office. Written Notice of Claim given by or on behalf of the Participant or Dependent to the Fund Office with sufficient information to identify the Participant or Dependent will be considered notice to the Fund. As used in Section 6.2, "Notice of Claim" means the first (1st) time that the Fund Office is made aware that a claim was incurred on a specific date. No charges can be considered for payment by the Fund until all information required for processing is on file. No claim will be paid or considered for payment if the charges incurred more than twelve (12) months prior to the date Notice of Claim is received unless the claim is for benefits for which the Fund is secondary. In such cases, no claim will be paid or considered for payment if the final payment by the primary carrier took place more than twelve (12) months prior to the date notice of claim is received. However, failure to give written notice within the twelve (12) month period will neither invalidate nor reduce any claim if proof can be submitted of a provider or Participant's attempt to submit a claim to the Fund within twelve (12) months or it can be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as reasonably possible.
2. Authorized Representative. An Authorized Representative of a Participant or Dependent may act on behalf of such Participant or Dependent in pursuing a benefit claim or appeal of an Adverse Benefit Determination. A Participant's Spouse or a parent of a minor Participant or Dependent may serve as the Participant or Dependent's representative without prior notice to the Fund Office. Except in cases involving "urgent care", a Participant or Dependent must submit a written designation of any other representative to the Fund. In the case of a claim involving urgent care, a health care professional with knowledge of a Participant or Dependent's medical condition shall be permitted to act as the Authorized Representative of the Participant or Dependent. An Authorized Representative appointed under this provision does not have any independent rights under this Plan or ERISA.
3. In the case of a failure by a Participant or Dependent or an Authorized Representative of a Participant or Dependent to follow the Plan's procedures for filing a "pre-service claim", the Participant or Dependent or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Participant or Dependent or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days twenty-four (24) hours in the case of a failure to file a claim involving "urgent care")

following the failure. Notification may be oral, unless written notification is requested by the Participant or Dependent or Authorized Representative.

4. Section 6.2.A.3 shall apply only in the case of a failure that:
   a. is a communication by a Participant or Dependent or an Authorized Representative of a Participant or Dependent that is received by a person or organizational unit customarily responsible for handling benefit matters; and
   b. is a communication that names a specific Participant or Dependent; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

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

C. Claim Review Procedure.

1. Manner and content of notification of benefit determination. The Fund Office shall provide a Participant or Dependent with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by 29 C.F.R §2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the Participant or Dependent:
   a. The specific reason or reasons for the Adverse Benefit Determination;
   b. Reference to the specific Plan provisions on which the determination is based;
   c. A description of any additional material or information necessary for the Participant or Dependent to perfect the claim and an explanation of why such material or information is necessary;
   d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Participant or Dependent's right to bring a civil action under ERISA

Section 502(a) following an Adverse Benefit Determination on review;

e. The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant or Dependent's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

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

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

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

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

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

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

eight (48) hours, to provide the specified information. The Fund shall notify the Participant or Dependent of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

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

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

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

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

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

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

be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

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

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

D. Appeal Procedure.

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

a. was relied upon in making the benefit determination;

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

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

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

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

3. In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation on an appeal shall not be an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal or the subordinate of any such individual. The Fund will identify to the Participant or Dependent any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant or Dependent's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

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

E. Timing of notification of benefit determination on appeal.

1. General Rule. The Fund's Board of Trustees, having regularly schedule meetings at least quarterly, shall make a benefit determination no later than

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

2. Urgent care claims. In the case of a claim involving urgent care, the Fund shall notify the Participant or Dependent of the Plan's benefit determination on the appeal as soon as possible, taking into account medical urgency, but not later than seventy-two (72) hours after receipt of the Participant or Dependent's request for review of an Adverse Benefit Determination by the Plan.
3. Pre-service claims. In the case of a pre-service claim, the Fund shall notify the Participant or Dependent of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the Participant or Dependent's request for review of an Adverse Benefit Determination.
4. Calculating time periods. For purposes of this Section 6.2.E the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant or Dependent's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant or Dependent until the date on which the Participant or Dependent responds to the request for additional information.
5. Furnishing documents. In the case of an Adverse Benefit Determination on review, the Fund shall provide such access to, and copies of, documents, records.

F. Manner and content of notification of benefit determination on appeal. The Fund shall provide a Participant or Dependent with written or electronic notification of a Plan's benefit determination on appeal. Any electronic notification shall comply with the standards imposed by 29 C.F.R § 2520.104b 1(c)(1)(i), (iii), and (iv). In the case of an Adverse Benefit Determination, the notification shall set forth, in a

manner calculated to be understood by the Participant or Dependent the information described in Section 6.2.C.1 and the following statement: You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

G. Access to Medical Records. In order to process claims and any appeals from initial determinations of claims, the Fund reserves the right to review medical records as deemed necessary to accurately apply the benefits of the Plan.

H. External Review – Only With Respect to No Surprises Services.

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

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

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

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

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

c. the Participant or Dependent has exhausted the Plan's internal claims appeal process; and

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

I. Statute of Limitations and Venue. Any legal action brought against the Plan or the Trustees under Section 502(a) of ERISA must be filed no later than 1 year from the date of the Trustees' or IRO's final determination on appeal. Any such action must be brought in the United States District Court for the Eastern District of Virginia.

Section 6.3 Physical Examination and Autopsy

The Fund, at its own expense, will have the right and opportunity, while a claim is pending, to have a Physician of its choice examine any Individual whose Injury or Illness is the basis of a claim when and so often as it may reasonably require. The Fund may also require, at its expense and if permitted by law, an autopsy be performed in the case of death.

Section 6.4 Physician-Patient or Dentist-Patient Relationship

Although the Fund provides financial incentives to encourage the use of In-Network Hospitals and Physicians, Participants and Dependents will have free choice of any Physician or Dentist practicing legally. The Fund will in no way disturb the Physician-Patient or Dentist-Patient relationship.

Section 6.5 Assignment

A Participant or Dependent cannot assign, transfer or convey any of the benefits provided by the Fund. Similarly, no Participant or Dependent may assign, transfer, or convey any rights that he has or may have under ERISA. This prohibition on assignments or rights specifically includes any legal right a Participant or Dependent has or may have to bring claims for benefits, breaches of fiduciary duty, prohibited transactions, statutory violations, and statutory penalties. Any

attempt to assign any benefits provided under the Fund or under any of the Fund's Schedule of Benefits, or legal rights to any third party, including, but not limited to, a healthcare provider, shall be immediately invalid, void, and unenforceable. The purported assignments a Participant or Dependent may be asked to sign by a healthcare provider, at or around the time of service, do not invalidate, alter, or supersede these prohibitions. The Fund's Trustees, in their sole and absolute discretion, may decide to pay benefits due to a Participant or Dependent from the Fund directly to a healthcare provider. When this happens, it is done solely for the Participant's or Dependent's convenience. Nothing in this Plan document obligates the Fund to pay any benefits directly to any healthcare provider or alters the Fund's prohibition on assigning rights and benefits under the Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

Section 6.6 Subrogation

In the event the Fund pays Medical Benefits, including Prescription Drug ("Benefits"), under any schedule to any Participant or Dependent, or health care provider for Injuries, expenses, or loss caused by the negligence or wrongful act of a third party, the Fund shall be subrogated, and entitled to first right of reimbursement, for the amount of such payments to all rights of the Participant or Dependent against any person, firm, corporation, or other entity which is, or may become, liable or otherwise obligated to said Participant or Dependent, as respects, arises, or results from such Injuries, expenses, or loss, including the death of such Participant or Dependent. The Fund shall also be entitled to obtain reimbursement of any and all sums (including applicable fees) paid by the Fund to the Fund's Preferred Provider Organization directly attributable to benefit payments to any such Participant, Dependent or health care provider on account of such Injuries, expenses, loss or death.

The Fund shall furthermore have a constructive trust, lien and/or equitable lien by agreement in favor of the Fund on any amount received by a Participant or Dependent or a representative of a Participant or Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by a Participant or Dependent for the benefit of the Fund until paid to the Fund. A Participant or Dependent consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or equitable lien by agreement, a Participant or Dependent agrees to cooperate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this Section, if the Participant or Dependent submits claims for any Benefits from the Fund for an Injury, expense, or loss that may give rise to any claim against any third party, the Participant or Dependent will be required to execute the Fund's Subrogation and Reimbursement Agreement ("Subrogation Agreement") affirming the Funds' rights of reimbursement and subrogation with respect to such Benefits before the Fund will pay Benefits. However, even if the Participant or Dependent does not execute the required Subrogation Agreement and the Fund nevertheless pays Benefits to or on behalf of the Participant or Dependent, the Participant or Dependent's acceptance of such Benefits shall constitute the Participant or Dependent's agreement to the Fund's right to subrogation or reimbursement from any payment, amount and/or recover by the Participant or Dependent from a third party that is based on the circumstance from which the Benefits paid by the Fund arose, and the Participant or Dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund.

Any refusal by a Participant or Dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery he receives, no matter how characterized, up to the full amount paid by the Fund on a Participant or Dependent's behalf relating to the applicable Injury, loss or expense, will be considered a breach of the agreement between the Fund and a Participant or Dependent that the Fund will provide the benefits available under the Fund. Further, by accepting benefits from the Fund, a Participant or Dependent affirmatively waives any defenses, he may have in any action by the Fund to recover amounts due under this Section 6.6 or any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense to the extent permissible under applicable law.

If the Participant or Dependent refuses to reimburse the Fund from any payment, amount, and/or recovery he receives, or refuses to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all Benefits paid by any and all methods which include, but are not necessarily limited to, filing a lawsuit and/or offsetting the Benefit amounts paid against the Participant or Dependent's future claims for Benefits under the Fund.

If the Fund is required to pursue legal action against the Participant or Dependent to enforce its equitable lien, establish a constructive trust, obtain repayment of the Benefits advanced by the Fund, or obtain any other equitable relief that may be allowed by law, the Participant or Dependent shall pay all costs and expenses, including attorney's fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. If legal action is required, the Participant or Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Participant or Dependent becomes obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against the Participant or Dependent in any state or federal court that has jurisdiction over the Fund's claim.

The Fund, by counsel of its choice, may sue, compromise, or settle in the name of the Participant or Dependent, or otherwise, all such rights, claims, interest, or causes of action to the extent of the benefits paid. The Participant or Dependent, or his attorney, shall not discharge or release any such right, claim, interest, or cause of action against any third party without first obtaining the express written consent of the Fund.

If the Participant or Dependent chooses to proceed by legal action against the third party with the assistance of his own attorney, the Fund shall be fully reimbursed without any deductions for legal fees or costs. The Fund does not recognize and is not bound by the "common fund" doctrine. If the Participant or Dependent resolves his claim, by settlement or judgment, with or without the assistance of an attorney, they shall fully reimburse the Fund from the proceeds of such judgment or settlement proceeds without any deductions.

The Fund's right of subrogation shall apply regardless of whether the Participant or Dependent who suffers the Injury, expense, or loss is made whole from the recovery realized from said third party. The Fund is entitled to reimbursement first and completely from any recovery. The Fund does not recognize and is not bound by the so called "make whole" doctrine.

The Participant or Dependent who suffers any such Injuries, expenses, or loss shall so notify the Fund as soon as practicable after the date of the first occurrence of such Injury, expense, or loss, and shall provide the Fund with all information the Fund requests, and shall assist the Fund in prosecuting any such rights, interests, claims, or causes of action (civil and/or criminal) against any person, firm, corporation, or other entity which is or may become liable or otherwise obligated therefore.

Section 6.7 Overpayment Policy

A. Except for Participant or Dependent overpayments of twenty-five dollars ($25) or less, in cases where an overpayment is made by the Fund on behalf of a Participant or his Dependent, the Fund will attempt to recover the overpayment from the party to whom the benefit check was made payable.

1. Participant, Dependent or Fund's prescription carrier. In cases where such overpayment has been made directly to a Participant, Dependent or the Fund's prescription carrier on behalf of a Participant or Dependent and after advising the Participant or Dependent in writing, the Fund shall deny payments on any and all claims submitted on behalf of the overpaid Participant or his Dependent until a Satisfactory Payment Agreement is executed. A "Satisfactory Payment Agreement" must provide for repayment within the maximum term set forth below and include annual interest on the amount of the overpayment at the prime rate of interest as stated in the Wall Street Journal on the 31st day following the first repayment request.

Satisfactory Payment Agreement

Debt Amount	Maximum Payoff Period	Related Monthly Payment (includes interest at prime rate)
Under $1,000	12 months	$82 for $1,000
$1,001 - $5,000	24 months	$215 for $5,000
$5,001 - $10,000	36 months	$292 for $10,000
$10,001 and over	48 months	$334 for $15,000

If applicable, a second (2nd), third (3rd), and final repayment request letters are to be issued.

2. The Fund shall furthermore have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid benefits received by a Participant or his Dependent or a representative of a Participant or his Dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by a Participant or his Dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, a Participant or his Dependent consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or

advancement of benefits, and in accordance with that constructive trust, lien and/or equitable lien by agreement, agrees to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by a Participant or his Dependent to reimburse the Fund for an overpaid amount will be considered a breach of the agreement with the Fund that the Fund will provide the benefits available under the Fund and a Participant or his Dependent will comply with the rules of the Fund. Further, by accepting benefits from the Fund, a Participant or his Dependent affirmatively waives any defenses he may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against a Participant or his Dependent to obtain repayment of the benefits advanced by the Fund, a Participant or his Dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, a Participant or his Dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date the Participant or his Dependent becomes obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against a Participant or his Dependent in any state or federal court that has jurisdiction over the Fund's claim.

3. Provider. In cases where such overpayment has been made to a provider, with the exception of the Fund's prescription carrier, the Fund shall:
   a. for claims related to providers participating in the Fund's Preferred Provider Organization, refer the matter to the Preferred Provider Organization for collection;
   b. for claims unrelated to the Fund's Preferred Provider Organization;
      (i) Issue repayment request letter to the overpaid party,
      (ii) Apply benefit payments on any and all claims submitted on behalf of the affected Participant or his Dependents payable to the overpaid service provider to the debt,
      (iii) If applicable, issue a second (2^{nd}), third (3^{rd}) and final repayment request letter.
   c. or for claims incurred greater than 18 months prior to the attempt to collect;
      (i) Apply benefit payments on any and all claims submitted on behalf of the affected Participant or his Dependents payable to the overpaid service provider; and

(ii) Issue up to four (4) repayment request letters directly to the provider.

In cases where the full overpayment is not received through the procedures established in Section 6.7.A.1 and Section 6.7.A.3 within the first (1st) six (6) months of the first (1st) attempt, refer the matter to the Board of Trustees.

B. Ineligible Participant. The following rules shall apply with respect to overpayments made by the Fund on behalf of an ineligible Participant or his Dependents:
   1. The Fund will offset any available or future claims received that would otherwise have been payable in order to recover the amount overpaid in full;
   2. If claims as described in Section 6.7.A.1 above, are not available, or if such claims fail to offset the full amount of the overpayment, then the Fund shall make four (4) attempts to recover the overpayment from the party to whom the benefit check was made payable.

C. If the Fund is unsuccessful in all attempts to recover the overpayment, the matter will be referred to the Board of Trustees.

Section 6.8 Miscellaneous

A. Law Applicable. All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with ERISA and, as to matters not preempted by ERISA, the laws of the Commonwealth of Virginia.

B. Savings Clause. Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Fund.

C. Captions. Captions shall be read as integral elements of this Plan to assist in the interpretation of the Plan provisions to which they relate.

D. Schedule of Benefits. References in this plan to the "Schedule of Benefits" shall be deemed references to the benefits that cover the Participant and eligible Dependents.

E. Construction. The Trustees are empowered to determine all questions pertaining to the interpretation, administration, construction, and application of the Plan, including, but not limited to, the determination of all questions of eligibility and the status and rights of all individuals claiming an interest in benefits provided by the Plan; their decisions are final and binding on all parties.

F. Trustees. All questions arising under or with respect to the Plan shall be determined by the Board of Trustees, whose decisions shall be final and binding on all parties. The Trustees have absolute discretion to review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Trustees determine such should be paid. This authority specifically permits the Trustees to settle disputed claims for benefits and any other disputed claims made against the Plan.

G. Termination of Group Coverage. To the extent permitted by law and unless otherwise specifically set forth herein, no benefits will be provided after the date coverage hereunder for any group ceases due to termination of the group coverage.

H. Abandoned Property. Plan benefits that are payable directly to a Participant, Spouse, or a Participant's family member or estate, shall be considered abandoned if, after reasonable efforts to contact said Participant, Spouse, family member or estate, such benefits remained unclaimed for more than three (3) years after the date the claim is incurred. "Reasonable efforts" shall include, but not be limited to, mailing or delivering the benefits payments to the last known address of the Participant, Spouse, family member or estate.

I. No Vesting in Fund. No Participant shall have any right to, or interest in, any assets of the Fund upon termination of his employment or otherwise, except as provided under this Plan, and then only to the extent of the benefits payable under the Plan to such Participant out of the assets of the Fund. No Participant, Dependent, or Qualified Beneficiary shall at any time have any vested right to any benefits currently provided or hereafter provided by the Plan, including health benefits. Except as otherwise may be provided under Title IV of ERISA, all payments of benefits as provided for in this Plan shall be made solely out of the assets of the Fund and none of the fiduciaries shall be liable therefore in any manner.

J. Amendment and Termination of Benefits. Notwithstanding any other provision of the Plan, the Trustees shall have the absolute right, in their sole discretion, to amend or terminate health and welfare benefits for Participants, Dependents, and Qualified Beneficiaries at any time.

K. Waiver. No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppels against enforcing any provision of the Plan, except in writing by the Trustees. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

L. Severability of Provisions. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof, and this Plan shall be construed and enforced as if such provisions had not been included.

M. Submission of Documents. Documents received electronically or by facsimile are deemed official and equivalent in status to an original. However, the Trustees reserve the right to require the submission of original documents and/or signatures as they may see fit.