INTERNATIONAL UNION OF OPERATING ENGINEERS

HEALTH CARE PLAN

DECISION SCIENCE, INC.
ADMINISTRATORS

JANUARY 1, 2007
PROGRAM OF INSURANCE BENEFITS

HEALTH & WELFARE TRUST FUND
FOR
INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 99 & 99A

ACTIVE EMPLOYEES

5901 Harford Road – Suite C
Baltimore MD 21214
Effective Date: January 1, 2007

UPDATED: April 1, 2011
SECTION 1

IMPORTANT NAMES AND CONTACT INFORMATION
<table>
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<th>ORGANIZATION NAME</th>
<th>FUNCTION/RELATIONSHIP</th>
<th>CONTACT INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC/BS CAREFIRST PPO Group #: W29L Pre Fix = A52</td>
<td>PPO - discounts all in-network MEDICAL claims prior to forwarding to Fund for payment</td>
<td>PO Box 10104, Fairfax, VA 22038-8004 ph# 800 235-5160, <a href="http://www.carefirst.net">www.carefirst.net</a></td>
</tr>
<tr>
<td>NATIONWIDE BETTERHEALTH (NWBH)</td>
<td>Pre-certifies in-patient MEDICAL admissions and helps coordinate after care/ Medical Consultant</td>
<td>300 Clubhouse Rd, Suite 100, Hunt Valley, MD 21031 ph# 800 925-8573</td>
</tr>
<tr>
<td>CVS/CAREMARK</td>
<td>Prescription drug vendor</td>
<td>Paper RX claim address: PO Box 52196, Phoenix AZ 85072-2196 Mail Order Address: PO Box 94467, Palatine, IL 60094-4467 Ph# 866 282-8503 <a href="http://www.caremark.com">www.caremark.com</a> <a href="http://www.cvs.com">www.cvs.com</a></td>
</tr>
<tr>
<td>DECISION SCIENCE INC. c/o OEBF LOCAL 99</td>
<td>TPA, processes all payments for medical, dental, optical and short term disability. Handles all operations related to registration and eligibility.</td>
<td>5901 Harford Rd, Ste C, Baltimore, MD 21214. ph# 410 254-9595, 800 367-7848, fax: 410 254-2016</td>
</tr>
<tr>
<td>RELIANCE STANDARD LIFE INSURANCE CO.</td>
<td>Administers Long Term Disability (LTD) benefits, Accidental Death and Basic Death benefits for qualified participants</td>
<td>LTD acct: GL143559 Phone: 1800 351- 7500 DEATH BENEFIT Acct: VAR204184 Phone: 1 800 351- 7500</td>
</tr>
</tbody>
</table>
LOCAL 99 BENEFIT FUND PHONE DIRECTORY
DECISION SCIENCE INC.

OFFICE HOURS 8AM - 4PM M-F
LOCAL (410) 254-9595
TOLL FREE 1 800 367-7848

IF YOU NEED HELP WITH:

ADDRESS CHANGES
BENEFIT BOOK REQUEST
COBRA CONTINUATION COVERAGE
DENTAL BENEFITS
DENTAL APPEALS
DEPENDENT REGISTRATION
ELIGIBILITY DUE TO EMPLOYMENT
FAMILY STATUS CHANGES
HIPAA (PRIVACY ISSUES)
ID CARD ORDERS
INJURY / SUBROGATION QUESTIONS
LIFE INSURANCE
LONG TERM DISABILITY
MEDICAL APPEALS
MEDICAL BENEFITS
OPEN ENROLLMENT
OPTICAL BENEFITS
OPTICAL APPEALS
ORTHODONTIC BENEFITS
PHARMACY MAIL ORDER PLAN
PPO BOOK REQUEST
PRESCRIPTION BENEFITS
REGISTRATION APPEALS
RETIREE BENEFITS
RETIREE SELF PAY PLAN
RX APPEALS
SHORT TERM DISABILITY
STATUS OF PAYMENT
STUDENT VERIFICATION

CONTACT:

Linda
Laura
Barbara
Crystal, Jenn, Denise, Hollie
Sandy Dickerson
Linda
Laura
Linda
Laura, Karen Corzine
Linda
Crystal, Denise
Karen Corzine
Karen Corzine
Sandy Dickerson
Denise, Koren, Cindy, Sandy
Laura, Linda
Crystal, Jenn, Denise, Hollie
Sandy Dickerson
Crystal, Jenn, Denise, Hollie
Cathy Bacastow
Laura
Cathy Bacastow
Cathy Bacastow
Koren Heimberger
Tricia
Cathy Bacastow
Hollie
Crystal, Jenn, Denise, Cindy, Koren
Linda

MANAGEMENT

PLAN ADMINISTRATOR
OFFICE MANAGER
ACCOUNTING/RX MANAGER
BENEFIT/CLAIM MANAGER
CLAIM SUPERVISOR
ACCOUNTING SUPERVISOR

Carole Maggio
Karen Corzine
Cathy Bacastow
Sandy Dickerson
Koren Heimberger
Trisha Easto

cmaggio@dsibenefitfund.org
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sdickerson@dsibenefitfund.org
korenh@dsibenefitfund.org
teaast@dsibenefitfund.org

UPDATED MAY 2010
Researching a Doctor or Hospital

Providers listed on these sites may not be CareFirst BlueCross BlueShield participating providers. Remember to search our Provider Directory before contacting them to arrange care.

Quality Comparison Tools:

- **WebMD Hospital Comparison Tool** - This tool provides information on complication rates, mortality rates, length of stay, and how frequently a hospital performs specific procedures. You can select a procedure and compare the results for different hospitals in your area. To access the tool, log in to My Account. For a demonstration of the tool, which shows only heart-related procedures, click here.

- **HealthGrades**
  [http://www.healthgrades.com](http://www.healthgrades.com)
  HealthGrades provides a variety of information on physicians and hospitals based on data from the Centers for Medicare and Medicaid Services. Hospital ratings include mortality by diagnosis and Leapfrog status. (Note: There is a charge for some reports).

- **Hospital Compare**
  [http://www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
  Hospital Compare allows you to compare the quality of care provided in acute-care hospitals (general hospitals) and critical access hospitals (rural community hospitals) for adult patients with common medical conditions such as heart attack, heart failure and pneumonia.

- **Leapfrog Group**
  [http://www.leapfroggroup.org](http://www.leapfroggroup.org)
  The Leapfrog Group provides information on the quality of certain aspects of care relevant to urban area hospitals.

- **Maryland Health Care Commission Hospital Guide**
  The Maryland Health Care Commission's Hospital Guide provides a variety of reports on Maryland hospitals, including quality measures.

- **National Committee for Quality Assurance (NCQA)**
  Research providers certified by NCQA who were recognized by the Bridges to Excellence Program (BTE). Physicians in the BTE program have taken specific steps to enhance the quality of care delivered to members under their care. Select your state and the Physician Practice Connections Recognition Program. Please note that this is a new certification program, and all states are not represented.

- **Quality Check**
  Quality Check is a comprehensive guide to the nearly 16,000 Joint Commission-Accredited Health Care Organizations (JCAHO) and programs throughout the United States. JCAHO provides organization-specific Quality Reports which include:
  - JCAHO accreditation status;
  - Compliance with the Joint Commission's National Patient Safety Goals, and performance on National Quality Improvement Goals (hospitals only). National Quality Improvement Goals allow hospitals to report on the key indicators of quality of care in up to four treatment areas: heart attack, heart failure, community acquired pneumonia, and pregnancy and related conditions; and
  - Special quality awards.

Physician Resources:

- **American Medical Association (AMA)**
  http://webapps.ama-assn.org/doctorfinder/home.html
  The AMA's Web site "DoctorFinder" allows you to search for information by name, medical specialty or by location. You can find out if the physician is a member of the AMA. If so, you can also find information on the physician's gender, specialty and Board status, medical school and graduation date, and residency training.

- **American Psychological Association (APA)**
  http://www.apa.org
  Find out if a psychologist belongs to the APA by:
  - Telephone: Call 1-800-964-2000 and a Customer Service Representative will provide you with the phone number of the APA referral system in your area.

- **District of Columbia Department of Health**
  http://doh.dc.gov/doh/site/default.asp
  Find out if a physician has a current license by:
  - Telephone: (202) 724-4900
  - Online: http://hlsa.doh.dc.gov/weblookup

- **Maryland Board of Physicians**
  http://www.mbp.state.md.us (select "Search Practitioner Profiles")
  The Maryland Board of Physicians provides license number and address, and whether there are any actions sanctioned against physicians.

- **The Maryland State Medical Society**
  http://www.msms.org (select "Find a Physician")

- **Medical Society of the District of Columbia**
  http://www.msdc.org

- **Virginia Board of Medicine**
  http://www.vehealthprovider.com (Practitioner Information)
  https://www.virginiainteractive.org/dhp/cgi-bin/search_publicdb.cgi (License Lookup)

Print: Close Window

HOW TO LOCATE A CAREFIRST PROVIDER ON LINE

***for locating Medical Providers only***

- Log on to WWW.CAREFIRST.COM
- You should see an option that reads "FIND A DOCTOR" Click on the tab.
- The next screen explains different ways you can search.
- Choose a method to search by. Be sure to limit your search to the following:
  - PPO (Preferred Provider Organization)
    - PPO/Blue Preferred/Select Preferred
  - Stay within MD/DC/Northern VA

IMPORTANT:

- Your plan has an active agreement with care first for medical providers only. In most cases, the plan allows a greater benefit if you use in network providers.

- Always call the provider's office to confirm continued participation prior to making an appointment. Provider contracts can change on a daily basis.

- Your plan does not require you to use specific dental or optical providers. You may choose any provider and if your specific plan includes this benefit it will be applied accordingly.

- Providers can also be located by calling Care First BC/BS @ 1 800 235-5160. Please have your prefix and group # handy when you call.

Updated Feb 2011
SECTION 2

SUMMARY OF
IUOE LOCAL 99
HEALTH BENEFITS

(UPDATED APRIL 2011)
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We urge you to read the booklet carefully and share it with your family members who are included in your coverage. Please keep in mind that this handbook is a summary of an official legal document and, if it conflicts with the wording of the actual plan document, the plan document will govern.
SUMMARY OF BENEFITS

JANUARY 1, 2007

This is a revised summary of benefits available under your plan. For more details, turn to the referenced section of the Plan or contact the Fund Office.

Please Note: This chart outlines the amount of Charges that could be paid by the Fund. Any portion of the charges not paid by the Fund and amounts in excess of the covered Charges will be your responsibility. All Charges are generally subject to deductible.

<table>
<thead>
<tr>
<th>AMOUNT OF BENEFIT</th>
<th>PARTICIPANT &amp; DEPENDENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO</td>
</tr>
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</table>

THE MEDICAL PLAN

BASIC MEDICAL BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Plan Year Deductible for a Family of 3 or More</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>Lifetime Limit</td>
<td>$1,000,000 Per Plan Participant</td>
<td></td>
</tr>
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</table>

INPATIENT HOSPITAL CARE
(Pre-Certification Required)

<table>
<thead>
<tr>
<th>Maximum Room and Board Charges</th>
<th>First 20 Days</th>
<th>First 20 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid at 100% at average semiprivate rate*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Excess of 20 Days</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

* The Plan Administrator reserves the right to establish the acceptable semiprivate rate if not otherwise available.
# Summary of Benefits

## BENEFITS

<table>
<thead>
<tr>
<th>AMOUNT OF BENEFIT</th>
<th>PARTICIPANT &amp; DEPENDENT</th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous Charges</td>
<td>First 20 Days</td>
<td>First 20 Day</td>
<td>100%</td>
</tr>
<tr>
<td>In Excess of 20 Days</td>
<td>Paid at 100%</td>
<td>Paid at 100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### OUTPATIENT HOSPITAL CARE*
- Hospital Charges for Sudden & Serious Illness: 100% for PPO, 100% for NON-PPO
- Facility Fees for Outpatient Surgery: 100% for PPO, 100% for NON-PPO
- Outpatient Physical Therapy: 80% for PPO, 80% for NON-PPO
- Miscellaneous Outpatient Care: Depends on Itemized Charge

* $50 co-pay on all ER Facilities Fees if not admitted. (If admitted, 100% paid.)

### GLOBAL CASE CHARGES

100% for both PPO and NON-PPO

### SURGICAL CARE
- Maximum Physician Charge not to exceed URC
- Inpatient: 100% for PPO, 80% for NON-PPO
- Outpatient: 100% for PPO, 80% for NON-PPO
- Assistant Surgeon Charges: 50% for PPO, 50% for NON-PPO
- Anesthesia: 100% for PPO, 100% for NON-PPO
### Summary of Benefits

#### BENEFITS

<table>
<thead>
<tr>
<th>PHYSICIAN CHARGES</th>
<th>PARTICIPANT &amp; DEPENDENT</th>
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</thead>
<tbody>
<tr>
<td>(All PPO Physician Charges are subject to a $10 Co-Pay per Visit)</td>
<td></td>
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<tr>
<td>Inpatient Doctor’s Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Doctors’ Visit</td>
<td>100%</td>
</tr>
<tr>
<td>Home Visit</td>
<td>100%</td>
</tr>
</tbody>
</table>

| DIAGNOSTIC LAB & X-RAY EXAMINATIONS | | |
| (All PPO diagnostic lab & x-rays are subject to a $10 co-pay per date of Service) | 100% | 70% |

| DURABLE MEDICAL EQUIPMENT ("DME") | |
| Annual maximum 80% of Charges (Not to exceed $250) | 80% | 80% |

| HEARING AIDS | | |
| | 80% | 80% |
| ($1,000 Lifetime Limit) | |

| MENTAL HEALTH | | |
| | 80% | 80% |

| HOME HEALTH CARE (RN, LPN Charges Only) | |
| 100 Visits Per Plan Year | 100% | 80% |
| (See p. 26 for coverage limitations) | |

| HOSPICE CARE | |
| 180 Days Maximum | 100% | 80% |

| EXTENDED CARE/SKILLED NURSING FACILITY (180 Days Per Plan Year) | |
| First 20 Days Inpatient | 100% | 100% |
| In Excess of 20 Days | 100% | 80% |
## Summary of Benefits

### BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>AMOUNT OF BENEFIT</th>
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<tbody>
<tr>
<td></td>
<td>PARTICIPANT &amp; DEPENDENT</td>
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<tr>
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<td>PPO</td>
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**ORTHOTICS**
Annual Maximum 70% of Charges
(Not to Exceed $700)

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<tbody>
<tr>
<td></td>
<td>70%</td>
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**WELL BABY CARE TO AGE 24 MONTHS**
(All PPO Well Baby Care Visits are Subject to a $10.00 Co-Pay per visit)

<p>| | |</p>
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<tbody>
<tr>
<td></td>
<td>100%</td>
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**PRIMARY MAJOR-MEDICAL BENEFIT**

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<th></th>
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<tbody>
<tr>
<td></td>
<td>80%</td>
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**RECONSTRUCTIVE JAW SURGERY**
(Lifetime Limit of $2,000)

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<tbody>
<tr>
<td></td>
<td>80%</td>
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### OPTICAL EXPENSE BENEFITS

12-Month Maximum

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<tr>
<td></td>
<td>$150</td>
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### SECONDARY MAJOR-MEDICAL

#### BENEFITS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible</td>
<td>$200</td>
</tr>
<tr>
<td>Lifetime Maximum Payment</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient - First Five Days Balance</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
</tr>
</tbody>
</table>

**All expenses for alcoholism and drug dependency, acupuncture and chiropractic care are payable under the Secondary Major-Medical Benefit part of the Plan. None of these expenses are covered under the Basic Medical Benefit.
### Summary of Benefits

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>AMOUNT OF BENEFIT</th>
<th>PARTICIPANT &amp; DEPENDENT</th>
<th>PPO</th>
<th>NON-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESCRIPTION DRUG BENEFITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory Generic</td>
<td>Retail</td>
<td>Mail Order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retail and Mail Order Co-Pays</td>
<td>$10</td>
<td>$20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>Preferred Brand</td>
<td>Non-Preferred Brand</td>
<td>$20</td>
<td>$30</td>
</tr>
<tr>
<td>DENTAL/ORTHODONTIC BENEFITS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services Annual Deductible</td>
<td>$50</td>
<td>$50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
<td>50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Calendar Year Benefit</td>
<td>$1,500</td>
<td>$1,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Benefit</td>
<td>(Dependent Children Only)</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services Annual Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td></td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

### DEATH, ACCIDENT AND DISABILITY BENEFITS (Active Employees Only)

| DEATH BENEFIT | $50,000 |
| ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT | $50,000 |
### Summary of Benefits

#### WEEKLY DISABILITY BENEFIT

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Weekly Indemnity</th>
<th>Waiting Period – Accident</th>
<th>Waiting Period – Sickness</th>
<th>Maximum Period of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$500***</td>
<td>0 Days</td>
<td>7 Days</td>
<td>26 Weeks</td>
</tr>
</tbody>
</table>

#### LONG TERM DISABILITY BENEFIT

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Monthly Indemnity 60% of Base –</th>
<th>Maximum $2,500</th>
<th>Waiting Period</th>
<th>Waiting Period</th>
<th>Maximum Period of Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>180 Days</td>
<td></td>
<td>To Age 65</td>
</tr>
</tbody>
</table>

#### NOTE:

1. The lifetime maximum that the Basic Medical Benefit will pay for each Participant or Dependent is $1,000,000.

2. Plan Year Deductible - The Basic Medical Deductible is $250 per covered individual. The maximum deductible is $750 for a family of three or more.

3. The Stop-Loss Limit - Plan Year Out-of-Pocket maximum for Basic Medical Benefits is $1,500 for an individual, $3,000 for two people and $4,500 for a family of three or more, after the cash deductible has been met.

4. Non-PPO Professional Fees Rendered at a PPO Hospital - Charges for professional fees from Non-PPO professionals (Emergency Room Physicians, Radiologists, Pathologist, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider, and (3) the services provided were a covered benefit under the Plan.

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**PRESCRIPTION NOTE: MANDATORY GENERIC PROGRAM**

Your prescription drug program mandates an FDA-approved Generic Drug to be used to fill prescriptions when one is available. If your physician prescribes a brand drug and writes "DAW" (dispense as written) or "BRAND ONLY" on your prescription slip and a generic drug is available for that specific drug, you will be given the brand drug and charged the difference between the brand cost and the generic cost. Please consult with your physician on this matter before a prescription is written as he/she may not be aware of the additional cost you may incur by limiting your prescription choice.

*** Kaiser Participants receive only $250.***
SECTION A
GENERAL PROVISIONS

Unless the Summary of Benefits pages state otherwise, the following provisions apply to all Participants and their Dependents covered under this Plan:

<table>
<thead>
<tr>
<th>ELIGIBLE INDIVIDUALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those employees of a contributing employer who are in a collective bargaining unit represented by Local Union 99 and 99A of the International Union of Operating Engineers will be eligible for coverage under this Plan.</td>
</tr>
</tbody>
</table>

1. GENERAL INFORMATION.

A. Definition of Employee - Those employees of an employer for whom contributions are required to be made to the Fund.

B. Employer Contributions - Will be made in accordance with the rates and terms contained in the applicable collective bargaining agreement, for any month or a portion thereof in which an employee is employed by an employer.

C. Disabled Participants – A Participant who is temporarily disabled, and who is receiving either Weekly Income Benefits from the Plan or Workers’ Compensation, shall be entitled to maintain eligibility for a period of six consecutive months, beginning with the month following the last month in which all required contributions are made on the Participant’s behalf. If the employee is temporarily disabled for longer than six consecutive months, he may continue his coverage in accordance with the COBRA rules by paying on his own behalf the necessary contributions and submitting necessary proof of the continuation of disability.

When an employee is disabled due to an occupational injury or illness, he/she must submit a completed physicians statement or other satisfactory proof to be properly credited for the time disabled.
General Provisions
Employee Eligibility/Electing Coverage

Disabled Participants. If you become disabled you may be able to continue your benefits during the following period:

- Each month that you and your Employer remits the full required premium.
  
  PLUS

- Six months during which your Employer does not submit any premiums.
  
  PLUS

- Your COBRA continuation period (if you pay the required premiums). Note that insurance benefits (STD, LTD, AD&D and life insurance) are not available during COBRA.

The six month period may be eight months if you had a three month waiting period when you were initially eligible and your Employer paid the required premiums.

2. EMPLOYEE ELIGIBILITY.

Generally, any Employee will become eligible for coverage on the first day of the month immediately following a period of three consecutive months for which the established contributions are received. If you are an Employee and you are not at work on the date your coverage would commence and your absence is caused by a health factor, your coverage will still be effective. An Employee who was ineligible for a three month period during which established contributions are received, will remain eligible for continuation coverage for two calendar months after he terminates employment. The two month coverage period shall be at the same level of coverage that existed prior to termination. Such employee does not have the option to change his coverage level.

In special situations, the three month eligibility period can be waived when a new Employer Group joins the Plan. When a new Employer Group joins the Plan, only those individuals who qualify as Employees receive immediate coverage. If you are a new hire and you do not report to work because of a health factor, you will not have coverage until you report to work and become an Employee. If the three month eligibility period is waived for a new Employer Group, the Employees of the new Employer Group will not remain eligible for a period of two consecutive calendar months after termination.

3. ELECTING COVERAGE.

Once you become eligible to participate in the Fund, you should contact the Fund Office and elect whether you want single or family coverage. If you fail to make a timely election, you will automatically have single coverage. If you elect family coverage, you must notify the Fund Office of your Dependents and provide proper verification to the Fund Office of their status. If the Fund asks you to provide verification of your
General Provisions
ELECTING COVERAGE

Dependents and you do not respond in a timely and complete manner, the Fund has the
duty to terminate your Dependent coverage.

Once you are covered under the Fund, you will have two opportunities to change your
coverage. Your existing coverage remains in effect (from year to year) until you make a
change.

Annual Open Enrollment. In December of each year, the Fund will allow you to change
your existing coverage under the Plan effective as of the following January 1st. To make
a change, you need to complete a new registration form (front and back) and indicate
either individual or family coverage. The card needs to be forwarded by the date
designated by the Plan Administrator to the following address:

Decision Science, Inc.
5901 Harford Road
Suite C
Baltimore, MD 21214

If you are changing to family coverage, Dependents must be listed on the back of the
registration card. Also include copies of marriage certificates, birth certificates or other
information required to establish the validity of a Dependent to receive health coverage.
If you are adding a Dependent, pre-existing conditions may apply if the Dependent did
not have prior health coverage under another carrier. If the Dependent did have
coverage, a “certificate of credible coverage” must be obtained from the other carrier.
Please contact the Fund Office at 1-800-367-7848 or (410) 254-9595 if you have any
questions.

You need to also inform the employer of a change in coverage by the date your employer
needs to process the information by the payroll and benefits paying department. You
may have a payroll deduction for your share of family coverage and your employer can
inform you of the amount if any.

Mid-Year Changes. If you have certain “changes in family status”, you may be allowed
to change your health coverage in the middle of a calendar year. A “change in family
status” would include a marriage, the birth or adoption of a child, your spouse’s loss of
coverage from another source, or a divorce. Please see the Administrator for more
information as to whether or not your situation constitutes a “change in family status”. If
you have a change of family status, you can make a coverage change which will be
effective the 1st day of the month following the month in which you notify the Fund and
your employer of the requested change.

If you become a Dependent of an Employee through marriage, birth or adoption, you may
be enrolled as a Dependent within 31 days from the date of the marriage, birth, adoption
or placement for adoption.

Special Enrollment Rule. The Plan complies with the Special Enrollment requirements
of the tax law. Please see the Administrator for more details.
General Provisions
Remaining Eligible/Termination of Coverage/
Employer Withdrawing from Participation

4. REMAIN ELIGIBLE.

To continue to be eligible for coverage as of the first day of each succeeding month, an Employee must remain employed with a contributing employer and must be represented by Local 99 and 99A.

**If the Fund asks you to provide verification of your Dependents and you do not respond in a timely and complete manner, the Fund has the right to terminate your Dependent coverage.**

5. TERMINATION OF COVERAGE.

Your coverage under this Plan will be terminated on the last day of the month in which the first of the following events occur:

- You cease to be covered by the bargaining agreement between the contributing employer and by Local 99 and 99A.
- You are no longer eligible for coverage.
- You or your Employer do not timely make a required contribution.
- The Plan is terminated.
- Your Dependent no longer qualifies as a Dependent.
- You or your Dependent receive the maximum lifetime benefit under the Plan.
- Your Dependent coverage can terminate if you do not timely respond to a Plan audit or information request.
- Your Prescription Drug coverage can terminate if, in the opinion of the Plan’s Medical Consultant, you are purchasing an excessive amount of drugs so that it is likely that you are reselling the drugs.

6. TERMINATION OF ELIGIBILITY RESULTING FROM EMPLOYER WITHDRAWAL FROM PARTICIPATION.

In the event that an Employer or group of Employers shall cease to contribute to or otherwise cease to participate in the Local 99 and 99A Health and Welfare Trust Fund, for reasons other than cessation of operation, the eligibility of Participants employed by such Employer(s), and their Dependents, shall terminate upon the date that their Employer shall cease to contribute to or participate in the Fund. Such termination of coverage for Employees and their Dependents shall be without regard to whether the initial eligibility of such Employees had commenced immediately upon contributions being made on their behalf or had commenced following a three month period of contributions being made on their behalf.
7. REINSTATEMENT OF COVERAGE.

An Employee’s coverage will be reinstated on the first day of the month following the month in which he returns to active employment with a contributing employer for which the established contributions are received, providing he is re-employed within two calendar months of termination.

8. CONTRIBUTION TOWARD PREMIUM BY EMPLOYEE.

Contributions may be required by Participants.

9. DEPENDENT ELIGIBILITY.

A Dependent’s coverage will be effective on the date he or she becomes eligible as long as the Participant is covered on that date. (Also see Notice of Continuation of Coverage)

Special Rule for Dental Coverage. Participants with single coverage only will be eligible for dental coverage for themselves only. If a Participant wishes to provide dental coverage for his family, he must have family coverage under the health plan.

10. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

The Health Insurance Portability and Accountability Act (HIPAA) privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the “minimum necessary” for these purposes, as defined under the HIPAA rules. The Plan may also disclose your health information without your written authorization to your Employer for plan administration purposes.

11. DEFINED TERMS.

Included below are certain defined terms which are used throughout this document. For more information, please ask to see a copy of the Plan document.

Active Employee

An “Active Employee” is a current Employee who is regularly employed. An individual on COBRA is not an Active Employee.

Benefits

“Benefits” under the Plan may include the benefits as outlined in Section B and such other insured and non-insured health and welfare benefits as may be selected by the Trustees, or by an employer pursuant to an adoption agreement. The Plan does not create vested rights in the
General Provisions
Defined Terms (Cont’d.)

Participants or Dependents to receive Benefits, and all Benefits under the Plan are subject to amendment at the discretion of the Trustees.

Charges

The term “Charge” or “Charges” means the usual, customary and reasonable fees for payment for services or items for which Benefits are payable under the Plan as follows:

(a) **Usual** means the fee that is usually charged for a given service by a physician to his or her private patient (i.e., his or her own usual fee).

(b) **Customary** means the fee within the range of usual fees charged by physicians of similar training and experience for the same service within the same specific and limited geographical area.

(c) **Reasonable** means the fee which meets the definitions for both usual and customary, or in the opinion of the responsible medical association’s review committee, is justifiable considering the special circumstances of the particular case in question.

Excessive charges will be the responsibility of the Participants or Dependents.

Dependent

The term, **Dependent** may include the following individuals, depending upon the coverage elected by the Participant: the Participant’s spouse and each unmarried child of the Participant who has not attained his or her nineteenth (19th) birthday who depends on the Participant for support. Benefits will be provided until the end of the month in which he or she turned nineteen (19). After such time, eligibility for additional Benefits will cease.

Coverage for a Dependent child who is enrolled and attending an accredited school or college on a full-time basis on or after age 19 will be treated as follows:

(a) if the dependent child’s attendance is on a full-time continual basis (i.e., fall and spring semesters), the child shall be eligible for Benefits until the end of the school year during which he reaches age twenty-three (23). In such an instance, the child’s eligibility for coverage will include the summer months for all years prior to the school year in which the Dependent child reaches age twenty-three (23).

(b) if the dependent child’s attendance is sporadic, the child shall be eligible for Benefits only during the semester that the child is attending school.

For purposes of this definition, children shall include (A) a blood descendant of the first degree, (B) a legally adopted child (including a child living with the adopting parents during the period of probation), (C) a child permanently residing in the household of which the Participant is the head and which child is actually being supported solely by the Participant, provided the
Participant is the child's legal guardian, or (D) any unmarried child age nineteen (19) or over who is incapable of self-support because of mental retardation or physical incapacity that commenced prior to such child's attaining the age of nineteen (19) and who is dependent upon the Participant for support, provided that proof of such child’s incapability is furnished to the Plan Administrator no later than thirty-one (31) days after the child attains the maximum age limit and the child was listed as a Dependent prior to age nineteen (19). Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time.

**Note:** A stepchild qualifies as a Dependent of a nonbiological parent only if the nonbiological parent has adopted the child or been appointed the legal guardian of the child.

Legal documentation of a decree or pending proceeding to establish a Participant’s status as a legal guardian of a child must be presented to the Plan Administrator before the child will be considered a Dependent of the Participant.

Newborn children shall be eligible as Dependents for Benefits under the Plan from the date of birth. You have 31 days to change your coverage level to include a newborn child.

If a Participant has no Dependents on the day he or she becomes eligible for benefits provided herein, his or her Dependent Benefits will become effective upon the date he or she does have an eligible Dependent, provided that the Participant is then still eligible for benefits and the Participant adds the Dependents during an Open Enrollment period or within 31 days of a Dependent’s birth, adoption or placement for adoption. Notwithstanding the above, any child of a Participant who is named as an Alternate Recipient in a Qualified Medical Child Support Order shall be deemed to be Dependent during the period to which the Qualified Medical Child Support Order applies.

An individual who is entitled to Benefits as a Participant will not be treated as a Dependent under this Plan.

***It is your responsibility to determine whether individuals qualify as Dependents and can be provided coverage under this Plan. If the Plan covers family members who do not qualify as Dependents, the Plan has the right to terminate your Dependent coverage and seek reimbursement of any claims that were improperly paid.***

**Disability**

“Disability” means you are unable to perform each and every duty pertaining to your regular job because of an illness or accidental injury.

**Extended Care/Skilled Nursing Facility**

An “Extended Care/Skilled Nursing Care Facility” means an institution which is primarily engaged in providing skilled nursing care, or extended care, and related services or rehabilitative services to residents.
Hospice

The term “Hospice” means a facility, agency or service that (A) is licensed, accredited or approved by the proper regulatory authority to arrange, coordinate and/or provide programs to meet the special physical, psychological and spiritual needs of dying individuals (including terminally ill individuals) and their families (collectively “Hospice Care Services”); and (B) maintains records of Hospice Care Services that are provided and bills for such services on a consolidated basis.

Hospital

The term “Hospital” means a (A) legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Care Organizations; (B) a hospital, psychiatric hospital, or a tuberculosis hospital, as those terms are defined in the Medicare Laws, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare; or (C) an institution which fully meets all of the following tests: (1) it maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians, and (2) it continuously provides on the premises twenty-four (24) hours a day nursing service by or under the supervision of registered graduate nurses, and (3) it is operated continuously with organized facilities for operative surgery on the premises.

The term “Hospital” does not include a nursing home or any part of an institution which (1) is primarily a facility for convalescence, nursing, rest, or (2) furnishes primarily domiciliary or custodial care, including training in daily living routines, or (3) is operated as a school.

Medically Necessary

The term “Medically Necessary” means services which are (A) appropriate medical treatment for the Participant’s or Dependent’s condition; (B) expected to provide benefits that outweigh the potential risks; and (C) necessary to protect or restore the physical health and/or necessary to protect or restore the mental or physical health of the Participant or Dependent. The determination of what services are Medically Necessary shall be made by the Plan or an agent designated by the Trustees under the Plan. In the event of any conflict of opinion between the Plan and the provider of care, the decision made by the Plan (or its agents) in its discretion shall be final.

Participant

The term “Participant” means a current Employee who has satisfied the eligibility provisions in the Plan or a former Employee who makes an election to continue coverage either as a retiree or through COBRA.

Plan Year

The term “Plan Year” means the twelve-month period ending on the 31st day of December of each year.
Pre-Existing Condition

A "Pre-Existing Condition" is any condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within the three (3) month period ending on the first day a Participant or Dependent has coverage, or if there is a waiting period, the first day of the waiting period.

The Plan will not cover charges for care required for Pre-Existing Conditions until after the earlier of: (i) a period of three consecutive months ending after such person otherwise becomes entitled to benefits under the Plan during which no medical care is provided to the person or (ii) a period of twelve (12) consecutive months ending after such person otherwise becomes entitled to benefits under the Plan (or twelve months measured from the waiting period if there is a waiting period). The three month and twelve month periods will be reduced by prior periods of creditable coverage as required by the Health Insurance Portability and Accountability Act of 1996.

If you had group health insurance with your previous job, contact your prior employer for a "Certificate of Creditable Coverage." An adopted child is not subject to the Pre-Existing Conditions.

12. CONTINUATION DURING FAMILY AND MEDICAL LEAVE...

If you take a leave of absence under the Family and Medical Leave Act of 1993 ("FMLA"), benefits shall continue to be paid under the Plan as if you remained in active employment. You will be considered to have terminated your employment on the earliest to occur of:

(i) the date you notify your Employer that you are not intending to return to work,
(ii) the date you fail to return to employment at the end of leave, or
(iii) the effective date of termination of the Plan.
SECTION B
THE MEDICAL PLAN - SUMMARY OVERVIEW

How the Medical Plan Works

Generally, Basic Medical Benefits are paid according to the Summary of Benefits set forth at pages 1-6 of this Summary Plan Description. In some cases, the scheduled payment is not intended to cover the full cost of all of your medical care. Therefore, the Medical Plan provides Primary Major-Medical Benefits as well.

There is no Basic Medical Benefit for treatment for alcoholism and drug addiction, chiropractic care or acupuncture. These expenses are covered only under the Secondary Major-Medical Benefit.

Usual, Reasonable and Customary Charges

In the description of medical benefits, you will find the word, “Charges”. This is a defined term which refers to the necessary, usual, reasonable and customary charge for a covered service.

The Medical Plan pays all or a percentage of the necessary, usual, reasonable and customary charge, depending upon the treatment or service provided. Please refer to the Summary of Benefits for specific details. Some doctors or physicians charge more than the usual, reasonable and customary amount or perform services that are not Medically Necessary. If your doctor or physician does so, you will have to pay your deductible and those excess fees.

No Vesting of Benefits

The Benefits offered under the Plan do not vest and may be amended by the Trustees from time to time.
How the Medical Plan Works

Six Parts of the Medical Plan

The Medical Plan is divided into six parts: Basic Medical Benefit, Secondary Major-Medical Benefit, Prescription Drug Benefit, Dental/Orthodontic Benefit, Optical Expense Benefit, and Insurance Benefits.

1. The Basic Medical Benefit covers basic medical services like inpatient hospital care, outpatient care, surgical care, anesthesia charges, doctors’ or physicians’ services, diagnostic laboratory and x-ray examinations, mental health benefits, home health care, well baby care, extended care/skilled nursing care, hospice care, orthotics, and other miscellaneous services.

2. The Secondary Major-Medical Benefit provides coverage for treatment of alcoholism, treatment for drug dependency, chiropractic care and treatment by acupuncture, subject to the tax law limitations.

3. The Prescription Drug Benefit provides prescription drug coverage for Participants and their Dependents.

4. The Dental/Orthodontic Benefit helps defray part of the cost of a wide range of dental services, including orthodontics for Dependent children only.

5. The Optical Expense Benefit provides coverage for vision care.

6. The Death, Accident and Disability Benefit provides Life Insurance, Accident Insurance, a Weekly Disability benefit for temporarily disabled ill or injured Participants and a Long Term Disability Benefit for totally disabled ill or injured Participants.

* Items 1-5 apply to Participants and their eligible Dependents. Item 6 applies to Active Employee Participants only.
Section C
Basic Medical Benefit – Inpatient Care

SECTION C

I. Basic Medical Benefit. Each Participant and his Dependents covered under the Plan shall be subject to a lifetime limit of $1,000,000 on all benefits except the Reconstructive Jaw Surgery Benefit and the Hearing Aid Benefit under this Section C-I. The Basic Medical Benefit also includes a plan year out-of-pocket maximum and a cash deductible, and, in certain instances, a co-payment. These are set forth in the Summary of Benefits. If you receive a Global Bill (which is a bill that does not include an itemized line-by-line breakdown of the separate charges), you will not be subject to a co-payment for the bill.

(A) Inpatient Care.

(1) Covered Charges. Inpatient Care Charges will be subject to the applicable deductible, the lifetime maximum, the limitations contained in subsection (3) below and the exclusions in C-III on page 33. A Participant or Dependent who is admitted to a Hospital for treatment or sickness of a non-work related accidental injury as a bed patient and who obtains treatment through a PPO provider shall generally be entitled to payment or reimbursement of 100% of the required Hospital Charges. In the event the treatment is obtained through a non-PPO provider, the Participant or Dependent shall be entitled to payment or reimbursement of one hundred percent (100%) of the required Hospital Charges for the initial twenty (20) days and eighty percent (80%) thereafter. Hospital Charges shall include:

(a) Administration of blood, blood plasma and plasma substitutes.

(b) Admissions for diagnostic studies when the studies are directed toward the definite diagnosis of a disease or injury.

(c) Anesthetic materials.

(d) Basal metabolism tests.

(e) Blood processing.

(f) Coronary and intensive care units.

(g) Dressing and bandages, casts and splints.

(h) Drugs and medicines which are officially accepted for general use at the time of hospitalization.

(i) Electrocardiograms.

(j) Electroencephalograms.

(k) Laboratory examinations, including tissue examinations.
Section C
Basic Medical Benefit – Inpatient Care

(l) Medical services and supplies which are customarily provided by a Hospital, unless otherwise specifically excluded by this Plan.

(m) Occupational therapy while in a Hospital, except when rendered with respect to confinements for alcohol or drug abuse treatment.

(n) Oxygen as provided by a Hospital.

(o) Physicians’ visits which are billed by a Hospital.

(p) Physiotherapy, hydrotherapy and occupational therapy when performed by duly qualified therapists.

(q) Professional ambulance service used locally to a Hospital for a covered inpatient admission.

(r) Room and board, delivery room, recovery room and miscellaneous medical services for a female Participant or a Participant’s spouse who is confined to a Hospital because of a pregnancy or resulting childbirth, spontaneous abortion or miscarriage up to the maximum, if any, as set forth in the Summary of Benefits.

(s) Room and board (including meals, special diets and general nursing services) for “semi-private accommodations,” up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common “semi-private” rate. Intensive or coronary care unit at twice the most common “semi-private” rate. To the extent the Hospital is an all-private room facility, room and board for “private accommodations” up to the daily maximum, if any, set forth in the Summary of Benefits.

(t) Use of operating, treatment and/or recovery room.

(u) X-ray examinations.

(v) X-ray radium and radioactive isotope therapy.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Inpatient Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III, on page 33.

(3) Coverage Limitations.

(a) Coverage During Hospital Confinements.
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Basic Medical Benefit – Inpatient Care &
Outpatient Care

(i) Limitation on Hospital Confinement. As detailed in the Summary of Benefits, Hospital Inpatient Care provided as a Basic Medical Benefit shall be covered beyond the twentieth (20th) day of confinement for Participants and their Dependents (including newborn children) but, the Plan’s payment percentage will decrease if the care is provided by a non-PPO provider.

(ii) Successive Confinements - Participants and Dependents. In the event a Participant enters the Hospital, is later discharged upon complete recovery and/or returns to active work on a full-time basis for an Employer for at least one full working day, and then enters the Hospital again, the second hospitalization is considered separate from the first. If the Participant does not completely recover or return to active work on a full-time basis for an Employer for at least one full working day after the first Hospital stay, the second Hospital stay will be considered part of the first, and the Hospital time under both visits will be aggregated in determining the maximum coverage limitation set forth in the Summary of Benefits.

(b) Costs After Discharge. The Plan shall not be responsible for any Charges for Hospital services rendered after the day for which discharge has been authorized by the confined person’s physician. Moreover, if the Hospital, pursuant to such an authorization, shall request the Participant or Dependent to vacate the room in which he has been a bed patient and such person fails or refuses to do so upon request or within two hours after such request, whichever occur later, the Plan shall not be responsible for any Charges for care rendered by the Hospital thereafter.

(c) Reserve Costs. Notwithstanding anything herein to the contrary, Hospital benefits shall be paid or reimbursed only for days of actual confinement, and shall not include any Charges for holding or reserving space, or for pass or therapeutic leave days.

(B) Outpatient Care.

(1) Covered Charges. There are three different types of Covered Charges under the category of Outpatient Care: Outpatient Surgery, Sudden and Serious Illness, and Miscellaneous Outpatient Care. Each is discussed below.

(a) Outpatient Surgery. Outpatient Surgery Charges will be subject to the applicable deductible, the lifetime maximum, the limitations outlined below and the exclusions in C-III on page 33. A
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Basic Medical Benefit – Outpatient Care

Participant or Dependent who goes to the Hospital for an outpatient surgery that is not work related shall generally be entitled to payment or reimbursement of 100% of the required Hospital Charges for both PPO and non-PPO providers.

(b) Sudden and Serious. Sudden and Serious Condition Charges will be subject to the applicable deductible, the lifetime maximum, the limitations outlined below and the exclusions in C-III on page 33. Except as set forth in the next sentence, a Participant or Dependent who is treated for a non-work related sudden and serious condition which does not result in an inpatient admission to a Hospital shall generally be entitled to payment or reimbursement of 100% of the required Hospital Charges for a PPO or non-PPO provider. If a Participant or Dependent is not admitted to the Hospital, the Participant or Dependent will be subject to a co-pay on the ER Facilities, as set forth in the Schedule of Benefits.

(i) The Fund covers Hospital charges for treating certain sudden and serious illnesses. Benefits are payable if the illness had a sudden onset, and is considered as life endangering. Benefits are only for care received during the first visit to the emergency room of a Hospital, provided the illness is treated within 48 hours of its onset and the treatment is billed by the Hospital.

(ii) Examples of Serious and Sudden Outpatient Care:

- Acute Abdominal Pain
- Acute Chest Pains
- Acute Coronary
- Allergic reactions, Acute (except allergy tests)
- Appendicitis, Acute
- Asthmatic Attack
- Bronchitis, Severe
- Chest Pains
- Colitis
- Coma
- Convulsions and/or Seizures
- Diabetic Coma
- Diarrhea, Severe
- Drug Reaction
- Epistaxis, Severe
- Fecal Impaction, Severe
- Food Poisoning
- Foreign Body in Eye, Ear, Nose or Throat
- Gall Bladder, Acute Attack
- Heart Attack, Suspected
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- Hemorrhage
- High Fever (102 degrees F)
- Hysteria
- Insertion of Catheter (for acute urine retention)
- Insulin Shock (overdose)
- Kidney Stones
- Pleurisy
- Pneumonitis
- Poisoning (including overdose, subject to exclusions)
- Pyelitis
- Pyelonephritis
- Shock
- Spasms, Cerebral or Cardiac
- Spontaneous Pneumothorax
- Strangulated Hernia
- Stroke
- Sun Stroke
- Tachycardia
- Thrombosis and/or Phlebitis
- Unconsciousness
- Urinary Retention, Acute
- Vision Loss, Sudden Onset
- Vomiting, Severe

This is not a complete list of covered conditions. Benefits are payable only for emergency treatment, not for treatment that can be provided at home or in your doctor’s and/or physician’s office. The Fund also will pay or reimburse the charges for professional ambulance service used locally to an emergency room of a Hospital in connection with a covered condition. The opinion of the attending doctor or physician will normally decide whether an illness was sudden and serious. The Fund will pay Hospital Charges per the Summary of Benefits. Other related services, including doctors and physicians charges, may constitute covered expenses under other parts of the Medical Plan.

(c) Miscellaneous Outpatient Care. This category includes all other services rendered as an outpatient that would not be considered surgery or sudden and serious. This is subject to the applicable deductible, the lifetime maximum, the limitations outlined below and the exclusions in C-III on page 33. Charges for non-work related services or illnesses are generally entitled to payment or reimbursement of a percentage of the charges. If treatment is obtained through an PPO provider, all diagnostic work would be covered at 100%, and any other services such as emergency room charges, pharmacy, testing, clinic, supplies, physical therapy, cardiac rehabilitation, etc. would be considered Primary Major-
Section C
Basic Medical Benefit – Outpatient Care & Surgical Care

Medical and covered at 80%. If treatment is obtained through a Non-PPO provider all diagnostic work would be covered at 70%, and any other services (such as those listed above) would be considered at 80% under the Primary Major-Medical benefit.

*This is for medical services only and does not apply to psychological diagnosis or drug and alcohol rehabilitation.

(d) **Non-PPO Professional Fees Rendered at PPO Hospital.** Charges for professional fees from Non-PPO professionals (emergency room physicians, radiologists, pathologists, etc.) will be paid at the PPO rate providing that (1) services were rendered while an eligible Plan Participant was either on an inpatient or outpatient status at a PPO Hospital, (2) the patient did not have a choice in selecting the provider and (3) the services provided were a covered Benefit under the Plan.

(2) **Exclusions From Coverage.** Charges for Basic Medical Benefits for Outpatient Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III, on page 33.

(C) **Surgical Care.**

(1) **Covered Charges.** Surgical Care Charges will be subject to the applicable deductible, the lifetime maximum, and the exclusions contained in subsection (2). The Plan will pay or reimburse 100% of the Charges made by a duly qualified surgeon who is a member of the Preferred Provider Organization. The Plan will pay or reimburse 80% of the Charges made by a duly qualified surgeon who is not a member of the Preferred Provider Organization. This section covers physician charges for performing a surgical operation on account of a Participant’s or Dependent’s accidental injury, sickness, or as necessary for pain management, subject to the following:

(a) Charges will be covered regardless if the surgery is done in a Hospital, physician’s office, outpatient surgical center or the home of a Participant or Dependent.

(b) Charges made by an Assistant Surgeon will be paid or reimbursed at 50% for a Participant or their Dependents.

(c) Surgery includes the treatment of fractures and dislocations.

(d) Charges for obstetrical procedures or operations performed by a Physician due to the pregnancy of a female Participant or Dependent spouse which results in childbirth, spontaneous
Section C
Basic Medical Benefit –Surgical Care,
Anesthesia and Diagnostic Lab and X-rays

abortion or miscarriage are also payable or reimbursable at the
level set forth in the Summary of Benefits under the Plan.

(e) The Plan will pay the cost of a second surgical opinion if it is
rendered and billed by a provider other than the physician who
performed the surgery or provided the first opinion.

(f) In certain instances, the Plan will pay some or all of the charges for
services and supplies in connection with pre-approved transplant
procedures which are deemed to be Medically Necessary based on
the written opinion of two separate doctors. Please see the Plan
Administrator for more details.

(2) Exclusions from Coverage. Charges for surgical care are not payable or
reimbursable by the Plan for the services or items, or under the conditions
listed in Section C-III on page 33.

(D) Anesthesia.

(1) Covered Charges. Anesthesia Charges will be subject to the applicable
deductible, the lifetime maximum, and the exclusions contained in
subsection (2) below. The Plan will pay or reimburse 100% of the Charges
made by a duly qualified anesthesiologist for administering anesthetics on
account of an accidental injury, sickness, surgery, or pain management
involving a Participant or his Dependents.

(2) Exclusions from Coverage. Charges for Anesthesia are not payable or
reimbursable by the Plan for the services or items or under the conditions
listed in Section C-III on page 33.

(E) Diagnostic Laboratory and X-Ray Examinations.

(1) Covered Charges. Diagnostic Charges will be subject to the applicable
deductible, the lifetime maximum, a co-payment, and the exclusions
contained in subsection (2) below. A Participant or Dependent will be
subject to a $10.00 co-payment per PPO date of service. A Participant or
Dependent who incurs Charges rendered for Diagnostic Laboratory and X-
Ray Examinations to diagnose a non-occupational illness or injury will
generally be entitled to payment or reimbursement of 100% of the
required Charges for a PPO provider after paying the $10.00 co-payment.
In the event the treatment is obtained through a non-PPO provider, the
Participant or Dependent shall be entitled to payment or reimbursement of
70% of the required Charges.
Section C
Basic Medical Benefit – Diagnostic Lab and X-rays, Durable Medical Equipment, Hearing Aids, Mental Health

(2) Exclusions from Coverage. Charges for Diagnostic Laboratory and X-Ray Examinations are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 33.

(F) Durable Medical Equipment.

(1) Covered Charges. Durable Medical Equipment will be subject to the applicable deductible, the lifetime maximum, a co-payment and the exclusions contained in Subsection (2) and (3) below.

(2) Coverage Limitations. Each Participant and Dependent shall be subject to an annual limit of $250 on the amount paid or reimbursed for Charges for Durable Medical Equipment.

(3) Exclusions from Coverage. Charges for Durable Medical Equipment are not payable or reimbursable by the Plan under the conditions referenced in Section C-III on page 33.

(G) Hearing Aids.

(1) Covered Charges. Charges for a hearing aid, a hearing exam or related expenses necessitated by a functional defect caused by a congenital disease or an accidental injury or surgery resulting from a disease will be subject to the lifetime maximum and the exclusions contained in subsections (2) and (3) below.

(2) Coverage Limitations. Each Participant and Dependent shall be subject to a lifetime limit of $1000 on the amount paid or reimbursed for Charges for Hearings Aids.

(3) Exclusions from Coverage. Charges for the purchase of or examination for the fitting of hearing aids that are required for any condition, disease or accident arising out of or in the course of a Participant's or Dependent's employment will not be covered by the Plan.

(H) Mental Health.

(1) Covered Charges. Charges for Mental Health benefits will be subject to the applicable deductible, the lifetime maximum and the exclusions set forth in subsection (2) below. The Plan shall provide payment for or reimbursement of 80% of the required Charges incurred by Participants and Dependents for mental health benefits.

(2) Exclusions from Coverage. Charges for Mental Health benefits are not payable or reimbursable by the Plan under the conditions referenced in Section C-III on page 33.
Section C
Basic Medical Benefit – Home Health Care & Hospice Care

(I) Home Health Care.

(1) **Covered Charges.** Home Health Care Charges will be subject to the applicable deductible, the lifetime maximum, and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Home Health Care Charges will generally be entitled to payment or reimbursement of 100% of the required Home Health Care Charges rendered by a member of the Preferred Provider Organization. In the event the treatment is obtained through a non-Preferred Provider Organization, the Participant or Dependent shall generally be entitled to payment or reimbursement of 80% of the required Home Health Care Charges. This section covers Charges incurred for private duty nursing services for a Participant or Dependent which (i) require the skills of a Licensed Practical Nurse (LPN) or Registered Nurse, (ii) are rendered in the Participant’s or Dependent’s home, (iii) are medically necessary as determined by the Plan’s medical consultants and (iv) are prescribed by the patient’s physician and such prescription is documented in the medical record.

(2) **Coverage Limitation.** Coverage for Home Health Care is provided as a Basic Medical Benefit but is limited to 100 visits per Plan Year. Charges in excess of 100 visits will not be covered under any other Plan provisions. Generally, other charges associated with home health care (i.e. intravenous charges, durable medical equipment) will be eligible for coverage in accordance with the rules for the Primary Major-Medical Benefits.

(3) **Exclusions from Coverage.** Charges for Home Health Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 33.

(J) Hospice Care.

(1) **Covered Charges.** Hospice Care Charges will be subject to the applicable deductible, the lifetime maximum and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Hospice Care Charges will generally be entitled to payment or reimbursement of 100% of the required Hospice Care Charges rendered by a member of the Preferred Provider Organization. In the event the treatment is obtained through a non-Preferred Provider Organization, the Participant or Dependent shall generally be entitled to payment or reimbursement of 80% of the required Hospice Care Charges. This section covers Hospice Care benefits rendered to a Participant or Dependent who (i) has a confirmed diagnosis of terminal illness; (ii) has a life expectancy of six months or less; (iii) has no further use nor desire for other curative therapy; and (iv) has signed an informed consent indicating an acceptance and understanding of Hospice Care.
Section C
Basic Medical Benefit – Hospice Care &
Extended Care/Skilled Nursing Care

Hospice services can be rendered on an inpatient or outpatient basis. If rendered on an inpatient basis, all treatment must be under the direction of a physician. If rendered on an outpatient basis, the services must be (i) rendered in the Participant’s or Dependent’s home, (ii) billed by a Hospice provider, and (iii) include services from the following list:

(a) Nursing care by a registered nurse or licensed practical nurse.

(b) Services of a home health agent who provides non-skilled personal care to the Participant or Dependent while under the supervision of a registered nurse or a licensed member of the Hospice Care team.

(c) Homemaker services for the Participant or Dependent only.

(d) Services of a licensed or certified physical, respiratory, occupational or speech therapist or social worker;

(e) Nutritional services provided by a dietician;

(f) Rental of durable medical equipment, such as hospital beds, respirators, oxygen tents, crutches and wheelchairs when billed by the Hospice providers;

(g) Medically Necessary surgical and medical supplies.

(h) Drugs and medicines listed in the official forms billed by the Hospice providers.

(i) Radiation therapy and chemotherapy.

(2) Coverage Limitation. Charges for Hospice Care provided as a Basic Medical Benefit is limited to the Charges incurred for a total of 180 days. Charges for Hospice Care in excess of 180 days will not be covered under any other Plan provisions.

(3) Exclusions from Coverage. Charges for Hospice Care are not payable or reimbursable from the Plan for the services or items or under the conditions listed in Section C-III on page 33. Notwithstanding the foregoing, the exclusions in Section C-III pertaining to Hospice Services shall not apply to Hospice Care.

(K) Extended Care/Skilled Nursing Care.

(1) Covered Charges. Extended Care/Skilled Nursing Care Charges will be subject to the applicable deductible, the lifetime maximum, and the exclusions in subsection (2) below. The Plan will generally pay or reimburse 100% of the Charges incurred by Participants or Dependents for
medical services during their first twenty (20) inpatient days while confined in an Extended Care/Skilled Nursing Care facility. The Plan will generally pay 100% of the Extended Care/Skilled Nursing Care Charges incurred after the initial twenty (20) day period if the services are rendered by a Preferred Provider Organization and 80% of the Extended Care/Skilled Nursing Care if the services are rendered by a non-Preferred Provider Organization. For this purpose, charges will not be covered under any Plan provision if the Participant or Dependent stays in the facility more than 180 days in a Plan Year. Charges shall be covered in this section only if ineligible for coverage elsewhere under the Plan. Covered charges for Extended Care/Skilled Nursing Care expenses include the following medical services and supplies:

(a) Room and board, except private room charges in excess of the Extended Care/Skilled Nursing Care Facility’s (the “Facility”) average charge for semi-private accommodations.

(b) Routine nursing care provided by the Facility on other than a private duty basis.

(c) Physical or speech therapy provided by the Facility or others under arrangement with the Facility.

(d) Medical social services provided by the Facility.

(e) Such drugs, biological supplies, appliances and equipment which are normally provided by the Facility for the care and treatment of its inpatients.

(f) Diagnostic and therapeutic services furnished by the Hospital, including medical services of a Hospital intern or resident-in-training under the teaching program of a Hospital, with which the Facility has a transfer agreement, but not including any other medical care or treatment by a doctor, resident doctor, or intern.

(g) Such other services necessary to maintain the health of the patients as are generally provided by the Facility.

(2) Exclusions From Coverage. Charges for Basic Medical Benefits for Extended Care/Skilled Nursing Care are not payable or reimbursable by the Plan for the services or items, or under the conditions listed in Section C-III on page 33. Notwithstanding the foregoing, the exclusions in Section C-III for Custodial Care shall not apply to Extended Care/Skilled Nursing Care Benefits.
Section C
Basic Medical Benefit – Orthotics, Well Baby Care
& Primary Major-Medical Benefit

(L) Orthotics.

(1) Covered Charges. Charges for Orthotics will be subject to the applicable deductible, the lifetime maximum and the limitations and exclusions contained in subsections (2) and (3) below. A Participant or Dependent who incurs Orthotics Charges will generally be entitled to payment or reimbursement of 70% of the required Orthotic Charges regardless whether the service is rendered by a member or non-member of the Preferred Provider Organization. This section covers Charges for Orthotics which is defined as medical devices (such as leg, arm, back or neck braces) which are used to activate or supplement a weakened limb or function, and are recognized by Medicare.

(2) Coverage Limitation. Each Participant and Dependent shall be subject to an annual limit of $700 on the amount paid or reimbursed for Charges for Orthotics.

(3) Exclusions from Coverage. Charges for Orthotics are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 33.

(M) Well Baby Care.

(1) Covered Charges. Well Baby Care Charges will be subject to the applicable deductible, the lifetime maximum, a co-payment and the exclusions in subsection (2) below. A Participant or Dependent will be subject to a $10.00 co-payment per PPO Well Baby Care visit. After paying the co-payment, a Participant or Dependent who incurs Well Baby Care Charges during the twenty-four month period following birth will generally be entitled to payment or reimbursement of 100% of the required Well Baby Care Charges rendered by a member of the Preferred Provider Organization. In the event the treatment is obtained through a non-Preferred Provider Organization, the Participant or Dependent shall be entitled to payment or reimbursement of 80% of the required Well Baby Care Charges after payment of the co-payment. For this purpose, Well Baby Care Charges include routine preventive tests, immunizations, and services that monitor the baby's physical and mental development.

(2) Exclusions from Coverage. Charges for Well Baby Care are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 33.

(N) Primary Major-Medical Benefit.

(1) Covered Charges. Charges for Primary Major-Medical Benefits will be subject to the applicable deductible, the lifetime maximum and the exclusions set forth in subsection (2) below. The Plan shall provide
payment for or reimbursement of 80% of the Charges incurred by Participants or Dependents for the following Medically Necessary services, treatment or confinement, to the extent they exceed Charges covered under subsections (A) through (L) above:

(a) Services of physicians and specialists provided on an outpatient basis.

(b) Private duty nursing services in a Hospital which require the skills of a Registered Nurse (RN) or Licensed Practical Nurse (LPN); provided:

(i) The services are Medically Necessary as determined by the Plan's medical consultant(s), and are of such an intensive skilled level that they cannot be provided by the Hospital's general nursing staff (intermediate, custodial or personal care is not covered); and

(ii) The services are prescribed by the patient's attending physician and such prescription is documented in the medical record.

(c) Medically Necessary services in a Hospital, including the following:

(i) Room and board (including meals, special diets and general nursing service) for "semi-private accommodations," up to the daily maximum, if any, as set forth in the Summary of Benefits. Private room at the most common "semi-private" rate. Intensive or coronary care unit which exceeds two times the most common "semi-private" rate.

(ii) Use of treatment rooms.

(iii) Cost of oxygen and its administration.

(iv) X-ray radium and radioactive isotope therapy.

(v) Blood transfusions, including the cost of blood plasma and blood plasma expanders.

(vi) Drugs, medicines and dressings used in a Hospital.

(vii) Physicians' visits.

(viii) The Charges for room and board (as described in subsection (i)) beyond the twentieth day of confinement for
Section C
Basic Medical Benefit – Primary Major-Medical
Benefit & Reconstructive Jaw Surgery and
Related Treatment

Participants and Dependents when the care is provided by a non-PPO provider.

(d) Medical supplies and surgical dressings including:

(i) Casts and splints.

(ii) Catheters.

(iii) Colostomy bags and supplies required for their use which are not readily available under the prescription mail order program.

(iv) Dressings when medically necessary for such conditions as cancer, burns or diabetic ulcers.

(v) Injectable drugs which are under $250, and are obtained and administered in a physician’s office. Injectable drugs in excess of $250 may be covered after review and approval by the Fund’s Medical Consultant.

(vi) Rental of an artificial respirator and other durable medical or surgical equipment necessary for temporary treatment to improve functions of a malformed body member or to prevent or retard further deterioration of the Participant’s or Dependent’s condition.

(vii) Syringes, needles and insulin when medically necessary for conditions such as diabetes, which are not readily available under the prescription mail order program.

(e) All other items and Charges not previously addressed.

(2) Exclusions from Coverage. Charges for Primary Major-Medical Benefits are not payable or reimbursable by the Plan for the services or items or under the conditions listed in Section C-III on page 33.

(1) Covered Charges. Reconstructive Jaw Surgery and Related Treatment Charges will be subject to the applicable deductible, the lifetime maximum, and the exclusions set forth in subsections (2) and (3) below. A Participant or Dependent who incurs Reconstructive Jaw Surgery and Related Treatment Charges will generally be entitled to payment or reimbursement of 80% of the required Charges for medical and dental treatment (including orthodontic treatment, if necessary), regardless if the services are rendered by a member or non-member of the Preferred
Section C
Basic Medical Benefit – Reconstructive Jaw Surgery and Related Treatment
Secondary Major-Medical Benefits – Covered Charges

Provider Organization. Such Charges will be covered under the section if they relate to reconstructive jaw surgery which results from any reason other than a birth defect or an accident.

(2) Exclusions from Coverage. Charges for Reconstructive Jaw Surgery are not payable or reimbursable by the Plan under the conditions referenced in Section C-III on page 33:

(3) Coverage Limitations. Each Participant and Dependent shall be subject to a lifetime maximum of $2,000 for Reconstructive Jaw Surgery. The lifetime limit will include, but not be limited to, medical, dental, orthodontic treatment, surgery fees, facility fees, office visits and x-rays.

II. Secondary Major-Medical Benefit.

(A) Covered Charges. Each Participant and his Dependents covered under the Plan shall be subject to a lifetime limit of $25,000 on all Secondary Major-Medical Benefits under this C-II. This section will cover the Charges listed below. Secondary Major-Medical Benefits will be subject to an annual plan year deductible of $200, the lifetime maximum of $25,000 and the exclusions in subsection II(B) below.

(1) Categories of Secondary Major-Medical Benefits. This section will cover medical care and services for Participants and their Dependents (whether provided on an inpatient or outpatient basis) as follows:

(a) Treatment for alcoholism.

(b) Treatment for drug dependency.

(c) Chiropractic care.

(d) Treatment by acupuncture.

(2) Inpatient Care. Inpatient Care Charges will be subject to the applicable deductible, the lifetime maximum, and the exclusions in C-III on page 33. A Participant or Dependent who is admitted to a facility for treatment of sickness that qualifies as a Secondary Major-Medical Benefit and who obtains treatment through a PPO provider shall generally be entitled to payment or reimbursement of 100% of the required Hospital Charges for the initial five (5) days and 80% thereafter. In the event the treatment is obtained through a non-PPO provider, the Participant or Dependent shall be entitled to payment or reimbursement of 80% of the required Hospital Charges.

(3) Outpatient Care. A Participant or Dependent who incurs Secondary Major-Medical Charges which are incurred for outpatient treatment will
Section C
Secondary Major-Medical Benefits – Covered
Charges & Exclusions from Coverage for Secondary
Exclusions from Coverage

generally be entitled to payment or reimbursement of 80% of the required
Charges, regardless if the Charges are rendered by a member or non-
member of the Preferred Provider Organization.

(B) Exclusions from Coverage. Charges for Secondary Major-Medical Benefits are
not payable or reimbursable by the Plan for the services or items or under the
conditions listed in Section C-III on page 33. Notwithstanding the foregoing, the
exclusions in Section C-III pertaining to Chiropractic Care or Services,
Acupuncture, and Alcoholism and Drug Dependency will not apply to Secondary
Major-Medical Benefits.

III. Exclusions from Coverage. Except where specifically stated otherwise and except where
required under the Health Insurance Portability and Accountability Act, the Basic
Medical Benefit and the Secondary Major-Medical Benefit portion of the Plan will not
pay or reimburse charges for the following treatment (including, but not limited to,
examinations, hospitalizations, services, supplies and surgery) or under the conditions
outlined below:

(A) Acupuncture. Acupuncture, anesthesia by hypnosis, or anesthesia for noncovered
services. Notwithstanding the foregoing, the exclusion for Acupuncture will not
apply to the Secondary Major-Medical Benefit.

(B) Ailments of the Foot. Treatment of corns, bunions (except capsular or bone
surgery), calluses, nails of the feet (except surgery for ingrown nails), or
symptomatic complaints of the feet (except when surgery is performed).

(C) Artificial Insemination. Artificial insemination, in vitro fertilization, chromosome
studies, fertility studies, reversal of sterilization and like procedures.

(D) Behavior Modification Techniques. Smoking cessation programs, weight loss
programs or treatment for obesity (including gastric by-pass surgery and similar
like procedures and/or services at a health spa, gymnasiums or similar facility)
and like programs.

(E) Braces, Prosthetic Appliances, Etc. Procurement or use of special braces,
appliances or equipment, except as may be required on account of accidental
injury to natural teeth. Notwithstanding the foregoing, the exclusion for Braces,
Prosthetic Appliances, etc. will not apply to the Orthotic Benefit.

(F) Chiropractic Care or Services rendered by a Chiropractor. Notwithstanding the
foregoing, the exclusion for Chiropractic Care will not apply to the Secondary
Major-Medical Benefit.

(G) Claim Processing. Services for completing claim forms or for providing other
records or reports.
Section C
Exclusions from Coverage

(H) **Contraceptive Materials.** Contraceptive materials and devices. Coverage for these items may be available under the Prescription Plan.

(I) **Cosmetic Surgery and Related Charges.** Cosmetic surgery and related charges except when accident related or required under the Women’s Health and Cancer Rights Act of 1988 including but not limited to breast reduction (except as deemed medically necessary by the Plan), and breast augmentation.

(J) **Coverage Under Another Plan.** Any services or treatment to the extent available from or provided by any other coverage, except that the Plan will coordinate the payment of Charges with any other coverage where permissible under the existing laws and regulations in the manner set forth in Section E.

(K) **Custodial Care.** Domiciliary, intermediate or custodial care or services in rest homes, health resorts, homes for the aged, infirmaries, or places primarily for domiciliary or custodial care or similar institutions providing primarily non-medical care. This exclusion does not apply to Home Health Care Benefits, as provided in Section C-1(l), Hospice Benefits (as provided under Section C-1(J)), or Extended Care/Skilled Nursing Care benefits, as provided under Section C-1(K).

(L) **Dental Care or Treatment.** Services and supplies for dental care; including dental X-rays or treatment, dental prosthetic appliances or the fitting of any thereof, except when necessary to treat an accidental injury to natural teeth and a dentist’s or oral surgeon’s charges for certain cutting procedures in the oral cavity. Coverage for these items may be available under the Dental Plan.

(M) **Drug or Alcohol Impairment.** Examinations, hospitalization, services, supplies, surgery and/or treatment incurred by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication of such person from drugs or alcohol or resulting from the individual’s being influenced by drugs or alcohol. The impairment, intoxication, or influence shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides, and shall include all impairment, influence or intoxication caused by ingestion or administration of drugs or alcohol other than according to a physician’s prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits. This exclusion can be applied even if a Participant or Dependent is not formally charged with or convicted of driving while intoxicated.

(N) **Education or Training.** Any class, service or treatment incurred by a Participant or Dependent to educate or train a Participant or Dependent regarding a medical treatment, condition, disease or a healthy lifestyle.

(O) **Experimental Procedures and Drugs/Clinical Procedures.** Procedures or operations not recognized by the American Medical Association, and drugs not approved by the U.S. Food & Drug Administration. Notwithstanding the
foregoing, the Plan may pay certain "standard of care" costs, which are the minimum costs that would have been incurred by the Participant or Dependent regardless of whether the Participant or Dependent received conventional or experimental treatments if the Participant or Dependent appeals his claim and can provide the Plan with sufficiently detailed documentation which, in the Trustees' sole opinion, establishes the "standard of care" costs.

(P) **Eye Care or Treatment.** Eye refraction or eyeglasses, except as may be required on account of accidental bodily injury to physical organs or parts sustained by a Participant or Dependent while eligible for Benefits under this Plan. Coverage may be available under the Optical Benefit of C-VI.

(Q) **Free Services.** Treatment for which a Participant or a Dependent do not have to pay.

(R) **Genetic testing for cancer,** including but not limited to, BRAC testing, COLARIS testing, MELARIS testing, and similar chromosome testing or DNA testing.

(S) **Government Owned Hospital Care.** Confinement in, or treatment received from (including surgery), a sanitarium, state or federal hospital, any state or political subdivision thereof, or the Veterans Administration Hospital owned or operated by the U.S. Government, unless such confinement or treatment is not covered by any other government sponsored health insurance, entitlement or benefit program or for which a Participant or Dependent would not be required to pay anything if there were no coverage provided under this Plan; provided, however, that nothing herein shall cause the exclusion of charges incurred by an individual who is eligible for coverage under this Plan while simultaneously eligible for coverage under a State plan for medical assistance approved under Title XIX of the Social Security Act.

(T) **Hospice Services.** Hospice Services rendered at an inpatient facility or at the residence of a Participant or Dependent. Notwithstanding the foregoing, this exclusion does not apply to Hospice Care, provided under Section C-I(I).

(U) **Imaging Not Preserved on Film or Digital Images.** X-ray examinations made where the image is not preserved on film or digital images.

(V) **Injectibles.** Injectibles, excluding certain common drugs such as imitrex and insulin, and those costing less than $250 that are administered in a doctor's office.

(W) **Injuries While Committing a Felony.** Services or treatment for injuries sustained while participating in or attempting to commit a felony, regardless of whether the Participant or Dependent is convicted.

(X) **Injuries While Employed or Engaged in any Activity For Profit.** Services or treatment in connection with injuries sustained while doing any act or thing pertaining to any occupation or employment for compensation or profit.
Section C
Exclusions from Coverage

(Y) Non-Listed Expenses. Any service or item not specifically listed as a covered Charge under other sections of the Plan.

(Z) Non-Medically Necessary Care. Services, supplies or treatment deemed not to be medically necessary for the diagnosis or treatment of an injury, illness or symptomatic complaint. The Plan shall have the right to submit disputed cases to a medical review committee appointed by the Trustees. Charges for medical care deemed not medically necessary, in whole or in part, shall not be payable or reimbursable by the Fund. Notwithstanding the foregoing, charges for voluntary sterilization shall be an allowable Plan charge.

(AA) Obstetrics for Dependent Children. Obstetrical procedures or operations provided to Dependent children are not payable or reimbursable under this Plan, except to the extent required by law.

(BB) Occupational Illness or Injury. Treatment or services for an occupational illness or injury.

(CC) Participation in Voluntary Reckless Activity. Services, supplies or treatment for injuries sustained while participating in any reckless activity voluntarily, which is unnecessary and for recreational purposes, and which, in the opinion of the Trustees, constitutes "reckless endangerment".

(DD) Pre-Existing Condition. Treatment of a Pre-Existing Condition for the time periods prescribed in the definition of "Pre-Existing Condition".

(EE) Pre-Paid Providers. Services and supplies provided by or available from a health maintenance organization ("HMO"), preferred provider organization or association ("PPO"/"PPA") or similar arrangement to which a Participant or Dependent subscribes individually or through a group unrelated to the Union or Plan, and Charges which result from failure to use the health management provisions of such organizations, such as second opinions for surgical procedures.

(FF) Prescription and Non-Prescription Drugs that are separately purchased by the Participants and/or their Dependents, Vitamins, and Minerals.

(GG) Radiokeratotomy, Laser Eye Correction, or Like Procedures.

(HH) Self-inflicted Injuries. Services or treatment for self-inflicted injuries, including those associated with or resulting from suicide attempts.

(II) Specified Examinations or Hospitalization for Examinations. Eye refractions; examinations for the fitting of eyeglasses or hearing aids; dental examinations; diagnostic study relating to routine physical examinations or checkups, as required by a job, recreational activity or school, or to obtain insurance.
Section C
Exclusions from Coverage
Prescription Drug Benefit – Covered Charges

(JJ) **Sex Therapies.** Services related to sex transformation or sexual dysfunctions or inadequacies. This exclusion will not apply to the office visits and related diagnostic charges associated with organic impotence.

(KK) **Take Home Items.** Take home drugs and personal items such as admission kits, TV, telephone, cots and visitors’ meals at any institution.

(LL) **Therapies.** Activity, recreational or family therapy, or marriage, pastoral, or financial counseling or similar services.

(MM) **Travel.** Travel, whether or not recommended by a physician, other than the local use of an ambulance.

(NN) **Treatment and Supplies to Currently Hospitalized.** Treatment and supplies furnished to or surgery performed on a Participant or Dependent who, on his effective date, is confined in a Hospital or any other institution (other than for his own birth), so long as such person is continuously confined in any such institution, except to the extent required by the Health Insurance Portability and Accountability Act.

(OO) **Treatment and Supplies Rendered by Non-Qualified Physicians.**

(PP) **Treatment for Alcoholism and Drug Dependency.** Notwithstanding the foregoing, the exclusion for treatment of Alcoholism and Drug Dependency will not apply to the Secondary Major-Medical Benefit.

(QQ) **Treatment Not Approved by a Qualified Physician.** Examination or treatment (including surgery) furnished without a physician’s approval.

(RR) **Treatment of Participants as Dependents.** Examination or treatment of a Dependent if such Dependent is simultaneously entitled to Benefits as a Participant. If an individual can have simultaneous coverage both as a Participant and as a Dependent, the Plan will not recognize the dual coverage. The Plan will recognize the individual’s coverage as a Participant and, when that ceases, the Plan will recognize the individual’s coverage as a Dependent, to the extent applicable.

IV. Prescription Drug Benefit.

(A) **Covered Charges.** Subject to the Prescription Drug Co-Payment Feature and the rules set forth in this paragraph (A), the Plan shall pay for or reimburse all costs for prescription drugs for Participants and their Dependents as follows:

1. **Maintenance Prescriptions.** Drugs which are to be taken on an ongoing basis for a chronic condition (90 days or more) are “Maintenance Prescriptions.” With this definition as a guide, the registered pharmacist receiving the prescription request will initially determine whether it is a
Section C
Exclusions from Coverage
Prescription Drug Benefit – Covered Charges

Maintenance Prescription. "Maintenance Prescriptions" can be ordered by mail from the pharmacy designated by the Trustees. Diabetic supplies are covered by the Plan only if purchased from the mail order pharmacy.

(2) Non-Maintenance Prescriptions. Drugs which are to be taken for a definite period for a non-chronic condition are, "Non-Maintenance Prescriptions." Subject to the Co-Payment feature, the Plan will pay in full the cost for such drugs when the Participant or Dependent submits a prescription drug card to a pharmacist participating in the Plan. Alternatively, the Plan may reimburse the Participant or a Dependent up to 75% of the cost, less the co-payment, of the covered Prescription Drug under the Plan when the Participant or Dependent presents the receipt of sale from the pharmacy indicating his name and Social Security number, name of the person requiring the prescription, date and doctor's name, the pharmacy, the national drug code number, quantity and cost.

(3) Mandatory Generic. Subject to the Co-Payment feature, to the extent generically equivalent FDA-approved drugs are available, the maximum cost of "Maintenance Prescriptions" or "Non-Maintenance Prescriptions" which the Plan will pay for or reimburse will be limited to the cost of the generically equivalent drug, regardless of whether the Participant or their Dependents elect to receive the generically equivalent drug. To the extent that generically equivalent drugs are not available, the Plan will pay for or reimburse the brand name cost of "Maintenance Prescriptions" and "Non-Maintenance Prescriptions", subject to the Co-Payment feature.

To the extent the Fund receives written notification from a physician that medical reasons prohibit a Participant or their Dependents from receiving generic drugs, the Plan will pay or reimburse the brand name cost of the "Maintenance Prescription" or "Non-Maintenance Prescriptions."

(4) Non-Participating Pharmacies. To the extent prescription drugs are purchased at non-participating pharmacies, the Trustees have the discretion to pay a reduced percentage (lower than that currently shown in the Summary of Benefits) of the Charges for the prescription drugs.

(5) Special Rules for Terminated Employees. If a Terminated Employee pays for the Prescription Drug Benefit by paying three monthly premiums in advance, such Terminated Employee shall remain a Participant and shall be eligible to continue to use the Plan's prescription card. If the Terminated Employee pays a monthly premium, the Terminated Employee must purchase prescriptions (i) by mail from the pharmacy designated by the Trustees, (ii) at a pharmacy and pay a 10% co-pay and request reimbursement by the Plan, subject to Plan terms.

(6) Injectibles. Injectibles may be covered subject to co-payment as determined by the Trustees from time to time.
(7) **Special Rules for Diabetic Supplies.** Diabetic supplies are covered only if purchased from the mail order pharmacy. This means you must purchase a 90 day supply of medicine.

(B) **Exclusions From Coverage.** The Plan will not pay for or reimburse a Participant or Dependent for the following Charges for prescriptions:

(1) Prescriptions that are not taken pursuant to orders given by a physician.

(2) The cost of prescriptions required by a Participant or Dependent in connection with any injury resulting from the impairment or intoxication of that individual from drugs or alcohol or resulting from the individual’s being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Participant or Dependent resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a physician’s prescription. To the extent the evidence indicates that the Participant or Dependent was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or deny the requested benefits.

(3) Prescriptions required to treat a Pre-Existing Condition.

(4) Prescriptions for:

(a) Abdominal supports, trusses, or oxygen.

(b) Any drug labeled, “Caution - Limited by Federal Law to Investigational Use”, or experimental drugs, even though charges are made to the individual.

(c) Braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items.

(d) Canes, crutches, wheelchairs or any means of conveyance or locomotion.

(e) Charges payable under any other benefits of the Fund to the extent that the portion of such charges are paid.

(f) Contraceptive materials (including RX U486), contraceptive devices (excluding the Norplant device and depoprovera). Oral contraceptives prescribed by a physician are not excluded whereas the surgical implant of the Norplant device is excluded.

(g) Infertility medication.
Section C
Prescription Drug Benefit - Exclusions from Coverage

(h) Drugs or medicines delivered or administered to the eligible individual by the prescriber.

(i) Self-administered injectibles except certain common items; i.e., imitrex and insulin.

(j) Immunizing agents, biological serum, blood plasma, injectibles, and any prescription directing parental administration or use, except insulin.

(k) Medication which is to be taken or administered to, in whole, or in part, by the Participant or Dependent while he or she is a patient in a Hospital, nursing home, rest home, sanitarium, skilled nursing care facility, convalescent hospital, or similar institution.

(l) Non-Legend, patent or proprietary medicine or medication not requiring a prescription.

(m) Prescriptions not listed with the Plan Administrator as excluded Charges.

(n) Smoking cessation or weight loss prescriptions

(o) The cost of prescriptions required by a Participant or Dependent in connection with any injury incurred while the Participant or Dependent was participating in or attempting to commit a felony.

(p) Vitamins, vitamin prescriptions, cosmetics, dietary supplements, health or beauty aids.

(5) Prescriptions for which a Participant or Beneficiary requests reimbursement or payment after the date the Participant's or Dependent's Prescription Drug Benefit is terminated because of misusing the Benefit.

(6) Prescriptions purchased for the purpose of resale for compensation.

(7) Excessive amounts of the same prescription as determined by the Trustees based on advice from the Plan's medical consultant.

(8) Diabetic supplies which are not purchase through the mail order pharmacy.
Section C
Dental and Orthodontic Benefit – Dental Benefit

V. Dental and Orthodontic Benefit.

(A) Dental Benefit.

(1) Covered Charges. Subject to the annual deductible and limits set forth in the Summary of Benefits and the exclusions and limitations contained in subsection (2) below, the Plan will pay or reimburse 100% of the Charges incurred by Participants and their Dependents for certain preventive care services, 80% for basic services and 50% for major services. The allowable Charges are set forth on a separate schedule maintained by the Fund which is incorporated herein by reference. The list of allowable Charges includes, but is not limited to:

(a) Preventive Care.

(i) Oral examinations, up to two per calendar year
(ii) Cleaning, up to two per calendar year
(iii) One full-mouth fluoride treatment per calendar year
(iv) X-rays with a preventive exam or cleaning
(v) Space maintainers for baby teeth

(b) Basic Care.

(i) Oral surgery
(ii) Periodontics
(iii) Root canal therapy
(iv) Bite guards
(v) Dentures
(vi) Restorations

(c) Major Care.

(i) Crowns (temporary or permanent)
(ii) Bridgework
(iii) Inlays or Onlays

(2) Exclusions and Limitations from Coverage.

(a) The Plan will not pay or reimburse Charges for the following dental treatments and/or services for Participants and their Dependents:

(i) Any dental procedures not started and completed while covered under the Plan.

(ii) Charges for tooth implants (or preparation for implants) by any name called.
Section C  
Dental and Orthodontic Benefit – Dental Benefit

(iii) Charges resulting from failure to follow primary carrier’s guidelines.

(iv) Cosmetic procedures except those required as a result of an injury which occurred while covered by the Dental Plan.

(v) Dental appointment charges for canceled appointments.

(vi) Dental services performed by a non-licensed provider.

(vii) Non-prescription drugs, medicines or supplies intended primarily for home use, such as toothpaste and cleaning supplies.

(viii) Replacement of full or partial dentures or bridgework more often than once every five years.

(ix) Replacement of a lost or stolen appliance.

(x) Services rendered by pre-paid providers which will not supply an Explanation of Benefits (E.O.B.) from the primary carrier.

(xi) Treatment of reconstructive jaw surgery. (This is covered under Section C-1.)

(b) Participants and their Dependents will be responsible to pay the deductible set forth in the Summary of Benefits. Subject to the annual deductible set forth in the Summary of Benefits and the limit set forth in (c), the Plan will pay 50% of the Charges for inlays, onlays, gold fillings, crowns (temporary and permanent) and bridgework. Charges for all other basic care services will be paid at 80%, after the annual deductible set forth in the Summary of Benefits and subject to the limit set forth in (c) has been paid.

(c) The maximum limit the Plan will pay for each Participant and each Dependent for dental preventive, basic services and major services care is $1,500 per calendar year.

(d) Dental and orthodontic charges for reconstructive jaw surgery will not be covered under the dental benefit portion of the Plan; it will be covered under the Reconstructive Jaw Surgery and Related Treatment section.

(3) Coordination with the Medical Plan. When a billed procedure involves a medical service, the Medical Plan will become the primary payer.
Section C
Dental and Orthodontic Benefit – Dental Benefit

Between the Medical and Dental Plan, the total paid amount will not exceed 80% of the total amount charged because the medical procedure is considered a basic service under the Dental Plan.
Section C
Dental and Orthodontic Benefit – Dental Benefit

Example:

Your Oral Surgeon determines that you have two (2) impacted wisdom teeth that must be surgically removed. You undergo the oral surgery and a bill of $1,000 is submitted.

Your Medical Plan covers charges billed for the removal of the impacted wisdom teeth. The Medical Plan requires that you meet a $250 deductible which you have not satisfied. Therefore, payment under the Medical Plan will be calculated as follows:

\[
\begin{align*}
\text{Billed} & : \quad 1000.00 \\
\text{Medical Deductible} & : \quad -250.00 \\
\text{} & : \quad 750.00 \\
\times & : \quad 0.80 \\
\text{} & : \quad 600.00 \\
\end{align*}
\]

You are entitled to additional benefits under the Dental Plan because your Medical deductible was taken out. Therefore, since your Dental Plan would have paid 80% or $800 (if the Dental deductible is not met, the payment would be $760), you are entitled to an additional benefit.

EX. 1  Dental Deductible is met.

\[
\begin{align*}
\text{Medical Deductible Taken} & : \quad 250.00 \\
\times & : \quad 0.80 \\
\text{} & : \quad 200.00 \\
\end{align*}
\]

EX. 2  Dental Deductible is not met.

\[
\begin{align*}
\text{Medical Deductible taken} & : \quad 250.00^* \\
\text{Dental Deductible applied} & : \quad -50.00 \\
\text{} & : \quad 200.00 \\
\times & : \quad 0.80 \\
\text{} & : \quad 160.00 \\
\end{align*}
\]

*(This is now considered under the Dental Plan)*

Had your deductible been satisfied under the Medical Plan, your Dental Plan would not have been able to provide the additional coverage because the Medical Plan would have paid $800.
Section C
Dental and Orthodontic Benefit – Dental Benefit, Optical Expense Benefits and Insurance Benefits

(B) Orthodontic Benefit.

(1) Covered Charges. Subject to the lifetime maximum set forth in the Summary of Benefits, the Plan may pay or reimburse the Charges incurred by the Dependent children of Participants for services in connection with straightening and repositioning teeth.

(2) Exclusions and Limitations from Coverage. The Plan will not pay or reimburse Charges for Orthodontic Benefits for the spousal Dependent of any Participant. The Plan will also not pay or reimburse charges for Orthodontic Benefits for Dependent children for treatment or services outlined in Section C-V(A)(2).

VI. Optical Expense Benefits.

(A) Covered Charges. Charges for Optical Expense Benefits will be subject to the annual limit and the exclusions set forth in subsection (B) below. Subject to the $150 annual limit, the Plan shall provide payment for or reimbursement of 100% of the Charges incurred by Participants and their Dependents for the following optical services:

(1) Complete eye examination, including refractions. Eye examinations performed for medical reasons would be paid for or reimbursed as a Basic Medical Benefit or a Primary Major-Medical Benefit.

(2) Eyeglasses with prescription lenses; and

(3) Contact lenses.

(B) Exclusions from Coverage. The Plan will not pay or reimburse Charges for Optical Expenses for any tinted, oversized, faceted and other cosmetic lenses and designer frames.

VII. Insurance Benefits.

(A) Types of Benefits. This Plan provides four categories of insurance benefits: (a) Weekly Disability Benefits, (b) Death Benefits, (c) Accidental Death, Dismemberment and Loss of Sight Benefits, and/or (d) Long-Term Disability Benefits. The insurance benefits are available only to Employees who are Participants but each of the four categories of insurance benefits may not be available to all Employees. The actual benefits provided to the different groups of Employees who are Participants will be determined based on the terms of the adoption agreement and the applicable Summary of Benefits.
Section C
Insurance Benefits – Weekly Disability Benefits

(B) Weekly Disability Benefit.

(1) Coverage. Subject to the limitations and exclusions set forth in (3) below, the Plan will provide a "Weekly Disability Benefit" to Employees who are Plan Participants who have a Disability. The Fund will pay the Weekly Disability Benefit from the first day of the Disability resulting from an accident and from the seventh day of the Disability resulting from a sickness (including pregnancy).

(2) Amount and Length. The amount and length of Weekly Disability Benefit payments will be determined as set forth in the Summary of Benefits.

(3) Exclusions and Limitations on Coverage. The Plan will not make Weekly Disability Benefit payments for:

(a) Successive periods of Disability separated by less than two weeks of active full-time employment with an Employer. Such successive periods shall be considered part of the same period of Disability unless the subsequent period results from an illness or injury unrelated to the previous Disability.

(b) Participants who are not under the care of a Physician during the period of Disability.

(c) Injuries incurred by a Dependent.

(d) Injuries occurring while an Employee is not a Participant or a Participant is not a current Employee.

(e) Injuries resulting from a suicide, attempted suicide, or intentionally inflicted injury.

(f) Injuries resulting from an occupational illness or injury.

(g) Injuries resulting from participating in or attempting to commit a felony.

(h) Injuries resulting from the impairment or intoxication of the Participant from drugs or alcohol or resulting from the individual’s being influenced by drugs or alcohol. The impairment, influence or intoxication shall be determined by the attending medical personnel, or in accordance with the applicable laws of the State in which the Participant resides and shall include all impairment, influence or intoxication caused by ingestion of drugs or alcohol other than according to a Physician’s prescription. To the extent the evidence indicates that the Participant was under the influence of drugs or alcohol, the Trustees shall have the discretion to pay or
Section C
Insurance Benefits – Weekly Disability Benefits

deny the requested benefits, regardless of whether a driving while intoxicated conviction is received.

(i) Injuries resulting from war, any act of war, military service while a country is engaged in war or military policy duty.

(j) Injuries sustained while the Participant was doing any act or thing pertaining to any occupation or employment for remuneration or profit, or sickness for which benefits are payable in accordance with the provisions of any workmen’s compensation or similar law.

(k) Participation in any reckless activity voluntarily, which is unnecessary and for recreational purposes, and which, in the opinion of the Trustees constitutes “reckless endangerment”.

(C) Death Benefit, Accidental Death, Dismemberment Benefit and Long-Term Disability Benefit. The Fund will provide a Death Benefit, an Accidental Death, Dismemberment Benefit and a Long-Term Disability Benefit to Participants where such coverage is provided by the terms of the applicable collective bargaining agreement. The amount of the coverage is set forth in the Summary of Benefits and the terms of the coverage as of the Effective Date is set forth in the Fund’s separate contract with the insurance carrier, the terms of which are incorporated by reference. The Fund has purchased an insurance contract from ReliaStar Life Insurance Company and you recently received a Certificate of Coverage detailing the various benefits. Please refer to your Certificate of Coverage for more information. Successor contracts are hereby incorporated by reference.
Section D
Continuation of Coverage – In General, Qualifying Events

SECTION D
CONTINUATION OF COVERAGE

1. IN GENERAL.

Notwithstanding any Plan provision to the contrary, each Qualified Beneficiary who would otherwise lose Medical Care coverage hereunder as a result of a Qualifying Event shall be entitled to elect, within the election period, to obtain and pay premiums for Continuation Coverage. “Continuation Coverage” shall consist of Medical Care coverage which, as of the time such coverage is being provided, is identical to Medical Care coverage provided under the Plan to similarly situated Participants (and their Dependents) with respect to whom a Qualifying Event has not occurred.

Medical Care coverage includes Medical Benefits, Prescription Drug Benefits, Dental and Orthodontic Benefit and Optical Benefits. COBRA coverage does not include any of the insurance benefits (disability benefits, death benefits, AD&D and LTD).

If Medical Care coverage under the Plan is modified for any group of similarly situated Participants or Dependents, such Medical Care coverage shall also be modified in the same manner for all Participants and Dependents who are Qualified Beneficiaries with respect to such group. Any such modifications will continue to credit any Deductible, Co-Payment Feature and Lifetime Maximum in effect prior to the amendment.

2. QUALIFYING EVENTS.

For purposes of this Section, the term “Qualifying Event” means, with respect to any Participant (and his or her Dependents), any of the following events which, but for the Continuation Coverage hereunder, would result in loss of Medical Care coverage for a Qualified Beneficiary:

(A) The death of the Participant.

(B) The termination (other than by reason of a Participant’s gross misconduct), or reduction of hours, of the Participant’s employment. The term “gross misconduct” means conduct of a Participant which is (1) a deliberate and willful disregard of standards of behavior which the Employer has a right to expect, showing a gross indifference to the Employer’s interest; or (2) a series of repeated violations of employment rules proving that the Participant has regularly and wantonly disregarded his or her obligations.

(C) The divorce or legal separation (if recognized by state law) of the Participant from the Participant’s spouse.

(D) The Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act, as amended.
Section D
Continuation of Coverage – Qualifying Events, Qualified Beneficiary, Period of Coverage

(E) A Dependent child of a Participant ceases to be a Dependent child under the specific terms of the Plan, as amended from time to time.

(F) An Employer’s filing of Chapter 11 Bankruptcy.

3. QUALIFIED BENEFICIARY.

The term “Qualified Beneficiary” means:

(A) any Participant or Dependent who, on the day before the Qualifying Event is eligible for Benefits under the Plan on the basis of being either (i) the Participant, (ii) the Dependent child of the Participant or (iii) the spouse of the Participant. Except as set forth in (B), no Participant, Dependent spouse or Dependent child may be considered a Qualified Beneficiary if, on the date prior to the Qualifying Event, such individual was not already eligible for Benefits under the Plan.

(B) newborn infants and children placed for adoption who become Dependents during the period of time when a Participant is eligible for COBRA coverage but who were not covered under the Plan on the day before the Qualifying Event are still treated as “Qualified Beneficiaries”.

(C) The term "Qualified Beneficiary" shall exclude nonresident aliens to the extent permitted by law.

4. PERIOD OF COVERAGE.

(A) Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable “Maximum Coverage Period,” as defined in Section 5.

(2) The first day for which a payment is not made to the Plan within 30 days of the first day of the coverage period.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

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Section D
Continuation of Coverage – Period of Coverage,
Coverage Period for COBRA

(5) The date, after the date of the election, that the Qualified Beneficiary first
enrolls in the Medicare program (either part A or part B, whichever occurs
earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the
later of:

(a) 29 months after the date of the Qualifying Event, or (ii) the first
day of the month that is more than 30 days after the date of a final
determination under Title II or XVI of the Social Security Act that
the disabled Qualified Beneficiary whose disability resulted in the
Qualified Beneficiary's entitlement to the disability extension is no
longer disabled, whichever is earlier; or

(b) the end of the Maximum Coverage Period that applies to the
Qualified Beneficiary without regard to the disability extension.

(B) The Plan can terminate for cause the coverage of a Qualified Beneficiary on the
same basis that the Plan terminates for cause the coverage of similarly situated
non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

5. MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE.

(A) The Maximum Coverage Periods are based on the type of the Qualifying Event
and the status of the Qualified Beneficiary, as shown below.

(1) In the case of a Qualifying Event that is a termination of employment or
reduction of hours of employment, the Maximum Coverage Period ends
18 months after the Qualifying Event if there is not a disability extension
and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a Participant’s enrollment in the Medicare program before
experiencing a Qualifying Event that is a termination of employment or
reduction of hours of employment, the Maximum Coverage Period for
Qualified Beneficiaries other than the Participant ends on the later of:

(a) 36 months after the date the Participant becomes enrolled in the
Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the
date of the covered Employee’s termination of employment or
reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the Maximum Coverage
Period for a Qualified Beneficiary who is the covered retiree ends on the
date of the retiree’s death. The Maximum Coverage Period for a Qualified
Beneficiary who is the covered Spouse, surviving Spouse or Dependent
Section D
Continuation of Coverage – Coverage Period for COBRA
Premium Requirements

child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the Maximum Coverage Period is the Maximum Coverage Period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the Maximum Coverage Period ends 36 months after the Qualifying Event.

(B) Expanded Maximum Coverage Period. If a Qualifying Event that gives rise to an 18-month or 29-month Maximum Coverage Period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months Maximum Coverage Period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA Maximum Coverage Period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

(C) Disability Extension. A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month Maximum Coverage Period. This notice should be sent to the Plan Administrator.

6. PREMIUM REQUIREMENTS.

(A) A Qualified Beneficiary shall be required to pay a premium for Continuation Coverage. The Plan Administrator shall cause an actuary to determine the applicable premium for each calendar year of Continuation Coverage, either on the basis of a reasonable estimate of the cost of providing such Medical Care coverage for similarly situated beneficiaries, or on the basis of actual cost for the preceding year for similarly situated beneficiaries (adjusted to reflect cost-of-living increase as measured by the GNP deflator), in a manner which complies with the Code and ERISA.
Section D
Continuation of Coverage – Premium Requirements, Insurability and Conversion Option & Qualified Beneficiary’s Election

(B) The Qualified Beneficiary may elect to pay such premium in monthly installments. Payment is due within 30 days after the first day of the coverage period. If Continuation Coverage is elected after the Qualifying Event has occurred, the Qualified Beneficiary shall be permitted for a period of forty-five (45) days after the date of his or her election to pay the premium for Continuation Coverage during the period preceding his or her election. Payment is considered made on the date on which it is postmarked to the Plan.

7. INSURABILITY AND CONVERSION OPTION.

The availability of Continuation Coverage shall not be conditioned upon, or discriminate on the basis of, a lack of evidence of insurability. The Plan does not provide any Participants or Dependents with the right to convert to an individual policy. Therefore, the Plan also does not provide to a Qualified Beneficiary the option of enrollment under a conversion health plan when the Qualified Beneficiary’s COBRA coverage would otherwise end.

8. QUALIFIED BENEFICIARY’S ELECTION.

(A) Each Qualified Beneficiary who would otherwise lose coverage under the Plan because of a Qualifying Event shall be entitled to make an independent election, within the Election Period, to have Continuation Coverage under the Plan.

(B) A Qualified Beneficiary may choose to purchase coverage for medical, dental and vision Benefits under the Plan, or coverage for only medical Benefits. At the time of election, the Plan Administrator will provide the cost of each option.

(C) The "Election Period" shall be the period which:

(1) Is at least sixty (60) days in duration; and

(2) Ends no earlier than sixty (60) days after the later of:

   (a) the date on which coverage would normally terminate; or

   (b) the date of the notice given by the Plan Administrator to a Qualified Beneficiary with respect to a Qualifying Event.

(D) Except as otherwise specified in an election, any election of Continuation Coverage by a Qualified Beneficiary who is either a Participant or the spouse of a Participant shall be deemed to include an election of Continuation Coverage on behalf of any other Qualified Beneficiary who otherwise would lose coverage by reason of the Qualifying Event.

(E) A Qualified Beneficiary who waives Continuation Coverage may revoke such waiver at any time before the end of his or her Election Period, provided that no Benefits shall be payable for Charges incurred during the period commencing on
Section D
Continuation of Coverage – Qualified Beneficiary’s Election and Notice

the date that the Qualified Beneficiary’s coverage under the Plan terminated and ending on the date the Participant revokes such waiver. Revocation of a waiver is an election of COBRA coverage. Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or designee, applicable.

9. NOTICE.

The following notice requirements shall apply:

(A) The Employer shall notify the Plan Administrator of a Qualifying Event by reason of death, or entitlement to Medicare benefits or the Employer’s Chapter 11 Bankruptcy filing, within thirty (30) days of the date of any such Qualifying Event. The determination of the occurrence of a Participant’s termination of employment or reduction of hours as a Qualifying Event shall be made by the Plan Administrator.

(B) In the case of a Qualifying Event by reason of death, termination of employment, reduction of hours, or entitlement to Medicare benefits, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of such beneficiary’s right to elect Continuation Coverage.

(C) Each Participant shall have sole responsibility for notifying the Plan Administrator of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, within sixty (60) days after the date of such Qualifying Event. If notice is not given within such 60-day period, any right to elect Continuation Coverage shall be terminated.

(D) In the case of a Qualifying Event by reason of divorce, legal separation, or a Dependent child ceasing to be a Dependent under the terms of the Plan, where the Participant notifies the Plan Administrator, the Plan Administrator shall notify each Qualified Beneficiary with respect to such event of his or her right to elect Continuation Coverage hereunder.

(E) For purposes of giving notice to Qualified Beneficiaries, any such notice shall be given within fourteen (14) days after the date on which the Plan Administrator is notified of a Qualifying Event by reason of death, entitlement to Medicare benefits, divorce or legal separation, a Dependent child ceasing to be a Dependent under the terms of the Plan, or an Employer’s Chapter 11 Bankruptcy filing, provided that the Plan Administrator receives notice within the time prescribed by applicable law or regulation, as summarized above.

(F) Any Qualified Beneficiary who believes he is disabled and therefore eligible for an extended period of continuation coverage must provide the requisite notices to the Plan Administrator as set forth in Code Section 4980B.
Section D
Continuation of Coverage – Notice and
USERRA RULES

10. SPECIAL RULES FOR THE UNIFORM SERVICES EMPLOYMENT AND
REEMPLOYMENT RIGHTS ACT OF 1994.

Special rules exist under the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a Participant who is on military leave. The Plan incorporates these rules by reference.

A Participant who qualifies for these special rules is permitted to continue his medical, dental and vision benefits for the lesser of

- 24 months from the start of the employee’s absence due to performing uniformed service; or

- when the service period is less than 24 months, the period ending on the date the employee fails to return from service or to apply for reimbursement.

A person who elects to continue coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee’s share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The USERRA continuation period runs concurrently with the COBRA continuation period.
Section E
Coordination of Benefits – Limitation of Coverage &
Primary-Secondary Payment Rules

SECTION E
COORDINATION OF BENEFITS

**These rules apply based on the presumption that a family member qualifies as a Dependent. If a family member does not qualify as a Dependent, then no coverage will be provided by this Plan and this Section does not apply.**

1. LIMITATION OF COVERAGE.

Benefits under the Plan will be coordinated with any other group or blanket health care coverage and limited in all cases to a maximum of one hundred percent (100%) of the actual Charges to the Participant and any Dependents for eligible Benefits. Benefits shall also be coordinated in the same manner with payments made or available under a “no-fault” statute to the maximum extent permitted by law.

2. “PRIMARY-SECONDARY” PAYMENT RULES.

(A) In processing a claim where two or more group health plans exist, the “primary-secondary” payment rule determines the provision of payment. It is applied in the following manner:

(1) The Plan will accept primary responsibility on claims in which:

(a) The patient is a Participant; or

(b) The patient is the covered Dependent child of a Participant. Where the Dependent child is simultaneously covered under this Plan as a Dependent of a Participant, and under another plan as a Dependent of the Participant’s spouse, this Plan will accept primary responsibility if the Participant’s birth date precedes his or her spouse’s birth date in the calendar year.

(2) The Plan will accept secondary responsibility on claims in which:

(a) Another health care plan is primarily responsible because the patient is covered thereunder; or

(b) Another health care plan is primarily responsible because the Dependent patient is covered under another plan as a Dependent of the Participant’s spouse and the Participant’s spouse has a birthday that falls earlier in the calendar year than the Participant’s.

(B) Notwithstanding the foregoing, the following rules apply to the coverage of Dependent children in the event that the Participant is divorced or legally separated from his or her spouse:
Section E
Coordination of Benefits – Primary-Secondary
Payment Rules, Duplicate Coverage, Lack of
Coordination

(1) If there is a court decree which establishes financial responsibility for
medical or other health care expenses for the Dependent child, the plan
covering the parent who has that responsibility shall be primary and the
plan covering the other parent shall be secondary.

(2) If there is no such court decree, and the parent with custody of the
Dependent child has not remarried, the plan covering the parent who has
custody of the Dependent child shall be primary, and the plan covering the
other parent shall be secondary.

(3) If there is no such court decree, and the parent with custody of the
Dependent child has remarried, the order of priority is:

(a) The plan covering the parent who has custody.

(b) The plan covering the spouse of the parent who has custody (that
is, the stepparent of the Dependent child).

(c) The plan covering the parent without custody.

3. DUPLICATE COVERAGE.

If a Participant is covered under more than one plan through two jobs, the primary plan
shall be determined as follows:

(A) If a Participant is actively employed in only one job, the plan that covers the
Participant as an active Employee shall be the primary plan.

(B) In all other cases, the plan which has covered him or her for the longer period of
time shall be primary.

4. LACK OF COORDINATION.

Notwithstanding any other provision of the Plan, if Charges covered hereunder are also
covered in whole or in part by any group insurance plan or group health plan which does
not contain provisions for coordination of benefits, payment will be made under this Plan
only with respect to those Charges not covered by such group insurance or plan.
SECTION F
THIRD PARTY RESPONSIBILITY (SUBROGATION)

1. THIRD PERSON RESPONSIBILITY.

(A) Benefits shall be modified when a third person, other than the person for whom a claim is made, is considered responsible or liable for payment due to a sickness or injury. To the extent payment is made for such sickness or injury, or may be in the future, by or for such responsible or liable third person (as a settlement, judgment or in any other way), Charges arising from such sickness or injury are not covered and Benefits for any period of Disability resulting (in whole or in part) from such sickness or injury are not payable. Accepting Benefits under this Plan automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurers regardless of whether the Participant or Dependent chooses to pursue the claim. The Participant or Dependent must repay to the Plan benefits paid on his or her behalf out of the monies paid to the Participant or Dependent by the third party or insurer.

(B) When a Benefits claim is received, Plan benefits which would be payable except for the above modifications, will be paid if:

(1) Payment by or for the responsible third person has not yet been made; and

(2) The Participant or Dependent involved (or if incapable, that person's legal representative) acknowledges that the Plan has a 100% first dollar priority lien on any amount recovered (whether or not designated as payment for medical expenses) and agrees in writing to pay back within fifteen days of payment from such third person the Benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the responsible or liable person for the sickness or injury. The agreement is to apply whether or not: (A) liability for the payments is admitted by the responsible persons; and (B) such payments are itemized. A reasonable share of fees and costs incurred to obtain such payments may be deducted from amounts to be repaid.

(3) Amounts due to repay Benefits as described above may be deducted from other Benefits payable under the Plan after payments by or for the responsible person are made.

(4) The Plan's right to the third party recovery/subrogation still applies if the recovery received by the Participant or Dependent is less than the claimed damage, and, as a result, the claimant is not made whole.

(5) The Plan shall have no obligation whatsoever to pay Benefits to a Participant or Dependent if a Participant or Dependent refuses to
Section F
Third Party Responsibility (Subrogation)
Right of Reimbursement

cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. Further, in the event the Participant or Dependent is a minor, the Plan shall have no obligation to pay any Benefits caused by a responsible third party until after the Dependent or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

(6) The third party right of recovery applies to all monies paid to the Participant or Dependent, including, but not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever, by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect Benefits covered by the Plan.

(C) If you recover any money from a third party or insurer, (regardless of whether the money is identified as being reimbursement for medical expenses), the Plan has the right to be reimbursed for the expenses it has already paid on your behalf, and court costs and attorneys' fees incurred in obtaining the amount. The Participant or Dependent must repay to the Plan Benefits paid on his or her behalf out of the monies paid to the Participant or Dependent by the third party or insurer.

2. RIGHT OF REIMBURSEMENT.

The Plan shall have a right of subrogation to the extent of its payment to or for the benefit of any Participant or Dependent, and shall have a lien to the extent of such payment, where the Participant or Dependent does or may recover any amount from a third person, his or her insurance company, or any other responsible party, as a result of a covered injury or illness. The Plan may exercise its right of subrogation either in its own name or in the name of the Participant or Dependent in order to recover payments made to such person, who shall take any such action as the Plan Administrator may reasonably require to enable the Plan to enforce its rights.

Please note: Once you accept a settlement, no further expenses will be paid from the Fund, to the extent allowed by law.
SECTION G
FEDERAL LAW REQUIREMENTS

NOTICE OF COMPLIANCE UNDER THE
WOMEN'S HEALTH AND CANCER RIGHTS' ACT

The Women’s Health and Cancer Rights Act of 1998 (the “1998 Law”) requires the Trustees of this Plan to notify you, as a participant or beneficiary of the Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided under the “Basic Medical Benefits” portion of the Plan. These benefits will be subject to the applicable deductible, the lifetime maximum and the general co-payment provisions which exist in the Plan.

Keep this Notice for your records and call your Plan Administrator for more information.

NOTICE OF COMPLIANCE UNDER
THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Under federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan may not set the level of benefits or out-of-pocket cost so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Plan Administrator.
SECTION H
FILING A CLAIM

IMPORTANT INFORMATION TO KNOW

Filing a Claim

If your claim is for Hospital expenses, the Hospital will file a claim for you. Present your
Medical Benefit Card when you are admitted into the Hospital. The billing instructions are
printed on the back of the card.

If you need a claim form for other medical expenses, please contact the Fund Office at
(410) 254-9595 or toll free 1(800)367-7848. Please note that claim forms are not mandatory but
will be provided for your convenience.

Your claim must including all of the following information:

* Member’s name
* Member’s identification number
* Member’s home address
* Patient’s name and age
* Employer’s name
* Doctor’s diagnosis and surgical procedure, if applicable
* Doctor’s Federal Tax ID Number and NPI number
* Doctor’s name, address, phone number
* Doctor’s signature in original form
* Appropriate procedure codes

If services have been rendered as a result of an injury of any kind, please provide a brief
description of how, when and where the injury occurred.

If your Dependents have primary coverage through another health care plan, program, or
insurance policy, please submit a copy of the itemized bill (including the information described
above) and the original explanation of benefits. Payments will not be made without both of these
statements.

If you want payment to be made directly to the provider of services, please submit the
provider’s tax identification number and complete name and address. You must also sign an
authorization in order for the Fund to release benefits to the provider. Please refer to the
attending physician form, a copy of which may be obtained from the Fund Office. If you wish to
be directly reimbursed for a claim and the claim exceeds $100.00, please provide the original
proof of payment (paid receipt, canceled check, etc.).
Section H
Time Limit for Filing a Claim, How to File an Appeal

Time Limit for Filing Claims

No amounts will be reimbursed and no benefits will be paid by the Fund for claims filed more than twelve (12) months following the later of (1) the end of the benefit period during which the service was rendered or (2) the date a primary carrier processed payment.

When your claim form is completed, attach original of all bills and mail to:

Operating Engineers Local 99 Benefit Fund
5901 Harford Road, Suite C
Baltimore, Maryland 21214-1852

How to File an Appeal

In the event that you or your Dependents need an item or service which is not covered by this Plan or have a benefit which has been denied by the Plan, you may file an appeal to your Board of Trustees. All of the information related to the appeal must be received in the Fund Office at least ten (10) days prior to the scheduled quarterly meeting of the Trustees in order to ensure review. Appeals received after the cut-off period will be held until the next quarterly meeting. Please contact the Fund Office for the meeting dates.

The following information must accompany all formal appeals:

1. A letter from the Participant or Dependent briefly describing the situation and detailing the special request.

2. A letter from the physician who prescribed the item or service explaining that the item or service is Medically Necessary. The letter should include the anticipated benefits of using the item or service.

3. A cost quote from the supplier. The estimate must be in writing and on the company’s letterhead.

Please forward all appeal requests to:

Operating Engineers Local 99
5901 Harford Road, Suite C
Baltimore, Maryland 21214
ATTN: Appeal Department

The Participant’s identification number should appear on all appeal items. Please contact the Fund Office if you have any questions concerning the appeal process.
Section H
Time Limit for How to File an Appeal

Special Rules for Disability Claims

If you file a claim for disability benefits, it will be subject to the rules set forth above with the following modifications:

1. Once you file your disability claim, the Plan Administrator will notify you within 45 days of receipt if it is denied. The 45-day period may be extended an additional 30 days if you are notified in writing before the original 45-day period ends. The 30-day extension period can be extended another 30 days if you are notified in writing before the first 30-day extension expires.

2. If your claim is denied, you will receive a written notification which will contain the information identified above, plus it will include a statement notifying you about your rights to bring a civil action. It will also notify you that you will have the right to request a copy, free of charge, of any internal rule, guideline or similar criteria, or exclusion or limitation (such as medical necessity or experimental treatment) which formed the basis for the adverse determination. You will have 180 days to appeal the decision.
SECTION I
OTHER IMPORTANT INFORMATION

YOUR RIGHTS UNDER THE FUND

As a member of the Fund, you are entitled to certain rights and protections under ERISA -- the Employee Retirement Income Security Act. This section describes those rights and explains how you can put them to work for you.

Right to Information

One right entitles you to a full summary of the Fund. This booklet is designed to provide that information. In addition to the summary, you can examine without charge at the Administrator’s office and at other specified locations, all Fund documents and contracts, including financial reports, the collective bargaining agreement, the latest 5500 filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, and plan descriptions. To get copies of any legal documents, write to the Fund Office. You may have to pay a small fee for copying charges.

Continue Group Health Plan Coverage

Another right entitles you to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You also have the right to reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 6 months after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Section I
Other Important Information – Your Rights Under the Fund

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Assignment of Benefits

Generally, no assignment for the benefit of creditors of any benefit provided under the Fund will be valid.

Qualified Medical Child Support Order

The Plan has a procedure which details how it evaluates a medical child support order. You can obtain a copy, at no addition charge, from the Plan Administrator.
SECTION J
ADMINISTRATIVE INFORMATION

Fund Administration

The Board of Trustees sponsors the Fund described in this booklet. Decision Science, Inc. is the Administrator of the Fund.

Fund Records

All Fund records are kept on a Plan Year basis, from January 1st to December 31st.

Legal Matters

If you have a question about any legal Fund Provision, contact the Plan Administrator. You may serve legal papers on the Fund Sponsor or the Fund Administrator. The Trustees have the discretion to construe and/or interpret the terms of the Plan.

You may obtain, upon request, a complete list of the employers participating in the Plan, the collective bargaining agreement, if any, that pertains to employers whose employees are covered by the Plan, and a list of providers included in the PPO network. Please see the Administrator for more details.

The common name for the Fund is the Operating Engineers Local 99 and 99A Health Care Fund.

Future of the Fund

The Fund expects to continue the benefits described in this booklet, but has the right to change or terminate them. Any changes must be approved by the Board of Trustees. You'll be told how the change affects your benefits, if at all.
SECTION K

IMPORTANT NAMES AND NUMBERS

Name of the Fund: Health and Welfare Trust Fund for International Union of Operating Engineers Local 99 and 99A

Fund Number: 501

Employer Identification Number: 52-6072849

Plan Year: January 1st to December 31st

Type of Fund: Self-Funded Health and Welfare Benefit Fund

Fund Sponsor: Board of Trustees of the Health and Welfare Fund for the International Union of Operating Engineers Local 99 and 99A
5901 Harford Road, Suite C
Baltimore, MD 21214-1852
Tele: (410) 254-9595
1-800-367-7848

Plan Administrator: Decision Science, Inc.
5901 Harford Road, Suite C
Baltimore, MD 21214-1852
Tele: (410) 254-9595
1-800-367-7848

Board of Trustees:

Union Trustees
R. Keith Laird
IUOE Local 99
2461 Wisconsin Avenue, N.W.
Washington, DC 20007
Tele: (202) 337-0099
FAX: (202) 625-7982

Michael R. Murphy
IUOE Local 99
2461 Wisconsin Avenue, N.W.
Washington, DC 20007
Tele: (202) 337-0099
FAX: (202) 625-7982
Section K
Important Names and Numbers

Harry Geety, III
IUOE Local 99
2461 Wisconsin Avenue, N.W.
Washington, DC 20007
Tele: (202) 337-0099
FAX: (202) 625-7982

Employer Trustees
John N. Gallagher
Polinger, Shannon & Luchs Co.
5530 Wisconsin Avenue, N.W.
Suite 1000
Chevy Chase, MD 20815
Tele: (301) 657-3600
(301) 657-3611 ext 186 Direct Line
FAX: (301) 986-9533

John Flaherty
Marriott Wardman Park Hotel
2660 Woodley Road
Washington, DC 20008
Tele: (202) 328-5681
FAX: (202) 329-5603

Mark J. Trichtinger
SSI Services
OHB GC-97
Washington, DC 20505
Tele: (703) 482-0255
FAX: (703) 482-2726

Decision Science, Inc.
5901 Harford Road - Suite C
Baltimore, MD 21214-1852
Tele: (410) 254-9595
1-800-367-7848

The Board of Trustees can be contacted in care of:
Primary/Preferred Drug List

The CVS Caremark Primary/Preferred Drug List is a guide within select therapeutic categories for clients, plan members and health care providers. Generics should be considered the first line of prescribing. If there is no generic available, there may be more than one brand-name medicine to treat a condition. These preferred brand-name medicines are listed to help identify products that are clinically appropriate and cost-effective. Generics listed in therapeutic categories are for representational purposes only. This list represents brand products in CAPS and generic products in lowercase italics.

PLAN MEMBER

Your benefit plan provides you with a prescription benefit program administered by CVS Caremark. Ask your doctor to consider prescribing, when medically appropriate, a preferred medicine from this list. Take this list along when you or a covered family member sees a doctor.

Please note:

- Your specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document.
- For specific information regarding your prescription benefit coverage and copay information, please visit www.caremark.com or contact a CVS Caremark Customer Care representative.
- CVS Caremark may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription.
- Any brand drug for which a generic product becomes available may be designated as a non-preferred product.

HEALTH CARE PROVIDER

Your patient is covered under a prescription benefit plan administered by CVS Caremark. As a way to help manage health care costs, authorize generic substitution whenever possible. If you believe a brand-name product is necessary, consider prescribing a brand name on this list.

Please note:

- Generics should be considered the first line of prescribing.
- This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage.
- The member's prescription benefit plan may have a different copay for specific products on the list.
- Unless specifically indicated, drug list products will include all dosage forms.
- Log in to www.caremark.com to check coverage and copay information for a specific medicine.

- ANTI-INFECTIVES
- ANTIBACTERIALS
  - dicloxacillin
  - penicillin VK
  - § TETRACYCLINES
    - doxycycline hyclate
    - minocycline
    - tetracycline
  - § ANTIFUNGALS
    - fluconazole
    - itraconazole
    - terbinafine tablet
  - ANTIVIRALS
  - § HERPES AGENTS
    - acyclovir
    - valacyclovir
  - § INFLUENZA AGENTS
    - amantadine
    - rimantadine
    - RELENZA
    - TAMIFLU
  - § MISCELLANEOUS
    - clindamycin
    - metronidazole
    - nitrofurantoin
    - sulfamethoxazole-trimethoprim

- CARDIOVASCULAR
  - § ANGIOTENSIN II RECEPTOR ANTAGONISTS / DIURETIC COMBINATIONS
    - losartan / losartan-hydrochlorothiazide
    - BENICAR / BENICAR HCT
    - DIOVAN / DIOVAN HCT
    - MICALDIA / MICALDIA HCT
    - ANGIOTENSIN II RECEPTOR ANTAGONIST / DIRECT REINH INHIBITOR COMBINATIONS
    - VALTURNA
  - § ACE INHIBITOR / DIURETIC COMBINATIONS
    - fosinopril-hydrochlorothiazide
    - lisinopril-hydrochlorothiazide
    - quinapril-hydrochlorothiazide
  - § ACE INHIBITORS
    - fosinopril
    - lisinopril
    - quinapril
    - ramipril
  - § FIBRATES
    - fenofibrate
    - TRICOR
    - TRILIP
  - § HMG-CoA REDUCTASE INHIBITORS
    - pravastatin
    - simvastatin
    - CRESTOR
    - LIPTOR
  - § NIACINS / COMBINATIONS
    - NIASPAN
    - SIMCOR
  - § BETA-BLOCKERS
    - atenolol
    - carvedilol
    - metoprolol
    - metoprolol succinate extended-release
    - nadolol
    - propranolol
    - BYSTOLIC
    - COREG CR
| A | ACANYA | ACU-CHEK STRIPS AND KITS 3 | ACTONEL | ACTOPLUS MET | ACTOS | ACYCOVIR | ADAPALENE | ADVAIR | ALTIREL | ALDERENONATE | ALPHAGAN P | ANAMCEPT | ANGELICA | ANGELIQUE | ANGIBAL | APIDRA | APSONEX | ASTEPRO | ASTENOL | AVEL ox | AVODART | AZELASTINE | AZITHROMYCIN |
| B | BD INSULIN SYRINGES AND NEEDLES | BENICAR | BENICAR HCT | BETOPTIC S | BEYAZ | BONIVA | bromodine 0.2% | budenoside inhalation suspension | buprofen | bucprofen ext-rel | BYETTA | BYSTOLIC |
| C | CADUET | calcitonin-salmon | candesartol | cetacide | cefadroxil | cephalaxin | cholestyramine | CIPIRO SUSPENSION | ciprofloxacin ext-rel | ciprofloxacin tablet | citalopram | clarithromycin |
| D | DETROL | DETROL LA | DEXLANT | DEXICLON | DIFER L | DIFER 6 | DIFLUXER | DIOVAN | DIOVAN HCT | DOXOROCIN | DOXYCYCLINE HYDRATE | DUAC CS | DUETACT | DULERA |
| E | ENABLEX | ENJUVIA | EPIDUO | EPIDUO | EPIDUR | EPIDUR 6 | ERYTHROMYCIN | ESTRADERM | estradiol | estradiol-nonfiatriderone | estropina | ethinyl estradiol | drosipirone | ethinyl estradiol | levonorgestrel | ethinyl estradiol-norgestimate | EVA 6 | EVISTA |
| F | FERFLORIDE | FERFLORIDE | FLOZINE | FLOZINE | FLOXACE | FLUCONAZOLE | FLUCINDINE | FUTALEX | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | GLUTAMAL | HEMOPHILIC |
| G | GELNIQUE | GELNIQUE | GLIPIZIDE | GLIPIZIDE ext-rel | GLIPIZIDE METFORMIN | HUMALOG | HUMALOG | HYDROCHLOROFLUOROIDE | I | I | I | I | I | I | I | I | I | I |
| H | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET | JANUMET |
| L | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS | LANTUS |
| M | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT | MAXALT |
| N | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL | NEDOL |
| O | ONETOUCH STRIPS AND KITS 3 | ONGLYZA | ORTHO EVRA | ORTHO TRICYCLEN LO | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL | OXYTROL |
| P | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA | PARISIDRA |
| Q | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI | QUINAPPI |
| R | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL | RAMIPRIL |

Your specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. For specific information, visit www.caremark.com or contact a CVS Caremark Customer Care representative.
<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>PREFERRED ALTERNATIVE(S)</th>
<th>DRUG NAME</th>
<th>PREFERRED ALTERNATIVE(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE CARE STRIPS AND KITS</td>
<td>fenofibrate, TRICOR, TRILIPIX</td>
<td>XOPENEX HFA</td>
<td>PROAIR HFA, PROVENTIL HFA, VENTOLIN HFA</td>
</tr>
<tr>
<td>TRUE TEST STRIPS AND KITS</td>
<td>ACCU-CHEK STRIPS AND KITS</td>
<td>ZODERM</td>
<td>adapalene, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tetracycline, ACAMIA, DIFFERIN, DUAC GS, EPIDUO, RETIN-A MICRO, VELTIN</td>
</tr>
<tr>
<td>TRUE TRACK STRIPS AND KITS</td>
<td>EPIGEN, EPIGEN JR</td>
<td>ZYFLO, ZYFLO CR</td>
<td>SINGULAR</td>
</tr>
<tr>
<td>TWIJECT</td>
<td>doxazosin, lansoprazole, terazosin, RAPAFL</td>
<td></td>
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</tr>
<tr>
<td>UROXATRAL</td>
<td>cilbesartol</td>
<td></td>
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<tr>
<td>VANOS</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOR YOUR INFORMATION:** Generics should be considered the first line of prescribing. This drug list represents a summary of prescription coverage. It is not inclusive and does not guarantee coverage. Any brand drug for which a generic product becomes available may be designated as a non-preferred product. Specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. The member's prescription benefit plan may have a different copay for specific products on the list. Unless specifically indicated, a drug list product will include all dosage forms. This list represents brand products in CAPS and generic products in lowercase italic. Generics listed in therapeutic categories are for representative purposes only. This is not an all-inclusive list. Listed products may be available generically in certain strengths or dosage forms. Dosage forms on this list will be consistent with the category and use where listed. Log in to www.caremark.com to check coverage and copay information for a specific medicine.

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8 The preferred alternative products in this list are a broad representation within therapeutic categories of available treatment options and do not necessarily represent clinical equivalency.

§ Generics are available in this class and should be considered the first line of prescribing.

1 Copayment, copay or coinsurance means the amount a member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

2 Indicates the proposed mechanism of action, based on the American Psychiatric Association Summary of Treatment Recommendations.

3 An Accu-Chek or OneTouch blood glucose meter will be provided at no charge by the manufacturer to those individuals currently using a meter other than Accu-Chek or OneTouch. For more information on how to obtain a blood glucose meter, call toll-free: 1-800-528-4462. Members must have CVS Caremark Mail Service Pharmacy benefits to qualify.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information. CVS Caremark may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark. Listed products are for informational purposes only and are not intended to replace the clinical judgment of the prescriber.

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www.caremark.com

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Your specific prescription benefit plan design may not cover certain categories, regardless of their appearance in this document. For specific information, visit www.caremark.com or contact a CVS Caremark Customer Care representative.
The New Value Generic Program

Beginning 8/1/10 your prescription plan is offering a value generic program for which you will be automatically enrolled in.

- More than 350 widely prescribed and used generic medications are on the value generic list.
- A 30 day supply can be obtained for a $3.33 co-pay.
- A 90 day supply can be obtained for a co-pay of $9.99.
- Generics not included in the value program will be at the regular co-pay.

A current list of the generics are provided for your review.
CVS Caremark Value Generic Drug List

The CVS Caremark Value Generic Drug List offers access to a 90-day supply of select maintenance generic medicines under your plan that can be filled either through a CVS/pharmacy retail store or through CVS Caremark Mail Service Pharmacy.

ALLERGY
C-PHEN DROPS
CYPROHEPTADINE 4 MG TABLET
FEXOFENADINE 30 MG TABLET
HYDROXYZINE 10 MG/5 ML SYRUP

ARTHRITIS & PAIN
ALLOPURINOL 100 MG TABLET
ALLOPURINOL 300 MG TABLET
BACLOFEN 10 MG TABLET
CHLORZOXAZONE 500 MG TABLET
CYCLOBENZAPRINE 5 MG TABLET
CYCLOBENZAPRINE 10 MG TABLET
DEXAMETHASONE 0.5 MG TABLET
DEXAMETHASONE 0.75 MG TABLET
DEXAMETHASONE 4 MG TABLET
DICLOFENAC 50 MG TABLET EC
DICLOFENAC 75 MG TABLET EC
IBUPROFEN 100 MG/5 ML SUSPENSION
IBUPROFEN 400 MG TABLET
IBUPROFEN 800 MG TABLET
IBUPROFEN 800 MG TABLET
INDOMETHACIN 25 MG CAPSULE
INDOMETHACIN 50 MG CAPSULE
KETOPROFEN 50 MG CAPSULE
KETOPROFEN 75 MG CAPSULE
LIDOCAINE 2% VISCOUS SOLUTION
MELOXICAM 7.5 MG TABLET
MELOXICAM 15 MG TABLET
METHOCARBAMOL 500 MG TABLET
NAPROXEN 250 MG TABLET
NAPROXEN 375 MG TABLET
NAPROXEN 500 MG TABLET
NAPROXEN SODIUM 275 MG TABLET
NAPROXEN SODIUM 550 MG TABLET
PIROXICAM 10 MG CAPSULE
PIROXICAM 20 MG CAPSULE
TIZANIDINE 2 MG TABLET
TIZANIDINE 4 MG TABLET
TRAMADOL 50 MG TABLET

ASTHMA
ALBUTEROL 0.83 MG/ML SOLUTION
ALBUTEROL 2 MG TABLET
ALBUTEROL 4 MG TABLET
ALBUTEROL 5 MG/ML SOLUTION
ALBUTEROL SULFATE 2 MG/5 ML SYRUP
IPRATROPIUM 0.02% SOLUTION
THEOPHYLLINE 100 MG TABLET ER
THEOPHYLLINE 200 MG TABLET ER

CHOLESTEROL
LOVASTATIN 10 MG TABLET
LOVASTATIN 20 MG TABLET
LOVASTATIN 40 MG TABLET
PRAVASTATIN 10 MG TABLET
PRAVASTATIN 20 MG TABLET
PRAVASTATIN 40 MG TABLET

DIABETES
CHLORPROPAMIDE 100 MG TABLET
GLIMEPIRIDE 1 MG TABLET
GLIMEPIRIDE 2 MG TABLET
GLIMEPIRIDE 4 MG TABLET
GLIPIZIDE 5 MG TABLET
GLIPIZIDE 5 MG TABLET ER
GLIPIZIDE 10 MG TABLET
GLYBURIDE 1.25 MG TABLET
GLYBURIDE 2.5 MG TABLET
GLYBURIDE 5 MG TABLET
GLYBURIDE MICRONIZED 1.5 MG TABLET
GLYBURIDE MICRONIZED 3 MG TABLET
GLYBURIDE MICRONIZED 6 MG TABLET
GLYBURIDE-METFORMIN 5-500 MG TABLET
METFORMIN 500 MG TABLET
METFORMIN 500 MG TABLET ER
METFORMIN 850 MG TABLET
METFORMIN 1000 MG TABLET

FUNERAL INFECTIONS
FLUCONAZOLE 100 MG TABLET
FLUCONAZOLE 200 MG TABLET
NYSTATIN 100,000 UNIT/SIGM OINTMENT
TERBINAFINE 250 MG TABLET

GASTROINTESTINAL HEALTH
CIMETIDINE 300 MG TABLET
CIMETIDINE 400 MG TABLET
CIMETIDINE 800 MG TABLET
DICYCLOMINE 10 MG CAPSULE
DICYCLOMINE 20 MG TABLET
FAMOTIDINE 20 MG TABLET
FAMOTIDINE 40 MG TABLET
LACTULOSE 10 GM/15 ML SOLUTION
METOCLOPRAMIDE 5 MG TABLET
METOCLOPRAMIDE 5 MG/5 ML SYRUP
<table>
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<tr>
<th>Mental Health &amp; Central Nervous System</th>
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<tbody>
<tr>
<td>Amitriptyline 75 mg tablet</td>
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<tr>
<td>Amitriptyline 100 mg tablet</td>
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<tr>
<td>Amitriptyline 150 mg tablet</td>
</tr>
<tr>
<td>Benztrapine 0.5 mg tablet</td>
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<td>Benztrapine 1 mg tablet</td>
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<td>Benztrapine 2 mg tablet</td>
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<tr>
<td>Buspirone 5 mg tablet</td>
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<td>Buspirone 10 mg tablet</td>
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<tr>
<td>Buspirone 15 mg tablet</td>
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<td>Carbamazepine 200 mg tablet</td>
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<td>Chlorpromazine 25 mg tablet</td>
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<td>Citalopram 10 mg tablet</td>
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<td>Doxepin 10 mg capsule</td>
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<td>Fluoxetine 1 mg tablet</td>
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<tr>
<td>Fluoxetine 5 mg tablet</td>
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<tr>
<td>Gabapentin 100 mg capsule</td>
</tr>
<tr>
<td>Haloperidol 0.5 mg tablet</td>
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<tr>
<td>Haloperidol 1 mg tablet</td>
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<tr>
<td>Haloperidol 2 mg tablet</td>
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<tr>
<td>Haloperidol 5 mg tablet</td>
</tr>
<tr>
<td>Hydroxyzine Pamoate 25 mg capsule</td>
</tr>
<tr>
<td>Imipramine HCl 10 mg tablet</td>
</tr>
<tr>
<td>Imipramine HCl 25 mg tablet</td>
</tr>
</tbody>
</table>

| Lithium Carbonate 300 mg capsule       |
| Mirtazapine 15 mg tablet               |
| Nortriptiline 10 mg capsule            |
| Nortriptiline 25 mg capsule            |
| Nortriptiline 75 mg capsule            |
| Paroxetine HCl 10 mg tablet            |
| Paroxetine HCl 20 mg tablet            |
| Paroxetine HCl 30 mg tablet            |
| Paroxetine HCl 40 mg tablet            |
| Perphenazine-Nortriptiline 2 mg-10 mg  |
| tablet                                  |
| Perphenazine-Nortriptiline 2 mg-25 mg  |
| tablet                                  |
| Perphenazine-Nortriptiline 4 mg-25 mg  |
| tablet                                  |
| Sertraline 25 mg tablet                 |
| Thioridazine 10 mg tablet               |
| Thioridazine 25 mg tablet               |
| Thioridazine 50 mg tablet               |
| Thiothixene 2 mg capsule                |
| Trazodone 50 mg tablet                  |
| Trazodone 100 mg tablet                 |
| Trazodone 150 mg tablet                 |
| Trihexyphenidyl 2 mg tablet             |
| Zonisamide 25 mg capsule                |

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<tr>
<td>Chlorhexidine 0.12% rinse</td>
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<td>CytrA-2 Oral Solution</td>
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<td>CytrA-K Oral Solution</td>
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<td>Hydrocortisone 20 mg tablet</td>
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<td>Isoniazid 300 mg tablet</td>
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<tr>
<td>Meclazine 12.5 mg tablet</td>
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<td>Megestrol 20 mg tablet</td>
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<tr>
<td>Methylprednisolone 4 mg tablet</td>
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<tr>
<td>Oxybutynin 5 mg tablet</td>
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<tr>
<td>Prednisolone 5 mg tablet</td>
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<tr>
<td>Prednisone 1 mg tablet</td>
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</table>
BRAND DRUGS GOING GENERIC 2010

CARDIOVASCULAR
Corvert - February 2010
Cardizem LA - March 2010
Cozaar - April 2010
Hyzaar - April 2010
Sular - June 2010
Tarka - June 2010

ENLARGED PROSTATE
Flomax - March 2010

GASTROINTESTINAL
Axd Sol - January 2010
Pepcid Sol - May 2010
Zegerid - July 2010
Prevacid - October 2010

MENTAL HEALTH
Ambien Cr – October 2010
Aricept – November 2010
Effexor XR - June 2010
Prozac – March 2010

RESPIRATORY
Astelin - June 2010
Tussionex - October 2010
Accolate - November 2010
Xyzal - November 2010
BRAND DRUGS GOING GENERIC 2011

CARDIOVASCULAR

Lotrel - January 2011
Rythmol SR - January 2011
Caduet - 4th Qtr 2011
Lipitor - 4th Qtr 2011

MENTAL HEALTH

Neurontin - February 2011
Concerta - 2nd Qtr 2011
Tegretol XR - 3rd Qtr 2011
Symbyax - 4th Qtr 2011
Zyprexa - 4th Qtr 2011

RESPIRATORY

Allegra D - January 2011
Nasacort AQ 2nd Qtr 2011
Patanase - 2nd Qtr 2011
BRAND DRUGS GOING GENERIC 2012

CARDIOVASCULAR
Avalide - 1st Qtr 2012
Avapro - 1st Qtr 2012
Lescol - 2nd Qtr 2012
Plavix - 2nd Qtr 2012
Diovan - 3rd Qtr 2012
Diovan HCT - 3rd Qtr 2012
Tricor - 3rd Qtr 2012

DIABETES
Avandamet - 1st Qtr 2012
Avandaryl - 1st Qtr 2012
Avandia - 1st Qtr 2012
Actos - 3rd Qtr 2012
Actoplus Met - 4th Qtr 2012

MENTAL HEALTH
Keppra XR - 1st Qtr 2012
Lexapro - 1st Qtr 2012
Seroquel - 1st Qtr 2012
Provigil - 2nd Qtr 2012
Maxalt - 4th Qtr 2012

RESPIRATORY
Clarinex - 1st Qtr 2012
Singulair - 3rd Qtr 2012
Xopenex - 3rd Qtr 2012
SECTION 4

LTD AND LIFE BENEFITS
GROUP LONG TERM DISABILITY INSURANCE PROGRAM

International Union of Operating Engineers Local 99-99A Health & Welfare Fund
CERTIFICATE OF INSURANCE

We certify that you (provided you belong to a class described on the Schedule of Benefits) are insured, for the benefits which apply to your class, under Group Policy No. LTD 120463 issued to International Union of Operating Engineers Local 99-99A Health & Welfare Fund, the Policyholder.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

[Signatures]
Charles [Signature]  
Secretary

[Signature]  
President

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE
<table>
<thead>
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<th>TABLE OF CONTENTS</th>
<th>Page</th>
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</thead>
<tbody>
<tr>
<td>SCHEDULE OF BENEFITS</td>
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<td>DEFINITIONS</td>
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<td>TRANSFER OF INSURANCE COVERAGE</td>
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<td>CLAIMS PROVISIONS</td>
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<td>LIMITATIONS</td>
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<td>SURVIVOR BENEFIT - LUMP SUM</td>
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<td>WORK INCENTIVE AND CHILD CARE BENEFITS</td>
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<td>EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES</td>
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<td>EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)</td>
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<tr>
<td>EXTENDED DISABILITY BENEFIT</td>
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</tbody>
</table>
SCHEDULE OF BENEFITS

EFFECTIVE DATE: February 1, 2010

ELIGIBLE CLASSES: Each active, Full-time employee of an employer
participating in the International Union of Operating Engineers Local 99 &
99A Health and Welfare Plan, except any person employed on a
temporary or seasonal basis.

WAITING PERIOD: 90 days of continuous employment, unless waived
for health and welfare benefits

YOUR EFFECTIVE DATE: The first of the Policy month coinciding with
or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 6 months

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 180 consecutive days of Total Disability.

MONTHLY BENEFIT: The Monthly Benefit is an amount equal to 60%
of Covered Monthly Earnings.

To figure this benefit amount payable:
(1) multiply your Covered Monthly Earnings by the benefit
percentage(s) shown above;
(2) take the lesser of the amount:
(a) of step (1) above; or
(b) the Maximum Monthly Benefit shown below; and
(3) subtract Other Income Benefits, as shown below, from step (2),
above.

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:
(1) disability income benefits you are eligible to receive because of
your Total Disability under any group insurance plan(s);
(2) disability income benefits you are eligible to receive because of
your Total Disability under any governmental retirement system,
except benefits payable under a federal government employee
pension benefit;
(3) all benefits (except medical or death benefits) including any
settlement made in place of such benefits (whether or not liability
is admitted) you are eligible to receive because of your Total
disability under:
(a) Workers' Compensation Laws;
(b) occupational disease law;
(c) any other laws of like intent as (a) or (b) above; and
(d) any compulsory benefit law;

(4) any of the following that you are eligible to receive from the Policyholder:
    (a) any formal salary continuance plan;
    (b) wages, salary or other compensation excluding the amount allowable when engaged in Rehabilitative Employment; and
    (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;

(5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and

(6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and

(7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits. Only your benefit will be included under this item. We will not include benefits paid for your spouse or children.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or do not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number 7 above will not apply to disabilities which begin after age 70 if you are already receiving Social Security Retirement Benefits while continuing to work beyond age 70.

MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than $100.

MAXIMUM MONTHLY BENEFIT: $2,500 (this is equal to a maximum Covered Monthly Earnings of $4,167).
MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the duration specified below:

<table>
<thead>
<tr>
<th>Age at Disablement</th>
<th>Duration of Benefits (in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 or less</td>
<td>To Age 65: 3 1/4</td>
</tr>
<tr>
<td>62</td>
<td>3</td>
</tr>
<tr>
<td>63</td>
<td>2 1/2</td>
</tr>
<tr>
<td>64</td>
<td>2</td>
</tr>
<tr>
<td>65</td>
<td>1 1/4</td>
</tr>
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CHANGES IN MONTHLY BENEFIT: Increases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work. Decreases in the Monthly Benefit are effective on the first of the Policy month coinciding with or next following the date the change occurs.

CONTRIBUTIONS: You are not required to contribute toward the cost of this insurance.

Premium contributions will not be included in your gross income.

For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as taxable. It is recommended that you contact your personal tax advisor.
DEFINITIONS

"You", "your" and "yours" means a person who meets the Eligibility Requirements of the Policy and is enrolled for this insurance.

"We", "us" and "our" means Reliance Standard Life Insurance Company.

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of an injury or Sickness.

"Any Occupation" means an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

"Claimant" means you made a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Covered Monthly Earnings" means your basic monthly salary received from the Policyholder on the first of the Policy month just before the date of Total Disability, prior to any deductions to a 401(k) or Section 125 plan. Covered Monthly Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as Covered Monthly Earnings.

If you are an hourly paid employee, the number of hours worked during a regular work week, not to exceed forty (40) hours per week, times 4.333, will be used to determine Covered Monthly Earnings. If you are paid on an annual basis, then the Covered Monthly Earnings will be determined by dividing the basic annual salary by 12.

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, you return to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that you are Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to you if you become eligible under any other group long term disability insurance plan.

"Full-time" means working for the Policyholder for a minimum of 30 hours during your regular work week.
"Hospital" or "Institution" means a facility licensed to provide care and treatment for the condition causing your Total Disability.

"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

"Physician" means a duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which a claim is made. The Physician may not be you or a member of your immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by your Physician according to generally accepted medical standards in your locality, be of a demonstrable medical value and be necessary to meet your basic health needs.

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. We will look at your occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

1. any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
2. Retirement Benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act; or
3. an employer’s retirement plan where payments are made in a lump sum or periodically and do not represent contributions made by you.

Retirement Benefits do not include:

1. a federal government employee pension benefit;
2. a thrift plan;
3. a deferred compensation plan;
4. an individual retirement account (IRA);
5. a tax sheltered annuity (TSA);
6. a stock ownership plan; or
7. a profit sharing plan; or
8. section 401(k), 403(b) or 457 plans.
"Sickness" means illness or disease causing Total Disability which begins while your insurance coverage is in effect. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

1) during the Elimination Period and for the first 24 months for which a Monthly Benefit is payable, you cannot perform the material duties of your Regular Occupation;
   (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. If you are Partially Disabled you will be considered Totally Disabled, except during the Elimination Period;
   (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and
2) after a Monthly Benefit has been paid for 24 months, you cannot perform the material duties of Any Occupation. We consider you Totally Disabled if due to an Injury or Sickness you are capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis.

If you are employed by the Policyholder and require a license for such occupation, the loss of such license for any reason does not in and of itself constitute "Total Disability".

"Treatment" means care consistent with the diagnosis of your Injury or Sickness that has its purpose of maximizing your medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for the Injury or Sickness and conform with generally accepted medical standards to effectively manage and treat your Injury or Sickness.
TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability Insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

If you were covered under the prior group long term disability plan maintained by the Policyholder prior to the Policy's Effective Date, but were not Actively at Work due to Injury or Sickness on the Effective Date of the Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) You must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of the Policy.

Waiting Period Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy any Waiting Period of the prior group long term disability insurance plan will be credited towards the satisfaction of the Waiting Period of the Policy.
GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: After the Policy has been in force for two (2) years from its Effective Date, no statement made by you on a written application for insurance shall be used to reduce or deny a claim after your insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, the Plan Administrator, or us:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

NOT IN LIEU OF WORKERS' COMPENSATION: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

WAIVER OF PREMIUM: No premium is due us while you are receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of your Total Disability, premium payments must begin again if insurance is to continue.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after a Total Disability covered by the Policy occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include your name, the Policyholder’s name and the Policy Number.

CLAIM FORMS: When we receive the notice of claim, we will send you the claim forms to file with us. We will send them within fifteen (15) days after we receive notice. If we do not, then the proof of Total Disability will be met by giving us a written statement of the type and extent of the Total Disability. The statement must be sent within ninety (90) days after the loss began.

WRITTEN PROOF OF TOTAL DISABILITY: For any Total Disability covered by the Policy, written proof must be sent to us within ninety (90) days after the Total Disability occurs. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as was reasonably possible. In any event, proof must be given within one (1) year after the Total Disability occurs, unless you are legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of Total Disability covered by the Policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable.

We will pay benefits to you, if living, or else to your estate.

If you died and we have not paid all benefits due, we may pay up to $1,000 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance certificate and the Plan. The claims review fiduciary has the discretionary authority to Interpret the Plan and the insurance certificate and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

ARBITRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding your Total Disability may be settled by arbitration when agreed to by you and us in accordance with
the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to you and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, your ERISA claim appeal remedies, if applicable, must be exhausted before the claim may be submitted to arbitration. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction over such awards.

Unless otherwise agreed to by you and us, any such award will be binding on you and us for a period of twelve (12) months after it is rendered assuming that the award is not based on fraudulent information and you continue to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total Disability may again be submitted to arbitration in accordance with this provision.

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.

PHYSICAL EXAMINATION AND AUTOPSY: We will, at our expense, have the right to have you interviewed and/or examined:
   (1) physically;
   (2) psychologically; and/or
   (3) psychiatrically;

   to determine the existence of any Total Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending.

We can have an autopsy made unless prohibited by law.

LEGAL ACTIONS: No legal action may be brought against us to recover on the Policy within sixty (60) days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is received.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you:
(1) are a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) have completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: If you are continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits page, then you have satisfied the Waiting Period.

EFFECTIVE DATE OF YOUR INSURANCE: If the Policyholder pays the entire Premium due for you, your insurance will go into effect on Your Effective Date, as shown on the Schedule of Benefits page.

If you pay a part of the Premium, you must apply in writing for the insurance to go into effect. You will become insured on the latest of:
(1) Your Effective Date, as shown on the Schedule of Benefits page, if you apply on or before that date;
(2) on the date you apply, if you apply within thirty-one (31) days from the date you first met the Eligibility Requirements; or
(3) on the date we approve any required proof of health acceptable to us. We require this proof if you apply:
(a) after thirty-one (31) days from the date you first met the Eligibility Requirements; or
(b) after you terminated this insurance but remained in an Eligible Class, as shown on the Schedule of Benefits page.

The insurance for you will not go into effect on a date you are not Actively at Work because of a Sickness or Injury. The insurance will go into effect after you are Actively at Work for one (1) full day in an Eligible Class, as shown on the Schedule of Benefits page.

TERMINATION OF YOUR INSURANCE: Your insurance will terminate on the first of the following to occur:
(1) 60 days following termination the Policy terminates;
(2) 60 days following termination you cease to meet the Eligibility Requirements;
(3) the end of the period for which Premium has been paid for you; or
(4) 60 days following termination you enter military service (not Including Reserve or National Guard).
YOUR REINSTATEMENT: If you are terminated, your insurance may be reinstated if you return to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:

(1) on a leave of absence approved by the Policyholder; or
(2) on temporary lay-off.

You will not be required to fulfill the Eligibility Requirements of the Policy again. The insurance will go into effect after you return to Active Work for one (1) full day. If you return after having resigned or having been discharged, you will be required to fulfill the Eligibility Requirements of the Policy again. If you return after terminating insurance at your request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before you may be reinstated.
BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:
(1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
(2) are under the regular care of a Physician;
(3) have completed the Elimination Period; and
(4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:
(1) have not been applied for; or
(2) have been applied for and a decision is pending; or
(3) have been denied and the denial may be appealed.

The Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:
(1) of the amount awarded; or
(2) that benefits have been denied and the denial cannot be further appealed.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Monthly Benefit or ask for a lump sum refund. If we reduce the Monthly Benefit, the Minimum Monthly Benefit, if any, as shown on the Schedule of Benefits page, would not apply. Interest does not accrue on any underpaid or overpaid benefit unless required by applicable law.

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.
TERMINATION OF MONTHLY BENEFIT: The Monthly Benefit will stop on the earliest of:
(1) the date you cease to be Totally Disabled;
(2) the date you die;
(3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended; or
(4) the date you fail to furnish the required proof of Total Disability.

RECURRENT DISABILITY: If, after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability for the same or related cause will be part of a new period of Total Disability. A new Elimination Period must be completed before any further Monthly Benefits are payable.

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Elimination Period is not required. Our liability for the entire period will be subject to the terms of the Policy for the original period of Total Disability.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this recurrent disability section will not apply to you.
EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:
(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted injury; or
(3) your committing a felony; or
(4) an injury or sickness that occurs while you are confined in any penal or correctional institution.
LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If you were confined in a Hospital or Institution and:
(1) Total Disability continues beyond discharge;
(2) the confinement was during a period of Total Disability; and
(3) the period of confinement was for at least fourteen (14) consecutive days;
then upon discharge, Monthly Benefits will be payable for the greater of:
(1) the unused portion of the twenty-four (24) month period; or
(2) ninety (90) days;
but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:
(1) bipolar disorder (manic depressive syndrome);
(2) schizophrenia;
(3) delusional (paranoid) disorders;
(4) psychotic disorders;
(5) depressive disorders;
(6) anxiety disorders;
(7) somatoform disorders (psychosomatic illness);
(8) eating disorders; or
(9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.
If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:
(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the Substance; or
(4) the need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals’ Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

A Substance Abuse Rehabilitation Program means a program supervised by a Physician or a licensed rehabilitation specialist approved by us.

PRE-EXISTING CONDITIONS: Benefits will not be paid for a Total Disability:
(1) caused by;
(2) contributed to by; or
(3) resulting from;
a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date you became insured.

"Pre-Existing Condition" means any Sickness or injury for which you received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to your effective date of Insurance.
SPECIFIC INDEMNITY BENEFIT

If you suffer any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

(1) the Loss must occur within one hundred and eighty (180) days; and
(2) you must live past the Elimination Period.

For Loss of:                                      Number of Monthly Benefit Payments:

Both Hands.................................................................46 Months
Both Feet .................................................................46 Months
Entire Sight in Both Eyes .................................46 Months
Hearing in Both Ears..................................................46 Months
Speech .................................................................46 Months
One Hand and One Foot ..................46 Months
One Hand and Entire Sight in One Eye ..................46 Months
One Foot and Entire Sight in One Eye ..................46 Months
One Arm ...............................................................35 Months
One Leg ..............................................................35 Months
One Hand ...........................................................23 Months
One Foot ............................................................23 Months
Entire Sight in One Eye ...........................................15 Months
Hearing in One Ear ..................................................15 Months

"Loss(es)" with respect to:
(1) hand or foot, means the complete severance through or above the wrist or ankle joint;
(2) arm or leg, means the complete severance through or above the elbow or knee joint; or
(3) sight, speech or hearing, means total and irrecoverable Loss thereof.

If more than one (1) Loss results from any one accident, payment will be made for the Loss for which the greatest number of Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your
estate, unless a beneficiary is on record with us under the Policy.

Benefits may be payable longer than shown above as long as you are still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.
SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to your Survivor when we receive proof that you died while:

(1) you were receiving Monthly Benefits from us; and
(2) you were Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

"Survivor" means your spouse. If your spouse dies before you or if you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivor(s). If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.

A benefit payable to a minor may be paid to the minor's legally appointed guardian. If there is no guardian, at our option, we may pay the benefit to an adult that has, in our opinion, assumed the custody and main support of the minor. We will not be liable for any payment we have made in good faith.
WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

1) the Monthly Benefit prior to offsets with Other Income Benefits; and

2) earnings from Rehabilitative Employment;

exceed 100% of your Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

1) you are receiving benefits under the Work Incentive Benefit;
2) your Child(ren) is (are) under 14 years of age;
3) the child care is provided by a non-relative; and
4) the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: your unmarried child(ren), including any foster child, adopted child or step child who resides in your home and is financially dependent on you for support and maintenance.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.
A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder’s policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated if you become Totally Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Monthly Benefit which becomes payable will be based on your Covered Monthly Earnings immediately prior to the date of Total Disability.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage will be reinstated.
EXTENDED DISABILITY BENEFIT

We will pay an Extended Disability Benefit to you if you:

(1) meet all the requirements of Total Disability of the Policy; and
(2) are receiving a Total Disability Benefit under the Policy that will be exhausted because the Maximum Duration of Benefits has ended; and
(3) are unable to function without another person's Direct Assistance or verbal direction due to:

(a) an inability to perform at least two Activities of Daily Living (ADL) as defined; or
(b) Cognitive Impairment as defined; and

(4) are either:

(a) confined as an Inpatient in a Skilled Nursing Home, Rehabilitation Facility or Rehabilitation Hospital in which patients receive care from licensed medical professionals; or
(b) receiving Home Health Care or Hospice Care; and

(5) make a Written Request for this benefit within thirty (30) days after the Maximum Duration of Benefits has ended.

The Extended Disability Benefit:

(1) will be an amount equal to 85% of the Monthly Benefit after offsets with Other Income Benefits which was payable prior to you qualifying for the Extended Disability Benefit up to a maximum of $5,000 per month; and
(2) is payable for a maximum of sixty (60) months measured from the date that the Maximum Duration of Benefits has ended.

Definitions:

"Activities of Daily Living (ADL)" means:

(1) Bathing - the ability to wash oneself in the tub or shower or by sponge bath from a basin without Direct Assistance;
(2) Dressing - the ability to change clothes without Direct Assistance, including fastening and unfastening any medically necessary braces or artificial limbs;
(3) Eating/Feeding - the ability to eat without Direct Assistance, once food has been prepared and made available;
(4) Transferring - the ability to move in and out of a chair or bed without
Direct Assistance, except with the aid of equipment (including support and other mechanical devices); and

(5) Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to adjust clothing without Direct Assistance.

"Cognitively Impaired" and "Cognitive Impairment" means your confusion or disorientation due to organic changes in the brain resulting in a deterioration or loss in Intellectual capacity as confirmed by cognitive or other tests satisfactory to us.

"Direct Assistance" means you require continuous help or oversight to be able to perform the Activity of Daily Living (ADL).

"Home Health Care" means medical and non-medical services, provided in your residence due to Injury or Sickness, including: visiting nurse services; physical, respiratory, occupational or speech therapy; nutritional counseling; and home health aide services. Home Health Care services must be: (1) prescribed by and provided under the supervision of a Physician; and (2) rendered by a licensed home health care provider who is not a member of your Immediate family. Home Health Care does not include: homemaker, companion and home delivered meals services; nor informal care services provided by your family members.

"Hospice Care" means a program of care which coordinates the special needs of a person with a Terminal Illness. Hospice Care must be: (1) prescribed by and provided under the supervision of a Physician; and (2) rendered by a licensed hospice care provider who is not a member of your immediate family.

"Inpatient" means a person confined in a Skilled Nursing Home, Rehabilitation Facility or Rehabilitative Hospital, for whom a daily room and board charge is made.

"Pre-existing Condition" means with respect to the Extended Disability Benefit only, any Sickness or Injury for which you received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately preceding your effective date of insurance.

"Rehabilitation Facility or Rehabilitative Hospital" means any facility or Hospital that is licensed in the state in which it is operating to provide rehabilitation services, therapy or retraining to you to enable you to walk, communicate, and/or function as a member of society.
"Skilled Nursing Home" means a facility or part of a facility that is licensed or certified in the state in which it is operating to provide Skilled Nursing Care.

"Skilled Nursing Care" means that level of care which:

1. requires the training and skills of a Registered Nurse;
2. is prescribed by a Physician;
3. is based on generally recognized and accepted standards of health care by the American Medical Association; and
4. is appropriate for the diagnosis and treatment of your Sickness or Injury.

"Terminal Illness" means a Sickness or physical condition that is certified by a Physician in a written statement, on a form prescribed by us, to reasonably be expected to result in death in less than twelve (12) months.

"Written Request" means a request made, in writing, by you to us.

Pre-existing Conditions Limitation:

With respect to the Extended Disability Benefit only, benefits will not be paid for a Total Disability:

1. caused by;
2. contributed to by; or
3. resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months measured from your effective date of insurance with us.

No benefits will be paid under the Extended Disability Benefit if your Total Disability occurred before your effective date of Insurance with us.

The Extended Disability Benefit will cease to be payable on the earliest of the following dates:

1. the date you die; or
2. the date you no longer meet the requirements of Total Disability of the Policy; or
3. the date you:
   (a) are no longer confined as an Inpatient in a Skilled Nursing Home, Rehabilitative Facility or Rehabilitation Hospital; or
(b) are no longer receiving Home Health Care or Hospice Care; or

(4) the date you are no longer considered Cognitively Impaired; or
(5) the date you are no longer unable to perform at least two Activities of Daily Living (ADL); or
(6) the date you receive your 60th monthly Extended Disability Benefit payment.

The Extended Disability Benefit will not be payable for Total Disability which is caused by or results from conditions for which Monthly Benefits are specifically limited by the Policy such as Mental or Nervous Disorders, alcoholism, drug addiction, or other Substance Abuse, musculoskeletal and connective tissue disorders, chronic fatigue syndrome, Environmental Allergic or Reactive Illness, or Self-Reported Conditions.

If the Policy contains a Survivor Benefit, Activities of Daily Living Benefit (ADL), Catastrophic Care Benefit, Supplemental Pension Benefit, Living Benefit, Cost of Living Benefit or a Conversion Privilege, such benefits are not applicable when receiving benefits under the Extended Disability Benefit.
REHABILITATION BENEFIT

"Rehabilitative Employment" means work in any gainful occupation for which your training, education or experience will reasonably allow. The work must be supervised by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms of the Policy and are able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that you can perform such employment.
SUMMARY OF GENERAL PURPOSES AND CURRENT LIMITATIONS OF COVERAGE

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of the Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted later in this summary.

DISTRICT OF COLUMBIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agent are

LRS-8767-0593
prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.

Policyholders with additional questions may contact:

<table>
<thead>
<tr>
<th>Mr. Robert M. Willis</th>
<th>Mr. Thomas E. Hampton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director</td>
<td>Commissioner</td>
</tr>
<tr>
<td>District of Columbia Life and Health Insurance Guaranty Association</td>
<td>District of Columbia Department of Insurance, Securities and Banking</td>
</tr>
<tr>
<td>1200 G Street, N.W.</td>
<td>810 First Street, N.E.</td>
</tr>
<tr>
<td>Washington, DC 20005</td>
<td>Suite 701</td>
</tr>
<tr>
<td>(202) 343-8771</td>
<td>Washington, D.C. 20002</td>
</tr>
<tr>
<td>Fax: (202) 347-2990</td>
<td>(202) 727-3000</td>
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The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. The following information contains a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act of the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.
COVERAGE

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or if they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation);

- their insurer was not authorized to do business in the District of Columbia; or

- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;

- any policy of reinsurance (unless an assumption certificate was issued);

- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;

- interest rate guarantees which exceed certain statutory
limitations;

- dividends, experience rating credits of fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or for
- unallocated annuity contracts.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- with respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender or net cash withdrawal values for life insurance; or
  - $100,000 in health insurance benefits, including net cash surrender or net cash withdrawal values; or
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values.

Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.
SUMMARY PLAN DESCRIPTION
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

**SUMMARY PLAN DESCRIPTION**

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

| PLAN NAME: | Group Long Term Disability Insurance |
| PLAN SPONSOR: | International Union of Operating Engineers Local 59-59A Health & Welfare Fund 2461 Wisconsin Avenue NW Washington, DC 20007 |
| SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: | 52-6072849 |
| PLAN NUMBER: | 501 |
| TYPE OF PLAN: | Welfare Benefit Plan |
| PLAN BENEFITS: | Fully Insured - Group Long Term Disability Insurance Benefits |
| TYPE OF ADMINISTRATION: | The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090. |
| PLAN ADMINISTRATOR: | The Plan Sponsor named above. |
AGENT FOR SERVICE OF LEGAL PROCESS:
The Plan Sponsor named above.

PLAN YEAR:
The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS:
The cost of the benefits provided under the plan are paid for by the employer.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS:
A plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION:
The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-844-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims

If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the Initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, 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 claimant’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 claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse 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 determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant's claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

(a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and

(b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, 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 as above due to a claimant'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 claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, 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 as above due to a claimant'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 claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims
A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable);
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse 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 determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
6. 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” (where applicable).
DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- 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;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

**ERISA STATEMENT OF RIGHTS**

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.