WISCONSIN ELECTRICAL EMPLOYEES
HEALTH AND WELFARE PLAN
Restated Rules and Regulations Effective April 1, 2020

WISCONSIN ELECTRICAL EMPLOYEES
HEALTH AND WELFARE PLAN

ADOPTION RESOLUTION

RESOLVED, that effective April 1, 2020, the Board of Trustees of the Wisconsin Electrical Employees Health and Welfare Plan adopt the attached Restated Rules and Regulations to provide benefits for Eligible Individuals upon the following understanding and conditions:

1. It is recognized that the payments provided for in these Restated Rules and Regulations can be made only to the extent that the Plan has available adequate resources for such payments. No Employer has any liability directly or indirectly, to provide the benefits hereunder beyond the obligation of the Employer to make contributions as stipulated in the applicable Labor Agreement or Participation Agreement. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make such payments.

2. None of the payments provided for in these Restated Rules and Regulations are insured by any contract of insurance (other than through a stop-loss insurance contract) and there is no duty or liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Plan collected and available for such purpose.

The undersigned Chairman and Secretary of the Wisconsin Electrical Employees Health and Welfare Plan do hereby certify that the foregoing Adoption Resolution was duly adopted at a meeting duly called and held on April 28, 2020.

______________________________	______________________________
Chairman	Secretary

WISCONSIN ELECTRICAL EMPLOYEES
HEALTH AND WELFARE PLAN

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WISCONSIN ELECTRICAL EMPLOYEES
HEALTH AND WELFARE FUND

RULES AND REGULATIONS

INTRODUCTION

The Plan shall pay benefits as provided in these Rules and Regulations only to the extent that the Plan's assets allow. The Wisconsin Electrical Employees Health and Welfare Plan Trust Agreement ("Trust Agreement") shall at all times control the provision of benefits and the operation and administration of the Rules and Regulations. Section 7.2 of the Trust Agreement provides that the Plan's program of benefits shall be described in a written instrument. Effective as of September 1, 1989, the Trustees of the Plan agreed that the Plan's program of benefits shall be self-funded. A written instrument describing those noninsured benefits provided by the Plan was required to replace the various programs of benefits previously provided to the participants of the health plans maintained by participating employers and local unions of the International Brotherhood of Electrical Workers, AFL-CIO. This document, entitled "Wisconsin Electrical Employees Health and Welfare Fund Rules and Regulations," is the written instrument prescribed by the foregoing notice in section 7.2 of the Plan's Trust Agreement. Because of numerous changes these Rules and Regulations were restated January 1, 1994 and April 1, 2020.

All rights and powers of the Plan as provided herein shall be vested in the Trustees. The Trustees have adopted these Rules and Regulations pursuant to the Trust Agreement to define the terms and conditions determining the eligibility of Employees for benefits and to prescribe the amount, extent, conditions and method of paying and funding such benefits. Consistent with their obligation to maintain, within the funds available, a sound and economical program providing reasonable benefits for Employees, Participants and Dependents, the Trustees expressly reserve the right, in their sole discretion, to:

1. establish, amend or terminate the amount, eligibility requirements or conditions with respect to any benefit;

2. alter the method of paying any benefit;

3. amend any provision of these Rules and Regulations; and

4. interpret these Rules and Regulations.

ARTICLE I

DEFINITIONS

1.1 Accident. "Accident" means a sudden and unforeseen event or occurrence which results in injury or death of an individual.

1.2 Active Employee. "Active Employee" means any person actively employed by an Employer, the Union, the Fund Office or the Association on whose account the Employer, Union, Fund Office or Association is, or has been required to make contributions to the Plan, or is eligible for benefits. The term "Active Employee" shall also include "Active Hourly Employee" and "Active Employer Staff Employee". An owner of an unincorporated entity, including a sole proprietor or a partner of a partnership, shall not be deemed an Active Employee.

1.3 Active Hourly Employee. "Active Hourly Employee" means any person on whose account the Employer is or has been required to make contributions to the Plan under a Collective Bargaining Agreement and who is eligible for coverage under section 2.2 or section 2.4.

1.4 Active Employer Staff Employee. "Active Employer Staff Employee" means any person employed in the State of Wisconsin on whose account the Employer, Union, Fund Office or Association is or has been required to make contributions to the Plan and who is eligible for coverage under section 2.3. The term "Active Employer Staff Employee" also means a former Participant who is performing services for the Union and on whose behalf the Union is obligated to make contributions pursuant to a Participation Agreement for that category of former Participant(s).

1.5 Affordable Care Act. “Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended, and implementing regulations and guidance.

1.6 Ambulatory Surgical Center. "Ambulatory Surgical Center: means an institution which satisfies all of the following requirements:

(a) It is licensed by the proper authority;

(b) It primarily provides, for compensation from its patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons as outpatients; and

(c) It provides such facilities under the supervision of a staff of Physicians, registered nurses and other health care professionals.

1.7 Approved Clinical Trial. "Approved Clinical Trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-threatening Condition and is:

(a) Approved or funded by one of the following:

(i) The National Institute of Health;

(ii) The Centers for Disease Control and Prevention;

(iii) The Agency for Health Care Research and Quality;

(iv) A cooperative group or center of any of the above entities or the Departments of Defense or Veterans Affairs;

(v) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(vi) The Departments of Veterans Affairs, Defense, or Energy if certain conditions are met;

(b) Conducted under an investigational new drug application reviewed by the FDA; or

(c) A drug trial that is exempt from having such an investigational new drug application.

1.8 Association. "Association" means the Wisconsin Chapter of the National Electrical Contractors Association, Inc.

1.9 Beneficiary. "Beneficiary" means a person designated by a Participant to receive any Death and/or Accidental Death and Dismemberment benefits under this Plan.

1.10 Board of Trustees or Trustees. "Board of Trustees or Trustees" means the Board of Trustees as established by the Trust Agreement or their successor or successors. The Board of Trustees is the plan administrator.

1.11 COBRA. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

1.12 Collective Bargaining Agreement. "Collective Bargaining Agreement" means an agreement which requires contributions to the Plan and is entered into between the Association and the Union regulating the terms and conditions of employment and any amendments, renewals or modifications thereof and any similar agreements which require contributions to the Plan made between the Union and any Employer not represented by the Association. It shall also include an agreement between a participating Local Union and another labor organization with which it bargains which provides for participation of the Local Union's employees in the Plan.

1.13 Concurrent Review. "Concurrent Review" means the review of the confinement while an Eligible Individual is inpatient confined. The review of the continued stay in the facility is coordinated with the Physician, the facility and the review coordinator for determining Medically Necessary and Reasonable care. The review is designed to eliminate unnecessary treatment or unneeded, prolonged confinements.

1.14 Continuously Disabled. "Continuously Disabled" means unable to perform any duties of any job available by the Employer for which the Active Hourly Employee, Active Employer Staff Employee or Self-Pay Active Hourly Employee was working at the time of disability.

1.15 Covered Charges. "Covered Charges" means any Medically Necessary, reasonable service or supply rendered in the care of an eligible individual for which benefits are provided in accordance with the applicable Plan provisions.

1.16 Covered Employment. "Covered Employment" means employment for an Employer for which it is required to make contributions to the Plan under a Collective Bargaining Agreement. For purposes of Plan section 2.2 (e)(v), Covered Employment shall mean (a) employment with a non-participating employer in the same "trade or craft" and "industry" (as defined under ERISA section 203(a)(3)(B)) in which Participants are engaged that would have generated a contribution to the Plan if performed with an Employer or (b) employment with a non-participating employer that would otherwise have been performed by an Employer and its employees.

1.17 Covered Drug. "Covered Drug" means a drug or medicine prescribed for human use by a licensed Physician acting within the scope of his practice and dispensed by a licensed pharmacist, except a drug or medicine excluded under the terms of the Plan. The prescription must be a written order signed by the Physician, and must bear the name, address and license classification of the Physician, the name and address of the patient, the name and quantity of the drug prescribed, directions for use and date of issue, and must bear the legend, "Caution-Federal Law Prohibits Dispensing Without a Prescription," or is otherwise restricted by state law to sales by prescription. A Covered Drug must be prescribed in accordance with and for a medical condition for which the FDA has authorized such use.

1.18 Covered Provider. "Covered Provider" means the following providers:

(a) A program in an outpatient treatment facility if approved by the Department of Health and Social Services ("DHSS") and if established and maintained according to the rules promulgated by DHSS;

(b) A licensed Physician who has completed a residency in psychiatry;

(c) A licensed psychologist who is listed in the national register of health service providers in psychology;

(d) A social worker on the staff of a certified outpatient clinic who satisfies the requirements of Wis. Admin. Code HSS 61.96(1)(B) and (3). The term "social worker" shall include the following:

(i) Persons with a masters degree from a graduate school of social work accredited by the council on social worker education; or

(ii) A registered nurse with a masters degree in psychiatric mental health nursing or community mental health nursing from a graduate school of nursing accredited by the national league for nursing; and

(e) A psychological assistant, trainee or intern conducting diagnostic testing and treatment techniques under the direct supervision of a licensed psychologist.

1.19 Custodial Care. Any care intended primarily to help a disabled person meet basic personal needs when:

(a) There is no plan of active medical treatment to reduce the disability; or

(b) The plan of active medical treatment cannot reasonably be expected to reduce the disability.

1.20 Dentist. "Dentist" means a Doctor of Dental Surgery or Doctor of Medicine in Dentistry.

1.21 Dependent. A “Dependent” is one of the following:

(a) The Participant's spouse, pursuant to a marriage that was lawfully licensed and performed between two individuals, unless the Participant and spouse are legally separated under the terms of a legal separation agreement that does not require the Participant to provide health coverage to the spouse.

(b) The Participant's natural born child, legally adopted child and child placed for adoption from birth until the end of the calendar month in which the child attains his 26th birthday. A child placed for adoption means the assumption and retention by the Participant of a legal obligation for total or partial support of the child in anticipation of adoption of such child.

(c) The Participant's unmarried other dependent child from birth until the end of the calendar year in which the child attains his 19th birthday, or to the end of the calendar month in which the child attains his 26th birthday if attending school as a full time student.

(i) A "full time" student means a child who is attending a post-secondary accredited college, university, graduate or vocational school on a full-time basis, as defined by such institution, or who is taking the minimum credits required for graduation during their final semester or quarter, provided, however that the Trustees shall review the circumstances and approve full-time status if the minimum credits fall below six credit hours during such last semester or quarter. A full-time student whose quarter or semester begins in one calendar year and ends in the next calendar year will be covered until the end of the calendar year in which the semester or quarter ends. A full-time student enrolled in the first semester or quarter following January 1 of each year will be covered until the end of the calendar year. A full-time student who is not enrolled in the first semester or quarter following January 1 will be terminated at the end of the calendar year in which full-time student status ended and shall be reinstated as a Dependent from the date he becomes a full time student until the end of the calendar year. Notwithstanding

the above, no Dependent child shall be covered under this provision after the last day of the calendar month in which the child attains age 26.

(ii) If an other dependent child who is covered under the Plan has full-time student status immediately before the first day of a medically necessary leave, Plan coverage shall not terminate for such Dependent child due to a medically necessary leave of absence before the date that is the earlier of:

[a] The date that is one year after the first day of the medically necessary leave of absence; or

[b] The date on which such coverage would otherwise terminate under the terms of the Plan.

A medically necessary leave of absence means, for purposes of this subsection (c)(ii), a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that

[a] Commences while such child is suffering from a serious Illness or injury;

[b] Is medically necessary; and

[c] Causes such child to lose student status as a full-time student for purposes of coverage under the terms of the Plan.

A treating physician of the Dependent child must provide a written certification to the Plan that the Dependent child is suffering from a serious Illness or injury and that the leave of absence (or other change of enrollment) described above is medically necessary.

The Plan shall include with any notice regarding a requirement for certification of student status for coverage under the Plan, a description of the terms of this subsection (c)(ii) in understandable language, for continued coverage during a medically necessary leave of absence.

A Dependent child whose benefits are continued under this subsection (c)(ii) shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to have full-time student status at the institution of higher education and was not on a medically necessary leave of absence.

If the Plan coverage changes while a Dependent child is being covered pursuant to a medically necessary leave of absence, then the provisions of this subsection (c)(ii) shall apply to the changed coverage of the Dependent child for the remainder of the period of the medically necessary leave of absence in the same manner as it would have applied to the previous coverage, provided the Plan continues to provide Dependent coverage.

(iii) An "other dependent" child will qualify as a Dependent child of a Participant provided he:

[a] Maintains a parent-child relationship with the Participant as a step child, foster child, or a child whose custody is court ordered;

[b] Does not provide more than half of his financial support during the calendar year;

[c] Has the same principal residence as the Participant for more than half the calendar year except for temporary absences, (such as an absence to attend school);

[d] Is younger than the Participant (unless the Dependent child is Totally and Permanently Disabled); and

[e] Is unmarried.

Further, an individual described in the preceding paragraphs of this subsection (c) can qualify as a Dependent child if

[a] He bears a relationship to the Participant described in subsection (c)(iii)[a];

[b] The Participant provides over one half of the individual's support for the calendar year; and

[c] The individual is not considered a "qualifying child" of the Participant or another taxpayer pursuant to Code section 152.

(d) The Participant's unmarried dependent children who are incapable of self-sustaining employment because they are Totally and Permanently Disabled, and who become so incapable prior to the date the coverage would otherwise terminate, will continue to be covered for benefits beyond the limiting ages provided the child

(i) Receives over half of his annual financial support and maintenance from the Participant;

(ii) Has the same principal residence as the Participant for more than half the calendar year except for temporary absences or resides in a treatment center (or alternatively, is not considered a qualifying child of the Participant or another taxpayer pursuant to section 152 of the Code); and

(iii) The Participant continues Dependent coverage.

Notification and satisfactory proof of such incapacity must be furnished to the Fund Office within 31 days of the date the Dependent child's coverage would otherwise terminate.

(e) Any unmarried natural or adopted child (or child placed for adoption) who is an alternate recipient under a qualified medical child support order or National Medical Support Notice for whom the Participant must provide health benefits.

(f) A Dependent child shall be a citizen or national of the United States or a resident of the United States, Canada or Mexico. This provision does not exclude an adopted child who does not meet the citizenship criteria if the child has the same principal residence as the Participant, is a member of the Participant's household and the Participant is a citizen or national of the United States.

(g) A child shall in no event be eligible as a Dependent if he is also a Participant covered under this Plan or is an eligible employee covered under the plan of another Employer. The preceding sentence shall not apply to a child described in subsection (b) of this section.

(h) A child shall cease to be eligible as a Dependent if, at any time after the child's eighteenth birthday, the child is legally adopted and issued a new birth certificate that does not list a Participant as a parent.

(i) The Participant is responsible for confirming that individuals are properly enrolled as Dependents. Proof of dependency status for a spouse or children may be required from time to time by the Board of Trustees. The Participant and/or Dependent is also responsible for notifying the Plan if a Dependent loses dependent status.

1.22 Disabled Employee. A “Disabled Employee” is an Active Employee or Self-Pay Active Hourly Employee who becomes Totally and Permanently Disabled, while covered under the Plan.

1.23 Dollar Bank. The "Dollar Bank" is a system in which the contributions for hours worked for an Employer are accumulated for credit in an Active Hourly Employee's "Dollar Bank Account."

1.24 Early Retiree. "Early Retiree" means a retiree who is under age 65 and not eligible for Medicare.

1.25 EGWP. "EGWP" means an Employer Group Waiver Program sponsored by a Center for Medicare services, approved administrator and adopted by the Trustees.

1.26 Eligible Employee. An “Eligible Employee” means each Active Employee, Self-Pay Active Hourly Employee, Self-Pay Disabled Employee, Early Retiree and Retiree. In addition, Eligible Employees’ surviving spouses will be considered Eligible Employees.

1.27 Eligible Individual. An “Eligible Individual” means each Participant, each Dependent, and each Qualified Beneficiary.

1.28 Employer. An “Employer” means an employer as defined in section 1.4 of the Trust Agreement.

1.29 FMLA. "FMLA" means the Family Medical Leave Act of 1993, as amended, and interpretive guidance.

1.30 Formulary. "Formulary" means a list of preferred brand name drug products adopted by the Trustees, which is subject to change.

1.31 Fund Office. “Fund Office” means the entity designated and engaged by the Board of Trustees to administer the Plan and process benefit claims.

1.32 HIPAA. "HIPAA" means Health Insurance Portability and Accountability Act and interpretive guidance.

1.33 Home Health Care. “Home Health Care” means the program for care and treatment of an Eligible Individual in a private residence by or through an organization or agency which meets the requirements for participation as a Home Health Care Agency under Medicare.

1.34 Home Health Care Agency. “Home Health Care Agency” means

(a) A certified rehabilitation agency; or

(b) A non-profit public home care service or agency possessing a valid certificate or approval issued in accordance with Title XVIII of the Social Security Act of 1965, as amended from time to time, or duly licensed if such licensing is required, by the appropriate licensing authority.

1.35 Hospice. “Hospice” means an organization, agency or facility licensed by the state in which it is headquartered or accredited by a national accrediting organization or recognized as a hospice program by the U.S. Department of Health and Human Services and meets the certification requirements of a hospice agency as required by Medicare.

1.36 Hospice Care. “Hospice Care” means palliative and supportive medical, health care and other services provided to Terminally Ill Patients to meet special physical and emotional needs as part of dying so that a Hospital patient may remain at home, to the maximum extent possible, with home-like Inpatient care utilized only if and while it is necessary.

1.37 Hospital. “Hospital” means an institution which is duly licensed as a hospital (to the extent such licensing is required by state or federal law) and which is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis and which meets all of the following requirements:

(a) Is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a hospital, a psychiatric hospital or a tuberculosis hospital, as those terms are defined by Medicare, that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;

(b) Provides organized facilities for diagnosis and surgery either on its premises or at an institution with which such establishment has a formal arrangement for the provisions of such facilities;

(c) Provides 24-hour-a-day nursing serviced by registered or graduate nurses on duty or call;

(d) Has a staff of one or more licensed Physicians available at all times; and

(e) Is not primarily a clinic, nursing facility, rest facility, convalescent facility, facility for the aged, or an extended care facility or similar establishment. Confinement in a special unit of a Hospital used primarily as a nursing facility, rest facility, convalescent facility, facility for the aged or an extended care facility is deemed, with respect to coverage provided by the Plan, to be confinement in an institution other than a Hospital.

To the extent that benefits are provided, a facility approved under the laws of the state of its jurisdiction, for the treatment of Mental, Nervous or Emotional Disorders and Substance Abuse will be considered a "Hospital" under this Plan, with respect to benefits for such treatment.

1.38 Illness. "Illness" means a disease, disorder, or condition that requires treatment by a Physician, including pregnancy.

1.39 Injury or Bodily Injury. “Injury” or “Bodily Injury” means physical damage caused by purely accidental means, independently of all other causes of loss. Only non-work related Injury or Bodily Injury is considered for benefits under this Plan, except under the Death Benefits or Accidental Death and Dismemberment Benefits.

1.40 Inpatient. “Inpatient” means confinement of an Eligible Individual in a Hospital or Substance Abuse Treatment Facility as a registered bed patient.

1.41 Intensive Care Unit. “Intensive Care Unit” means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a registered nurse (R.N.) or other trained Hospital personnel.

1.42 Life-threatening Condition. "Life-threatening Condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

1.43 Maintenance Drug. “Maintenance Drug” means a Covered Drug taken by an Eligible Individual on a continued basis for a chronic health condition.

1.44 Medical Emergency. “Medical Emergency” means a sudden and unexpected Illness or accidental Bodily Injury manifesting itself by acute symptoms, including severe pain, which are severe enough that a prudent layperson could reasonably expect that the lack of immediate medical attention to result in any of the following:

(a) The patient's health would be placed in serious jeopardy.

(b) Bodily function would be seriously impaired.

(c) There would be serious dysfunction of a bodily organ or part.

1.45 Medically Necessary and Reasonable. "Medically Necessary and Reasonable" means a service or supply which is appropriate and consistent with the diagnosis of an Eligible Individual's particular condition and which meets all of the following requirements:

(a) It is appropriate and necessary for the symptoms (i.e., diagnosis or treatment of a medical condition);

(b) It is provided for the diagnosis or direct care and treatment of a medical condition;

(c) It is within standards of good medical practice within the organized medical community;

(d) It is not primarily for the convenience of the patient, the attending or consulting Physician, or any other health care provider; and

(e) It is the most appropriate level of services or supplies which can be safely provided.

The Trustees in their discretion will interpret what is Medically Necessary and Reasonable. The Trustees will take into account relevant information including, but not limited to, clinical utilization management guidelines or medical policies approved, accepted or endorsed by the organizations selected by the Trustees to serve as the Plan's utilization review or management firm.

1.46 Medicare. "Medicare" means the benefits provided under Title XVIII of the Social Security Amendment Act of 1965, and as amended from time to time.

1.47 Mental, Nervous and Emotional Disorders. "Mental, Nervous and Emotional Disorders" means any nervous, psychoneurosis, psychopathy, psychosis or mental or emotional disease of any kind regardless of whether such disease or disorder is organic or functional, including bulimia, anorexia nervosa, and similar disorders.

1.48 Morbid Obesity. "Morbid Obesity" means a condition of obesity in which all of the following additional conditions are found to exist:

(a) The Eligible Individual is twice his ideal weight or more, has a body mass index (BMI) of 40 or more, or has a BMI of 35 or more with life threatening co-morbid condition;

(b) The Eligible Individual has demonstrated to the reasonable satisfaction of the Trustees or their delegated representatives his inability to control weight over a period of five consecutive years;

(c) The Eligible Individual is found by competent evidence of a reasonable medical certainty to suffer from a documented separate condition which is aggravated by obesity;

(d) The Eligible Individual must be determined by competent medical evidence of a reasonable medical certainty to be psychiatrically stable;

(e) The Eligible Individual must demonstrate that he participated in three medically supervised weight loss programs which have failed;

(f) The Eligible Individual must be at least 21 years old;

(g) The Eligible Individual's treating Physician confirms in writing that the individual has tried in good faith for at least 12 consecutive months to lose weight; and

(h) The Eligible Individual has demonstrated the ability to modify his eating patterns by losing at least 5% of his weight during the 12-consecutive month period preceding his request for treatment.

1.49 Network Pharmacy. A "Network Pharmacy" means a pharmacy participating in the SavRx Pharmaceutical Services Network.

1.50 Occupational Therapy. "Occupational Therapy" means the use of educational, vocational, and rehabilitative techniques to restore a patient's functional ability to previous levels or to live independently.

1.51 Optional Benefits. "Optional Benefits" means the Comprehensive Dental Benefits, Preventive Dental Benefits, Vision Care Benefits, Supplemental Unemployment Benefits or Flexible Benefit Account Program. These benefits are optional provided the Employer or Union has elected such in writing. Comprehensive Dental Benefits can only be elected if the Employer or Union previously had a preventive dental plan or was covered under this Plan's Preventive Dental Benefits for a period of two or more years. An Employer or Union who elects any of the Optional Benefits for a period must commit to continue that coverage continuously for at least five years. Optional Benefits, other than Flexible Benefit Account Program, are not available to Retirees or Early Retirees or their Dependents.

1.52 Outpatient. "Outpatient" means services or treatment rendered to an Eligible Individual at a Hospital or licensed treatment facility as an outpatient and is not assigned or registered as a bed patient.

1.53 Participant. "Participant" means an Eligible Employee covered under the Plan pursuant to Article II.

1.54 Participation Agreement or Memorandum of Understanding. "Participation Agreement" or "Memorandum of Understanding" means an agreement in the form or content acceptable to the Trustees pursuant to which an Employer consents to be bound by the Trust Agreement and Collective Bargaining Agreement and adopts the Plan.

1.55 Physical Therapy. "Physical Therapy" means the use of physical agents to treat a disability resulting from disease or injury to restore a patient's functional ability to previous levels. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.

1.56 Physician. "Physician" means an individual holding an unlimited license to practice medicine and surgery as a physician as recognized by the state in which he practices,

provided he is acting within the scope of his license. To the extent that benefits are provided and while practicing within the scope of his license, the term "Physician" includes a Medical Doctor (M.D.), Osteopath (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Podiatrist (D.P.M.), Chiropractor (D.C.), Licensed Clinical Psychologist (Ph.D.) or Optician (O.D.). In addition, to the extent required by the Affordable Care Act, if a practitioner's service is covered under the Plan, the Plan will not discriminate based on the practitioner's license or certification, if the practitioner is licensed to provide such services in the state in which the services are performed and the practitioner is acting within the scope of that license.

1.57 Plan. “Plan” means the Wisconsin Electrical Employees Health and Welfare Plan established by the Trust Agreement and as amended from time to time.

1.58 Plan Year. “Plan Year” means the 12-month period beginning January 1 and ending December 31.

1.59 Preferred Provider Option (PPO). “Preferred Provider Option” or “PPO” means those Physicians, Hospitals, clinics or other service providers, so designated by an organization approved by the Trustees, to provide quality medical care and services to Eligible Individuals in accordance with established and prearranged procedures and fees.

1.60 Qualified Beneficiary. “Qualified Beneficiary” means a Participant or Dependent who, on the day before a Qualifying Event, is covered under the Plan. In addition, a child born to or placed for adoption with an Eligible Employee while the Employee is continuing Plan coverage under COBRA shall also be a Qualified Beneficiary under the Plan.

1.61 Qualifying Event. “Qualifying Event” means any of the following events when such event results in the loss of coverage under the Plan:

(a) The death of an Eligible Employee;

(b) The voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of an Active Employee;

(c) The date the Eligible Employee enters the Armed Forces of the United States on full-time active duty;

(d) The divorce or legal separation of an Eligible Employee from their spouse;

(e) A Self-Pay Active Hourly Employee's, Self-Pay Disabled Employee's or Retiree's entitlement to Medicare coverage;

(f) A Dependent child ceasing to be a Dependent child.

1.62 Qualified Individual. "Qualified Individual" is an Eligible Individual who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition and either (1) the referring health care professional is a participating provider and has concluded that the Eligible Individual's participation in the Approved Clinical Trial would be appropriate or (2) the Eligible Individual's

provides medical and scientific information establishing that participation in the Approved Clinical Trial would be appropriate.

1.63 Rehabilitation Facility. "Rehabilitation Facility" means a facility that is recognized by the Plan and licensed or certified to perform rehabilitative health care services by the state or jurisdiction where services are provided. Services of such a facility must also be among those covered by the Plan.

1.64 Respite Care. "Respite Care" means care that is furnished to an Eligible Individual when confined as an Inpatient so that the family unit may have relief from the stress of the care of the Eligible Individual.

1.65 Retiree . "Retiree" means an Active Hourly Employee, Active Employer Staff Employee, a Self-Pay Active Hourly Employee or a Self-Pay Disabled Employee, who subsequently elects to continue medical coverage under Self-Payment for Retirees.

1.66 Routine Patient Costs. "Routine Patient Costs" include items and services typically provided under the Plan for an Eligible Individual not enrolled in an Approved Clinical Trial. However, such items and services do not include (1) the investigational item, device or service itself; (2) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (3) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

1.67 Self-Pay Active Hourly Employee. "Self-Pay Active Hourly Employee" means an Active Hourly Employee, who subsequently elects to continue coverage under the Self-Payment Provisions.

1.68 Self-Pay Disabled Employee. "Self-Pay Disabled Employee" means an Active Hourly Employee, Active Employer Staff Employee or a Self-Pay Active Hourly Employee who becomes Totally and Permanently Disabled and subsequently elects to continue coverage under the Self-Payment for Disabled Employees.

1.69 Specialty Drugs. "Specialty Drugs" are Covered Drugs used to treat complex conditions, such as, but not limited to, cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, and multiple sclerosis, that are identified on the listing of medications provided by the Plan's Pharmaceutical Service Network provider, as modified from time to time without notice, when accessed through the specialty drug program adopted by the Trustees.

1.70 Skilled Nursing Facility. "Skilled Nursing Facility" means a lawfully operated institution for the care and treatment of persons convalescing from a Bodily Injury or Illness which meets all of the following requirements:

(a) Maintains permanent and full-time facilities for bed care of three or more resident patients;

(b) Has available at all times the service of a Physician;

(c) Has one or more registered nurses (R.N.) or Physicians on full-time duty in charge of patient care and one or more registered nurses (R.N.) or licensed practical nurses (L.P.N.) on duty at all time;

(d) Maintains a daily medical record for each patient;

(e) Is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent state of their Illnesses or Injuries and is not, other than incidentally, a rest home or a home for Custodial Care; and

(f) If a nursing home, is operating lawfully in the jurisdiction where it is located.

1.71 Speech Therapy. "Speech Therapy" means services used for diagnosis and treatment of speech and language disorders to restore the patient's functional ability to previous levels.

1.72 Substance Abuse. "Substance Abuse" means alcohol or drug usage resulting in the need for medical treatment.

1.73 Substance Abuse Treatment Facility. "Substance Abuse Treatment Facility" means an institution primarily engaged in the treatment of Substance Abuse which meets all of the following requirements:

(a) Maintains permanent and full-time facilities for bed care and full-confinement of at least 15 resident patients;

(b) Has a Physician in regular attendance;

(c) Continuously provides 24-hour a day nursing service by registered nurses (R.N.);

(d) Has a full-time psychiatrist or psychologist on staff;

(e) Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse; and

(f) Is licensed by the state of jurisdiction.

1.74 Terminally Ill Patient. "Terminally Ill Patient" means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six months or less.

1.75 Totally and Permanently Disabled. "Totally and Permanently Disabled" means complete inability due solely to accidental Bodily Injury or Illness of the Active Employee to perform his regular and customary work, and a Dependent child's complete inability due solely to Bodily Injury or Illness to engage in the normal activities of a person in good health of the same sex and age.

(a) An Active Employee will be deemed Totally and Permanently Disabled upon determination by the Social Security Administration that he is entitled to a Social Security Disability Award. The Board of Trustees may at any time require evidence of continued entitlement to such Social Security Disability Award.

(b) An Active Employee may also be deemed Totally and Permanently Disabled for the first two years if the Board of Trustees determine, in accordance with standards consistently applied, that he is fully incapable, due to a physical or mental impairment, of performing every duty of his regular and customary work.

(c) After the first two-year period and for the rest of such continuous period of total disability, the Board of Trustees may deem such employee Totally and Permanently Disabled if such full incapacity, which is due to a physical or mental impairment, keeps him from doing every duty of any occupation or employment for which he is qualified by education, training or experience.

(d) The Board of Trustees may from time to time request evidence of an Active Employee's or Dependent child's being continually Totally and Permanently Disabled. Any expense incurred as a result of such request shall be the responsibility of the Eligible Employee.

1.76 Trust Agreement or Trust. “Trust Agreement” or “Trust” means the Wisconsin Electrical Employees Health and Welfare Plan Trust Agreement, as amended from time to time.

1.77 Union. “Union” means the locals of the International Brotherhood of Electrical Workers AFL-CIO which have adopted the Trust as set forth in Appendix A.

1.78 Usual, Customary and Reasonable or UCR. “Usual, Customary and Reasonable” or “UCR” means the charge for the services and/or supplies by other health care providers in the same geographic area where services were rendered as determined in accordance with the schedule as published by ePlan, or its successor, from time to time. For Hospital and medical services or supplies rendered or supplied by a PPO Hospital, PPO Physician or other PPO provider to or on behalf of an Eligible Individual, the UCR shall mean the lesser of the prearranged fee established under the PPO agreement or the billed charged of the PPO provider. With respect to dental benefits, the UCR for PPO charges shall be based on the allowance established in accordance with the agreement between the PPO and the Plan and with respect to the charges of a non-PPO provider, the allowance established by the PPO. Under no circumstances will the Plan pay a UCR for services or supplies provided by a non-PPO provider that is determined by any provider, facility, or other person or organization other than the Trustees or organization designated by the Trustees.

1.79 Withdrawal. A “Withdrawal” shall occur when an Employer's Collective Bargaining Agreement ceases to require contributions to the Plan for Active Employees or the Employer otherwise ceases to be required to make contributions to the Plan.

1.80 Withdrawal Group. “Withdrawal Group” means the current and former Active Employees of an Employer which experiences a Withdrawal. Where a local Union negotiates health benefit coverage for a substantial number of its members from a source other than the Plan, then the Trustees may treat all of the current and former Active Employees of the affected

Employers which had Collective Bargaining Agreements with the affected local Union as a single Withdrawal Group. The Withdrawal Group shall include persons on COBRA (in certain circumstances), retirees, self-pay and surviving Dependents who were eligible for that coverage on account of Covered Employment under the Withdrawal Group.

ARTICLE II

PARTICIPATION AND ELIGIBILITY REQUIREMENTS

2.1 Participation.

(a) Active Hourly Employees. Eligibility for coverage is based on Active Hourly Employee hours and contributions, as reported and submitted, either directly or through reciprocal transfer, by a signatory Employer as required by the Collective Bargaining Agreement.

Hours for employment will be credited only on those hours remitted upon by an Employer.

Each Union must provide medical, short-term disability, death and accidental death and dismemberment benefits. Optional Benefits can be elected by the Union.

(b) Active Employer Staff Employees. The office staff of any Employer shall be eligible to participate in this Plan on the first day of the calendar month following receipt of the required contribution at the agreed upon prevailing rate. If the Employer is not signatory to the Collective Bargaining Agreement of participant local Unions, the Trustees must approve such eligibility.

The term "Active Employer Staff Employee" shall include former Participants who are performing services for the Union and for whom the Union has agreed to continue participation under the Plan while said service is being performed pursuant to the rules which are acceptable to the Trustees provided that all of the following conditions are met:

(i) The affected individual is a former Participant who has coverage under the Plan at the time an individual commences his services for the Union;

(ii) The Union is obligated to contribute at the prevailing rate for all hours worked for a full-time Active Employee for each month in which the service is performed in order that coverage is maintained for the affected individual on a continuous basis. This rule does not apply where the employee's coverages were interrupted or lapsed prior to the individual's performing services for the Union; and

(iii) The Union agrees contractually to contribute to the Plan on behalf of all individuals falling within the same category for which the Trustees have agreed to permit continuation of coverage by contributions by the Union.

An Active Employer Staff Employee who commences coverage under the Plan and whose eligibility for benefits terminates for any reason, including the Employer's withdrawal from the Plan, cannot be reinstated until a period of 12 consecutive months elapses, and the required contribution(s) on the employee's behalf are received and approved.

Employers who elect to participate in this Plan must provide medical, short-term disability, death and accidental death and dismemberment benefits. Optional Benefits can be elected by the Employer.

2.2 Eligibility for Active Hourly Employees.

(a) General Provisions. An Active Hourly Employee will become eligible for coverage in accordance with the following rules, provided sufficient contributions have been made by an Employer.

(b) Dollar Bank Eligibility. Eligibility for benefits provided by the Plan will be established under the Dollar Bank system. Under this system, an employee can accumulate additional dollars for eligibility to be used during periods of unemployment, including retirement.

(c) Initial Eligibility for Active Hourly Employees. The Active Hourly Employee will be covered for benefits in accordance with the terms of the Collective Bargaining Agreement of the local Union of which he is a member. An Active Hourly Employee will become eligible on the first day of the calendar month following the month in which the Fund Office receives contributions either from a participating Employer(s) or through reciprocity for at least 300 work hours in a 12 consecutive month period.

(d) Continuation of Eligibility.

(i) In order that there will be sufficient time for the Employer and reciprocity reports to be received and processed by the Fund Office, a one month lag will be used in determining an Active Hourly Employee's continued eligibility. The one month lag is the month between the month hours are received by the Fund Office and the month of actual coverage.

(ii) Dollars contributed by an Employer for an Active Hourly Employee will be credited to the Active Hourly Employee's Dollar Bank. Premiums for coverage will be deducted from the Active Hourly Employee's Dollar Bank for each month of coverage.

(iii) Whenever an Active Hourly Employee is credited with more than the prevailing premium during a month (which is required to furnish one month's coverage), the excess money will be added to the Active Hourly Employee's Dollar Bank Account. The Active Hourly Employee will be allowed to accumulate unlimited excess money in his Dollar Bank Account after deduction for the current month's coverage.

(e) Termination of Eligibility. An Active Hourly Employee's coverage under the Dollar Bank will terminate on the earliest of the following dates:

(i) The last day of the calendar month in which the credits in his Dollar Bank Account fall below the required premium after deduction of premium for the current month's coverage;

(ii) The date he enters the Armed Forces of the United States on full-time active duty;

(iii) Death, at which time any remaining credits in the deceased Active Hourly Employee's Dollar Bank shall be forfeited unless the deceased Employee is survived by a Dependent eligible to participate under sections 2.7 or 2.9, or a transfer is permitted under 2.16(d).

(iv) The date the Plan is discontinued;

(v) If an Active Hourly Employee starts to work in Covered Employment for an Employer who is not a contributing Employer and not subject to a written agreement requiring contribution into the Plan, the Active Hourly Employee shall have his Dollar Bank eligibility and benefits from the Plan terminated on the last day of the month in which such employment commenced or is discovered, whichever is earlier. The Board of Trustees shall, under the appeal process of the Plan, have discretion to make all findings of fact and conclusions with respect to the loss of coverage of any Employee under this section.

(vi) An Active Hourly Employee who loses eligibility under this section, shall not be permitted to self-pay after the date his eligibility is terminated and shall not be eligible for COBRA continuation coverage. Such individual may again become eligible for coverage from the Plan only upon completion of the requirements set out in the Initial Eligibility for Active Hourly Employees provision or the Special Eligibility Rules for Newly Organized Employers.

(vii) If an Active Hourly Employee continues employment, of any kind, with a former contributing Employer for whom the Active Hourly Employee worked prior to such Employer dropping out of the Plan, and the Employer is no longer obligated to contribute to the Plan under the terms of a written agreement or under the National Labor Relations Act during a period of bargaining, the Active Hourly Employee shall have his Dollar Bank eligibility and benefits from the Plan terminated on the last day of the month in which the contributing Employer's obligation to contribute to the Plan ceases. The Board of Trustees shall, under the appeal process of the Plan, have discretion to make all findings of fact and conclusions with respect to the loss of coverage of any employee under this section.

(viii) Any Active Hourly Employee who participates in, assists, or conceals any scheme, artifice, plan or conduct by a contributing Employer which is intended to defraud the Plan by paying contributions less than those which are due under the Collective Bargaining Agreement shall have his Dollar Bank eligibility and benefits terminated on the last day of the month in which such participation, assistance, or concealment commences or is discovered, whichever is earlier. All amounts credited to an Active Hourly Employee's Dollar Bank shall be forfeited to the Plan upon such termination of eligibility. An Active Hourly Employee who has knowledge of such conduct, scheme or plan, or who has knowledge that a contributing Employer is not paying all contributions due to the Plan, and who fails to report all known information to the Board of Trustees of the Plan, shall lose eligibility in accordance with this provision.

An Active Hourly Employee who loses eligibility under this section is guilty of gross misconduct, and shall not be permitted to self-pay after the date eligibility is terminated and shall not be eligible for COBRA continuation coverage. An Active Hourly Employee who has lost eligibility under this provision shall again become eligible for coverage only upon completion of the requirements set out in the Initial Eligibility for Active Hourly

Employees provision . An individual working in the bargaining unit who has lost eligibility under this section shall not have any contributions after such loss of eligibility credited to his Dollar Bank in accordance with the Initial Eligibility for Active Hourly Employees requirements, until that individual has demonstrated to the satisfaction of the Board of Trustees that he is no longer participating in or assisting any actions by an Employer to defraud the Plan and that he has reported all information and knowledge he possesses regarding such conduct to the Board of Trustees.

(ix) The date of a Withdrawal.

Notification of loss of eligibility for any reason will be made by the Fund Office to the Active Hourly Employee that he may elect to continue coverage under the Self-Payment for Active Hourly Employees or Self-Payment for Continuation of Coverage (COBRA), whichever may be applicable.

(f) Reinstatement of Eligibility. An Active Hourly Employee whose eligibility has terminated under the Dollar Bank shall again become eligible on the first day of the calendar month following the month in which the Fund Office receives contributions either from a participating Employer(s) or through reciprocity for at least 150 work hours in a 12 consecutive month period, except as otherwise noted in section 2.2(e)(v), (vi) or (vii).

(g) Reinstatement of Dollar Bank. An Active Hourly Employee who has his Dollar Bank credits cancelled under the provisions of section 2.2(e)(v) or 2.2(e)(vi) and who returns to Covered Employment within 12 months of the date Dollar Bank credits were cancelled shall have his Dollar Bank credits that were cancelled reinstated effective as of the first day of the calendar month following the month in which the Fund Office receives contributions from a participating Employer or through reciprocity for at least 150 work hours in a 12 consecutive month period.

(h) Forfeiture of Dollar Bank. A dollar bank containing less than the amount necessary to pay for one (1) month's coverage and that has not received contributions from an Employer for thirty-six (36) consecutive months shall, subject to the exception described in section 2.5(d), be forfeited.

2.3 Eligibility for Active Employer Staff Employees.

(a) Initial Eligibility for Active Employer Staff Employees.

(i) Employees of Existing Employers Who Cover Staff Employees. An Active Employer Staff Employee who is employed with an Employer whose Staff Employees participate under the Plan must either enroll to participate in the Plan or waive coverage pursuant to section 2.3(b). An Active Employer Staff Employee who participates in the Plan shall become eligible on the first day of the calendar month following date of hire and receipt of two months required Employer contributions by the 15th day of the month prior to month for which coverage is intended.

(ii) Employees of New Employers. The Active Employer Staff Employees of an employer who begins participating in the Plan as an Employer (a "New Employer") must enroll in the Plan within 60 days following the earliest to occur of the date the

New Employer becomes obligated to participate in the Plan by signing a Collective Bargaining Agreement, Letter of Assent, Participation Agreement or Memorandum of Understanding.

An Active Employer Staff Employee shall become initially eligible on the first day of the calendar month following the date of hire and receipt of two months required Employer contributions by the 15th day of the month prior to the month for which coverage is intended.

(b) Waiver Requirements. Active Employer Staff Employees who are covered by their spouse's group health coverage or have Medicare may elect to waive coverage with this Plan by completing a written waiver of benefit form and forwarding it to the Fund Office within 30 days of becoming eligible and providing proof of spousal coverage and/or Medicare eligibility. A copy of such waiver should be retained by the Employer.

(c) Enrollment Following Waiver. An Active Employer Staff Employee who previously waived coverage with the Plan by providing a waiver of benefit form may elect coverage at a later date if any of the following requirements are satisfied. In such cases, the effective date of coverage will be the first day of the first calendar month following receipt of the written request and enrollment form.

(i) The Active Employer Staff Employee loses other coverage, provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 30 days of the date the other coverage terminates.

(ii) The Active Employer Staff Employee or his Dependent loses coverage under Medicaid or the State Children's Health Insurance Program ("SCHIP"), provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 60 days of the date the coverage terminates.

(iii) The Active Employer Staff Employee or his Dependent becomes eligible for assistance through Medicaid or SCHIP for coverage under this Plan, provided he submits a written request to the Fund Office and completes an enrollment form prepared by the Fund Office within 60 days of becoming eligible for such assistance.

(d) Termination of Coverage. The coverage of an Active Employer Staff Employee shall cease on the earliest of the following dates:

(i) The last day of the month following the month in which employment terminates;

(ii) The date the Plan is discontinued;

(iii) The end of the last period for which any required contribution has been made;

(iv) Death;

(v) The date the employee enters the Armed Forces of the United States on full-time duty;

(vi) Any Active Employer Staff Employee who participates in, assists, or conceals any scheme, artifice, plan or conduct by a contributing Employer which is intended to defraud the Plan by paying contributions less than those which are due under the Collective Bargaining Agreement shall have his eligibility and benefits terminated on the last day of the month in which such participation, assistance, or concealment commences or is discovered, whichever is earlier. All amounts credited to an Active Employer Staff Employee's eligibility shall be forfeited to the Plan upon such termination of eligibility. An Active Employer Staff Employee who has knowledge of such conduct, scheme or plan, or who has knowledge that a contributing Employer is not paying all contributions due to the Plan, and who fails to report all known information to the Board of Trustees of the Plan, shall lose eligibility in accordance with this provision.

An Active Employer Staff Employee who loses eligibility under this section (d)(vi) shall not be permitted to self-pay after the date eligibility is terminated. An Active Employer Staff Employee who has lost eligibility under this provision shall again become eligible for coverage only upon completion of the requirements set out in the Subsequent Eligibility for Active Employer Staff Employees provision . An individual who has lost eligibility under this section shall not have any contributions made after such loss of eligibility credited to his eligibility in accordance with the Subsequent Eligibility for Active Employer Staff Employees requirements , until that individual has demonstrated to the satisfaction of the Board of Trustees that he is no longer participating in or assisting any actions by an Employer to defraud the Plan and that he has reported all information and knowledge he possesses regarding such conduct to the Board of Trustees.

(vii) The date of a Withdrawal.

2.4 Special Eligibility Rules for Active Hourly Employees of Newly Organized Employers.

(a) General. When an Employer becomes newly organized by one of the Unions participating in the Plan, the Active Hourly Employees of the newly organized Employer may elect to be considered for participation under the normal Initial Eligibility rules or under the rules set forth in this section, provided that such election must be made at the time participation is negotiated and all Active Hourly Employees in such a group must either elect the rules specified below or reject them in favor of the normal Initial Eligibility rules. Whichever option is elected shall apply to all Active Hourly Employees of the newly organized Employer.

(b) Initial Eligibility Requirements. An Active Hourly Employee of a newly organized Employer shall become initially eligible for Plan coverage on the date of his Employer's participation in the Plan provided all of the following conditions are satisfied:

(i) All Employees of the Employer elect to reject the normal Initial Eligibility provisions;

(ii) The Employee was eligible under the Employer's group health plan program at the time the Employer was organized by a Union participating in the Plan; and

(iii) The Employee shall be credited with one full month of monthly premium for each of the two calendar months immediately before the first full month of his Employer's participation in the Plan in which the Active Hourly Employee worked for the Employer, provided the Active Hourly Employee agrees to pay the Plan the two full months of premium in full within 12 months of the effective date of coverage under the Plan.

(c) Continuation of Eligibility. An Active Hourly Employee who becomes initially covered for benefits under this section shall thereafter maintain continuation of eligibility for benefits under the Plan in accordance with the provisions of section 2.2(d).

(d) Termination of Eligibility. The termination of coverage for an Active Hourly Employee who becomes initially covered for benefits under this section shall be governed by provisions of section 2.2(e).

(e) Payment of Advanced Premium.

(i) Repayment Period. Payment of the two months' advanced premium shall be made by the Active Hourly Employee within 12 months of the Employee's effective date of Plan coverage. If any amount is not fully paid within this 12-month period, the Plan may recover this deficit amount from contributions for eligibility, from benefit payments or by any other method deemed appropriate by the Trustees. Transfer to another participating Employer or termination of eligibility under the Plan within the initial 12-month period shall not eliminate the required repayment of this two months' advanced premium by the affected individual within the 12-month period.

(ii) Amount and Form of Payment. Payment shall be made at the hourly employer contribution rate in effect on the effective date of coverage under the Plan. Payment shall be made by self-payment, by Dollar Bank reductions or any other form deemed acceptable by the Trustees.

2.5 Eligible Employees in Military Service.

(a) Military Service. Military service as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 or similar federal law, as amended from time to time (the "Act").

(b) Military Service of Less Than 31 Days. An Active Employee, Self-Pay Active Hourly Employee who performs Military Service and has reemployment rights under the Act, shall be deemed on military leave of absence effective on the date of his absence to perform such Military Service. The Active Employee or Self-Pay Active Hourly Employee's eligibility, and the eligibility for all of the Active Employee or Self-Pay Active Hourly Employee's Dependents under the Plan, shall continue through the 30th day of such leave at no cost to the Eligible Employee or his Employer and will terminate as of the 31st day of such military leave, subject to the continuation of health coverage provisions required by the Act. Upon returning to employment as an Active Employee or making himself available for such employment, the Employee and his covered Dependents shall be immediately entitled to benefits as if he had been continuously employed during the Military Service provided he has reemployment rights under the Act.

(c) Military Service of 31 Days or More. An Active Employee, Self-Pay Active Hourly Employee who performs Military Service and has reemployment rights under the Act shall be deemed on military leave of absence effective on the date of his absence to perform Military Service. His eligibility and the eligibility for all of the Active Employee or Self-Pay Active Hourly Employee's Dependents under the Plan shall continue through the 30th day of the leave and will terminate on the 31st day of such leave subject to the continuation of health coverage provisions of the Act . Upon returning to employment as an Active Employee or making himself available for such employment, the Employee and his covered Dependents shall be immediately entitled to benefits as if he had been continuously employed during the Military Service, regardless of whether the Employee continued coverage under the Plan pursuant to the provisions of federal law during Military Service provided he has reemployment rights under the Act.

(d) Effect on Active Hourly Employee Dollar Banks and Employer Staff Employee Coverage. Any unused credits in an Active Hourly Employee's Dollar Bank are to be preserved until such time as he is discharged from Military Service, provided he has reemployment rights under the Act. The Hourly Employee's accumulated credits will be reinstated immediately if he returns to employment as specified under the Act. If the Hourly Employee does not comply with the reemployment requirements specified above, his accumulated credits shall be forfeited to the Plan.

Any prepaid coverage of an Active Employer Staff Employee will be preserved until such time as he is discharged from Military Service, provided he has reemployment rights under the Act. The Active Employer Staff Employee's prepaid coverage will be reinstated immediately if he returns to employment as specified above. If the above requirement is not met, all prepaid coverage shall be forfeited to the Plan.

If, upon reinstatement to the Plan after returning to employment or making himself available for employment, as specified under the Act, the Active Employee or Self-Pay Active Hourly Employee has exhausted his Dollar Bank or prepaid coverage to pay for continuation coverage , the Active Employee or Self-Pay Active Hourly Employee will be required to make self-payments in an amount established by the Trustees from time to time until the balance of his Dollar Bank or prepaid account returns to a level sufficient to maintain eligibility under the Plan.

(e) Right of Continuation Coverage.

(i) Failure to Provide Timely Notice. If the Active Employee or Self-Pay Hourly Active Employee fails to provide advance notice of his Military Service, the Active Employee or Self-Pay Hourly Active Employee's coverage will terminate as of the 31st day of his leave to perform Military Service. The Active Employee or Self-Pay Hourly Active Employee will not be eligible to continue coverage unless the failure to provide advance notice is excused. The Trustees will, in their sole discretion, determine if the Active Employee or Self-Pay Hourly Active Employee's failure to provide advance notice is excusable under the circumstances and may require that the Active Employee or Self-Pay Hourly Active Employee provide documentation to support the excuse. If the Trustees determine that the Active Employee or Self-Pay Hourly Active Employee's failure to provide advance notice is excused, the Active Employee or Self-Pay Hourly

Active Employee may elect to continue coverage, retroactive to the date of his absence for Military Service, provided that the Active Employee or Self-Pay Hourly Active Employee elects such coverage and pays all amounts required for the continuation coverage.

(ii) Notice Timely Provided. Upon the Plan's notification of an Active Employee or Self-Pay Hourly Active Employee's reduction in hours due to a military leave of absence of 31 days or more, the Active Employee or Self-Pay Hourly Active Employee will be provided with the required notice of continuation rights. The Board of Trustees will establish the amount of the monthly self-payment contribution for this continuation coverage, within the guidelines established by federal law. The procedures to elect and make self-payment for this continuation coverage shall be the same as those set forth in subsection 2.12(c) (including all deadlines) and the available coverage for such Active Employee or Self-Pay Hourly Actively Employee and Dependents shall be the same as that set forth in subsection 2.12(f), provided that the COBRA rules do not conflict with the Act. If the Active Employee or Self-Pay Hourly Active Employee does not elect continuation coverage and does not submit payment for all amounts required to continue coverage within the applicable time frame, the Active Employee or Self-Pay Hourly Active Employee will lose the right to continue coverage under this section and such right will not be reinstated unless the Trustees determine such failure to timely elect and pay is excused.

The Active Employee or Self-Pay Hourly Active Employee shall have the option of applying his Dollar Bank or prepaid coverage, if available, to continue coverage. If the Active Employee or Self-Pay Hourly Active Employee elects to use his Dollar Bank or prepaid account and exhausts the Dollar Bank or prepaid account prior to the end of the maximum period for which he is entitled to continuation coverage, the Active Employee or Self-Pay Hourly Active Employee may make self-payments to continue coverage through the maximum period for which he is entitled to continuation coverage.

An Active Employee or Self-Pay Hourly Active Employee who takes a military leave of absence may continue coverage under the Plan for himself and for his eligible Dependents for a period of 24 consecutive months from the date the Active Employee or Self-Pay Hourly Active Employee's military leave began or until the date the Active Employee or Self-Pay Hourly Employee ceases to have reemployment rights under the Act, whichever period is shorter. Continuation coverage may terminate before the expiration of the maximum period described above for any of the reasons set forth in section 2.12(d), except those described in 2.12(d)(i).

An individual eligible for continuation coverage rights under both the Act and COBRA shall be entitled to the most generous coverage provisions available under the Act and COBRA. In addition, the periods of continuation coverage available under the Act and under COBRA shall run concurrently.

(f) Withdrawal. Coverage shall cease under this section for any Participant who is part of a Withdrawal Group.

2.6 Disability. If an Active Employee, or Self-Pay Active Hourly Employee is Continuously Disabled the cost of coverage will be deducted monthly from his Dollar Bank Account or prepaid account to provide coverage. After the exhaustion of the Dollar Bank Account,

a disabled Active Hourly Employee may continue the coverage in force in accordance with the terms of section 2.10, Self-Payment for Active Hourly Employees. A disabled Active Employer Staff Employee must provide written certification from an officer of his Employer that he is not receiving a salary while Continuously Disabled. Coverage shall cease under this section for any Participant who is part of a Withdrawal Group.

2.7 Eligibility for Dependents.

(a) Dependent Coverage - Enrollment Requirements. All Participants must complete an enrollment card and list all Dependents to be covered under the Plan. Such enrollment card is to be placed on file with the Fund Office before consideration of claims will be made.

(b) Dependent Effective Date of Coverage.

(i) Dependents will be eligible for coverage on the date the Participant becomes eligible, however no claims will be paid until a completed enrollment card and proof of dependent status (e.g., birth certificate, marriage license, or proof of adoption) is on file with the Fund Office.

(ii) Newly acquired Dependents of an eligible Participant will be included automatically as an eligible Dependent from the date of acquisition. However, no claims will be paid until a completed enrollment card including the newly acquired Dependent and proof of dependent status is on file with the Fund Office. If the required documentation is not provided within 90 days from the date of acquisition of the Dependent, all pended claims will be denied. Coverage for the Dependent can become effective the 1st of the month following the date the Fund Office receives the required documentation.

(c) Termination of Dependent Coverage. The coverage of a Dependent will terminate on the earliest of the following dates:

(i) The date of termination of the Participant's coverage;

(ii) The date the Dependent ceases to qualify as a Dependent unless otherwise set forth in that definition;

(iii) The date the Plan is discontinued; or

(iv) The date the Participant's eligibility ceases on account of a Withdrawal.

(d) Dependents of a Deceased Participant. Coverage for the Dependents of a deceased Participant will be continued until the last day of the month in which there is enough credit to provide coverage. At the time of loss of coverage due to exhaustion of credit, the surviving Dependents can continue coverage, so long as they remain eligible, under Self-Payment for Dependents of a Deceased Participant. If the surviving spouse remarries, the Dependent(s) become covered under another health plan, or the Dependent child ceases to qualify as a Dependent prior to the exhaustion of credit, any excess dollars in the deceased Participant's

Dollar Bank Account will be forfeited and the Dependent(s) may elect to continue coverage under Self-Payment for Continuation of Coverage (COBRA).

(e) A Dependent who qualifies as an Active Employee shall be considered a new Participant for purposes of the Plan's specific benefit maximums, deductible and out-of-pocket expenses.

2.8 Self-Payment for Retirees. If all of the eligibility requirements described below are met, Active Employees, Self-Pay Active Hourly Employees and Self-Pay Disabled Employees currently covered under the Plan may elect, upon retirement, to continue coverage for themselves and their Dependents, by making self-payments directly to the Plan at the applicable rate established by the Board of Trustees. Active Employees who have lost eligibility under section 2.2(e)(v), (vi) or (vii) and section 2.3(d)(vi) cannot continue coverage under this provision. An Early Retiree or a Retiree who was married when they began participating as an Early Retiree or Retiree and failed to enroll their spouse at that time may, on a one-time basis, enroll their spouse as a Dependent upon the spouse's loss of group health plan coverage provided that the spouse provides satisfactory written proof of continuous group health plan coverage. Any Eligible Individual who is otherwise eligible to make self-payments under this section 2.8 and who is enrolled in a Medicare Part D plan other than an EGWP shall be ineligible for the Prescription Drug Benefits described in Article XV effective on the date of enrollment in such Medicare Part D plan.

(a) Early Retiree Eligibility and Benefits. In order to be eligible for Plan coverage as an Early Retiree, an Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee must be at least 55 years of age, must cease from working in the industry and advise the Fund Office, in writing in a form acceptable to the Trustees, that he or she is an Early Retiree.

Such Early Retiree may continue coverage for medical and death benefits by making consecutive monthly self-payment contributions which shall first be deducted from the Early Retiree's Dollar Bank Account.

(b) Retiree Eligibility and Benefits. In order to be eligible for Plan coverage as a Retiree, an Active Employee, Self-Pay Active Hourly Employee, or Early Retiree must be at least 65 years of age. A Self-Pay Disabled Employee shall be eligible upon such Employee's entitlement to Medicare Parts A and B.

Such Retiree may continue medical and reduced death benefits by making consecutive monthly self-payment contributions. Self-payment contributions will be deducted from the Dollar Bank Accounts of Medicare-eligible Retirees if the Plan is secondary to Medicare. If the Plan is primary to Medicare then the Medicare-eligible Retiree shall participate in the Active Plan and the Plan shall deduct the appropriate monthly amount from the Retiree's Dollar Bank Account.

(c) Early Retiree and Retiree Classifications. The following Early Retiree and Retiree classifications apply for contribution rates:

(i) Single Retiree eligible for Medicare;

(ii) Retired with one Dependent, with one eligible for Medicare and the other not eligible for Medicare;

(iii) Retired with two or more Dependents, with one eligible for Medicare and others not eligible for Medicare;

(iv) Both spouses eligible for Medicare;

(v) Retired with or without Dependent(s), none eligible for Medicare; and

(vi) Retired with two or more Dependents, all eligible for Medicare.

(d) Retired Self-Payment Contribution Due Date. Monthly self-payments contributions are due the 15th day of the month prior to the month for which coverage is intended, with a five-day grace period.

In the event contributions are not received in a timely manner, coverage will terminate.

(e) Termination of Retiree Coverage. Coverage of any Retiree or Early Retiree and their Dependents will terminate on the earliest of the following dates:

(i) The last day of the month for which required contribution has been made;

(ii) Death;

(iii) The date the Plan is discontinued; or

(iv) The date of a Withdrawal.

(f) Not Accrued Benefit. Coverage provided pursuant to eligibility for benefits under this section 2.8 shall not be considered an "accrued benefit."

(g) Reduction or Elimination of Retiree Benefits. In the event the Trustees determine that Plan economic conditions warrant such action, the Trustees specifically reserve the right to take action to reduce or modify coverage for Early Retirees and Retirees, including coverage for Dependents, to increase Self-Payments for such coverage, or to completely terminate all or any part of such coverage, at any time and at their sole discretion.

2.9 Self-Payment for Dependents of a Deceased Participant. The Dependents of a deceased Participant may continue coverage by making monthly self-payment contributions after the exhaustion of any credits in the Active Employee's Dollar Bank Account.

In the event the widow(er) is on Medicare he/she may continue coverage under Self-Payment for Retirees for medical benefits only. In no event, however, can the widow(er)

continuing coverage under the Self-Payment for Retirees provisions add new dependents, other than the addition of a dependent by birth, adoption or court ordered custody.

(a) Benefit Options. The Dependents of a deceased Participant may elect to continue coverage under one of the following Benefit Options according to benefits they were covered for on the day of the Participant's death:

(i) Medical benefits only; or

(ii) Medical and all Optional Benefits covered for on the date of the Eligible Employee's death.

Once a Benefit Option is elected, it cannot be changed at a later date, unless they are transferred to coverage under Self Payment for Retirees.

(b) Self-Payment Contribution Rates. The self-payment contributions rate will be at the rate established by the Board of Trustees to provide monthly coverage.

(c) Self-Payment Contribution Due Date. Self-payment contributions for continuing coverage under this provision are due the 15th day of the month prior to the month for which coverage is intended, with a five-day grace period.

In the event self-payment contributions are not received in a timely manner, coverage will terminate the last day of the month for which required self-payment contributions were made.

(d) Termination of Self-Payment for Dependents of a Deceased Participant. The coverage of Dependents of a deceased Participant will terminate on the earliest of the following dates:

(i) The last day of the month for which required contribution has been made;

(ii) Death;

(iii) The date the Dependent child's coverage would otherwise terminate;

(iv) The date the Dependent spouse remarries;

(v) The date the Dependent becomes covered under any other group health plan;

(vi) The date the Plan is discontinued; or

(vii) The date of a Withdrawal.

In the event of termination of coverage due to items (ii), (iii), (iv) or (v) above, the Dependent(s) can elect to continue coverage under Self-Payment for Continuation of Coverage (COBRA).

2.10 Self-Payment for Active Hourly Employees. Active Hourly Employees who have lost coverage under the Dollar Bank may elect to continue coverage by making self-payments for coverages in effect at the time of termination of eligibility in lieu of electing COBRA continuation coverage, for a maximum period of 36 months, provided that they (1) remain available for work with an Employer through a Local Union's referral system and (2) waive election of coverage under COBRA continuation coverage. A COBRA continuation coverage waiver will also be pursued from the Active Hourly Employee's spouse and any adult Dependent child; a timely COBRA continuation coverage election by any family member will invalidate any election of a Self-Pay Active Hourly Employee coverage. However, an Active Hourly Employee who has lost coverage under section 2.2(e)(v), (vi) or (vii) cannot continue coverage under this provision. A Self-Pay Active Hourly Employee shall confirm with each Self-Payment contribution made to the Plan that he continues to qualify for benefits as a Self-Pay Active Hourly Employee.

(a) Self-Payment Contribution Rates. The self-payment contribution rate for the initial month of coverage will be the difference between the amount in the Active Hourly Employee's Dollar Bank Account and the amount required for one month's coverage. Subsequent payments will be at the rate established by the Board of Trustees to provide monthly coverage.

(b) Self-Payment Contribution Due Date. Self-payment contributions for Active Hourly Employees continuing coverage under this provision are due the 15th day of the month prior to the month for which coverage is intended, with a five-day grace period.

In the event self-payment contributions are not received in a timely manner coverage will terminate the last day of the month for which required self-payment contributions were made.

(c) Termination of Self-Payment for Active Hourly Employees. The coverage for Self-Payment Active Hourly Employees will terminate on the earliest of the following dates:

(i) The last day of the month for which the self-pay period has been exhausted;

(ii) The last day of the month for which the required self-payment contribution has been made;

(iii) Death;

(iv) The last day of the month the Self-Pay Active Hourly Employee becomes covered as an employee under another group health plan;

(v) The date coverage would otherwise terminate;

(vi) The date the Plan is discontinued;

(vii) The date of a Withdrawal; or

(viii) The first day of the month for which the Plan determines the Self-Pay Active Hourly Employee was ineligible for such coverage.

In the event of termination of coverage due to item (iii) above, the Self-Pay Active Hourly Employee's Dependent(s) can elect to continue coverage under Self-Payment for Dependents of a Deceased Participant or under Self-Payment for Continuation of Coverage (COBRA) for a maximum of 36 consecutive months measured from the date of the Employee's death.

(d) Benefit Options. A Self-Payment Active Hourly Employee may continue only those benefits which were in force at the time of Termination of Eligibility, and such benefit option cannot be changed at a later date.

(e) Return of Self-Payment Contributions. In the event late contributions are received from an Employer or through reciprocity for a period for which the Active Hourly Employee made self-payments for continuation of eligibility, the Plan shall return any excess self-payment to the Active Hourly Employee after calculation of eligibility based on the contributions from the participating Employer or through reciprocity which are not needed to maintain eligibility.

2.11 Self-Payment for Disabled Employees. A Self-Pay Disabled Employee may elect to continue coverage after the exhaustion of credits in his Dollar Bank Account or termination of coverage by making self-payments. This self-payment is in lieu of COBRA.

(a) Self-Payment Contribution Rates. The self-payment contribution rate will be at the rate established by the Board of Trustees to provide monthly coverage.

(b) Self-Payment Contribution Due Date. Self-payment contributions for Disabled Employees continuing coverage under this provision are due the 15th day of the month prior to the month for which coverage is intended, with a five-day grace period.

In the event self-payment contributions are not received in a timely manner coverage will terminate the last day of the month for which required self-payment contributions were made.

(c) Benefit Options. A Self-Pay Disabled Employee may elect to continue coverage under one of the following benefit options according to benefits he was covered for prior to his disability:

(i) Medical, death and accidental death and dismemberment; or

(ii) Medical, death, accidental death and dismemberment and all Optional Benefits he was covered for prior to his disability.

Once a benefit option is elected, it cannot be changed at a later date. Self-Pay Disabled Employees will not be entitled to Loss of Time benefits.

(d) Termination of Self-Payment for Disabled Employees. The coverage for Self-Payment Disabled Employees will terminate on the earliest of the following dates:

(i) The last day of the month for which required contribution has been made;

(ii) Death;

(iii) The last day of the month the Disabled Employee is no longer Totally and Permanently Disabled;

(iv) The last day of the month in which he becomes covered under another group health plan as an employee;

(v) The date the Disabled Employee is entitled to Medicare;

(vi) The date the Plan is discontinued; or

(vii) The date of a Withdrawal.

In the event of termination of coverage due to item (ii) above, the Self-Pay Disabled Employee's Dependent(s) can elect to continue coverage under Self-Payment for Dependents of a Deceased Participant or Self-Payment for Continuation of Coverage (COBRA) for a maximum of 36 consecutive months. In the event of termination of coverage due to items (iii) or (iv) above, the Employee and Dependents can elect to continue coverage under Self-Payment for Continuation of Coverage (COBRA). In the event of termination of coverage due to item (v) above, the Employee can make a one-time election to continue coverage under Self-Payment for Retirees for the Employee and the Employee's Dependents.

2.12 Self-Payment for Continuation of Coverage (COBRA).

(a) Eligibility. A Qualified Beneficiary may continue coverage under this section for the maximum periods specified below, by making election to do so with the Fund Office and submitting the applicable self-payment contribution. A Qualified Beneficiary can elect COBRA continuation coverage even if the Qualified Beneficiary is covered under another group health plan or entitled to benefits under Medicare on the date that the Qualified Beneficiary elects to. However, Active Employees and their Dependents who lost coverage in accordance with section 2.2(e)(v), (vi) or (vii) and 2.3(d)(vi), are not eligible to continue coverage under this provision. The amount of the monthly self-payment contribution will be established by the Board of Trustees, within the guidelines established by federal law.

(b) Classification - Those Eligible - Maximum Self-Payment Period.

(i) 18-Month Continuation Coverage. A Qualified Beneficiary may elect 18 months of continuation coverage beginning on the date Dollar Bank eligibility is lost or because of a Qualifying Event involving termination of employment or a reduction in hours. The 18-month period shall be extended to 24 months if an Eligible Employee is absent from employment due to entering the Armed Forces on full-time active duty. Any reference to the 18-month period in section 2.12 shall be deemed a reference to the 24-month period for Qualified Beneficiaries eligible for continuation coverage due to military service.

Qualified Beneficiaries eligible under this section may continue coverages under the benefit options identified in 2.12(f).

(ii) 11-Month Extension of Continuation Coverage for Disabled Qualified Beneficiaries. If the Social Security Administration determines that a Qualified Beneficiary was disabled within the first 60 days of continuation coverage following a Qualifying Event involving termination of employment or a reduction in hours, the 18-month period of continuation coverage can be extended 11 months up to a maximum of 29 months for the Qualified Beneficiary who is disabled and all individuals who are Qualified Beneficiaries with respect to the same Qualifying Event. Any of the Qualified Beneficiaries must notify the Fund Office within 60 days of the Social Security Administration's determination of disability and before the expiration of the initial 18-month period. Should the disability end during the 29-month period, the Qualified Beneficiary must notify the Fund Office within 30 days of the termination of the disability.

Qualified Beneficiaries eligible under this section can continue only those coverages previously elected.

(iii) 36-Month Extension of Continuation Coverage for Dependent Qualified Beneficiaries of a Medicare Eligible Qualified Beneficiary. If an Active Employee has a Qualifying Event involving termination of employment or reduction in hours, and becomes entitled to Medicare during the initial 18-month period of continuation coverage, Qualified Beneficiaries, other than the Active Employee, will be entitled to a maximum of 36 months of continuation coverage from the date of the Qualifying Event involving termination of employment or a reduction in hours.

Qualified Beneficiaries eligible under this section can continue only those coverages previously elected.

(iv) Extension of Continuation Coverage for Dependent Qualified Beneficiaries of an Employee Qualified Beneficiary Entitled to Medicare. If an Active Employee has a Qualifying Event involving termination of employment or a reduction in hours and is entitled to Medicare on the date of the Qualifying Event, Qualified Beneficiaries, other than the Active Employee, will be entitled to the greater of a maximum of 36 months of continuation coverage from the date of Medicare entitlement or 18 months from the date the Active Employee's Dollar Bank eligibility is lost.

Qualified Beneficiaries eligible under this section may continue coverages under the benefit options identified in 2.12(f).

(v) 36-Month Continuation Coverage. A Qualified Beneficiary who is a Dependent may elect 36 months of continuation coverage from the date of the Qualifying Event, because of a Qualifying Event described in section 1.61(a), (d), (e) and (f).

Qualified Beneficiaries eligible under this section may continue coverages under the benefit options identified in 2.12(f).

(vi) Multiple Qualifying Events. If a Qualifying Event described in section 1.61(a), (d) and (f) occurs during the 18 months after the date of loss of coverage resulting from a Qualifying Event described in section 1.61(b) and (c), a Qualified Beneficiary may elect to continue coverage until 36 months after the loss of coverage from the initial Qualifying Event. The reference to 18 months in the preceding sentence shall be deemed a reference to 29 months for Qualified Beneficiaries eligible for the 11-month extension of continuation coverage due to disability.

Qualified Beneficiaries eligible under this section may continue coverages under the benefit options identified in 2.12(f).

(c) Procedures to Elect Self-Payment for Continuation Coverage.

(i) In the case of a Qualifying Event described in section 1.61(b), a Qualified Beneficiary will receive information concerning continuation coverage, including the self-payment rates, within 44 days of the loss of coverage.

With respect to a disabled Qualified Beneficiary electing the 11-month extension of continuation coverage, such disabled Qualified Beneficiary must notify the Fund Office within 60 days of the determination of disability by Social Security and before the end of the initial 18-month continuation period.

Following receipt of timely notice of the Social Security determination the Fund Office will provide the disabled Qualified Beneficiary with information concerning continuation coverage and rates. In addition, the disabled Qualified Beneficiary must notify the Fund Office within 30 days of final determination by Social Security that the disability no longer exists.

(ii) In the case of a Qualifying Event as described in section 1.61(a), (c), (d), (e), and (f) a Qualified Beneficiary must notify the Fund Office within 60 days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for continuation coverage.

In the case of a Qualifying event described in section 1.61(a), (b) or (e), the Qualified Beneficiary's Employer shall notify the Fund Office within thirty days of the Qualified Beneficiary's loss of coverage due to the Qualifying Event.

Following receipt of timely notice of a Qualifying Event and within 14 days of receipt of such notice, the Fund Office will provide the eligible Dependent with information concerning continuation coverage and rates.

(iii) After notification of continuation coverage, the Qualified Beneficiary will have 60 days to elect continuation coverage, after the later of:

[a] The date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event; or

[b] The date that the Qualified Beneficiary is sent such notice.

If a Qualified Beneficiary chooses to waive coverage, a waiver of continuation coverage will be effective on the date that the waiver is sent to the Fund Office. A Qualified Beneficiary who, during the election period, waives continuation coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives continuation coverage later revokes the waiver, coverage will be effective on the date that the revocation of the waiver and election to continue is sent to the Fund Office.

(iv) The first monthly payment (which will include contributions for all months since coverage terminated) must be received by the Fund Office no later than 45 days after the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received prior to or on the last day of the month for which coverage is intended, or if later, 30 days after the due date. In the event a payment is received which is deficient by $10 or less, the Qualified Beneficiary shall have a 30-day period from the Plan Office's receipt of the payment to pay the deficient amount, provided, however, that a payment that is not made within such 30-day period shall result in termination of coverage .

(v) If contributions are not received in a timely manner, coverage will terminate. No eligibility will be verified and no claims will be paid until two weeks after receipt of a contribution payment by the Fund Office.

(d) Termination of Continuation Coverage. Continuation coverage will terminate on the earliest of the following dates, as applicable:

(i) The date after the election date of the Qualified Beneficiary's coverage that the Qualified Beneficiary becomes covered under any other group health plan coverage. In the event such other group health plan coverage has a pre-existing condition exclusion or limitation, continuation coverage will not terminate until exhaustion of the maximum period of continuation coverage allowed or until the pre-existing condition exclusion or limitation with the other group coverage has been satisfied;

(ii) The end of the period for which the last payment was made for coverage in a timely manner;

(iii) The maximum continuation period has been exhausted;

(iv) The date after the election date of coverage that the Qualified Beneficiary becomes entitled to Medicare;

(v) The date the Plan is discontinued;

(vi) The date of a Withdrawal if the Employer makes group health plan coverage available to a class of employees formerly covered under the Plan or the Employer starts contributing to another multiemployer plan.

(vii) For all Qualified Beneficiaries eligible for the 11 month extension of continuation coverage under on first day of the month beginning more than 30 days following

the date of the final determination by the Social Security Administration that such person's disability had ceased.

(e) Compliance with COBRA.

(i) Active Employees whose coverage is terminated due to an Employer termination of participation in the Trust are not entitled to COBRA continuation coverage unless they incur a Qualifying Event prior to the date of withdrawal of the Employer. Furthermore, COBRA continuation coverage shall be terminated for Qualified Beneficiaries of Employers on the date of termination of participation in the Trust by the Employer if the Employer ceases to provide any group health plan to any employee.

(ii) The Plan constitutes a multiemployer employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and is providing continuation of coverage for all Employers subject to the health care continuation requirements of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

(f) Benefit Options. A Qualified Beneficiary who loses coverage under Plan 1 may elect to continue coverage under Option 1 or under the benefit option he was covered under on the day before the Qualifying Event. If a Qualified Beneficiary was previously covered under medical and two of the Optional Benefit plans, he must select medical benefits only or medical and all of the Optional Benefits for which he was previously covered. Once a benefit option is elected, it cannot be changed at a later date unless the employee requalifies for Plan coverage and subsequently loses eligibility.

OPTION 1 - Medical Benefits only.

OPTION 2 - Medical and Preventive Dental Benefits, provided the individual was previously covered under the Preventive Dental Plan.

OPTION 3 - Medical, Preventive Dental and Vision Benefits, provided the individual was previously covered under the Preventive Dental and Vision Plans.

OPTION 4 - Medical and Comprehensive Dental Benefits, provided the individual was previously covered under the Comprehensive Dental Plan.

OPTION 5 - Medical, Comprehensive Dental and Vision Benefits, provided the individual was previously covered under the Comprehensive Dental and Vision Plans.

OPTION 6 - Medical and Vision Benefits, provided the individual was previously covered under the Vision Plan.

If a Qualified Beneficiary is eligible for the Flexible Benefit Account Program on the day before the Qualifying Event, any election of medical benefits will also include Flexible Spending Account Program benefits.

2.13 Termination Due to Withdrawal. Any provision in this Plan to the contrary notwithstanding, a Withdrawal shall result in termination of eligibility for any Participant or Dependent in the Withdrawal Group. This includes Participants under the retiree or other self-pay coverages who were eligible for that coverage on account of Covered Employment in a Withdrawal Group. However, Qualified Beneficiaries will remain covered under the Plan (subject to termination of coverage rule identified above) unless the withdrawing Employer makes group health plan coverage available to a class of employees formerly covered under the Plan or the Employer starts contributing to another multiemployer plan. A termination of eligibility shall mean that the affected individual shall cease to be eligible for benefits as to any claims incurred on or after the date on which the Withdrawal occurs. A Withdrawal shall be deemed to occur as of the last day of the second month following the month in which proper contributions were required and paid under the affected Collective Bargaining Agreement. Termination of eligibility shall also cancel all credit accrued under a Participant's Dollar Bank Account and no extended eligibility otherwise available for canceled credit under the Dollar Bank shall be available under the Plan. The Plan shall not transfer any assets from the Plan which are attributable to a Withdrawal Group, including amounts corresponding to credit in a Participant's Dollar Bank Account. However, the Trustees may, in their sole discretion, approve a transfer of amounts corresponding to a portion of an affected Participant's credit in his Dollar Bank Account to a successor trust fund established for the same purposes as the Plan, to the extent the reserves and Dollar Bank credits attributable to the affected Withdrawing Group exceeded the claims run off following the Withdrawal date. The determination by the Trustees will be made after 12 months have elapsed since the Withdrawal date and it shall be based on whatever reasonable procedures and formulas the Trustees establish from time to time for this purpose. One factor the Trustees shall consider in deciding whether such a transfer is appropriate, is any adverse impact the Withdrawal can reasonably be expected to have on the Participants remaining in the Plan.

2.14 Reciprocity. The Plan is a participating trust fund in the Electrical Industry Health and Welfare Reciprocal Agreement ("Reciprocal Agreement"). This section sets forth the reciprocity rights of an Active Employee with respect to the Plan and other trust funds signatory to the Reciprocal Agreement ("Reciprocal Plan").

(a) Acceptance of Reciprocal Contributions. An Active Hourly Employee who leaves employment covered by the Plan for employment covered by a Reciprocal Plan may elect to continue Plan coverage subject to satisfaction of the following requirements:

(i) The Plan is considered such Employee's "Home Fund" under the Reciprocal Agreement; and

(ii) The Active Hourly Employee completes the reciprocity authorization required by the Reciprocal Agreement necessary to enable the Reciprocal Plan to reciprocate contributions to the Plan on such Employee's behalf.

An Active Hourly Employee who satisfies (i) and (ii) above will receive credit in his Dollar Bank Account for the actual contribution amount the Plan receives for the Active Hourly Employee from the Reciprocal Plan reduced by amounts allocated to the Active Hourly Employee's Flexible Benefit Account .

(b) Transfer of Reciprocal Contributions. The Plan shall transfer contributions received on behalf of an employee who has directed the reciprocal transfer of such contributions, in accordance with the requirements of the Reciprocal Agreement, to the Reciprocal Plan that qualifies as the employee's Home Fund under the Reciprocal Agreement. The Plan shall transfer such reciprocal contributions in the manner set forth in the Reciprocal Agreement. An employee electing to reciprocate contributions to a Reciprocal Plan pursuant to the Reciprocal Agreement shall be ineligible for any benefits or credits to his Dollar Bank Account from the Plan on account of such contributions.

(c) Termination of Reciprocity Election. An Active Hourly Employee may elect to cease having contributions transferred to or from the Plan pursuant to the procedures set forth in the Reciprocal Agreement. Such election shall be effective as of the date set forth in the Reciprocal Agreement.

(d) Limitation of Reciprocity Rights. An Active Hourly Employee shall only be eligible for a transfer of contributions to or from the Plan to the extent required by the Reciprocity Agreement.

2.15 Special Eligibility Rules for Initial Eligibility of Active Hourly Employee.

(a) General. When an employee who is a member of one of the Unions participating in the Plan becomes employed in employment for which an Employer is required to contribute to the Plan pursuant to a Collective Bargaining Agreement, such individual may elect participation under the Plan as an Active Hourly Employee under the normal Initial Eligibility rules or, if qualified, under the following Special Initial Eligibility Rule .

(b) Special Initial Eligibility Rule. An Active Hourly Employee shall become initially eligible for Plan coverage on the first day of the calendar month following satisfaction of all of the following requirements:

(i) The affected employee's home local union is one of the participating Unions under the Plan;

(ii) The affected employee makes payment equal to two months' premium; and

(iii) The employee enrolls in the Plan within 30 days following the date the individual is employed in employment for which an Employer is required to contribute to the Plan, but no later than the 15th day of the month prior to the month for which coverage is intended.

Payment and the enrollment documentation must be received by the Fund Office no later than the 15th day of the month prior to the month for which coverage is intended.

An employee who does not satisfy the above requirements under the Plan under the Initial Eligibility rules. An employee shall have only one opportunity to establish eligibility pursuant to the Special Initial Eligibility Rule described above.

(c) Continuation of Eligibility. An Active Hourly Employee who becomes initially covered for benefits under the Special Initial Eligibility Rule shall thereafter maintain continuation of eligibility for benefits under the Plan under the continuation of Eligibility rules.

(d) Termination of Eligibility. The termination of coverage for an Active Hourly Employee who becomes initially covered for benefits under the Special Initial Eligibility Rule described in section 2.15(b) above shall be governed by the Termination of Eligibility rules.

2.16 Dollar Bank Transfers.

(a) Active Hourly Employees may voluntarily transfer a portion of their Dollar Bank credits (the "Transferor Employee") to the Dollar Bank Account of another Active Hourly Employee or to the self-payment of a Self-Pay Active Hourly Employee who becomes Totally and Permanently Disabled (the "Transferee Employee") in the following circumstances:

(b) Catastrophic Illness or Injury.

(i) For purposes of this section 2.16, "catastrophic illness" is defined as an injury or Illness that the Trustees or their delegate determine, in their discretion, incapacitates the Transferee Employee and creates a financial hardship, or an injury or Illness that incapacitates a Dependent of the Transferee Employee if it results in the Transferee Employee being required to terminate employment or reduce his hours of employment for an extended period of time to care for the Dependent.

(ii) A Transferor Employee may transfer Dollar Bank credits to a Transferee Employee of if all of the following conditions are satisfied:

[a] At the time of the transfer, the Transferee Employee must have lost eligibility as a result of a catastrophic Illness and have insufficient Dollar Bank credits to continue eligibility without making a self-payment. A Transferee Employee who has lost coverage under section 2.2(f)(v), (vi) or (vii) is ineligible for a Dollar Bank transfer. The Transferee Employee must submit medical proof or other documentation to evidence the catastrophic illness.

[b] The Transferor Employee can transfer only one month's eligibility from the Dollar Bank at a time and can, in the aggregate, transfer no more than three months' eligibility from the Dollar Bank to the same Transferee Employee.

[c] The Transferor Employee must execute a form acceptable to the Trustees waiving all rights and claims arising out of the transfer of credits from the Dollar Bank and confirming that the Transferor Employee has not received, and will not receive, any consideration for the transfer from any party.

[d] The Transferee Employee may receive a transfer of no more than one month's Dollar Banks per month from all sources.

[e] The Transferor Employee must have a minimum of six months' eligibility remaining in his Dollar Bank Account following a transfer.

(iii) An Active Employer Staff Employee who loses eligibility as a result of a catastrophic illness may qualify as a Transferee Employee eligible for Dollar Bank transfers from Transferor Employees subject to the above conditions and limitations provided the Active Employer Staff Employee who loses eligibility under section 2.3(d)(vi) is ineligible for a Dollar Bank transfer.

(c) Transfer to Participant’s Immediate Family. A Transferor Employee may transfer Dollar Bank credits to the Dollar Bank Account maintained for a Participant or Dependent who is the Transferor Employee’s child, parent or sibling ("Transferee"), provided all of the following conditions are satisfied:

(i) At the time of the transfer, the Transferee must have lost eligibility on account of the reduction of premium amount in the Transferee’s Dollar Bank Account, and have insufficient credits in his Dollar Bank and Flexible Benefits Account to continue eligibility without a self-payment being paid. A Transferee who has lost coverage under Plan section 2.2(f)(v), (vi) or (vii) is ineligible for a dollar bank transfer.

(ii) The Transferor Employee can transfer only one month's eligibility from his Dollar Bank at a time and must have a minimum of six months' eligibility remaining in his or her Dollar Bank Account following a transfer.

(iii) The Transferor Employee must execute a form acceptable to the Trustees waiving all rights and claims arising out of the transfer of credits from his Dollar Bank and confirming that the Transferor Employee has not received, and will not receive, any consideration for the transfer from any party.

(d) Transfer of Dollar Bank Account of Deceased Participant. If an Active Hourly Employee dies without any surviving Dependents but is survived by a parent or adult child who is an Active Hourly Employee Participant in the Fund, the Fund shall transfer the Dollar Bank credits from the deceased Active Hourly Employee’s Dollar Bank in the following order: first to the Dollar Bank of the deceased Active Hourly Employee's surviving children (in equal amounts if there are multiple surviving children who are Active Hourly Employees) or, if there are no such surviving children, to the Dollar Bank of the deceased Active Hourly Employee's surviving parent who qualifies as an Active Hourly Employee (or in equal amounts if there are two surviving parents who each qualify as an Active Hourly Employee). References in this section to Active Hourly Employees shall include Participants with a Dollar Bank who have ceased to maintain Active Hourly Employee status. A surviving parent or child who has lost coverage under Plan section 2.2(f)(v), (vi) or (vii) is ineligible for a Dollar Bank transfer.

2.17 Continuation of Coverage During Family and Medical Leave Act (FMLA). An Active Employee may be able to continue medical benefits during an FMLA leave of absence

granted by his Covered Employer. For purposes of this section, a Covered Employer means an Employer that is subject to FMLA.

(a) Maintenance of Medical Benefits. A Covered Employer must continue to make contributions for an eligible Active Employee while the eligible Active Employee is on FMLA leave to the extent and for the time period required by the FMLA. The Covered Employer must identify the FMLA contributions on a remittance form and submit the form and contributions to the Fund Office.

(b) Termination of Coverage. An eligible Active Employee who loses coverage under the Plan as a result of his Employer ceasing to have an obligation to contribute on his behalf under the FMLA will experience a Qualifying Event on the last day of the FMLA leave. A Qualified Beneficiary may elect COBRA continuation coverage upon the loss of coverage. The FMLA establishes when an FMLA leave ends; generally, FMLA leaves end on the earliest to occur of the following: (i) the date the Active Employee informs the Employer that he will not be returning to work, (ii) the last day of the maximum leave period prescribed by the FMLA, or (iii) the date on which the Active Employee ceases to be entitled to FMLA leave.

(c) Disputes Over Eligibility and Coverage. All disputes over an Active Employee's eligibility and coverage under the FMLA are between the employee and Covered Employer. Benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute.

2.18 Opt-Out For Dependents For High Deductible Health Plan.

(a) Opt-Out Eligibility Rules. A Dependent may elect to opt-out of coverage under this Plan if he can provide the Plan Office with acceptable written proof that he is eligible to enroll in a High Deductible Health Plan ("HDHP") offered by the Dependent's employer (or the parent's employer in the case of a Dependent child) in conjunction with a Health Savings Account ("HSA") upon waiver of Plan benefits and the Dependent satisfying all of the following requirements:

(i) The Dependent must complete and sign a Dependent Coverage Opt-Out Form acknowledging that he is opting-out of coverage under this Plan and its Flexible Benefit Account.

(ii) The Dependent's coverage under this Plan (including the Flexible Benefit Account) will terminate at the end of the last day of the month during which a completed and signed opt-out election form is received by the Plan Office.

(iii) The Dependent's opt-out election will automatically renew each year until the Dependent again reinstates coverage under the terms of the opt-in provision.

(iv) If a Dependent elects to opt-out of coverage under this Plan, no Flexible Benefit Account reimbursement will be made for any health care expenses incurred on the Dependent's behalf, including dental, vision or preventive care benefits, even if such health care expense would qualify as being a reimbursable expense under the Flexible Benefit Account.

(b) Reinstatement (Opt-In) Eligibility Rules. A Dependent who has opted-out of Plan coverage in may later reinstate coverage as a Dependent under the Plan, including its Flexible Benefit Account, provided all of the following requirements are satisfied:

(i) The Dependent's coverage under the HDHP and HSA plan of his employer (or the parent's employer in the case of a Dependent child) has terminated, the Dependent provides satisfactory written proof of the same to the Plan Office and the individual continues to qualify as a Dependent eligible for Plan coverage.

(ii) The Dependent must complete and sign the Dependent Coverage Opt-In form.

(iii) Coverage under this Plan as a Dependent will be effective for the Dependent on the first day of the month following the date a completed and signed opt-in form and satisfactory written proof of termination of coverage under the HDHP and HSA plan are received by the Plan Office. The Dependent will not be covered under the Plan for any health care expenses, including any applicable dental, vision or preventive care benefits, incurred prior to the effective date of the reinstatement of coverage. Notwithstanding the forgoing, if the Dependent has a special enrollment right under HIPAA relating to the acquisition of a new dependent and notifies the Plan of the event within 30 days of the event, the Plan will allow retroactive Plan coverage to the date the dependent was acquired.

ARTICLE III

DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Death Benefit and the Accidental Death and Dismemberment Benefit are provided through a group insurance policy, attached as Appendix B, that governs the provision of these benefits.

3.1 Death Benefit. If a Participant dies, his designated Beneficiary shall receive a lump sum payment amount based on the age of the Participant on the date of death in the amount set forth in the Schedule of Benefits. If a Participant dies without having designated a Beneficiary or if his designated Beneficiary has died, then the Death Benefit will be paid in equal shares to the first surviving class of the classes listed in the following order: the legal spouse, children, parents, siblings, or estate.

3.2 Accidental Death and Dismemberment Benefit. When an Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee incurs a Bodily Injury caused solely by an Accident while covered by this Plan, directly and independently of all other causes, and when this Accident results in any of the following losses within 90 days after the date of the Accident, such Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee or his designated Beneficiary will be paid for the loss based on the Principal Sum in addition to any other benefits under this Plan.

(a) Principal Sum. The Principal Sum shall mean the amount based on the age of the Active Employee, Self-Pay Active Hourly Employee or Self-Pay Disabled Employee on the date of the Accident in the amount set forth in the Schedule of Benefits.

(b) Termination of Coverage. Coverage under this section shall terminate on the earliest of the following events:

(i) The date an Active Employee or Self-Pay Disabled Employee becomes covered under the Self-Payment for Retirees provision

(ii) The 65th birthday of a Self-Pay Active Hourly Employee or Self-Pay Disabled Employee;

(iii) The date an Active Employer Staff Employee age 65 or older ceases working for a participating Employer; or

(iv) The date an Active Hourly Employee age 65 or older ceases working under the Collective Bargaining Agreement.

(c) Amounts Payable. The amounts payable are as follows:

(i) The Principal Sum for loss of life.

(ii) The Principal Sum for loss of:

[a] Both hands;

[b] Both feet;

[c] Both eyes;

[d] Any two such members.

(iii) One-half the Principal sum for loss of:

[a] One hand;

[b] One foot;

[c] One eye.

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. The loss of an eye means the total and irrecoverable loss of sight.

If more than one specific loss results from one Accident, the amount provided for the greatest loss will be paid. These payments will be made directly to the Active Employee, Active Hourly Employee or Self Pay Disabled Employee if living, otherwise to his designated Beneficiary. If an Active Employee, Active Hourly Employee or Self Pay Disabled Employee dies without having designated a Beneficiary or if his designated Beneficiary has died, then the Accidental Death and Dismemberment Benefit will be in equal shares to the first surviving class of the classes listed in the following order: the legal spouse, children, parents, siblings, or estate.

The benefits are payable whether the Accident occurs on or off the job.

ARTICLE IV

DISABILITY BENEFITS

4.1 Loss of Time (Short Term Disability) Benefits. An Active Employee or Self-Pay Active Hourly Employee shall be eligible to receive Loss of Time Benefits (also called Short Term Disability Benefits) in the amount of $500 in taxable income per week for up to a maximum of 26 weeks for any one disability. If an Active Employee or Self-Pay Active Hourly Employee is disabled for part of a week, he will receive one-seventh of the weekly benefit for each day of disability.

(a) Covered Disabilities. The Active Employee or Self-Pay Active Hourly Employee must be Continuously Disabled due to an Illness or Bodily Injury. Loss of Time Benefits are not payable for Bodily Injury or Illness which occurs during the course of any employment unless the Active Employee or Self-Pay Active Hourly Employee completes a worker's compensation reimbursement agreement. Loss of Time Benefits are payable if an Active Employee or Self-Pay Active Hourly Employee is Continuously Disabled because of a Bodily Injury or Illness and is under the care of a licensed M.D., D.O., D.C. or D.P.M.Benefit Commencement Dates. Payment begins with the first day in the event of Bodily Injury or Inpatient hospitalization or the eighth day in the event of Illness.Successive Disability Periods. In the event of successive disabilities, the disabilities will be considered separate disabilities only if:the Active Hourly Employee or Self-Pay Active Employee is available to return to employment after the initial disability for at least two weeks of full-time employment; or

(ii) the two disabilities are due to entirely different and unrelated causes and are separated by at least one day for which the Active Hourly Employee or Self-Pay Active Employee is available to resume active work on a full-time basis; or

(iii) the Active Employer Staff Employee returns to work after the initial disability for at least two weeks of full-time employment; or

(iv) the two disabilities are due to entirely different and unrelated causes and are separated by at least one day for which the Active Employer Staff Employee resumes active work on a full-time basis.

(d) Filing of Disability Claims. A claim for disability must be filed with the Fund Office within six months of the date the disability began. The Trustees require an individual requesting payment of Loss of Time Benefits to provide written certification of Continuous Disability from his treating Physician at least every four weeks in order to maintain eligibility for such benefits.

(e) Disability Credits. Three hours of coverage per day will be credited to the Active Employee's or Self-Pay Active Hourly Employee's account.

(f) Limitations. No Loss of Time Benefits are payable for the following:

(i) On behalf of an Active Employer Staff Employee unless an officer of his/her Employer certifies in writing that the Active Employer Staff Employee is not receiving a salary.

(ii) Any period for which any individual fails to provide a certification of Continuous Disability acceptable to the Trustees from a licensed M.D., D.O., D.C. or D.P.M.

(iii) Any period the individual collected unemployment benefits.

(iv) Any period the individual is collecting pay for attending school.

4.2 Long Term Disability Benefits. An Active Employee or Self-Pay Active Hourly Employee shall be eligible to receive Long Term Disability Benefits upon exhaustion of Loss of Time Benefits. Active Employee or Self-Pay Active Hourly Employee must have worked at least 450 hours in the 6-month period before becoming disabled to be eligible for Long Term Disability Benefits. Benefits will continue for two years or longer if the insurer determines the Active Employee or Self-Pay Active Hourly Employee remains disabled.

Long Term Disability Benefits are provided through a group insurance policy, attached as Appendix C, that governs the provision of these benefits.

4.3 Offset. In the event that benefits are payable by the Plan under this Article IV, and under a long-term disability or other insurance contract maintained by the Plan ("contract"), any disability income benefits payable under this Article IV shall be offset by the amount of any payments payable pursuant to such other contracts. In the event that any payment is made by the Plan under this Article IV to or for an individual and also under such contract, the Plan shall have the right to suspend or withhold payment of incurred claims and to reduce any future payments due to such person and/or, if applicable, his Dependents (including payments of medical benefits) by the amount of any overpaid disability amount and by any amount incurred by the Plan in pursuing the overpayment. The Plan shall also have the right to reduce the amount of the Active Hourly Employee's or Self-Pay Active Hourly Employee's Dollar Bank to recover any overpaid disability amount until the Plan has recovered the full amount.

ARTICLE V

MEDICAL BENEFITS

5.1 Benefits. If an Eligible Individual receives treatment for a Bodily Injury or Illness, the Plan will, subject to the provisions hereafter stated and after the satisfaction of the Deductible, pay for each Eligible Individual the Percentage of Covered Charges Payable, not to exceed the maximum benefits payable set forth in the Schedule of Benefits. In addition, benefits are subject to Peer Review.

5.2 Peer Review. The Board of Trustees reserves the right to submit claims to peer review for determination of the appropriateness of the prescribed courses of treatment for the diagnosis rendered, to determine if charges are Medically Necessary and Reasonable and if charges for medical care are Usual, Customary and Reasonable in amount. Medical charges can be denied if the peer review process and appeal to the Board of Trustees determines that the medical charges are unreasonable or for services which are not Medically Necessary and Reasonable or accepted as Usual, Customary and Reasonable for that particular condition.

5.3 Arrangements With Preferred Provider Organizations. At the sole discretion of the Board of Trustees, the Plan may enter into agreements with one or more Preferred Provider Organizations whereby Plan benefits will be paid in accordance with such agreements.

5.4 Deductible. The Deductible is the amount of expenses incurred for Covered Charges each calendar year before Benefits become payable. The Deductible does not apply to Covered Charges incurred for routine nursery care of a newborn Dependent child, Routine Physical Examinations, preventive care at a PPO Provider, Hearing Benefits, vision benefits or dental benefits.

5.5 Medical Case Management. To ensure quality medical care and maximize benefits of the Plan, the Board of Trustees reserves the right to require review of care and treatment of certain conditions in accordance with the terms of an agreement with a medical case management service and the Plan's guidelines on alternative care.

5.6 Out-of-Pocket Maximum. The out-of-pocket maximum is the maximum amount that an Eligible Individual is required to pay for Covered Charges per calendar year. After an Eligible Individual satisfies the Plan's applicable out-of-pocket maximum the Plan will pay 100% of any additional Covered Charges an Eligible Individual incurs for the remainder of the calendar year. If an Eligible Individual has satisfied the out-of-pocket maximum and is hospitalized on January 1, the Plan will consider continuous Inpatient Hospital Covered Charges as incurred in the prior year and will continue to cover at 100%. The out-of-pocket maximum applies to each Eligible Individual. The family out-of-pocket maximum is satisfied when the cumulative individual out-of-pocket maximums of three or more covered family members meet the family out-of-pocket maximum.

The PPO and Non-PPO provider expenses are separate and cannot be combined to reach the out-of-pocket maximums. The Plan does not apply all expenses to the out-of-pocket maximum. Whether an expense applies to the out-of-pocket maximum depends on whether it is a

PPO or Non-PPO expense. All Covered Charged provided by a PPO Provider including the Deductible and shall count toward the PPO provider out-of-pocket maximum. The following expenses are not applied to the out-of-pocket maximum:

(a) Prescription drug expenses (charges count toward the prescription drug out-of-pocket maximum only);

(b) Expenses not considered Covered Charges;

(c) Vision and dental expenses;

(d) Amounts in excess of the UCR for Non-PPO Covered Charges; and

(e) Amounts in excess of a benefit maximum or lifetime maximum.

5.7 Prior Authorization.

(a) Prior authorization from the provider of utilization review services as designated by the Board of Trustees must be established for all planned surgical and non-surgical admissions, Inpatient confinements and services, Outpatient surgical requests, implantable devices and all related changes and for all Outpatient services performed in a Hospital, licensed treatment facility or Ambulatory Surgical Center. Prior authorization is not required for emergency admissions or maternity admissions; however, maternity admissions with complications must be reported to the provider of utilization review services within 48 hours of such admission, or if a weekend admission, the next business day. A confinement that extends beyond the number of days authorized, without prior approval by the utilization review provider, will be covered by the Plan provided that the patient's Physician certifies that such additional days of inpatient confinement are Medically Necessary and Reasonable. If the utilization review provider determines that Inpatient care is not Medically Necessary and Reasonable, then the Plan can apply the determination to limit coverage to the cost of the Medically Necessary and Reasonable care on an Outpatient basis.

(b) Covered Charges for Non-PPO services and all related Non-PPO Physician's charges shall be reduced by 20% if prior authorization is not obtained. Such penalty reduction shall not be applied to the Eligible Individual's deductible or out-of-pocket maximum. Charges made by any Hospital for room and board and other miscellaneous charges shall not be reduced.

5.8 Covered Charges. Covered Charges include only Usual, Customary and Reasonable charges for those items described below. A Covered Charge is incurred at the time the service is rendered or the item is provided for which a charge is made.

(a) Hospital Benefits. Hospital Benefits include the following:

(i) Hospital room and board charges, up to the Hospital's semi-private room rate for the services being rendered. When confined in a private room, the Hospital's most common charge made for a semi-private room for the level of services rendered shall be allowed towards the cost of a private room;

(ii) Hospital charges for routine nursery care of a newborn child.

(iii) Hospital charges for confinement in an Intensive Care Unit.

(iv) Hospital miscellaneous charges for:

[a] services and supplies provided during confinement of an Eligible Individual as a registered Inpatient, at a time when the Hospital room and board benefits are payable, excluding charges for private duty nursing;

[b] anesthetics, whether charged by the Hospital or an outside agency, but not including their administration;

[c] whole blood or blood plasma, if not replaced, and the cost of its administration.

(v) Charges for professional ground ambulance service to and from a Hospital, and supplies and transport teams to the extent such charges would be covered if they had been incurred in a clinical setting.

(vi) Benefits payable in accordance with this subsection (a) when confined as a registered Inpatient for the treatment of Mental, Nervous or Emotional Disorders and Substance Abuse for Inpatient confinement or for partial hospitalization.

Partial hospitalization means continuous treatment of a Mental, Nervous or Emotional Disorder or Substance Abuse for at least three hours, but no more than 12 hours in a 24-hour period. Family counseling rendered by a Physician shall be covered during such Inpatient confinement.

(vii) Charges for professional air ambulance service for emergency transportation to a Hospital or for transferring from Hospital to Hospital, provided the Physician certifies that an Eligible Individual's condition requires specialized treatment at another Hospital and the condition requires transportation by air ambulance to the nearest Hospital qualified to provide the special treatment. Supplies and transport teams will be covered to the extent such charges would be covered if they had been incurred in a clinical setting. Transportation by professional air ambulance includes transportation only within the continental limits of the United States or Canada or within the geographical boundaries of Puerto Rico, Virgin Islands or Hawaii.

(b) Skilled Nursing Facility. Confinement in a Skilled Nursing Facility is payable as follows:

(i) Room and board charges, including charges for services, such as general nursing care, made in connection with room occupancy, up to the Skilled Nursing Facilities average semi-private room rate. When confined in a private room, the Skilled Nursing Facilities most common charge made for a semi-private room shall be allowed towards the cost of a private room;

(ii) Use of special treatment rooms;

(iii) X-ray and lab work;

(iv) Physical, Occupational or Speech Therapy;

(v) Oxygen and other gas therapy;

(vi) Drugs, biological, solutions, dressings and casts, but no other supplies;

(vii) Other Medically Necessary and reasonable services and supplies charged and furnished by the Skilled Nursing Facility, excluding services of a private duty nurse or Physician;

(viii) Benefits described in (i) through (vii) above are payable up to 60 days during any one period of confinement provided:

[a] such confinement follows at least three consecutive days of Hospital confinement as an Inpatient, while covered under this Plan;

[b] such confinement begins within 24 hours after the Hospital discharge date; and

[c] a Physician certified that such confinement and services are necessary to the continued treatment by the Physician of the Injury or Illness;

(ix) successive confinements in a Skilled Nursing Facility for the same condition will be considered one period of confinement unless separated by a period of at least 90 days during which the patient is not confined.

(c) Hospital Outpatient Benefits. Benefits are payable for Hospital charges incurred for medical services or supplies provided by that Hospital during Outpatient care of an Eligible Individual, resulting from accidental Bodily Injury, surgery, or a Medical Emergency provided services and supplies are rendered within 72 hours of the onset of such accidental Bodily Injury or Medical Emergency, and excluding services of a private duty nurse, Physician and routine physical examination.

Charges for medical services and supplies provided during Outpatient surgery will be considered Covered Charges if the charges are made by a Licensed Ambulatory Surgical Center.

(d) Pregnancy Benefits.

(i) Plan benefits are payable for charges incurred by an Eligible Individual, as a result of pregnancy, childbirth or a related medical condition, provided the Eligible Individual is covered by the Plan at the time of delivery.

(ii) Expenses for care received in a licensed birthing center for the treatment of childbirth are covered charges.

(iii) Plan benefits shall be payable for a Hospital stay for the mother and newborn child for a period of no less than 48 hours following a normal delivery or 96 hours following a cesarean delivery. However, this shall not preclude an attending Physician or a CNM, after consulting with the mother, from discharging the mother and newborn before this period expires.

(iv) Plan benefits are payable for obstetrical services rendered by a midwife to an Eligible Individual subject to all of the following conditions:

[a] The midwife must be certified as a CNM by the American College of Nurse Midwives and licensed as a CNM by the Board of Nursing in the State of Wisconsin; and

[b] The CNM must practice in collaboration with an obstetrician/gynecologist who is available to assume responsibility at any time during the pre-natal, delivery or post-natal process; and

[c] The actual birth must occur at a Hospital (no benefits are payable by the Plan for a home birth performed by any Provider, unless the home birth is performed on an emergency basis); and

[d] If the sum of the Covered Charges for the CNM's services and any necessary Physician's services exceeds the amount of the charges which would have been incurred by the Eligible Individual if the entire maternity process had been handled by a Physician, the maximum benefit payable by the Plan will be limited to the amount which would have been paid by the Plan if care throughout the entire maternity process had been handled by the Physician.

(e) Surgery-Anesthesia. Benefits are payable for the following surgical and anesthesia services:

(i) Professional surgical services rendered by the operating Physician in the performance of a surgical procedure.

(ii) Professional surgical services rendered by an assistant surgeon, in the performance of a surgical procedure, not to exceed 25% of the operating surgeon's benefit allowed by MDR. If MDR allows an assistant surgeon for the procedure performed, the Plan will pay a benefit equal to the fee charged, not to exceed 15% of the operating surgeon's benefit allowed under MDR, for the services of a legally licensed and qualified physician's assistant (P.A.) who is acting in the stead of an assistant surgeon as part of the surgical team.

(iii) The maximum surgical amount payable shall include the surgery and the follow-up care for the period indicated in MDR.

(iv) Surgical benefits for a procedure not listed in MDR and not otherwise herein excluded will be determined by the Board of Trustees and shall be an amount equal to that shown in MDR for a listed procedure of comparable gravity and severity.

When multiple or bilateral surgical procedures, which add significant time or complexity to patient care, are performed at the same operative session, the total amount payable shall be for the major procedure plus 50% of the amount for the lesser procedure(s) unless otherwise specified in MDR.

When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst, etc.) is performed through the same incision, the amount payable will be that of the major procedure only.

(v) Professional services rendered by an anesthesiologist or nurse anesthetist during performance of a surgical operation. Benefits are payable for the administration of anesthesia by the operating or assistant Physician, but not for local infiltration anesthesia, up to 50% of the amount that would otherwise be payable.

(f) Radiotherapy. Benefits are payable for radiotherapy, including the use of x-ray, radium, cobalt and other radioactive substances.

(g) Diagnostic X-ray and Laboratory Benefits. Benefits are payable for necessary x-ray and laboratory examinations for diagnosis of Bodily Injury or Illness, including allergy testing, basal metabolism determination, audiograms, electrocardiograms and initial diagnostic testing.

(h) Medical Services. Benefits are payable for medical services rendered by a Physician as follows:

(i) Daily Physician visits when confined in a Hospital, Skilled Nursing Facility or Substance Abuse Treatment Facility as a registered Inpatient. Benefits are payable at the time room and board benefits are payable;

(ii) Office visits;

(iii) Consultations, including virtual Physician consultations with a Physician in a program approved by the Trustees (e.g., Anthem's LiveHealth Online) and up to 4 tobacco counseling sessions of a minimum 10 minutes each from a PPO provider per calendar year in conjunction with a maximum of two calendar year smoking cessation attempts.

(iv) Visits at a place other than a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility or Physician's office; and

Nonresidential outpatient treatment of Mental, Nervous and Emotional Disorders or Substance Abuse by a Physician or by a Covered Provider and Family counseling by a Physician or a Covered Provide.

(v) Physician charges for the treatment of an accidental Bodily Injury or Medical Emergency, provided the treatment is rendered within 72 hours of the onset of such accidental Bodily Injury or Medical Emergency.

(i) Oral Surgery. Benefits are payable for the following:

(i) Repair or alleviation of damage to sound natural teeth caused by Injury sustained while an Eligible Individual under this Plan;

(ii) Removal of partially or completely unerupted impacted teeth;

(iii) Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require pathological examination;

(iv) Removal of apex of tooth root, "apicoectomy" (does not include root canal);

(v) Removal of exotoses, "growth of the jaw and hard palate;"

(vi) Treatment of fractures of facial bones;

(vii) External incision and drainage of cellulitis;

(viii) Incision of accessory sinuses, salivary glands, or ducts;

(ix) Surgical treatment for the correction of temporomandibular joint dysfunction (TMJ);

(x) Gingivectomy, excision of loose gum tissue to eliminate infection;

(xi) Aveolectomy, the leveling of structures supporting teeth for the purposes of fitting dentures;

(xii) Frenectomy, the cutting of the tissue in the middle of the tongue (frenulum); and

(xiii) Osseous surgery.

(j) Prescription Drugs, Appliances and Nursing Care. Charges payable under Hospital Benefits shall not be payable under this benefit. Covered Charges include:

(i) Injectable Covered Drugs purchased by an Eligible Individual through a Network Pharmacy or the mail order program adopted by the Trustees for at home administration, provided that the injectable Covered Drug would be covered under the Medical Benefits if administered by a Physician or R.N.

(ii) Rental of a wheel chair, hospital bed, oxygen equipment and other similar durable medical equipment required for therapeutic use and not normally utilized for everyday use. When determined by the Board of Trustees that purchase of durable medical equipment would be less expensive than the rental thereof, or such equipment is not available for rental, such purchase may be authorized by the Board of Trustees.

(iii) Prosthetic devices prescribed by a Physician, including but not limited to, artificial arms, legs and accessories, artificial eyes, and initial prosthetic implants due to malignancy or benign tumor removal subject to the maximums set forth in the Schedule of

Benefits. Benefits payable include charges for the fitting, adjusting and repair of such devices but exclude coverage for maintenance of the prosthetic's hardware. Replacement or repair of prosthetic devices is covered once every 5 years and as needed for pathological changes or normal growth. Coverage is excluded for implantable and/or inflatable prostheses and replacement of breast implants unless the breast implant is provided in conjunction with the reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, or prostheses and physical complications of all stages of mastectomy, including lymphedemas.

(iv) Casts, splints, trusses, braces, crutches, and surgical dressings.

(v) Custom fitted orthotics, leg braces, including attached shoes, arm braces, back braces and cervical collars prescribed by a Physician for a diagnosis not excluded by the Plan, up to the maximum set forth in the Schedule of Benefits, if cast impressions are taken and range of motion testing performed. Replacement or repair of orthotic device is covered once every 5 years and as needed for pathological changes or normal growth.

(vi) Custom fitted orthotics for a chronic conditions of the foot otherwise excluded by the Plan up to the maximum set forth in the Schedule of Benefits, if cast impressions are taken. Replacement or repair of the orthotic device is covered once every years.

(vii) Oxygen.

(viii) Purchase and installation of an insulin infusion pump every 3-5 years, if determined to be Medically Necessary and Reasonable and provided that other more conservative and less costly alternatives have been exhausted and failed.

(ix) The charge for the professional services of a registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) on a part-time or intermittent basis; except charges made by one who normally resides in the Eligible Individual's home or is the spouse, child, brother, sister, or parent of the Eligible Individual.

(k) Home Health Care. The following medical services and supplies furnished on a visiting basis in a private residence (not necessarily the residence of an Eligible Individual) for treatment of an Eligible Individual's Bodily Injury or Illness. The Home Health Care visit shall be limited to up to four hours in any 24-hour period. The maximum weekly benefit for Home Health Care shall not exceed the Usual, Customary and Reasonable weekly cost for care in a Skilled Nursing Facility.

(i) The charge for evaluation of the need for and the development of a plan, by a registered nurse (R.N.), medical social worker (M.S.W.), or Physician extender.

(ii) The charge for the professional services of a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.) or licensed physiotherapist on a part-time or intermittent basis; except charges made by one who normally resides in the Eligible Individual's home or is the spouse, child, brother, sister, or parent of the Eligible Individual.

(iii) The charge for the services of a home health aide, under the supervision of a registered nurse (R.N.) or a medical social worker (M.S.W.), on a part-time or intermittent basis.

(iv) The charge for Physical, Occupational, Speech, respiratory or rehabilitation therapy.

(v) Charges for medical supplies or services provided by or through the Home Health Agency, drugs and medication prescribed by a Physician, and laboratory services by or on behalf of a Hospital, if necessary, to the extent such items would have been covered under the Plan if the patient had been Inpatient confined.

(vi) Nutrition counseling provided by or under the supervision of a registered dietitian where services are Medically Necessary and Reasonable as part of the Home Health Care plan.

A Home Health Care benefit will be payable only if all of the following conditions are met:

(i) A Physician must certify that the individual would require Inpatient confinement in a Hospital or Skilled Nursing Facility if Home Health Care were not available. If the Eligible Individual was Inpatient confined in Hospital or Skilled Nursing Facility immediately prior to commencement of Home Health Care, the Physician who was the primary provider of services during the confinement shall also initially approve the Home Health Care plan.

(ii) The Home Health Care must be provided according to a plan of treatment ordered by and approved, in writing, by a Physician.

(iii) The continuing need for Home Health Care must be certified periodically (not more frequently than once every two months) by the attending Physician;

(iv) The Home Health Care services are provided or coordinated by a state licensed or Medicare certified Home Health Agency or a certified rehabilitation agency.

Home Health Care benefits will not be provided for the following services:

(i) massage therapy, personal training or other general physical fitness services;

(ii) Routine housekeeping chores, which are not necessary to prevent or postpone the Eligible Individual's hospitalization, or similar services which would materially increase the amount of time required for the visit unnecessarily;

(iii) Any services rendered to the Eligible Individual which could have been provided by any other properly trained person of the household without endangering the Eligible Individual's life or seriously impairing his condition; or

(iv) Any services or supplies that would be excluded if the Eligible Individual were confined as an Inpatient in a Hospital or Skilled Nursing Facility.

(l) Hospice Care. If a Physician certifies that an Eligible Individual is Terminally Ill, the Plan will pay for Covered Charges as follows:

(i) The charge, not to exceed Hospital benefits, of Hospice Care for the Inpatient confinement of an Eligible Individual;

(ii) The charge for home Hospice Care furnished to the Eligible Individual in a private residence (not necessarily the residence of the Eligible Individual). The Covered Charges for home Hospice Care include:

[a] Services of a home health aide;

[b] Professional services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.);

[c] Physical and respiratory therapy;

[d] Nutrition counseling and special meals;

[e] Services of a licensed or certified social worker for medical social services rendered not to exceed a maximum of six visits.

(iii) The Plan will not pay for more than a total of eight days of Inpatient cases for Respite Care per lifetime.

No benefits will be paid for Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services.

(m) Therapies. Occupational Therapy, Physical Therapy or Speech Therapy services prescribed by a Physician are payable up to three consecutive months when in the judgment of the Physician significant improvement can be obtained.

Additional need for therapy must be certified by the attending Physician to be Medically Necessary and Reasonable. Benefits are not payable for Occupational Therapy, Physical Therapy or Speech Therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. Physical Therapy and Occupational Therapy which are prescribed by a Physician in lieu of non-medical treatment (e.g., exercise) is not considered Medically Necessary and Reasonable treatment and is not payable by the Plan.

When prescribed or provided by a Physician, the following types of therapy are covered:

(i) Occupational Therapy performed by a properly accredited occupational therapist (OT), certified occupational therapy assistant (COTA), or, as appropriate, another provider acting within the scope of the provider's license.

(ii) Physical Therapy performed by a Physician or a registered physical therapist (RPT).

(iii) Speech Therapy and audio therapy, including audio diagnostic testing, when performed by a qualified therapist, or, as appropriate, another provider acting within the scope of the provider's license.

(n) Transplant Benefits. If a Physician certifies that an Eligible Individual is in need of a cornea, kidney/pancreas, liver, autologous or allogenic bone marrow, kidney, heart or heart/lung human-to-human transplant, the following services are payable by the Plan:

(i) The transplant and all phases of related transplant care, including, but not limited to treatments, procedures, services, supplies and medicines provided in connection with admission, surgery and post-transplant care, provided the services are performed at a provider which participates in the transplant network adopted or approved by the Board of Trustees at the time such transplant care is rendered. Pre-Transplant evaluation may be performed at a Network provider or outside the Transplant Network provided that such evaluation is monitored by and coordinated with the Plan's utilization review service.

(ii) Travel expenses for the transplant recipient only to and from a provider participating in the Transplant Network in conjunction with the transplant up to the maximum of set forth in the Schedule of Benefits. Travel expenses means ambulance, air ambulance or other professional transportation for the transplant recipient, including the recipient's travel by regularly scheduled airline or railroad to and from the Transplant Network provider.

(iii) No benefits are payable for donor expenses, except for available coverage for donor expenses as set forth as part of an all-inclusive discounted case rate charged by a provider in the Transplant Network retained by the Board of Trustees where such expenses do not increase the case rate. The transplant and all phases of related transplant care are subject to precertification and concurrent review by the Plan's utilization review service.

(o) Chiropractic Benefits. Benefits are limited to the following services for the treatment of spinal maladjustment:

(i) Initial office visit, including routine examination, patient history and/or treatment (new patient or condition).

(ii) Follow-up visit including:

[a] Manipulation, one per visit;

[b] Therapy, limited to one therapy per visit;

(iii) Diagnostic x-ray of one per Eligible Individual per calendar year.

No benefits are payable for Independent children under age 10.

(p) Routine Physical Examination and Preventive Care. The Plan pays for preventive care services recommended by the United States Preventative Service Task Force with a Grade A or B, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as required by the Affordable Care Act. The Plan pays for either a colonoscopy or a Cologuard kit under the preventive care benefit.

(q) Asbestosis Testing Benefits. Each Eligible Employee shall be entitled to one special breathing test and one X-ray analysis designed to detect the presence of a condition caused by the inhalation of asbestos fiber. Benefits are payable for a breath test provided the test is performed before any X-rays are taken. If the breath test indicates that X-rays are necessary, the testing doctor must submit a written report certifying that X-rays are required. If X-rays are required, the X-ray analysis must be performed by a doctor qualified to interpret X-rays in relation to asbestosis. If the Asbestosis testing is compensable under Workers Compensation, the Plan may be subrogated.

(r) Hearing Benefits. Hearing screenings and examinations, hearing aids/devices, hearing aid batteries and for repairs to existing hearing aids up to the maximum set forth in the Schedule of Benefits.

(s) Gastric Bypass Surgery. Charges for gastric bypass surgery as a direct result of Morbid Obesity up to the maximum set forth in the Schedule of Benefits. The lifetime maximum shall apply to all direct or indirect charges that the Eligible Individual incurs on account of the gastric bypass surgery, including but not limited to, charges made to the Eligible Individual by a Hospital, the surgical fees for the performance of the procedure, pre-surgical psychological examination performed in connection with the surgery, pre- and post-operative visits, anesthesia services, and treatment of health issues and complications that may arise from the surgery. Charges for gastric bypass surgery are subject to precertification before receiving services and the Plan's exclusions and limitations.

(t) Gene Therapy. Benefits are payable for the following:

(i) Gene therapy treatment prescribed by a Physician. The gene therapy must be approved by the Food and Drug Administration ("FDA") for the use for which it is prescribed at the time the gene therapy treatment is provided; and

(ii) All phases of related gene therapy treatment, including, but not limited to, genetic testing, treatments, procedures, services, supplies and medicines provided in connection with admission, the extraction of cells, the administration of the gene therapy treatment, and follow up care.

The gene therapy and all phases of related gene therapy treatment are subject to precertification and Concurrent Review by the Plan's utilization review service, except no precertification is required for related gene therapy treatment for which lack of immediate processing of the claim could seriously jeopardize the life or health of the Eligible Individual or subject the Eligible Individual to severe pain that cannot be adequately managed without such care.

(u) Implantable Devices. Benefits are payable for implantable devices, whether temporary or permanent, and their installation provided that other more conservative and less costly alternatives have been exhausted and filed.

5.9 Employee Assistance Program. As part of the Plan's Long-Term Disability insurance contract, Active Employees and Self-Pay Hourly Employees have access to an employee assistance program. The terms governing the employee assistance program are detailed in the group policy attached as Appendix C.

ARTICLE VI

OPTIONAL PREVENTIVE DENTAL BENEFITS

6.1 Benefits. If an Eligible Individual receives dental care, the Plan will pay benefits, for dental services and supplies listed in section 6.2, as set forth in the Schedule of Benefits.

6.2 Covered Dental Services.

(a) Oral examinations are a benefit twice in a calendar year.

(b) Prophylaxis (cleaning and scaling of teeth) is a benefit twice in a calendar year.

(c) Topical fluoride application and tooth sealants for back molars is a benefit only to children through age 15 and is a benefit once in a calendar year.

(d) Complete mouth radiographs are a benefit once in a 36 consecutive month period.

(e) Bite-wing radiographs are a benefit once in a six consecutive month period.

(f) Panoramic radiographs are a benefit once in a 60 consecutive month period.

(g) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth are a benefit only to children through age 18.

6.3 Courses of Treatment in Progress on Effective Date of Optional Preventive Dental Benefits. Benefits are not provided for treatment received prior to the effective date of Optional Preventive Dental Benefits. However, claims for a course of treatment which began prior to such effective date but completed while such coverage is in force with this Plan will be investigated to determine what amount of the entire fee, if any, should be allocated to the treatment which was actually received while covered by this Plan. Only that portion of the total fee which can be allocated to treatment received while covered under this Plan will be allowed as a benefit under this Plan.

6.4 Limitations and Exclusions. In addition to the General Exclusions and Limitations in Article IX, no benefits are payable for:

(a) Dental services and supplies not listed in section 6.2 above.

(b) Expenses for services or supplies not necessary according to or do not meet accepted standards of dental practice.

(c) Treatment by other than a Dentist, or, as appropriate, another provider acting within the scope of the provider's license, except charges for dental prophylaxis performed by a licensed dental hygienist under the direct supervision and direction of a Dentist.

6.5 Termination of Optional Preventive Dental Benefits. Optional Preventive Dental Benefits shall terminate on the earliest of the following dates:

(a) The date coverage would otherwise terminate under the Plan;

(b) The date the Eligible Individual becomes covered as a Retiree or Early Retiree or a Dependent of a Retiree or Early Retiree; or

(c) The date the Employer or Union terminates participation in the Optional Preventive Dental Benefits.

6.6 Treatment as Excepted Benefit. Optional Preventive Dental Benefits are characterized under the Plan as an excepted benefit under HIPAA and the Affordable Care Act.

ARTICLE VII

OPTIONAL COMPREHENSIVE DENTAL BENEFITS

7.1 Benefits. If an Eligible Individual receives dental care, the Plan will pay benefits, for dental services and supplies listed in section 7.2 subject to the maximum benefits described in the Schedule of Benefits.

7.2 Covered Dental Services.

(a) Preventive Services.

(i) Oral examinations are a benefit twice in a calendar year.

(ii) Prophylaxis (cleaning and scaling of teeth) is a benefit twice in a calendar year.

(iii) Topical fluoride application and tooth sealants for back molars is a benefit only to children through age 15 and is a benefit once in a calendar year.

(iv) Complete mouth radiographs are a benefit once in a 36 consecutive month period.

(v) Bite-wing radiographs are a benefit once in a six consecutive month period.

(vi) Panoramic radiograph are a benefit once in a 60 consecutive month period.

(vii) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth are a benefit only to children through age 18.

(b) Basic Services.

(i) Periodontics - Provides the necessary procedures for treatment of the tissues supporting the teeth.

(ii) Oral Surgery - Provides the necessary procedures for extractions and other oral surgery necessary, including pre- and post-operative care and those performed in connection with orthodontic treatment.

(iii) Restorative - Provides the necessary procedures to restore the teeth, other than cast restoration.

(iv) Endodontics - Provides the necessary procedures for pulpal and root canal therapy.

(v) Local anesthetic (e.g., Novocain), and when Medically Necessary and administered in connection with oral or dental surgery, general anesthetics.

(vi) Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.

(vii) Intraoral radiographs.

(c) Limitations - Basic Services.

(i) If anterior teeth can satisfactorily be restored with synthetic materials and posterior teeth can adequately be restored with amalgam, payment for such procedures will be made toward the cost of other procedures or materials selected by the dentist or the patient.

(ii) Veneers posterior to maxillary first molars or mandibular second bicuspids are considered optional, and as such, are not considered covered services.

(d) Major Services.

(i) Cast Restorations - Provides the necessary procedures to restore the teeth; gold restorations, crowns, and jackets will be provided when teeth cannot be restored with other materials.

(ii) Prosthodontics - Provides the necessary procedures associated with the construction, placement or repair of fixed bridges, partial and complete dentures.

[a] Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments except periodontal splinting).

[b] Initial installation (including precision attachments and adjustment during the six month period following installation) of partial or full removable dentures.

[c] Replacement of existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

[i] The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;

[ii] The existing denture or bridgework was installed at least five years prior to its replacement under this Plan or any other group plan, unless no payment was received and the existing denture or bridgework cannot be made serviceable; or

[iii] The existing denture is an immediate temporary denture which cannot be made permanent and replacement by permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally dentures will be replaced by dentures but if a professionally adequate result can be achieved with bridgework only, such bridgework will be a covered dental service.

(iii) Inlays, implements, onlays, fillings, or crown restorations to restore diseased teeth.

(iv) Implants - Provides the necessary procedures, techniques or materials for dental implants and appliances constructed in association therewith.

(e) Limitations - Major Services.

(i) If adequate retention and aesthetics can be obtained using only gold in the construction of a necessary crown, payment for such procedure will be made toward the cost of a more extensive procedure selected by the dentist or the patient.

(ii) Porcelain gold, porcelain veneer, and acrylic veneer precious metal crowns over vital teeth are not covered services for children under age 12.

(iii) Veneers on crown posterior to maxillary first molars or mandibular second bicuspids are considered optional, and as such, are not covered services.

(iv) Appliances for the replacement of the same natural teeth are a benefit only once in a five-year period.

(v) Temporary partial dentures are a benefit only when anterior teeth are missing.

(vi) Specialized techniques, precious metals for removable appliances, precision attachments, and associated appliances, personalization and characterization are considered optional, and as such, are not covered services. An allowance for a standard procedure will be made toward the cost of a more complex procedure.

(vii) Fixed bridges and/or cast partials are not a benefit for children under age 16.

(viii) A posterior fixed bridge is not a covered service when done in connection with a removable appliance in the same arch.

(f) Orthodontic Services. Orthodontic treatment means preventive and corrective treatment of all dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

Orthodontic procedures and treatment consist of appliance therapy and surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion).

(g) Limitations - Orthodontic Services. The maximum amount payable for expenses for orthodontic treatment will not exceed $100 in the case of a person whose initial expenses for orthodontic treatment are incurred less than three months prior to the date of termination of coverage.

7.3 Courses of Treatment in Progress on Effective Date of Optional Comprehensive Dental Benefits. Benefits are not provided for treatment received prior to the effective date of Optional Comprehensive Dental Benefits. However, claims for a course of treatment which began prior to such effective date but completed while such coverage is in force with this Plan will be investigated to determine what amount of the entire fee, if any, should be allocated to the treatment which was actually received while covered by the Plan. Only the portion of the total fee which can be allocated to treatment received while covered under this Plan will be allowed as a benefit under the Plan.

7.4 Limitations and Exclusions. In addition to the General Exclusions and Limitations in Article IX and the Limitations set forth in section 7.2, no benefits are payable for:

(a) Dental services and supplies not listed in section 7.2;

(b) Expenses for services or supplies not necessary according to or do not meet accepted standards of dental practice;

(c) Treatment by other than a Dentist, or, as appropriate, another provider acting within the scope of the provider's license, except charges for dental prophylaxis performed by a licensed dental hygienist under the direct supervision and direction of a Dentist;

(d) Treatment due to Injury to natural teeth as a result of an accident. Benefits for accidental Injury to sound natural teeth are paid under Article V, Medical Benefits;

(e) Correction of congenital, developmental or acquired malformations;

(f) Treatment for the disturbances of the temporomandibular joint (TMJ);

(g) Procedures necessary to alter occlusion or vertical dimension or restoration of tooth structure lost through attrition, including, but not limited to, treatment or appliances to prevent the loss of tooth structure through attrition;

(h) Hypnosis;

(i) Pre-medication;

(j) Treatment solely for cosmetic reasons;

(k) Charges for general anesthesia, except when administered in association with covered oral surgery;

(l) Charges for prescription drugs;

(m) Hospital charges, including hospital visits;

(n) Charges for completion of forms;

(o) Charges for lost or stolen appliances; and

(p) Experimental treatment and services.

7.5 Termination of Optional Comprehensive Dental Benefits. Optional Comprehensive Dental Benefits shall terminate on the earliest of the following dates:

(a) The date coverage would otherwise terminate under the Plan;

(b) The date the Eligible Individual becomes covered as a Retiree or Early Retiree or a Dependent of a Retiree or Early Retiree; or

(c) The date the Employer or Union terminates participation in the Optional Comprehensive Dental Benefits.

7.6 Extended Dental Benefits. No benefits shall be payable for any covered dental expenses incurred by an Employee or Dependent after the termination of coverage, except as follows:

(a) Expenses for a prosthetic device (including bridgework) will be included as a covered dental benefit only if the impressions were taken and abutment teeth fully prepared while coverage of the Eligible Individual was in force under the Plan, provided the prosthetic device is installed or delivered to the person within two calendar months following such termination of coverage;

(b) Expenses for a crown will be included as a covered dental benefit only if the tooth was prepared for the crown while coverage of the Eligible Individual was in force under the Plan, and the crown is installed within two calendar months following such termination of coverage; and

(c) Expenses for root canal therapy will be included as a covered dental benefit only if the tooth was opened while coverage of the Eligible Individual was in force under the Plan, and treatment is completed within two calendar months following such termination of coverage.

7.7 Treatment as Excepted Benefit. Optional Comprehensive Dental Benefits are characterized under the Plan as an excepted benefit under HIPAA and the Affordable Care Act.

ARTICLE VIII

OPTIONAL VISION BENEFITS

8.1 Benefits. If an Eligible Individual receives an eye examination, lenses or frames, the Plan will subject to the provisions hereafter stated, pay benefits, not subject to a deductible or coinsurance, in accordance with the following provisions.

8.2 Covered Services. Subject to the limitations set forth in section 8.3, the Plan will pay benefits up to the maximum benefit provided in the Schedule of Benefits for the following:

(a) An eye examination once each calendar year.

(b) One pair of lenses once each calendar year. Lenses shall include single vision, bifocals, trifocals, lenticular or contact lenses. Tints and coatings are also covered.

(c) One pair of frames once each two calendar years.

(d) Professional services or materials for radial keratotomy, LASIK surgery and other procedures for the surgical correction of myopia or other refractive errors.

8.3 Exclusions. In addition to the General Exclusions and Limitations in Article IX, no benefits are payable for:

(a) Vision services and supplies not listed in section 8.2 above;

(b) Professional services or materials connected with:

(i) Orthoptics or vision training;

(ii) Subnormal vision aids;

(iii) Aniseikonic lenses;

(iv) Lens coating;

(v) Any additional charge for no-line bifocals (blended type);

(vi) Two pairs of glasses in lieu of bifocals;

(vii) Tinting of lenses;

(viii) Photochromatic lenses;

(ix) Plan (non-prescription) lenses;

(x) Any additional charge for over-sized lenses (over and above the cost of basic clear lenses);

(c) Replacement or repair of lost or broken lenses or frames, except at the normal intervals when services are otherwise available;

(d) Medical or surgical treatment of the eyes; and

(e) Any eye examination required by an Employer as a condition of employment.

8.4 Termination of Optional Vision Benefits. Optional Vision Benefits shall terminate on the earliest of the following dates:

(a) The date coverage would otherwise terminate under the Plan;

(b) The date the Eligible Individual becomes covered as a Retiree or Early Retiree participant or a Dependent of a Retiree or Early Retiree participant; or

(c) The date the Employer or Union terminates participation in the Optional Vision Benefits.

8.5 Treatment as Excepted Benefit. Optional Vision Benefits are characterized under the Plan as an excepted benefit under HIPAA and the Affordable Care Act.

ARTICLE IX

GENERAL EXCLUSIONS AND LIMITATIONS

9.1 Exclusions and Limitations. If any services or supplies are not particularly addressed in these Rules and Regulations, whether as an exclusion or covered expense, it is not to be assumed that such services or supplies are covered under this Plan. The Plan shall not provide benefits for any expenses directly or indirectly related to the following:

(a) If, with respect to a Bodily Injury or Illness, an Eligible Individual is entitled, or could have been entitled if proper application had been made, to any medical benefits paid by, reimbursed by or provided by or under the authority of any government or any governmental agency, such benefit shall discharge the obligation of this Plan as though and to the extent such benefit had been paid hereunder, but no claim will be denied solely because treatment or services are rendered in a Hospital owned or operated by a state or a political subdivision thereof;

(b) Any charge under more than one type of coverage, unless specifically provided otherwise;

(c) If the Eligible Individual is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan unless care is rendered in a Veterans Administration Hospital for a non-military service connected disability;

(d) Any charge for any medical services or supplies unless such service or supply is provided for the treatment or diagnosis of a Bodily Injury or Illness and is prescribed by, or made at the direction of a Physician, except when such charges are provided as a benefit under the Plan (e.g., routine physical examinations and related charges);

(e) Expenses incurred for or in connection with any Bodily Injury or Illness resulting from and arising out of or occurring in the course of any employment or occupation for wages, compensation or profit, including work performed outside the Eligible Individual's regular trade for an employer who should have been covered under worker's compensation or if a separate company is set up as a for profit company, except for Death Benefits and Accidental Death and Dismemberment Benefits;

(f) Hearing aid or the fitting thereof, except as specifically covered;

(g) Eye examinations or refractions, eye glasses, contact lenses or fitting of eye glasses or contact lenses, except as specifically covered;

(h) Medical benefits for dental services and supplies, except as specifically covered;

(i) Cosmetic, plastic or reconstructive surgery for developmental malformations or as the result of earlier cosmetic, plastic or reconstructive surgery, except for:

[a] Initial plastic, cosmetic or reconstructive surgery due to a condition caused by a malignancy or removal of a benign tumor, including reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and physical complications of all stages of mastectomy;

[b] Plastic, cosmetic or reconstructive surgery necessary for the repair or alleviation of damage resulting from a disability caused by Bodily Injuries sustained by an Eligible Individual and charges are incurred within one year of the Bodily Injury and while coverage as afforded by the Plan is in effect with respect to such individual; or

[c] Plastic, cosmetic or reconstructive surgery necessary because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect;

(j) Custodial Care, medical care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home, or similar establishment;

(k) Bodily Injury or Illness resulting from any act of war, armed invasion or aggression occurring after the effective date of coverage evidenced herein;

(l) Bodily Injury or Illness incurred in or aggravated by past or present Military Service or service in the Armed Forces of any country;

(m) Bodily Injury or Illness resulting from any release of nuclear energy, except when being used solely for medical treatment of an Illness or Bodily Injury of the Eligible Individual under direction and prescription of a Physician;

(n) Bodily Injury or Illness resulting from or occurring during the commission or attempted commission of a criminal act by an Eligible Individual, except that losses resulting from acts of domestic violence will be covered;

(o) Replacement or repair of any prosthetic device or orthotic except as otherwise covered;

(p) Milieu therapy or recreational therapy;

(q) Expenses incurred for treatment, services or supplies which are experimental and investigative, including any treatment, procedure, facility, equipment, drug, device or supply which is not yet generally recognized as accepted medical practice or the use of any such item which requires federal or other government agency approval, including prescription drugs which are not approved by the federal Food and Drug Administration ("FDA") for the use for which the drug is prescribed, or for which approval has not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply as provided except that, to the extent required under the Affordable Care Act, the Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial; deny limit or impose additional conditions on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the Approved Clinical Trial; and will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial. Qualified Individuals must use a PPO

Provider if a PPO Provider is participating in an Approved Clinical Trial and the PPO Provider will accept the Qualified Individual as a participant in the Approved Clinical Trial.

(r) Orthopedic shoes or supportive devices for the feet, such as arch supports and heel lifts, and orthotics, except as specifically covered;

(s) Confinement, treatment, services, medications or prescription drugs provided for or in connection with a surrogate pregnancy (including, but not limited to, delivery and post-natal expenses of the mother, the host (surrogate) mother or child) except as required by law or for or in connection with infertility, restoration of fertility or the promotion of conception, including, but not limited to, artificial insemination, in-vitro fertilization, gamete intrafallopian tube procedures or reversal of surgically induced infertility;

(t) Humidifiers, air conditioners, exercise equipment, whirlpools, hot tubs, health spa or club, athletic club, or swimming pools, whether or not prescribed by a Physician;

(u) Charges incurred prior to the individual's effective date of coverage;

(v) Transsexual surgery;

(w) Private duty nursing care, medical care or treatment, performance of surgical procedures, or physical therapy, when those services are rendered by a professional that ordinarily resides in the Eligible Individual's home or who is a member of the Eligible Individual's immediate family;

(x) Callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat or pronated foot metatarsalgia, or foot strain, except as specifically covered;

(y) Weight loss or physical fitness programs, weight loss clinics or obesity, except for gastric bypass surgery to treat Morbid Obesity.

(z) Any non-surgical treatment or services rendered in connection with disturbance of the temporomandibular joint (TMJ dysfunction/pain syndrome);

(aa) Marital counseling;

(bb) Charges for orthoptics or vision training;

(cc) Charges for Speech Therapy that are not for correction of a pathological functional disorder;

(dd) Laetrile, enzymes and food supplements;

(ee) Any treatment or services rendered in connection with Pre-Menstrual Syndrome (PMS);

(ff) Any charges in connection with radial keratotomy, except as specifically covered;

(gg) Chelation therapy;

(hh) Travel expenses of an Eligible Individual, except as specifically covered;

(ii) Preparing medical reports or itemized bills;

(jj) Telephone consultations, except for any virtual consultation program approved by the Trustees;

(kk) Wigs, artificial hairpieces;

(ll) Acupuncture;

(mm) Elective procedures, such as prophylactic mastectomy or abortions;

(nn) Personal convenience items, education materials, etc.;

(oo) Expenses for grandchildren or children of Dependent children;

(pp) Court ordered classes or treatments;

(qq) Lamaze classes;

(rr) Vocation rehabilitation;

(ss) Transplants, except as specifically covered;

(tt) Donor expenses related to transplants, except for available coverage for donor expenses as set forth as part of an all-inclusive discounted case rate charged by a provider in the Transplant Network retained by the Board of Trustees where such expenses do not increase the case rate;

(uu) Non-surgical treatment of hemorrhoids (obliteration);

(vv) Drug testing required by an employer for employment;

(ww) Smoking cessation substances and devices, programs and clinics, except as specifically covered;

(xx) Massage therapy, self-help and stress management, and exercise stress testing and perceptual therapy;

(yy) Expenses for Occupational Therapy that retrains an individual for a job or career, Physical Therapy or Speech Therapy, except as specifically covered;

(zz) Expenses for biofeedback;

(aaa) Hypnosis;

(bbb) For or relating to any special education rendered to any Eligible Individual. This limitation applies regardless of the type of education, the purposes of the education, the recommendation of the attending Physician or the qualifications of the individual(s) rendering the special education. This limitation shall include, but is not limited to, programs for monitoring and management of pain, including biofeedback, and nutritional and dietary counseling or therapy;

(ccc) Sales taxes;

(ddd) Over-the-counter birth control pills and contraceptive devices; genetic counseling or confinements; treatment, services, medications or prescription drugs for sexual impotency, except as specifically covered;

(eee) Virtual colonoscopies.

(fff) For and relating to programs for monitoring and management of pain unless determined by the Plan, in consultation with its medical review firm, to be the appropriate prescribed course of treatment for the diagnosis rendered and Medically Necessary and Reasonable.

ARTICLE X

COORDINATION OF BENEFITS

10.1 Coordination of Benefits. If an Eligible Individual is entitled to benefits from another group plan for Hospital, medical, surgical, dental or vision care for which benefits are also payable by This Plan, then the benefits provided hereunder will be coordinated utilizing This Plan's benefits based on Usual, Customary and Reasonable Charges and Plan maximums. This Coordination of Benefits provision will coordinate on Allowable Expenses and the amount paid will be the difference between the amount the other plan pays and the maximum allowable amount under This Plan. In no event will benefits be provided by any or all Plans which would exceed 100% of the expenses actually incurred by the Eligible Individual.

(a) Definitions. The following definitions apply for purposes of this section 10.1:

(i) Plan. "Plan" means any plan providing benefits or services for or by reason of Hospital, surgical, medical, major medical benefits, dental or vision care or treatment, which benefits or services are provided in:

[a] Group, blanket or franchise coverage plan, or any other plan covering individuals or members as a group;

[b] Group practice and other group prepayment coverage;

[c] Group service plans;

[d] Any coverage under labor management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans;

[e] Any coverage under governmental programs;

[f] Any coverage required or provided by any statute, including any motor vehicle no-fault coverage required by statute;

[g] Any automobile insurance policies; and

[h] Any other insured or self-insured group plans.

The term "Plan" shall not include Medicare or any individual policy or contract.

The term "Plan" shall include any medical benefits required by statute under automobile insurance policies. The term "Plan" shall not include any plan of individual insurance or School Accident Type Coverages, written on either a blanket, group or franchise basis and should not be taken into consideration in coordination of benefits. In this context, School Accident Type Coverages are defined to mean coverage covering grammar school

and high school students for accident only, including athletic injuries, either on a 24-hour basis or "to and from school," for which the parent pays the entire premium. The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(ii) This Plan. "This Plan" means that portion of the Wisconsin Electrical Employees Health and Welfare Plan that provides the benefits that are subject to these provisions. (Any benefits provided under This Plan that are not subject to these provisions constitute another plan.) The term "This Plan" will also apply for purposes of section 10.2.

(iii) Allowable Expense. "Allowable Expense" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under This Plan. Benefits will be subject to This Plan's maximums and be equal to This Plan's benefits in the absence of other health insurance. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The term Allowable Expense shall not include any charges incurred (within or outside of the applicable service area) for services which would have been provided under an HMO (Health Maintenance Organization) program had participating providers been utilized and required HMO procedures for receiving treatment under the HMO program been correctly followed.

The term "Allowable Expense" will also apply for purposes of section 10.2.

(iv) Claim Determination Period. "Claim Determination Period" means a calendar year.

(b) No-Fault Automobile Insurance. Benefits under This Plan will be coordinated with minimum coverages required under any no-fault statute and any other applicable No Fault Law. If a "No Fault" policy provides coverage in excess of the minimum required by State Law then This Plan will coordinate benefits with those coverages in effect.

The benefits of This Plan will not be available to an Eligible Individual to the extent of minimum benefits required by the "No Fault" Law. However, This Plan does not coordinate benefits relating to any other person injured in a motor vehicle accident if the injured person is a non-owner operator, passenger or a pedestrian and such other person is not covered by No Fault Automobile Insurance.

(c) Application. These provisions shall apply in determining the benefits as to an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Eligible Individual during such period, the sum of:

(i) The benefits that would be payable under This Plan in the absence of this section 10.1; and

(ii) The benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this section 10.1 would exceed such Allowable Expenses.

(d) Reduction of Benefits. As to any Claim Determination Period with respect to which these provisions are applicable, the benefits that would be payable under This Plan in absence of this section 10.1 for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in the provisions entitled "This Plan's Benefits Determined First" shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had a claim been duly made therefor.

(e) This Plan's Benefits Determined First. If another Plan which is involved in the preceding paragraph and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and the rules set forth in the next paragraph would require This Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purpose of determining the benefits under This Plan.

(f) Order of Benefit Determination. For the purpose of the preceding paragraph, the rules establishing the Order of Benefit Determination are as follows:

(i) The benefits of a Plan which covers the Eligible Individual on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent. Notwithstanding anything herein to the contrary, if the Eligible Individual is also a Medicare beneficiary and, as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

[a] Secondary to the Plan covering the Eligible Individual as a dependent; and

[b] Primary to the Plan covering the Eligible Individual other than as a dependent (e.g., a retired employee);

then the benefits of the Plan covering the Eligible Individual as a dependent are determined before those of the Plan covering that person as other than as a dependent.

(ii) The benefits of a Plan which covers the Eligible Individual on whose claim is based as a Dependent child whose parents are not separated or divorced shall have benefits determined as follows:

[a] The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

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

If the other Plan does not have the provisions of (ii)[a] above regarding Dependents and as a result the other plan and This Plan do not agree on the Order of Benefit Determination, the provisions of paragraph (ii)[a] shall still apply to determine the order of benefits.

(iii) The benefits of a Plan which covers the Eligible Individual on whose claim is based as a Dependent child whose parents are separated or divorced shall have benefits determined as follows:

[a] When the parents are separated or divorced and the parent with custody (or, in the event of joint custody, primary placement) of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of such parent will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody (or, if applicable, primary placement).

[b] When the parents are divorced and the parent with custody (or, in the event of joint custody, primary placement) of the child has remarried, the benefits of a Plan which covers the child as a Dependent of such parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and benefits of a Plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a Dependent of the parent without custody (or, if applicable, primary placement).

Notwithstanding [a] and [b] above, if there is a court decree which would otherwise establish financial responsibility for the medical or other health care expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child, even when the parent with such financial responsibility fails to provide such medical or other health care expenses. When such parent has failed to provide coverage for medical or health care expenses for a Dependent child, the amount of benefits payable by This Plan shall be determined as the secondary payer and as if the benefits of such parent's plan were identical to This Plan's benefits.

(iv) In the event a married Dependent child of an Eligible Individual is covered by the Dependent child's spouse's Plan, the benefits of the plan which cover the married Dependent child as a spouse shall pay its benefits before the benefits of a plan which cover the person as a Dependent child.

(v) The benefits of a plan which covers the Eligible Individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that Eligible Individual as a laid off or retired employee (or as that employee's dependent).

(vi) The benefits of a Plan which covers the Eligible Individual as an employee, member or subscriber or the dependent of an employee, member or subscriber will determine its benefits before a plan covering that person under COBRA continuation coverage or any other right of continuation coverage provided under federal or state law.

(vii) When rules (i), (ii), (iii), (iv), (v) and (vi) do not establish an Order of Benefit Determination, the benefits of a Plan which has covered the individual on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(g) Right to Information. For the purpose of the applicability of and implementing the terms of this section 10.1 of This Plan or any provision of similar purpose of any other Plan, the Board of Trustees may, without the consent of or notice to any person, release to or obtain from any other insurance company or person any information, with respect to any person, which the Board of Trustees deems to be necessary for such purpose.

To obtain all benefits available, a claim should be filed under each applicable policy of Plan. Any person claiming benefits under This Plan shall furnish to the Board of Trustees such information as may be necessary to implement this section 10.1.

(h) Right to Make Payments. Whenever payments which should have been made under This Plan in accordance with these provisions have been made under any other Plan, the Board of Trustees shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section 10.1, and amounts so paid shall be deemed to be benefits paid under This Plan and, to the extent of such payments, the Board of Trustees shall be fully discharged from liability under This Plan.

(i) Right to Recover Payments. Whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, the Board of Trustees shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as the Board of Trustees shall determine:

(i) Any person to, for, or with respect to whom such payments were made;

(ii) Any other insurance companies;

(iii) Any other organizations.

Further, in cases where the Board of Trustees has determined that payment shall be recovered from the Participant (or a Dependent of the Participant), This Plan reserves the right to reduce the amount of the Participant's Dollar Bank Account until This Plan has recovered the full amount paid in excess.

(j) Coordination of Benefits With Noncomplying Plans. This Plan shall coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order

of benefit determination standards which are inconsistent with ("Noncomplying Plan") on the following basis:

(i) If This Plan is the primary plan it shall pay or provide its benefits on a primary basis;

(ii) If This Plan is the secondary plan it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if This Plan was the secondary plan. In such a situation, such payment shall be the limit of This Plan's liability; and

(iii) If the Noncomplying Plan does not provide the information needed by This Plan to determine its benefits within 60 days after it is requested to do so, This Plan shall assume that the benefits of the Noncomplying Plan are identical to its own and shall pay its benefits accordingly. However, This Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(iv) If the Noncomplying Plan is primary but refuses to pay, then This Plan, in consideration of being subrogated to the Eligible Individual's rights of recovery against the Noncomplying Plan shall provide benefits as if it were primary.

10.2 Coordination With Medicare.

(a) The Plan Primary to Medicare for an Eligible Employee or Spouse Age 65 or Older. Benefits shall be payable under This Plan without regard to an Eligible Individual's entitlement to Medicare if the Eligible Individual is not entitled and could not upon application become entitled to Medicare as an End Stage Renal Disease (ESRD) beneficiary and such Eligible Individual is:

(i) An Active Employee age 65 or older; or

(ii) The spouse age 65 or older of an Active Employee.

(b) The Plan Primary to Medicare for Disabled Person Under Age 65. Benefits shall be payable for covered items or services furnished under This Plan without regard to an Eligible Individual's entitlement or potential entitlement to Medicare if such Eligible Individual is:

(i) Under age (65);

(ii) An Active Employee, or a Dependent of an Active Employee; and

(iii) Entitled or potentially entitled to Medicare as a disabled beneficiary other than as an ESRD beneficiary.

(c) ESRD Beneficiary. Benefits for covered items or services shall be payable under the Plan without regard to an Eligible Individual's entitlement to Medicare if such Eligible

Individual is entitled to Medicare as an End Stage Renal Disease beneficiary, and not more than 30 months has elapsed since the earliest of the following months:

(i) The month in which the Eligible Individual began a regular course of renal dialysis;

(ii) The month in which the Eligible Individual received a kidney transplant;

(iii) The month in which the Eligible Individual was admitted to the Hospital in anticipation of a kidney transplant that was performed within the next two months; or

(iv) The second month before the month the kidney transplant was performed, if performed more than two months after admission.

(d) The Plan Primary to Medicare for an Eligible Retiree with Current Employment Status. Benefits shall be payable under this Plan for covered items or services furnished under This Plan without regard to an Eligible Individual's entitlement or potential entitlement to Medicare if such individual is covered by the Plan as Retiree who maintains a Dollar Bank Account for periods in which the Retiree is considered to have current employment status. Such Retiree will be deemed to have current employment status as this term is defined under Medicare secondary payer regulations. Subject to the coordination of benefits provisions in 10.1(i)(i) above, Plan benefits shall be payable primary to Medicare. Plan coordination of benefits under this subsection shall terminate (and the Plan shall pay secondary to Medicare) upon the first to occur of: (i) exhaustion of the Retiree's Dollar Bank Account or (ii) Retiree's providing supporting documentation to the Plan sufficient to establish the Retiree no longer has current employment status, such as, but not limited to, having given up employment and reemployment rights, withdrawing his or her name from job referral lists and terminating all employment covered by the Plan.

(e) The Plan Secondary to Medicare in All Other Cases.

(i) Coordination of Benefits. Benefits otherwise payable under the Plan shall be reduced to the extent necessary so that the sum of benefits paid by the Plan and by Medicare Parts A and B for Allowable Expenses shall not exceed the total of such Allowable Expenses. This paragraph shall apply where the Eligible Individual is covered under Medicare Parts A and B (except as an ESRD beneficiary) and by This Plan under the provisions of section 2.12. However, Retirees, Early Retirees and their Dependents covered by This Plan shall be ineligible for the Plan's Prescription Drug Benefits described in Article XV and prescription drug benefits under the Flexible Benefit Account Program described in Article XIV effective on the date of enrollment in a Medicare Part D plan other than an EGWP sponsored by a CMS-approved administrator and adopted by the Trustees from time to time.

(ii) All Eligible Persons Eligible Considered Enrolled. Benefits shall be considered payable by Medicare Parts A and B for purposes of section 10.2, whether or not the Eligible Individual eligible for Medicare benefits has enrolled in or applied for benefits under Medicare Parts A and B or has failed to take any other action required by Medicare to qualify for benefits. Benefits shall be considered payable by Medicare Part D for an Eligible Individual

covered as an Active Employee (or a Dependent of an Active Employee) for purposes of Section 10.2 only if such Eligible Individual has enrolled in or applied for benefits under Medicare Part D.

ARTICLE XI

GENERAL PROVISIONS

11.1 Payment of Claims. Any benefits referred to herein will be paid by the Plan to the Eligible Individual as they occur upon receipt of written proof of claim satisfactory to the Plan that the expenses for which the claim is made were actually incurred on the dates specified and the services were recommended and approved by a Physician, provided such charges are otherwise payable under the terms of this Plan.

11.2 Assignment of Benefits. Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person. Any purported action by an Eligible Individual in front of another person or entity, including but not limited to an institution in which he is or will be hospitalized, a provider of medical services or supplies in consideration for medical or Hospital services rendered or to be rendered, or supplies furnished or to be furnished, or to any other person or entity that may have provided or paid for, or agreed to provide or pay for, any benefits payable hereunder (collectively, a "Provider") shall be null and void. However, subject to the exceptions noted below, any Eligible Individual may direct that benefits due him be paid to a provider. The Plan will treat any document attempting to assign an Eligible Individual's rights, or to alienate a claim for benefits to a Provider, as an authorization for direct payment by the Plan to the Provider. In the event that the Plan receives a document claiming to be an assignment of benefits on behalf of a Provider, the Plan may send payments for the claims to the Provider, but will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to the Plan Participant or his authorized representative, as determined by the Plan. Notwithstanding the preceding, the Trustees reserve the right to make payments directly to the Eligible Individual without regard to an authorization or assignment executed by an Eligible Individual directing payment to the Provider.

11.3 Filing of Claims. Benefits will be paid by the Plan only if written notice of claim is received no later than one year after the date Covered Charges were incurred.

11.4 Application and Forms for Claims. The Trustees shall require an Eligible Individual to complete and file with the Trustees any claim forms approved by the Trustees, and to furnish all pertinent information and documents requested by the Trustees, such as, but not limited to, enrollment materials, as required to properly process and pay claims on an Eligible Individual's behalf before such payment is made. The Trustees may rely upon all such information so furnished it, including the Eligible Individual's current mailing address.

11.5 Facility of Payment. In the event the Plan determines that the Eligible Individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Individual has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Eligible Individual, pay any amount otherwise payable to the Eligible Individual to the husband or wife or relative by blood of the Eligible Individual, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Eligible Individual before all amounts payable

under the Plan have been paid, the Plan may pay any such amount to any person or institution determined by the Plan to be equitably entitled thereto.

The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Individual: lawful spouse, child or children, mother, father, brothers or sisters, or to the Eligible Individual's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

11.6 Claims Denial and Appeal Procedures. These provisions shall govern all claims and appeals except for those claims made on the basis of an insurance contract governing insured benefits, which shall be determined solely by the insurance company. A claimant (i.e., Eligible Individual) may authorize a representative to act on his behalf, provided any such authorization must be in writing on a form provided by the Fund Office and delivered to the Fund Office. However, for an Urgent Care claim, a health care professional with knowledge of the claimant's medical condition, may act as the claimants authorized representative and pursuant to any procedures adopted by the Trustees. A rescission of coverage is considered an adverse benefit determination subject to the procedures applicable to Health Claims.

(a) Time Limits on Decision of Claims.

(i) Health Claims.

[a] Pre-Service Claims. A Pre-Service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care. The Plan will inform the claimant of the decision on a Pre-Service claim within 15 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 15-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 15-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

[b] Urgent Care Claims. An Urgent Care claim is a type of Pre-Service Claim for which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care claim shall be determined by the Plan, deferring to the judgment of a physician with knowledge of the claimant's condition. The Plan will inform the claimant of the decision on an Urgent Care claim as soon as possible, but not later than 72 hours after the claim was filed. If, during the review, additional information is required from the claimant, the claimant shall be so notified within 24 hours and shall be provided at least 48 hours to provide the information. In such

a case, the Plan will inform the claimant of the decision no later than 48 hours after the additional information is submitted.

[c] Post-Service Claims. A Post-Service Claim is any claim that is not a Pre-Service Claim. The Plan will inform the claimant of the decision on a Post-Service claim within 30 days of the date the claim is filed, regardless of whether all necessary information was included with the claim. Within that 30-day period, the claimant shall receive notice of the decision or a notice that explains the circumstances requiring a delay in the decision, and sets a date, no later than 15 days after the ending of the initial 30-day benefit determination period, by which the claimant can expect to receive a decision.

If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time period for notice of a decision detailed above. The claimant shall have at least 45 days to provide such information. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of the decision.

[d] Concurrent Care Claims. Any request by a claimant to extend the duration or number of treatments previously approved through a Pre-Service claim is a Concurrent Care claim. The Plan will inform the claimant of the decision on a Concurrent Care claim involving Urgent Care within 24 hours after receiving the claim, if the claim was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. The claimant may provide any additional information required to reach a decision. If the Concurrent Care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., Urgent, other Pre-Service or Post-Service).

(ii) Loss of Time Benefit Claims. If a claim for Loss of Time Benefits is denied in whole or in part, the Plan will inform the claimant of the denial within 45 days of the date the initial claim was received, regardless of whether all necessary information was included with the claim.

[a] Extension. Special circumstances may require more time to review a claim. If so, written notice shall be provided within the 45-day period explaining the reason for the delay and setting a date upon which the notice will be issued, no later than 30 days after the end of the initial 45-day benefit determination period. If special circumstances again require more time to review a claim, a second 30-day extension may be taken subject to written notice within the initial 30-day extension, subject to the same rules as detailed above.

[b] Additional Information. If, during the review, additional information is required from the claimant, the claimant shall be so notified within the required time periods for notice of a decision or extension detailed above. The claimant shall have at least 45 days to provide such information. Following the claimant's provision of the required information, or the expiration of the time period for providing such information, the Plan shall issue a written notice of any denial within 30 days, unless special circumstances require a second 30-day extension, subject to the rules detailed above.

(b) Content of Denial Notice on a Claim.

(i) Health Claims. If a claimant's Health Claim is partially or wholly denied, the claimant will receive notice from the Plan that includes the following information:

[a] The specific reason(s) for the denial;

[b] Specific reference to the pertinent provision(s) of the Plan documents on which the denial is based;

[c] A description of any additional material or information required of the claimant in order to make the claim valid;

[d] An explanation of what steps must be taken to have the claim denial reviewed;

[e] A statement that the initial decision shall be a final decision unless the decision is appealed as hereinafter set forth;

[f] If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, the scientific or clinical judgment for the determination or a statement that a copy is available free of charge upon request;

[g] A statement that the claimant may bring a civil action under ERISA; and

[h] If an internal rule, guideline, protocol or other similar criterion was relied upon, a statement that a copy is available free of charge upon request.

(ii) Health Claims *except for* Dental and Vision Claims. If a claimant's Health Claim, other than a dental or vision claim, is partially or wholly denied, the notice from the Plan will also include the following information:

[a] Information sufficient to identify the claim involved, including the date(s) of service; health care provider; claim amount; denial code and its corresponding meaning and diagnosis and treatment, and codes, including their corresponding meanings, upon request and without charge.

[b] A statement that the claimant has the right to request an external review with an Independent Review Organization (IRO) after the Plan's claims procedures have been exhausted.

[c] The availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the internal claims and appeals and external review processes.

(iii) Loss of Time Benefit Claims. If a claimant's Loss of Time Benefit Claim is partially or wholly denied, the claimant will receive notice from the Plan that includes the following information:

[a] The specific reason(s) for the denial, including an explanation of the basis for disagreeing with or not following: a health care or vocational professional who treated or evaluated the claimant, a medical or vocational expert whose advice was solicited by the Plan in connection with the claim, or a disability determination made by the Social Security Administration;

[b] Specific reference to the pertinent provision(s) of the Plan documents on which the denial is based;

[c] A description of any additional material or information required of the claimant in order to make the claim valid;

[d] An explanation of what steps must be taken to have the claim denial reviewed;

[e] A statement that the initial decision shall be a final decision unless the decision is appealed as hereinafter set forth;

[f] If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, the scientific or clinical judgment for the determination or a statement that a copy is available free of charge upon request;

[g] A statement that the claimant may bring a civil action under ERISA;

[h] The internal rule, guideline, protocol or other similar criterion that was relied upon or a statement that such rules, guidelines, protocols, standards or other criterion do not exist; and

[i] A statement that the claimant is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the claim upon request, free of charge.

(c) Appeal of Denied Claim—How to Request a Review of a Denied Claim. If a claimant wants to have the denied claim reviewed, the claimant must send a written request for a review of the claim denial to the Plan no later than 180 days after the date the notice of denial is mailed by the Plan. Any claimant filing a timely request for review may submit additional materials for consideration on review including a written explanation of the issues and comments on the issue.

(d) Review of Denied Claim.

(i) Full and Fair Review.

[a] The Board of Trustees or its authorized Committee will review the denied claim according to the terms and conditions of the Plan. The review shall consider all comments, documents, records and other information submitted by the claimant, regardless of whether the information was submitted or considered in the initial determination. The claimant shall have the right to access and copy all documents, records and other information relevant to the claim (information relied upon, submitted, considered or generated in the review or demonstrating compliance with the claims processing requirements).

[b] For Health Claims, except dental and vision, the claimant shall receive copies of all new or additional evidence considered, relied upon or generated during the appeal as well as any new or additional rationale relied upon for the denial, if any. Such new or additional evidence or rationale will be provided as soon as possible and sufficiently in advance of the Trustees' final decision in order to give the claimant a reasonable opportunity to respond. If the new or additional evidence is received so late that it would be impossible to provide the claimant with a reasonable opportunity to respond, the time periods for making a determination on the appeal will be tolled until the claimant has had a reasonable opportunity to respond.

[c] If the decision requires medical judgment, the Board of Trustees or Committee will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

(ii) Time of Decision.

[a] Urgent Care Claims. The Plan will inform the claimant of the decision on the review of an Urgent Care claim within 72 hours of the Plan's receipt of the request for review.

[b] Pre-Service Claims. The Plan will inform the claimant of the decision on the review of a Pre-Service claim within 30 days of the Plan's receipt of the request for review.

[c] Post-Service Claims. The Trustees or its authorized Committee shall meet quarterly to render a determination on appeals of Post-Service Claims received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision shall be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan shall notify the claimant of the reasons for the delay prior to any extension. The Plan shall notify the claimant of the decision within five days of the date the decision is made.

[d] Concurrent Care Claims. The Plan will inform the claimant of the decision on the review of a Concurrent Care claim within 72 hours of the Plan's receipt of the request for review if the claim involves an Urgent Care claim; 30 days if the claim involves a Pre-Service claim; and 60 days if the claim involves a Post-Service claim.

[e] Loss of Time Benefits. The Trustees or its authorized Committee shall meet quarterly to render a determination on appeals of Loss of Time Benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a

meeting shall be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision shall be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan shall notify the claimant of the reasons for the delay prior to any extension. The Plan shall notify the claimant of the decision within five days of the date the decision is made.

(e) Content of Denial Notice on Review.

(i) Health Claims. If a claimant's Health Claim is partially or wholly denied on appeal, the claimant will receive notice from the Plan that includes the following information:

[a] The specific reason(s) for the denial;

[b] Specific reference to the pertinent provision of the Plan documents on which the denial is based;

[c] A statement that the claimant is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the claim upon request, free of charge;

[d] If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion, the scientific or clinical judgment for the determination or a statement that a copy is available free of charge upon request;

[e] A statement that the claimant may bring a civil action under ERISA ; and

[f] If an internal rule, guideline, protocol or other similar criterion was relied upon, a statement that a copy is available free of charge upon request.

(ii) Health Claims *except* Dental and Vision Claims. If a claimant's Health Claim, other than a dental or vision claim, is partially or wholly denied on appeal, the notice from the Plan will also include the following information:

[a] Information sufficient to identify the claim involved, including the date(s) of service; health care provider; claim amount; denial code and its corresponding meaning and diagnosis and treatment codes, including their corresponding meanings, upon request and without charge.

[b] A statement that the claimant has the right to request an external review with an IRO after the Plan's claims procedures have been exhausted.

[c] Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with the external claims and appeals.

(iii) Loss of Time Benefit Claims. If a claimant's Loss of Time Benefit Claim is partially or wholly denied on appeal, the claimant will receive notice from the Plan that includes the following information:

[a] The specific reason(s) for the denial including an explanation of the basis for disagreeing with or not following the views of: a health care professional or vocational professional who treated or evaluated the claimant, a medical or vocational expert whose advice was solicited by the Plan, the Board of Trustees or Committee in connection with the claim, or a disability determination made by the Social Security Administration

[b] Specific reference to the pertinent provision(s) of the Plan documents on which the denial is based, and a discussion of the decision.

[c] If the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, the scientific or clinical judgment for the determination or a statement that a copy is available free of charge upon request;

[d] A statement that the claimant is entitled to receive reasonable access to, and copies of, all documents, records and other information relevant to the claim upon request, free of charge;

[e] A statement that the claimant may bring a civil action under ERISA and the time frame for doing so, including the calendar date by which such action must be filed; and

[f] The internal rule, guideline, protocol or other similar criterion that was relied upon or a statement that such rules, guidelines, protocols, standards or other criterion do not exist.

(f) External Review of a Denied Health Claim *except* Dental and Vision Claims.

(i) Right to Request External Review. The Plan offers claimants the right to request an external review of their denied Health Claim other than dental and vision claims. Rescissions of coverage are also eligible for external review. The Plan will offer this right in accordance with and to the extent required by available guidance issued by the Departments of Health and Human Services, and Labor and the Internal Revenue Service.

(ii) Claims Eligible For External Review. Only certain Health Claims are eligible for external review. Dental Claims, Vision Claims, Loss of Time Benefits Claims and all other welfare benefit claims are not eligible for external review.

(iii) How to Request a Review of a Denied Health Claim *except* Dental and Vision Claims.

[a] Standard External Review. If a claimant wants to have the denied Health Claim or rescission of coverage reviewed, the claimant must send a written request

for an external review of the claim denial to the Plan no later than four months after the date the claimant receives the notice of denial on review.

[b] Expedited External Review. A claimant may request an expedited external review of the claimant's denied Health Claim only in the following instances:

[i] Simultaneously with an appeal to the Board of Trustees, if the claim denial involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function.

[ii] Upon receipt of a denial notice on review if the denial involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the health of the claimant or would jeopardize the claimant's ability to regain maximum function or if the denial on review concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services but has not been discharged from the facility.

Any claimant filing a timely request for review may submit additional materials for consideration on review, including a written explanation of the issues and comments on the issue.

(g) Further Action. In the event a claim for benefits has been denied, no lawsuit or other action against the Plan or its Trustees may be filed until the matter has been submitted for review in accordance with the claims appeal provisions set forth in this section. Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has again been denied, no lawsuit or other action against the Plan or its Trustees may be filed after 12 months from the date the participant or beneficiary has been given written notice of the Trustees' decision on his appeal.

If the time limitation in this section of the Plan is less than that required by law, such limitation is hereby extended to conform to the minimum period permitted by law.

11.7 Legal Proceedings. No action at law or in equity shall be brought to recover under the Plan unless the person bringing such action has properly filed an appeal pursuant to the Plan's appeal procedure and has received the Trustees' decision on such appeal.

11.8 Time Limitation. If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted by the law of the State of Wisconsin, such limitation, unless the state law is preempted by federal law, is hereby extended to agree with the minimum period by such law.

11.9 Proof of Claim. The Plan, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably be required during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

11.10 Submission of Falsified or Fraudulent Claims. All claims, enrollment forms and other information submitted to or provided to the Plan shall be honest, accurate and complete. If the Board of Trustees finds, at any time, that there has been an intentional falsification or misrepresentation of any document submitted or provided to the Plan, directly or indirectly, it shall have the right to immediately terminate coverage, retroactively rescind coverage (to the extent permitted by the Affordable Care Act), and/or refuse to honor any claim which is related to the falsified or fraudulent information. If the Trustees determine coverage will be terminated, all Eligible Individuals who are related to the person submitting the false or fraudulent claim may have their coverage terminated.

11.11 Offset. In the event any payment is made by the Plan to or for an individual (e.g., a Participant, Dependent or provider) who is not entitled to such payment or the full amount of such payment, the Plan shall have the right to suspend or withhold payment of incurred claims and to reduce future payments due to such person and/or, if applicable, his Dependents by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment. The Plan and Trustees may take other actions to recover the erroneous payments and other amounts, including, but not limited to, commencing a restitution action under ERISA or reducing the amount of the Participant's Dollar Bank Account until the Plan has recovered the full amount.

11.12 Worker's Compensation. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

11.13 Subrogation and Reimbursement.

(a) Plan's Right to Subrogation and Reimbursement. The Plan shall be entitled to subrogation or reimbursement with regard to all rights of recovery of a Participant or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Participant, (collectively, for purposes of this section 11.13, "Individual"), to the extent of any amounts which the Plan has paid or may become obligated to pay on account of any claim against any person, organization or other entity in connection with the Injury or Bodily Injury, sickness, Accident, Illness or condition, including accidental death or dismemberment, to which the claim relates ("Source"). A Source includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility and any employer of the Individual under the provisions of a Worker's Compensation or Occupational Disease Law, as well as an individual policy of insurance maintained by the Individual which may also include uninsured or underinsured insurance coverages.

The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual. Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or

as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. Once the Plan makes or is obligated to make payments on behalf of an Individual on account of the claim, the Plan is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

(b) Action Required of Individual. If requested in writing by the Trustees, the Individual shall take, through any representatives designated by the Trustees, such action as may be necessary or appropriate to recover payments made or to be made by the Plan from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section 11.13. The Individual shall assist and cooperate with representatives designated by the Plan to recover payments made by the Plan and shall do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

The Trustees may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Trustees, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Plan's request, or if the Agreement is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent adult) must execute the Agreement upon request of the Plan. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the Individual agrees that out of any Source, as described in subsection (a) above, the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Plan's benefit and that the Plan shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights shall apply regardless whether the Individual executes an Agreement.

Any claim which is first received by the Plan after a recovery, regardless of when the claim is incurred, shall be the responsibility of the Individual to the extent of the Individual's net recovery and shall be paid by the Individual and not the Plan. In the event the Plan inadvertently provides benefits for such claim, the Individual shall have an obligation to repay the Plan to the extent of the Individual's net recovery. The Plan has the enforcement rights set forth in subsection (c) of this section 11.13 to recover such amounts.

(c) Enforcement of Rights. The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this section 11.13 through any appropriate legal or equitable remedy, including but not limited to the initiation of a recognized cause of action under ERISA section 502(a)(3), including injunctive action to ensure

the claim amounts that the Plan has advanced are preserved and not disbursed, or applicable federal or state law, the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Further, in the event an Individual receives monies as the result of an Injury or Bodily Injury, sickness, Accident, Illness or condition and the Plan is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such Injury or Bodily Injury, sickness, Accident, Illness or condition, the Plan shall have the right to reduce future payments due to such Individual or the Employee of whom such Individual is a Dependent or any other Dependent of such Employee by the amount of benefits paid by the Plan or reduce the amount of the Dollar Bank until the Plan has recovered the full amount allowed under this section. The right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this section 11.13.

(d) Individual's Attorney's Fees. The Plan's subrogation and reimbursement rights apply to any recovery by the Individual without regard to legal fees and expenses of the Individual. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Injury or Bodily Injury, sickness, Accident, Illness or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Trustees, in their sole discretion, have agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses.

(e) Disavowal of Common Law Defenses. The Plan specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the Individual from any Source without regard to legal fees and expenses of the Individual and the Individual will be solely responsible for paying all legal fees and expenses. The Plan shall have a priority, first-dollar security interest and a lien on any recovery received from any Source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such Injury or Bodily Injury, sickness, Accident, Illness or condition.

(f) Trustees' Right to Waive. The Trustees of the Plan may waive the above subrogation or reimbursement rights, or any part thereof, if they decide such action is in the best interest of the Plan and its participants, unless determined to be acting in an arbitrary and capricious manner.

11.14 Trust Agreement. The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

11.15 Rights to Trust Assets. No employee shall have any right to, or interest in, any assets of the Trust Fund upon termination of his employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under the Plan to such employee out of the assets of the Trust Fund. All payments of benefits as provided for in this Plan shall be made solely out of the assets of the Trust Fund and none of the fiduciaries shall be liable therefor in any manner.

11.16 Plan TerminationThe Board of Trustees may terminate the Plan at any time in accordance with the provisions of this section.

(a) Partial Termination. Upon termination of the Plan, all claims for benefits received prior to such termination will be processed and paid in accordance with the terms of the Rules and Regulations

(b) Liquidation of Trust Fund. Upon termination of the Plan with respect to all employees of all Employers, the assets of the Trust Fund shall be liquidated, after provision is made for the expenses of liquidation, by providing for payment of the balance of the Trust Fund to a superseded plan, or otherwise used for the benefit of employees.

(c) Manner of Distribution. Subject to the foregoing provisions of this section, any distribution after termination of the Plan may be made, in whole or in part, to the extent that no discrimination in value results, in cash, in securities or other assets in kind, or in non-transferable annuity contracts, as the Board of Trustees in their sole discretion shall determine.

(d) Residual Amounts. In no event shall an Employer receive any amounts from the Trust Fund upon termination of the Plan.

11.17 Severability Clause. Should any provision of these Rules and Regulations be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless the illegality shall make impossible the functioning of the Plan. To the extent permitted by law, the Trustees shall not be held liable for any act done or performed in pursuance of any provisions hereof prior to the time such act or provision shall be held unlawful by a final order of a court of competent jurisdiction.

11.18 Non-Guarantee of Employment. Nothing contained in this Plan shall be construed as a contract of employment between any Employer and any employee, or as a right of any employee to be continued in the employment of any Employer, or as a limitation of the right of any Employer to discharge any of its employees, with or without cause.

11.19 Construction. Unless otherwise stated, the rights of any Eligible Individual shall be governed by the provisions of the Plan as in effect at the time the claim is incurred. Except to

the extent preempted by ERISA, the Plan shall be construed according to the laws of the State of Wisconsin. The words "hereof" and "herein" shall mean and refer to the entire Plan, not any particular provision or section.

11.20 Disclaimer. Death and Accidental Death and Dismemberment benefits are insured by a contact of insurance. All other benefits provided in these Rules and Regulations are self-insured (except for a stop-loss insurance contract) and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amounts in the Plan collected and available for such purpose.

11.21 Titles. Titles of provisions are for convenience of reference only and are not to be considered in interpreting this Plan.

11.22 Gender. Wherever any words are used in this Plan in masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in the Plan in the singular form, they should be construed as though they were also in the plural form in all situations where they would so apply, and vice versa.

11.23 Non-Sufficient Funds. Any Employer or self-pay Participant whose contribution is returned due to non-sufficient funds will be charged and must pay a $25 penalty. Payment of the $25 penalty must be included with the replacement contribution which must be by guaranteed funds (i.e., money order, cashier's check, certified check, etc.). Further, all contributions for the next six months following a non-sufficient funds incident must be made by guaranteed funds.

If a contribution is returned after the due date or is not replaced by guaranteed funds before the due date, then the Employer is delinquent and the Plan's Delinquency Collection Policy and Procedure provisions will apply. Any self-pay Participant whose contribution is returned due to non-sufficient funds after payment due period shall be notified by Certified, Return Receipt mail of non-sufficient funds and will be given five working days from the date of notification to replace the contribution as outlined above. In the event the self-pay contribution is not replaced by guaranteed funds within the five-day period, coverage will be terminated retroactive to the last day of the month for which a correct and timely payment was received.

11.24 Reinstatement of Participation. If a member of a Withdrawal Group seeks reinstatement of participation under the Plan, the affected individuals shall pay, in addition to the regular contribution to maintain benefits, an amount which the Trustees determine will be sufficient to pay the per participant share of the Plan's reserve as of the date participation is reinstated. In determining this amount, no credit shall be given on account of the group's prior participation.

11.25 Qualified Medical Child Support Orders. Consistent with applicable law, the Trustees may make payments for Covered Charges consistent with the terms and conditions of a qualified medical child support order which satisfies the requirements of ERISA section 609. The Trustees shall establish procedures consistent with applicable law for determining whether a medical child support order is qualified.

ARTICLE XII

ALTERNATIVE CARE

12.1 Benefits. The Trustees reserve the right to approve payment of benefits under the Plan, on a case-by-case basis, for alternative treatment or services received by an Eligible Individual or for treatment or services received by an Eligible Individual at alternative care facilities or provided by alternative care providers for the Illnesses and Injuries set forth in section 12.2 that would otherwise not be covered under the Plan, provided the following conditions are met:

(a) The treatment or services potentially involves costs in excess of $30,000;

(b) Such treatment or services were recommended by the Plan's medical case management service;

(c) The Eligible Individual consents in writing to such treatment or services if of legal age, or if the Eligible Individual is not of legal age, the Eligible Employee of which the Eligible Individual is a Dependent consents in writing to such treatment or care;

(d) The Eligible Individual's attending Physician consents in writing to such treatment or services; and

(e) It appears that such recommended treatment or services would either reduce the costs incurred by the Plan or improve the benefits realized by the Eligible Individual.

Benefits are payable up to the Usual, Customary and Reasonable amount, provided, however, that the total amount of benefits payable will not exceed the amount that would have been payable if the treatment or services proved to the Eligible Individual would have been payable under the Plan as Covered Charges for Hospital benefits.

12.2 Covered Illnesses, Injuries and Therapies. Alternative care treatment and services shall be covered if rendered in connection with the following Illnesses, Injuries or therapies.

(a) AIDS;

(b) Carcinoma;

(c) Coma/cerebral vascular accident (CVA);

(d) Crohn's Disease—with severe nutritional deficiencies;

(e) Head Injuries with neurological impairments;

(f) Multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), muscular dystrophy (MD) and Guillain-Barre;

(g) Premature birth with weight less than 1,600 grams and severe congenital defects;

(h) Kidney ailments—renal failure, end stage renal disease, or dialysis;

(i) Severe burns;

(j) Spinal cord Injuries with paralysis;

(k) Physical therapy—long term;

(l) Ventilators—home therapy;

(m) Dialysis;

(n) Extensive IV therapy—chemotherapy, ATBETTN and other nutritional support systems;

(o) Other terminal Illness;

(p) Mental, Emotional and Nervous Disorders and Substance Abuse treatment; and

(q) Any other Illness, injury or therapy where alternative care is recommended by the Plan's medical case management service.

The Trustees reserve the right to modify the list above from time to time.

12.3 Types of Alternative Care. Alternative Care, treatment or services for which the Trustees may approve payment of benefits under the Plan include, but is not limited to, treatment in a residential care facility and home health care.

12.4 Limitations. In addition to the General Exclusions and Limitations set forth in Article IX, no expenses are payable under this Article XII in excess of the total amount of expenses that would have been payable under other provisions of the Plan if the Eligible Individual had remained confined in a Hospital and the Trustees had not authorized payment of such alternative treatment or services.

ARTICLE XIII

SUPPLEMENTAL UNEMPLOYMENT BENEFITS

13.1 Eligibility for Active Hourly Employees. A supplemental unemployment benefit ("SUB") account, referred to as a SUB Account, will be established for Active Hourly Employees covered by a Collective Bargaining Agreement that requires SUB contributions on their behalf. The Trustees shall fund the SUB Accounts at the level established in the Collective Bargaining Agreement. As of January 1, 2020, the Collective Bargaining Agreements provide for funding a $4,500 SUB Account for eligible Active Hourly Employees.

13.2 SUB Pay Benefit. The Plan shall pay a $250 weekly benefit from the SUB Account of an Active Hourly Employee who qualifies for unemployment benefits and who has involuntarily terminated employment on account of a plant closing, layoff, reduction in work force or similar event. The Active Hourly Employee's SUB Account balance shall be reduced by the amount of each weekly SUB payment. An unemployed Active Hourly Employee will qualify for SUB benefits:

(a) First Six Weeks of Unemployment. By submitting evidence that the Wisconsin Unemployment Department or other similar State unemployment compensation program has determined that the Active Hourly Employee was unemployed for the affected week, which may include a receipt or payment stub, or other written confirmation that the Active Hourly Employee is unemployed (the "Receipt").

(b) Week Seven and Beyond. An Active Hourly Employee must submit a Receipt evidencing payment for an affected week and evidence that he has made himself available for employment through the employment referral program maintained by his Union (e.g., signing Book One or other similar employment referral document).

An Active Hourly Employee must submit the Receipt to the Plan within 30 days of receiving the Receipt to qualify for a SUB benefit.

13.3 Duration. An Active Hourly Employee who satisfies the eligibility requirements of section 13.2 shall continue to receive weekly SUB benefits as long as there are sufficient assets in the employee's SUB Account to pay an entire week's benefit. If the Active Hourly Employee exhausts benefits available under a State unemployment compensation program but maintains a balance in his SUB Account and remains unemployed and on the employment referral list maintained by his Union, the Active Hourly Employee shall continue to receive weekly $250 payments from his SUB Account if:

(a) The Active Hourly Employee has a State benefits Receipt based on a week of unemployment during the last 12 months; or

(b) The Active Hourly Employee became unemployed after a period of reemployment that does not qualify for State benefits and state unemployment benefits have been exhausted within the last 26 weeks.

13.4 Retirement. Upon retirement, the assets in an Employee's SUB Account shall be transferred to the Active Hourly Employee's Flexible Benefit Account or, if a Flexible Benefit Account is not maintained for the Active Hourly Employee, into the account maintained for the Active Hourly Employee under the Plan's Dollar Bank system. An Active Hourly Employee shall be considered retired upon approval of a retirement benefit from any retirement plan jointly maintained by the Union on behalf of the Employee.

13.5 Inactive Accounts. The Plan will forfeit the assets in the SUB Account of an inactive Active Hourly Employee. An Active Hourly Employee is considered inactive if no contribution is made to the Plan on his behalf for 24 consecutive months. In lieu of forfeiting the SUB Account, the assets will be transferred to the Active Hourly Employee's Flexible Benefit Account or Dollar Bank Account if either is maintained for the Active Hourly Employee at the time the forfeiture would otherwise occur.

13.6 Distribution Upon Death. All assets in an Active Hourly Employee's SUB Account at the time of his death shall be transferred to the Flexible Benefit Account maintained for the Active Hourly Employee's Dependents or, if no Flexible Benefit Fund Account is maintained for the Dependents, to the Dollar Bank Account maintained for the Dependents. If the Active Hourly Employee is not survived by any Dependents, the SUB Account assets will be transferred to the deceased Active Hourly Employee's Dollar Bank Account. If a Dollar Bank transfer is permitted under Plan section 2.16(d), then the credits in the deceased Active Hourly Employee's Dollar Bank will be transferred consistent with Plan section 2.16(d). If the Active Hourly Employee has no Dependents or a transfer pursuant to Plan section 2.16(d) is not possible, the SUB account assets will be forfeited to the Plan.

13.7 Earnings and Account Maximum. The Trustees shall credit all of the net earnings and losses relating to the SUB Accounts (i.e., earnings and losses generated by SUB Account assets reduced by expenses incurred to administer the SUB pay program) pro rata among the SUB Accounts. If there are no earnings, the Trustees may assess the SUB pay administrative expenses pro rata against the SUB Accounts. A $300 annual holiday benefit will be paid from SUB Accounts that exceed $5,500 as of October 31 of any calendar year. If the holiday benefit checks is not timely cashed, the benefit will forfeit to the Plan.

13.8 Tax Withholding. All benefits paid from a SUB Account shall be subject to appropriate federal and state tax withholding.

13.9 Termination and Modification of SUB Account Program. The Trustees reserve the right to eliminate or modify the SUB Account program at any time and in their sole discretion. Amounts held in the SUB Accounts do not vest and a Participant and beneficiary have no right to receive assets from the SUB Accounts except when due as benefit payments pursuant to the terms of the Plan document.

ARTICLE XIV

FLEXIBLE BENEFIT ACCOUNT PROGRAM

14.1 General Provisions. The Trustees have established a Flexible Benefit Program under which Participants and their Dependents can withdraw amounts from their individual Flexible Benefit Accounts to cover certain specified expenses which are related to but not covered under the regular provisions of the Plan.

14.2 Flexible Benefit Accounts.

(a) The Plan will allocate hourly Flexible Benefit Contributions paid by an Employer on behalf of a Participant whose Local Union has elected the Flexible Benefit Account option into the individual Flexible Benefit Account established by the Plan for the Participant.

(b) If a Participant is working outside the jurisdiction of the Plan under a reciprocity agreement, the Plan will allocate the first $1.00 of each hourly reciprocal contribution as a Flexible Benefit Contribution.

(c) If the Plan issues a Flexible Benefit reimbursement check to a Participant for a Flexible Benefit Covered Expense, the Participant's individual Flexible Benefit Account balance will be reduced by the amount of such reimbursement.

(d) Except for Active Employer Staff Employees, Flexible Benefit Account balances can be carried forward from year to year. Contributions made to the Flexible Benefit Account for an Active Employer Staff Employee during a calendar year must be applied to reimburse expenses incurred during that calendar year on or before March 31 of the next following calendar year; any remaining expenses are forfeited.

(e) The balance remaining in a Participant's Flexible Benefit Account will be forfeited back to the Plan and such Participant's Flexible Benefit Account balance will be reduced to zero if:

(i) There is $400 or less in his Flexible Benefit Account, no Employer Contributions have been made into his Flexible Benefit Account for an entire calendar year and no withdrawals have been made from his Flexible Benefit Account during this same calendar year;

(ii) There is more than $400 in his Flexible Benefit Account, no account activity (i.e., no contributions to or benefits paid from the Flexible Benefit Account) for five consecutive calendar years;

(iii) The Dollar Bank Account is terminated under Plan subsection 2.2(e)(v), (vi) and (vii);

(iv) Coverage is terminated under subsection 2.3(d)(vi); or

(v) The Participant, former Participant, retired Participant or Dependent of a deceased Participant opted-out of the Flexible Benefit Account Program prior to January 1, 2020.

A Participant's Flexible Benefit Account that is forfeited under subsection 14.2(e)(iii) or (iv) shall be forfeited the same day as the Dollar Bank Account or coverage is terminated. A Participant's Flexible Benefit Account that is forfeited pursuant to Plan section 2.2(e)(v) or 2.2(f)(vi) will be reinstated on the same date that Dollar Bank credits are reinstated under Plan subsection 2.2(g), .

(f) The forfeiture rule under section 14.2(e) shall not apply to a retired Participant, except that the forfeiture rule in subsection 14.2(e)(v) shall apply. For purposes of Article XIV, a Participant shall be considered "retired" upon the approval of his retirement application from a retirement plan, jointly or exclusively, maintained by his Employer or Union.

(g) The Plan offers an opportunity to opt-out of the Flexible Benefit Account Program to the extent required by the Affordable Care Act.

(i) A Participant, former Participant, and retired Participant may opt-out of the Flexible Benefit Account Program and waive all future reimbursements from the Flexible Benefit Account annually. Upon opt-out, any amounts remaining in the Flexible Benefit Account will be frozen as of the date of the opt-out and any flexible benefit contributions received on an Active Hourly Employee's behalf will be forfeited to the Plan. A frozen Flexible Benefit Account will be reinstated the earlier of:

[a] The January 1, following the 12-month period to which the opt-out applied, unless the Participant elects to opt-out for a subsequent 12-month period; or

[b] The Participant's death.

(ii) A Participant may opt-out of the Flexible Benefit Account Program upon loss of Plan eligibility. Upon opt-out, the Flexible Benefit Account will be frozen as of the date of the opt-out. The Frozen Flexible Benefit Account will be reinstated if the former Participant regains Plan eligibility. However, the forfeiture rules in subsection 14.2(e) will continue to apply.

(iii) A Participant may opt-out upon becoming eligible for Retiree coverage. Upon opt-out, the Flexible Benefit Account will be frozen as of the date of opt-out and will be reinstated the earlier of:

[a] The January 1 following the 12-month period to which the opt-out applied, unless the retired Participant elects to opt-out for a subsequent 12-month period;

[b] Loss of coverage under other group health plan coverage due to loss of eligibility or termination of the group health plan; or

[c] Death.

(iv) A Dependent may opt-out upon the death of the Participant. Upon opt-out, the Flexible Benefit Account will be frozen as of the date of the opt-out. The frozen Flexible Benefit Account will be reinstated the January 1 following the 12-month period to which the opt-out applied, unless the Dependents elect to opt-out for a subsequent 12-month period. Any amounts remaining in the Flexible Benefits Account will forfeit to the Plan upon the Dependents' death. The forfeiture rule in section 14.2(e) will continue to apply.

14.3 Flexible Benefit Covered Expenses.

(a) A Participant may only receive reimbursement from the Flexible Benefit Account for Flexible Benefit Covered Expenses described in section 14.3(b) which:

(i) Are incurred on or after the date on which a Union agrees to participate in the Flexible Benefit arrangement;

(ii) The Participant is required to pay;

(iii) Are not payable under the regular medical, prescription drug, dental or vision benefits provided by this Plan or any other source; and

(iv) For which the Participant has not previously taken a tax deduction.

A charge is incurred at the time the service is rendered or the item is provided for which a charge is made and, in addition, a charge is deemed incurred when an advance payment is made for an Eligible Individual's orthodontic services, provided satisfactory substantiation of the payment is provided to the Plan to the extent permitted by applicable law.

(b) Flexible Benefit Covered Expenses are medical expenses deductible under Internal Revenue Code section 213(d) as described in the Internal Revenue Service Publication 502 except that the expenses listed in subsection 14.3(c) are not considered Flexible Benefit Covered Expenses.

(c) The following types of expenses are not considered Flexible Benefit Covered Expenses and no reimbursement will be made from the Flexible Benefit Account for such expenses:

(i) Cosmetic surgery and treatments;

(ii) Health club memberships or expenses;

(iii) Household help;

(iv) Maternity clothes;

(v) Expenses for which reimbursement can be made by some other source;

(vi) Expenses not listed in section 14.3(b) ;

(vii) Long-term medical care insurance premiums and expenses; and

(viii) Insurance premiums for health care coverage, except that group health plan insurance premiums are Flexible Benefit Covered Expenses for former Participants, retired Participants, and Dependents of deceased Participants.

14.4 Eligibility.

(a) Only Participants are eligible to participate in the Flexible Benefit Account Program and receive Flexible Benefit Contributions. However, except where a Participant's individual Flexible Benefit Account is forfeited, a former or retired Participant who has a balance in his Flexible Benefit Account is eligible to use his Flexible Benefit Account for the Flexible Benefit Covered Expenses. In order to receive a Flexible Benefit reimbursement, the Participant does not have to be eligible for regular Plan benefits when the Flexible Benefit Covered Expense is incurred, when the reimbursement request is submitted or received, or when the Flexible Benefit reimbursement check is issued.

(b) Entitlement to reimbursement and the amount of any such reimbursement made by the Plan from the Participant's Flexible Benefit Account will be based on the amount of the Participant's individual Flexible Benefit Account balance at the time the reimbursement check is issued.

(c) If a Participant dies and there is a balance remaining in his Flexible Benefit Account, the spouse or other enrolled Dependents of the deceased Participant may use the balance remaining in the Participant's Flexible Benefit Account for the Flexible Benefit Covered Expenses. The balance shall be forfeited if there are no Dependents.

14.5 Flexible Benefit Reimbursement Requests.

(a) Flexible Benefit reimbursement requests can be submitted to the Plan at any time; however, such requests must be received by the Plan Office no later than March 31 of the following calendar year for Active Employer Staff Employees or one year (12 months) following the date on which the expense was incurred for all other Participants.

(b) The minimum amount a Participant can request is $100; however, if a Participant incurs less than $100 in Flexible Benefit Covered Expenses during a Calendar Year, he may submit a request for less than $100 at the end of the Calendar Year in which the expense was incurred.

(c) Flexible Benefit reimbursement requests must be submitted to the Plan with a properly completed request form which will be provided to the Participant by the Plan upon request. A copy of the itemized bill and explanation of benefits (EOB) must also be submitted.

(d) With respect to any expenses for which another plan is secondary to this Plan, the reimbursement request must also include a copy of the secondary plan's EOB.

(e) Flexible Benefit reimbursement requests for Self-Payment amounts must be accompanied by the self-payment billing issued by the Plan.

14.6 Flexible Benefit Reimbursements.

(a) Upon receipt of a properly completed reimbursement request for a Flexible Benefit Covered, the Plan will issue a reimbursement check payable to the Participant or, following the Participant's death, the Dependent (or legal representative of the Participant or Dependent, if applicable). If the recipient noted in the preceding sentence directs, the Plan will forward the reimbursement directly to the provider. The Plan will deduct the amount of such reimbursement from the Participant's Flexible Benefit Account. The amount of the reimbursement will be the amount of the Flexible Benefit Covered Expense up to but not to exceed the amount in the Participant's Flexible Benefit Account at the time the check is issued.

(b) If the reimbursement request is for a Self-Payment for coverage under the Plan, the full amount of the Self-Payment must be available in the Participant's Flexible Benefit Account. Withdrawals cannot be made for the purpose of making a partial Self-Payment for any coverage provided by the Plan.

(c) The Plan will issue Flexible Benefit reimbursement checks on the first day of the calendar month. If a reimbursement request is received by the Plan on or before the 15th of a month and if the Participant is eligible for reimbursement, the reimbursement check will be issued on the first day of the following calendar month. If the request is received after the 15th of a month, and if the Participant is eligible for reimbursement, the reimbursement check will be issued on the first day of the second month following the month in which the request is received by the Plan Office. The Plan will issue Flexible Benefit reimbursement checks at least as frequently as once per month.

14.7 Other Provisions Governing the Flexible Benefit Program.

(a) Flexible Benefit Accounts are not savings accounts from which the Participant can withdraw at will. Participants and their Dependents are not vested in their Flexible Benefit Account balances. Amounts accumulated in a Participant's Flexible Benefit Account can only be used for Flexible Benefit Covered Expenses, subject to the rules and provisions set forth in this Article.

(b) No amounts for which payment has been or will be made by another benefit or insurance plan, including benefit plans provided by any government program, including but not limited to Medicare, are reimbursable under this program. The total combined reimbursement from all benefit/insurance plans when added to the amount of the Flexible Benefit Account reimbursement cannot exceed 100% of the billed amount.

(c) The Trustees reserve the right to eliminate or modify this program at any time and in their sole discretion.

14.8 Coordination of Benefits. The Flexible Benefit Account Program shall not be considered a group health plan for coordination of benefits purposes under Plan section 10.1and its reimbursement benefits shall not be taken into account when determining other benefits payable under this Plan or benefits payable under any other health plan except for Medicare. The use of benefits under the Flexible Benefit Account Program may be restricted under some circumstances for active Employees or their Dependents who are enrolled in Medicare.

14.9 Self-Payment Account Automatic Deduction. A Participant may authorize the Plan in advance on written forms issued by the Plan to automatically deduct from his or her Flexible Benefit Account assets necessary to satisfy a monthly self-payment obligation that a Participant may be required to pay to maintain eligibility. The Plan shall notify a Participant who has elected automatic self-payment deduction if there are insufficient assets in the Flexible Benefit Account to satisfy the monthly self-payment amount. A Participant may terminate his or her automatic deduction election by notifying the Plan in writing. The Plan shall terminate the automatic deduction election as soon as administratively feasible after receiving a termination notice.

ARTICLE XV

Prescription Drug Benefits

15.1 Eligibility. An Eligible Individual is eligible for the Prescription Drug Benefits set forth in this Article XV, provided that the Eligible Individual satisfies the following requirements:

(a) The Eligible Individual's prescription is filled at a Network Pharmacy for up to a 30-day supply;

(b) For Maintenance Drugs, the Eligible Individual's prescription is filled through the mail order program adopted by the Trustees for up to a 90-day supply, or

(c) For Maintenance Drugs, the Eligible Individual's prescription is filled at a Network Pharmacy with which the Pharmaceutical Services Network adopted by the Trustees has negotiated a discount arrangement for such drugs for up to a 90-day supply.

(d) For certain Specialty Drugs, the Eligible Individual's prescription is filled through a Pharmaceutical Services Network Specialty Pharmacy program adopted by the Trustees whereby such program requires preauthorization and/or participation in a manufacturer's coupon arrangement for such Specialty Drug.

15.2 Benefit.

(a) Except as further described in this section, after payment of the Prescription Drug Benefit co-payment amount for generic drugs set forth in the Schedule of Benefits the Plan will pay the remainder of the charge incurred for a Covered Drug when a prescription is filled at a Network Pharmacy or through the mail order program adopted by the Trustees, but not to exceed the amount established by the prescription benefit manager selected by the Trustees for a Covered Drug.

(b) An Eligible Individual who chooses a brand name prescription drug (either Formulary or non-Formulary) when a generic equivalent prescription drug is available must pay the difference in cost between the generic prescription drug and the brand name prescription drug in addition to the Co-Payment amount for the brand name prescription drug, except in the event that the patient's treating Physician provides a written letter of Medical Necessity (LMN) requiring use of the brand name medication.

(c) Eligible Individuals with a prescription for a Specialty Drug covered under a manufacturer's coupon program will automatically be enrolled in the coupon program. Coupon payments for the Specialty Drug will not be treated as an Eligible Individual's Prescription Drug Benefit co-payment amount nor will coupon payments be applied to any deductible or the prescription drug out-of-pocket maximum described in the Schedule of Benefits.

(d) When a prescription for a Covered Drug is filled at a pharmacy that is not a Network Pharmacy or an Eligible Individual does not present the proper identification card, the

Eligible Individual must pay the pharmacy charge in full and submit a claim to the Pharmaceutical Services Network for reimbursement.

15.3 Maximum Benefit. Payment of benefits by the Plan under this Prescription Drug Benefit is subject to the maximum set forth in the Schedule of Benefits. The Prescription Drug Benefit has a separate out-of-pocket maximum. Only prescription drug copayments will count toward the prescription drug out-of-pocket maximum. Charges for Covered Drugs do not count toward the out-of-pocket maximum for Medical Benefits.

15.4 Prior Authorization. Certain specialty drugs must be pre-authorized by the Plan's Pharmaceutical Services Network as appropriate treatment for the condition for which the drug has been prescribed.

15.5 Excluded Expense. In addition to the General Exclusions set forth in Article IX, no benefits are payable under this Prescription Drug Benefit for charges for:

(a) Non-legend patent or propriety medicine or medication not requiring a prescription (including premeasured syringes) even when prescribed by a Physician;

(b) Canes, crutches, walkers, wheelchairs or any means of conveyance or locomotion;

(c) Braces, splints, dressings, bandages, heat lamps or similar items;

(d) Abdominal supports, trusses, support hosiery, hypodermic syringes and/or needles, oxygen;

(e) Vitamins (except as required by the Affordable Care Act), cosmetics, dietary supplements, smoking cessation medications or aids, (except as required by the Affordable Care Act), or health or beauty aids;

(f) Any drug or medication dispensed to an Eligible Individual by a Hospital or other institution (with the exception of dispensing drugs or medications for which coverage is specifically provided for elsewhere under these Rules and Regulations);

(g) Any drug labeled, "Caution-Limited by Federal Law to Investigational Use," or experimental drugs even though a charge is made to the Eligible Individual;

(h) Medication for which the cost is recovered or found to be recoverable, either by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law even though the recipient fails to claim his rights to such benefits; and

(i) Any specialty prescription drug or medication, for which the Plan requires pre-authorization, which is not approved by the FDA for the use for which the drug is prescribed and is not pre-authorized by the Plan's Pharmaceutical Services Network as Medically Necessary and Reasonable.

15.6 Termination of Eligibility for Prescription Drug Coverage. Eligibility of a Retiree, or their Dependents for Prescription Drug Benefits and prescription drug benefits under the Flexible Benefit Account Program shall terminate effective on the date of enrollment in a Medicare Part D plan other than an EGWP. Further, a Medicare-eligible Retiree's or Dependent's EGWP prescription benefit coverage will terminate on the last day of the month following the month for which the Medicare-eligible Retiree or Dependent paid the required contribution. The Trustees shall develop uniform and consistent rules addressing when, if at all, a Retiree, or their Dependents can re-enroll for Prescription Drug Benefits and prescription drug benefits under the Flexible Benefit Account Program if they terminate non-Plan sponsored Medicare Part D Plan coverage.

15.7 Smoking Cessation Benefit. The Plan shall provide a smoking cessation program for Eligible Individuals through the. The Plan will provide a calendar year maximum of two 90-day supplies of smoking cessation medications, provided the Eligible Individual has a prescription from a Physician and they are purchased at a Network pharmacy.

The Plan shall provide the following coverage under this benefit:

(a) A 90 day trial period of over the counter smoking cessation products, such as nicotine patch, lozenge or gum, used singly or in combination.

(b) A 90 day approval of generic prescription smoking cessation products, such as Buproban and generic Zyban, following failure, intolerance, allergy, or contraindication to the over the counter products.

(c) A 90-day approval of brand name prescription smoking cessation products, such as Chantix and Nicotrol, following an Eligible Individual's demonstrated intolerance and/or allergic reaction to over the counter and generic prescription products.

ARTICLE XVI

AMENDMENT OF PLAN FOR THE AFFORDABLE CARE ACT

16.1 Adoption and Effective Date of Amendment. This amendment of the Rules and Regulations is adopted to reflect certain provisions of the Affordable Care Act and. This amendment is intended as good faith compliance with the requirements of the Affordable Care Act and is to be construed in accordance with the Affordable Care Act and guidance issued thereunder. Except as otherwise provided, this amendment and its provisions shall be effective as January 1, 2011.

16.2 Supersession of Inconsistent Provisions. This amendment shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this amendment.

APPENDIX A
PARTICIPATING IBEW LOCAL UNIONS AS OF APRIL 1, 2020

1. Local No. 127 – Kenosha
2. Local No. 158 – Green Bay
3. Local No. 159 – Madison
4. Local No. 388 – Stevens Point
5. Local No. 430 – Racine
6. Local 577 – Appleton
7. Local No. 890 – Janesville
8. Local No. 14 – Eau Claire

APPENDIX B
ACCIDENTAL DEATH AND DISMEMBERMENT CONTRACT

APPENDIX C
LONG TERM DISABILITY CONTRACT

ADDENDUM NO. 1
HIPAA PRIVACY AND SECURITY PROVISIONS

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees"), as Plan Sponsor, for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

1. Disclosure of PHI to the Trustees.

(a) Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(b) Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

(i) The Plan's Payment activities;

(ii) Those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan; and

(iii) All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

2. Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

3. Privacy Safeguards. The Plan will disclose PHI to the Trustees only upon receipt of a certification from the Trustees that the Plan document has been amended to incorporate the following provisions and that the Trustees agree to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(b) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

(e) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;

(f) Make PHI available to an Individual in accordance with the Privacy Regulations' access requirements and the Plan's privacy policies and procedures;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

(j) If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

(k) Ensure that adequate separation between the Plan and the Trustees is established, as described below.

4. Adequate Separation. The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

5. Application of the Security Regulations. The Plan and the Trustees will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162, and 164 (the "Security Regulations"). The provisions in section 6 below apply to electronic PHI that is created, received, maintained, or transmitted by the Trustees on behalf of the Plan, except for electronic PHI: (a) the Trustees receive pursuant to an appropriate authorization (as described under 45 C.F.R. section 164.508); or (b) that qualifies as

Summary Health Information and that the Trustees receive for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending, or terminating the Plan (as described under 45 C.F.R. section 164.504(f)(1)(ii)). The Security Regulations are incorporated herein by reference.

6. Security Safeguards. The Trustees agree to:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the Trustees create, receive, maintain, or transmit on behalf of the Plan;

(b) Ensure that the "adequate separation" described above between the Plan and the Trustees, specific to electronic PHI, is supported by reasonable and appropriate security measures;

(c) Ensure that any agent to whom the Trustees provide electronic PHI agrees to implement reasonable and appropriate security measures to protect electronic PHI; and

(d) Report to the Plan any security incident of which the Trustees become aware regarding electronic PHI.

7. Hybrid Entity. For purposes of complying with the Privacy Regulations and Security Regulations, this Plan is a "hybrid entity" because it has both health plan and non-health plan functions. The Plan designates that its health plan components that are covered by the Privacy Regulations and Security Regulations include only health plan benefits and not other plan functions or benefits.

ADDENDUM NO. 2
SCHEDULE OF BENEFITS

DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Death Benefit (Participants only)	
Under Age 65	$10,000
Age 65-69	$6,500
Age 70 & Over	$5,000
Loss of Two Limbs/Eyes and Accidental Death (Active Employees, Self-Pay Active Hourly Employees and Self-Pay Disabled Employees only)	
Under Age 65	$10,000
Age 65-69	$6,500
Age 70 & Over	$5,000
Loss of Limb/Eye (Active Employees, Self-Pay Active Hourly Employees and Self-Pay Disabled Employees only)	
Under Age 65	$5,000
Age 65-69	$3,250
Age 70 & Over	$2,500

LOSS OF TIME (DISABILITY) BENEFITS (Active Employees Only)	
Short Term Disability	$500 per week for 26 weeks
Long Term Disability (Transitional)	$100 minimum/$1,800 maximum per month

MEDICAL BENEFITS		
	PPO Provider	**Non-PPO Provider**
Deductible per Calendar Year[1]		
Individual	$500	$500
Family	$1,500	$1,500
Maximum Out of Pocket Expense Per Calendar Year[2]		
Individual	$1,000	$3,000
Family	$3,000	$9,000
Coinsurance		
Plan	90%	70%
Participant	10%	30%
Specific Coinsurance Amounts (Paid by Plan)		
Emergency room	90%	90%
Affordable Care Act preventive care services[3] (including tobacco cessation)	100%	70%
LiveHealth Online visits[3]	100%	Not covered

SPECIFIC BENEFIT MAXIMUMS	
Skilled Nursing Maximum per Eligible Individual per confinement	60 days
Orthotics – custom fit Maximum per Eligible Individual per lifetime - after maximum is met covered orthotics will be paid 50% by the Plan	$10,000
Orthotics – custom fit for treatment of chronic foot conditions Maximum per Eligible Individual every 5 years	$500
Hearing Benefit[4] Maximum per Eligible Individual every 3 years	$1,500
Routine Physical Exams (including Well Baby check ups and immunizations)	
PPO[3]	100% paid by Plan
Non-PPO	100% paid by Plan up to $450 per Eligible Person; 10% paid by Plan thereafter

[1] PPO charges and Non-PPO charges are applied separately to satisfy deductible

[2] Does not include extended year deductible Covered Drug expenses, balance billing charges or excluded expenses

[3] Not subject to deductible at a PPO Provider.

[4] Not subject to deductible.

SPECIFIC BENEFIT MAXIMUMS	
Health Dynamics (one visit per year in lieu of physical exam, Participants and Dependent spouses only)[3]	100% paid by Plan
Gastric bypass surgery Maximum per Eligible Individual per lifetime	 1 procedure
Prosthetic device maximum	1 device (and related adjustments) per limb per 60-month period
Chiropractic benefits Follow-up visits per Calendar Year Manipulation Therapy Diagnostic x-ray	 30 1 per visit 1 per visit 1 per Calendar Year
Inpatient Respite Care Maximum per Eligible Individual per lifetime	 8 days
Asbestos detection Maximum per Eligible Individual per lifetime	 1 breathing test and 1 x-ray analysis

PRESCRIPTION DRUG BENEFIT		
Copays	**Generic**	**Brand[5]**
Retail 1-30 day supply	$10 copay	$50 copay
Mail order 1-60 day supply maintenance drugs	$10 copay	$50 copay
Mail order 61-90 day supply maintenance drugs	$15 copay	$75 copay
Preventive care drugs	No charge	No charge
Calendar Year out-of-pocket maximum	**Network Pharmacy**	**Non-Network Pharmacy**
Per individual	$6,650[6]	No limit
Per family	$11,800[4]	No limit
Calendar Year maximum – after maximum is met Covered Drugs will be paid 50% by the Plan and 50% by the Participant	$10,000	

[5] If a generic equivalent available, the brand copay and the difference in cost between the generic and the brand name prescription drug will apply unless the patient's treating Physician provides a written letter of Medical Necessity requiring use of the brand name medication.

[6] The calendar year out-of-pocket maximum for Covered Drugs received from a Network Pharmacy shall be adjusted each January 1 to automatically allow the Plan to meet the Affordable Care Act maximum out-of-pocket maximum.

OPTIONAL VISION BENEFITS	
Deductible	None
Copay	None
Calendar Year dollar maximum	
Adults	$300
Children under age 19[7]	None

OPTIONAL PREVENTIVE DENTAL BENEFITS	
Deductible	None
Copay	None

OPTIONAL COMPREHENSIVE DENTAL BENEFITS	
Deductible	None
Copay	
Preventive services	100% paid by Plan
Basic services	80% paid by Plan
Major services	80% paid by Plan
Calendar Year dollar maximum	
Adults	$1,700
Children under age 19[7]	None
Orthodontia	
Deductible	None
Copay	
First $1,400 of Covered Charges	50% paid by Plan
Next $1,800 of Covered Charges	100% paid by Plan
Lifetime maximum	$2,500

[7] Eligible Individuals are considered "children" for this purpose through the end of the calendar year the Eligible Individual reaches age 19.