SOUTHWEST HEALTH BENEFITS FUND

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

FEBRUARY 1, 2017 EDITION

SOUTHWEST HEALTH BENEFITS FUND

HEALTH & WELFARE PLAN

ADMINISTRATIVE MANAGER

Mark Crandell
Benefit Resources Inc.
8441 Gulf Freeway, Suite 304
Houston, TX 77017
Telephone: (713) 643-9300

BOARD OF TRUSTEES

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SOUTHWEST HEALTH BENEFITS FUND

Fund Office
8441 Gulf Freeway
Suite 304
Houston, Texas 77017-5066
Phone: 713-643-9300
Fax: 866-316-4794
Toll Free: 866-236-3148

LETTER TO ALL PARTICIPANTS

We are pleased to present you with this new Summary Plan Description (SPD) and incorporated Plan Document that describes the benefits provided by the Fund.

Medical benefits are paid for directly from the assets of the Fund.

We urge you to read this new SPD carefully so you will better understand the benefits that you and your family may be entitled to receive. While we hope that everyone will enjoy good health at all times, we believe that you will feel, as we do, that the Fund benefits provide financial security in times of need.

In order to have your claims paid on a timely basis, be sure to read and comply with the requirements outlined in "HOW TO FILE A CLAIM" on page XII of this SPD.

If you have any questions regarding your benefits, eligibility or how to file claims, please contact the Fund Office.

Please remember that, in order to be official and binding, any information concerning your rights under the Plan must be communicated to you in writing by the Board of Trustees.

Sincerely,
BOARD OF TRUSTEES

SOUTHWEST HEALTH BENEFITS FUND

Fund Office
8441 Gulf Freeway
Suite 304
Houston, Texas 77017-5066
Phone: 713-643-9300
Fax: 866-316-4794
Toll Free: 866-236-3148

Carta a todos los participantes

Estamos agradecidos de presentarle este nuevo Summary Plan Document (SPD) y el Documento del Plan incorporado que describe los beneficios proporcionados por el Fondo.

Los beneficios medicos se pagan directamente de los bienes del Fondo.

Le instamos a leer este nuevo SPD cuidadosamente para que pueda comprender mejor los beneficios que usted y su familia pueden tener el derecho a recibir. Aunque esperamos que todos disfruten de buena salud en todo momento, creemos que usted sentirá, como nosotros, que los beneficios del Fondo proporcionan seguridad financiera en momentos de necesidad.

Para que sus reclamaciones sean pagadas oportunamente, asegúrese de leer y cumplir con los requisitos descritos en "COMO PRESENTAR UNA RECLAMACIÓN" ("HOW TO FILE A CLAIM") en la página XII de este SPD.

Si tiene alguna pregunta con respecto a sus beneficios, elegibilidad o cómo presentar reclamos, comuníquese con la Oficina del Fondo. (713) 643-9300

Recuerde que para ser oficial y vinculante, cualquier información relacionada con sus derechos bajo el Plan debe ser comunicada por escrito por la Junta de Síndicos.

Sinceramente,
BOARD OF TRUSTEES

10 WAYS TO CONTROL YOUR HEALTH CARE BILLS

You can control your health care expenses. Start now. Although you may already be a conscientious user of the health care system, by practicing all 10 ways to control your health care expenses, you will positively affect your pocketbook and your health.

1. **Treat yourself right**. Many illnesses and injuries can be prevented. Major illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep and exercising regularly, you can be on the road to preventing Illness, both major and minor. Remember to wear your seatbelts when in any vehicle and take the time to be careful around your home to avoid unnecessary household accidents.

2. **Ask questions about your bills**. The only "dumb questions" are the questions that you don't ask. Ask about charges on your Hospital bill if you don't understand them. All Hospitals have people who can help answer your billing questions.

3. **Inquire about your medications/treatment plan**. Generic drugs often cost less than name brands and your Physician will prescribe them if you ask.

   If you have any doubts or questions about a treatment or procedure your Physician has recommended for you, get a second opinion from another Physician or Health Care Provider. Patients who are informed about what to expect during their Hospital confinement usually recover faster and have fewer complications than patients who are uninformed. Many Hospitals have patient information programs to help you. Use them!

4. **Don't be in when you can be out**. Ask your Physician about the use of Outpatient services in your Hospital or Physician's office for tests, treatments and many types of minor surgery. Outpatient care is always less expensive than a Hospital confinement and can often accomplish the same objective.

5. **Use the emergency room for emergencies.** Your Hospital's emergency room is an expensive place to treat minor aches and ailments. When possible, contact your Physician before deciding to use the emergency room.

6. **Understand your coverage before you have to use it**. Make sure you understand your health care coverage. Read this SPD. It describes how the benefits will work and what is and what is not covered.

7. **The shorter your Hospital confinement, the less you pay**. When it is practical, have tests performed before you enter the Hospital. Except in emergency situations, avoid being admitted to the Hospital at night or on the weekend because you may spend unnecessary time waiting for surgery or special treatment. Also, it is important to leave the Hospital as soon as your Physician tells you that you are ready.

8. **Don't expect a "free" lunch**. Be a cost-conscious consumer. Even though our Fund or the government may pay for most of your health care needs, the services and treatment you receive are never free. If you make an effort to control how you use health care services, everyone will benefit-- especially you.

9. **Watch for early warnings!** Learn the early warning signs of illnesses such as heart disease and cancer. Early detection of illnesses could save your life and may save you money.

10. **Use PPO Providers**. Since the Fund generally pays 70% of the covered charges when you and your covered Dependents are admitted to a PPO Hospital (rather than 30% for a Non-PPO Hospital) and PPO providers discount their fees for other services, you and the Fund will save money. Therefore, you will have a lower out-of-pocket expense when utilizing the services of PPO providers.

These 10 easy steps may lead you to better health and lower medical expenses.

SOUTHWEST HEALTH BENEFITS FUND

SCHEDULE OF BENEFITS
EFFECTIVE JANUARY 1, 2016

Life and AD&D Benefits for Active Employees	
Life Benefit	$10,000
AD&D Benefit	$10,000

The Life and AD&D Benefits are fully insured through ULLICO.

Medical Benefits	PPO Provider	Non-PPO Provider
Calendar Year Deductible	$750 per individual	$1,500 per individual
	$2,250 per family	$3,000 per family
Common Accident Deductible	If two or more covered family members are injured in the same accident, only one individual deductible will apply to all expenses incurred in connection with that accident during the Calendar Year.	
Deductible Carryover	The Covered Expenses used to satisfy the Calendar Year deductible during October through December of one Calendar Year may also be used to satisfy the deductible for the following Calendar Year.	
Calendar Year Out-of-Pocket Maximum	$7150.00 per individual, $14,300 per family. The out-of-pocket maximum includes amounts you pay towards the Calendar Year Deductible and any coinsurance or Once you meet the PPO out-of-pocket maximum, the Plan will pay 100% of the PPO Covered Expenses for the remainder of the Calendar Year.	No out-of-pocket maximum on services received out of network.
Annual Maximum Benefit	Unlimited	
Lifetime Maximum Benefit	Unlimited	

Medical Benefits	PPO Provider	Non-PPO Provider
Precertification Requirements	The Plan requires that all Inpatient Hospital admissions and home health care services be precertified. **Failure to precertify these services will result in a 10% penalty, up to a maximum penalty of $1,000 per procedure, occurrence or confinement.**	
Hospital Services (Inpatient)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Skilled Nursing Facility or Sub-Acute Facility	Plan pays 70% after Deductible	Plan pays 30% after Deductible
	Limited to 30 days per Calendar Year (PPO and non-PPO combined). Confinement in skilled nursing facility must begin within seven days immediately following Hospital confinement of at least five consecutive days.	
Physician Services (Office Visits, Hospital Visits, X-Rays and Laboratory Tests and 2nd and 3rd Surgical Opinions)	Plan pays 70% after your $40 copayment per visit, per provider (not subject to Deductible)	Plan pays 30% after Deductible
Physician Services (Surgery and Anesthesia)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Laboratory Services (Outpatient)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Radiology, Nuclear Medicine & Radiation Therapy Services (Outpatient)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Prescription Drugs	Plan pays 80% after Deductible for generic drugs and 70% after Deductible for brand name drugs	
Emergency Services in a Hospital Emergency Room (Must be for a "Medical Emergency")	Plan pays 70% after Deductible	Plan pays 70% after Deductible
Services in an Urgent Care Center	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Emergency Ambulance Transportation to Nearest Hospital	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Preadmission Testing (Outpatient)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
	Must be performed within seven days immediately preceding Hospital confinement.	
Hospital Outpatient Surgery or Ambulatory Surgical Facility	Plan pays 70% after Deductible	Plan pays 30% after Deductible

Medical Benefits	PPO Provider	Non-PPO Provider
Chiropractic Services (Manipulative Treatment)	Plan pays 70%, not subject to Deductible	Plan pays 30% after Deductible
	Benefits for manipulative treatment limited to 10 visits per person per Calendar Year.	
Chiropractic Services (Non-Manipulative Treatment, Office Visits, X-Rays and Lab Tests)	Plan pays 70% after your $40 copayment per visit, per provider (not subject to Deductible)	Plan pays 30% after Deductible
Corrective Appliances (Prosthetic & Orthotic Devices)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Durable Medical Equipment (DME)	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Home Health Care	Plan pays 70% after your $40 copayment per visit, per provider (not subject to Deductible)	Plan pays 30% after Deductible
	Limited to 30 visits per Calendar Year (PPO and non-PPO combined). Care must begin within 14 days after discharge from a Hospital or skilled nursing facility confinement.	
Mental Health Treatment	Plan pays 70% after Deductible	Plan pays 30% after Deductible
	All Inpatient and partial Hospitalization for mental health services and treatment must be precertified and is subject to continued stay review.	
Substance Use Disorder Treatment	Not covered	Not covered
Maternity Services	Plan pays 70% after Deductible	Plan pays 30% after Deductible
	No benefits for maternity services for Dependent children, except for certain prenatal care, as shown under Preventive Care Benefits and complications of pregnancy.	
Outpatient Physical, Occupational and Speech Therapy	Plan pays 70% after your $40 copayment per visit, per provider (not subject to Deductible)	Plan pays 30% after Deductible
Hospice Care Services	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Organ/Tissue Transplants	Plan pays 70% after Deductible	Plan pays 30% after Deductible
Preventive Care Services	Plan pays 100%, not subject to Deductible	Not Covered

HOW TO FILE A CLAIM

If you or your Eligible Dependent becomes sick or injured or dies, and you believe you may be entitled to benefits under this Plan:

1. You should telephone the Fund Office at (713) 643-9300 / 866-236-3148.

2. The Fund Office will tell you if you are eligible for benefits under the Plan.

3. The Fund Office will furnish you with a claim form.

4. You must complete your portion (Claimant's Statement) of the form.

5. If your claim is related to a disability, have your Physician complete the Attending Physician's Statement on the form.

6. Mail the form and all bills pertaining to the claim to the Fund Office at:

   SOUTHWEST HEALTH BENEFITS FUND
   c/o Benefit Resources, Inc.
   8441 Gulf Freeway, Suite 304
   Houston, TX 77017-5066

7. At the start of each Calendar Year, the Fund Office will send you an initial medical claim form for completion. This form must be completed and returned to the Fund Office before the Plan will pay any claims submitted for your Dependents for that Calendar Year.

8. After you complete and return the initial medical claim form for a Calendar Year, you will not need to submit another claim form for non-accident related claims for that Calendar Year. These will be paid by the Plan upon receipt of the appropriate documents from your Health Care Provider.

NOTE: Submitting claims forms, filing claims and providing proper documentation is your responsibility. If an itemized bill, which includes a diagnosis code and CPT code, does not accompany your claim, the Fund Office will not process the claim until all required information has been received. In addition, if you are filing a claim and the Fund is the secondary payer, an itemized bill that includes a diagnosis code and CPT code as well as the primary payer's explanation of benefits MUST accompany the claim. Otherwise, the Fund Office will not process the claim until all required information has been received. **It is your responsibility to file complete claims in a timely manner. Failure to do so may adversely affect the payment of your claim.**

YOU OR YOUR DEPENDENTS MUST NOTIFY THE FUND OFFICE WHEN:

1. You change your address.

2. New Dependents are to be covered (you must provide certified copies of birth certificates and/or adoption papers).

3. You become divorced (provide court certified divorce papers).

4. You become married (provide a certified copy of the marriage license).

5. There is a death (provide a certified copy of the death certificate).

6. A Dependent ceases to be a Dependent (e.g., your child attains age 26).

NOTICE

This SPD/Plan document will not be deemed to constitute a contract of employment or give any Employee of a Contributing Employer the right to remain in the service of the Employer or to interfere with the right of the Employer to discharge any Employee. These issues are covered by your Collective Bargaining or Participating Agreement.

You MUST satisfy all of the eligibility provisions in order to be eligible for the benefits of this Plan. Possession of this SPD does not automatically entitle you to the benefits provided by this Plan.

The Trustees have full and exclusive authority to determine, in their sole discretion, all questions of coverage and eligibility, the level and type of benefits provided, the methods of providing or arranging for benefits and other related matters. The Trustees also have full and exclusive authority to construe and interpret the provisions of the Agreement and Declaration of Trust establishing the Trust Fund and this SPD/Plan, which establishes and sets forth the terms and provisions of the coverages and benefits offered. All such determinations, constructions or interpretations adopted by the Trustees in good faith will be binding on all entities including, but not limited to, all eligible individuals covered under this Plan.

The medical benefits described in this SPD/Plan are not insured by any contract of insurance and there is no liability upon the Board of Trustees or any individual or entity to provide payment over and above the amount in the Trust Fund available for such purpose.

ARTICLE I – DEFINITIONS

While reading this SPD/Plan, you may come across terms that have a special meaning. We suggest that you become familiar with the following terms. Whenever these terms appear in this SPD/Plan as capitalized terms, they will have the meaning set forth below.

Section 1.1. Administrative Manager means the individual or entity designated and engaged by the Trustees and to whom the Trustees have delegated their authority to administer the Plan, to make eligibility determinations, to pay and process claims and/or to perform other administrative functions authorized by the Trust Agreement and applicable law. In the absence of an Administrative Manager, the Trustees shall retain the authority and responsibility to act in that role.

Section 1.2. Agreement and Declaration of Trust or Trust Agreement refers to the Agreement and Declaration of Trust by the Asbestos Workers Local Number 21 Welfare Fund effective April 24, 1990, including all amendments and modifications thereto.

Section 1.3. Allowable Charge means the amount of a provider's charge that the Plan recognizes as payable for services or supplies that are covered by the Plan (subject to any applicable deductible or limitation). The Allowable Charge will be the lowest of the following amounts: (i) the actual charge; (ii) the contractually agreed upon discounted rate for a Network Provider; and (iii) for a non-Network Provider, the allowed amount as determined by the Board of Trustees in a reasonable and uniform manner in accordance with the methodology, fee schedule, percentile and/or adjustment for the geographical area and nature and severity of the condition being treated, as approved for use by the Board. It is anticipated that the Allowable Charge for a non-Network Provider will be lower than the Allowable Charge for a Network Provider.

Section 1.4. Alternate Recipient means any child of yours who is recognized under a Qualified Medical child Support Order as having a right to enrollment under this Plan with respect to you.

Section 1.5. Ambulatory Surgical Facility means a public or private facility that is licensed as such by the state in which it is located that is equipped and operated solely as a setting for Outpatient surgery. The facility must have all of the following:

A. Staffing, which includes:
   1. Direction by a staff of Physicians or surgeons (MDS or DOs);
   2. Presence of a Physician or surgeon during each surgical procedure and recovery period (and presence of a certified anesthesiologist when general or spinal anesthesia is required);
   3. Provision of full-time skilled nursing services in the operating and recovery rooms (under the direction of RNs); and
   4. Extension of staff privileges to Physicians or surgeons who perform surgery in an area Hospital.

B. Facility and equipment, which includes:
   1. At least two operating rooms and one recovery room (but not a place for patients to stay overnight);
   2. Diagnostic x-ray and lab equipment (or a contract to use such equipment at an area medical facility); and
   3. Emergency equipment (including a defibrillator, a tracheotomy set and a blood volume expander).

C. Policies and procedures by which the facility:
   1. Regularly charges patients for services and supplies; and
   2. Contracts with an area Hospital, and displays written procedures, for immediate transfer of emergency cases.

Section 1.6. Assignment of Benefit means a written request by a Participant that the Plan pay all or any part of any benefits provided on account of Hospital, nursing, medical or surgical treatment or services directly to the person or entity that provided the services or treatment. The written request must include a proper notation on a provider billing form.

Section 1.7. Beneficiary means a person who is or who may become entitled to a benefit under the terms of the Plan.

Section 1.8. Calendar Year means the period commencing at 12:01 a.m. Central Standard Time on January 1, and continuing until 11:59 p.m. Central Standard Time on the immediately following December 31.

Section 1.9. COBRA means the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Section 1.10. Collective Bargaining Agreement (CBA) means any written agreement entered into by an Employer and the Union, which provides for Employer contributions to the Fund on behalf of its Employees (working in Covered Employment), as extended, renewed or amended from time to time.

Section 1.12. Contribution Rate means the amount an Employer agrees to pay to the Fund under the Collective Bargaining Agreement, for each hour of Covered Employment worked by its collectively bargained Employees.

Section 1.13. Covered Employment means employment by an Employer for which the Employer is obligated to contribute to the Fund, in accordance with the Collective Bargaining Agreement or a Participation Agreement.

Section 1.14. Covered Expense means those expenses that are outlined in Article VI and which are actually incurred by a Covered Person of this Plan, subject to the limitations outlined in Article VII. Covered Expenses must be Medically Necessary as defined herein, and be Reasonable and

Customary Expenses, as defined herein.

Section 1.15. Covered Person means a Participant or "Eligible Employee" and/or an "Eligible Dependent."

Section 1.16. Covered Service means Medically Necessary medical care, services, supplies or treatment for Injury or Illness that is not work related, or for preventive and wellness care, for which medical benefits are available under the Plan.

Section 1.17. Dependent or Eligible Dependent means any of the following:

A. Your lawfully married spouse, to the extent recognized by federal law;
B. Your common-law spouse, as permitted in the state of Texas or any other state that recognizes common law marriages;
C. Any child of yours who is less than twenty-six (26) years of age;
D. Any unmarried child of yours who is twenty-six (26) years of age or older who is incapable of self-sustaining employment by reason of a physical or mental disability for which the child has received a determination of Total Disability from the Social Security Administration. As a further condition of eligibility, the child must have become Totally Disabled prior to attaining age twenty-six (26) and must be chiefly Dependent upon you for support and maintenance. Acceptable written proof of the child's Total Disability must be furnished to the Fund Office within 31 days after the child attains the maximum age limit, and periodically thereafter as reasonably requested by the Plan. A child who qualifies under this provision will remain an Eligible Dependent for as long as you remain covered and the child continues to satisfy the conditions of this paragraph.

The term "child" shall include only your natural children, step-children, adopted children, foster children, children placed with you for adoption and children under your legal guardianship. The term "foster children" means children placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction. Being "placed for adoption" means that you have assumed, and retain a legal obligation for total or partial support of such child in anticipation of adoption of the child. The child's placement with you terminates upon termination of such legal obligation.

The Fund may require a statement to verify a claim that a step-child, foster child, legally adopted child or child under guardianship is an Eligible Dependent.

The Plan may from time to time require you to provide satisfactory documentation that your claimed Dependent satisfies the above requirements.

Proof of an individual's Dependent status includes, but is not limited to the following documents:

1. A valid marriage license or a certificate of common law marriage from a state that recognizes common law marriage;

2. A court decree of divorce or legal separation;
3. A birth certificate;
4. A court order of placement for adoption or foster care;
5. A Physician's statement of mental or physical incapacity;
6. A Qualified Medical child Support Order (QMCSO) within the meaning of ERISA Section 609(a).

In the event of divorce or remarriage, a divorce decree is required to be submitted to the Fund Office. Acceptable proof of common-law marriage, in a state that recognizes common law marriages, is a declaration of marriage or notarized statement on a form provided to the Trustees, attesting to the date of marriage and completion of a new enrollment card.

Section 1.18. Durable Medical Equipment is the equipment recognized as such by Medicare Part B, and that meets all of the following requirements:

A. It can withstand repeated use; and

B. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience; and

C. It is usually not useful to a person in the absence of Illness or Injury; and
D. It is appropriate for home use; and

E. It is certified in writing by a Physician as being Medically Necessary; and

F. It is related to the patient's physical disorder; and

G. It is for temporary use only. The anticipated length of time the equipment will be required for therapeutic use must be certified in writing; and

H. It is for the exclusive use of the Participant for whom the Health Care Provider has certified that is Medically Necessary.

Section 1.19. Eligible Charge means charges or expenses for medical services or supplies, but only to the extent that the expenses meet each of the following qualifications, as determined by the Plan Administrator or its designee: (i) the services are Medically Necessary; (ii) the charges for the services are Allowed Charges; (iii) coverage for the services or supplies is not excluded; (iv) any maximum Plan benefits for such services or supplies have not been reached; and (v) the charges are for the diagnosis or treatment of an Injury or Illness (except where wellness/preventive services are payable by the Plan).

Section 1.20. Eligible Employee means an Employee who satisfies the eligibility requirements for participation in the Plan as described by Article II.

Section 1.21. Employee means any individual employed by an Employer, with respect to whom contributions are required to be made by the Employer to the Fund in accordance with a Collective Bargaining Agreement or a Participation Agreement.

Section 1.22. Employer means each Employer that is a signatory to a Collective Bargaining Agreement and any successor that is bound by a Collective Bargaining Agreement, and each Employer signatory to a Participation Agreement, that contributes or is obligated to contribute to the Fund on behalf of its Employees, and is a party to or bound by the Trust Agreement for the Fund.

Section 1.23. ERISA means the Employee Retirement Income Security Act of 1974 and corresponding regulations, as amended.

Section 1.24. Experimental or Investigational means any drug, device or medical treatment, procedure or therapy that meets any of the following criteria in relation to the condition for which it is being dispensed or rendered: (1) it is not proven in an objective manner to have benefit for the patient; (2) it is restricted for use at medical facilities engaged primarily in carrying out scientific studies; (3) it is of questionable medical effectiveness; (4) for drugs, devices, services and supplies that are regulated by the FDA and cannot be legally marketed without FDA approval, FDA approval has not been granted at the time it is prescribed or provided; or (5) reliable evidence shows that the prevailing opinion among experts is that further studies or clinical trials may be necessary to determine the maximum tolerated dose, toxicity, safety or efficacy.

Examples of reliable evidence include published reports and articles in the authoritative medical and scientific literature, written protocol(s) and written informed consents, including studies, opinions and reference to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies or any other medical association or federal program or agency that has the authority to approve medical testing and treatment.

Section 1.25. FMLA: means the Family and Medical Leave Act of 1993.

Section 1.26. FMLA Leave: means a leave of absence, intermittent leave or leave on a reduced schedule, not to exceed twelve (12) work weeks, as determined and certified by a Contributing Employer or Participating Fund pursuant to the FMLA and the regulations promulgated thereunder.

Section 1.27. Fund, Trust or Trust Fund refer to the entire trust estate of the Southwest Health Benefits Fund established and maintained under the Trust Agreement, including but not limited to all funds owed and received in the form of contributions together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, all policies of insurance and any and all other property or funds for the purpose of holding contributions, providing authorized benefits to Participants and Beneficiaries and

defraying reasonable administrative expenses under the Plan.

Section 1.28. Health Care Provider: means a health care practitioner who is: (i) licensed to practice his or her respective professional skills in the state or jurisdiction where the services are rendered, and (ii) acting within the scope of that license at the time and place services are rendered. The term Health Care Provider shall include, but not be limited to, the following:

A. Doctor of Medicine (M.D.) (also referred to as "Physician")
B. Doctor of Dental Surgery (D.D.S.)
C. Doctor of Dental Medicine (D.D.M.)
D. Doctor of Osteopathy (D.O.)
E. Doctor of Podiatric Medicine (D.P.M.)
F. Doctor of Chiropractic (D.C.)
G. Physical therapist, occupational therapist or speech therapist
H. Psychologist
I. Licensed clinical social worker

Section 1.29. HIPAA means the Health Insurance Portability and Accountability Act of 1996 and corresponding regulations, as amended.

Section 1.30. Hospital means a licensed or legally operating institution that is engaged primarily in providing medical care and treatment to sick and injured persons on an Inpatient basis at the patient's expense and which fully meets all of the following requirements:

A. Is primarily engaged in providing diagnostic, rehabilitation and therapeutic services for the surgical and medical diagnosis, treatment, and care of injured, disabled or sick persons by or under the supervision of a staff of Physicians who are duly licensed to practice medicine; and
B. Maintains medical records on all patients; and
C. Has bylaws in effect with respect to its staff and Physicians; and
D. Provides daily twenty-four (24) hour nursing services rendered or supervised by registered nurses.

Unless specifically provided, the term Hospital shall not include any institution or part thereof that furnishes services or treatment principally as a rest or custodial facility, nursing facility, convalescent facility, facility for the aged, a school, or any institution that makes no charge for the services and/or supplies provided that you are required to pay.

Section 1.31. Illness or Sickness means a Sickness, disease, disorder or medical condition that requires treatment by a Physician. "Illness" or "Sickness" includes pregnancy and the resulting childbirth and miscarriage; however, it excludes male and female sterilization reversals, whether voluntary or otherwise.

Section 1.32. Injury means a physical trauma or damage sustained accidentally to a Participant's body by external means, which requires treatment by a Physician.

Section 1.33. Inpatient means a person receiving services or treatment for care of an Injury, Illness or Sickness or medical condition as a registered bed patient in a Hospital who is incurring Room and Board Charges at the Hospital.

Section 1.34. Lag Month is the calendar month between the Work Month and the corresponding Benefit Month. There is a one month lag between the last month in which you work in Covered Employment, and the month in which your eligibility is granted as a result of your work in Covered Employment (called the "Benefit Month"). This is discussed in greater detail in the "Continuing Eligibility" section.

Section 1.35. Medically Necessary means the services or supplies, treatment or confinement are determined by the Plan to be generally recognized within the Health Care Provider's profession as effective and essential for treatment of the Injury or Illness for which it is ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on the diagnosis. To be considered Medically Necessary, the care must be based on generally recognized and accepted standards of medical practice in the United States, and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. The fact that a service or supply is prescribed by a Physician does not necessarily mean that it is Medically Necessary for purposes of the Plan.

Section 1.36. Network Provider means a Hospital, Physician or other Health Care Provider that participates in the Plan's Preferred Provider Organization (PPO) and has agreed to provide health care services or supplies at discounted rates to Participants.

Section 1.37. Outpatient means a person receiving diagnosis, services or treatment for care of Illness or Sickness, Injury, or other covered condition in a Hospital, clinic or dispensary for diagnosis and/or treatment who is not an Inpatient.

Section 1.38. Participant means an Eligible Employee, Eligible Dependent, Qualified Beneficiary or Alternate Recipient who meets all requirements for coverage based on the Plan's eligibility rules and is in fact covered by the Plan.

Section 1.39. Participation Agreement means a written agreement between an Employer and the Trustees, and any extensions, renewals or amendments thereto, which obligates the Employer to make contributions to the Fund for its Non-Bargaining Unit Participating Employees who are covered by the agreement, and specifies the terms by which they will participate.

Section 1.40. Physician means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist or certified consulting psychologist, to the extent that such person, under his license, is permitted to perform services covered by the Plan and is acting within the scope of his license at the time such services are performed. In any

case, the Plan will not discriminate against Health Care Providers who are acting within the scope of their license or certification under applicable state law.

Section 1.41. Plan means this Southwest Health Benefits Plan/SPD, as amended from time to time.

Section 1.42. Preferred Provider Organization (PPO) is a network of Hospitals, Physicians and other Health Care Providers that will, when used, provide a discount on Eligible Charges.

Section 1.43. Prescription Drug means a drug that is purchasable only with a written prescription by a Physician (except for injectable insulin). The term does not include any of the following: (i) medical devices even if purchasable only with a written prescription; (ii) immunization agents; (iii) biological serum; (iv) blood or blood plasma; (v) oxygen (or its administration); (vi) allergens; (vii) syringes or needles; and (viii) infertility medication once infertility is diagnosed.

Section 1.44. Qualified Medical child Support Order or QMCSO means a court order that creates or recognizes the existence of an Alternate Recipient's rights to, or assigns to an Alternate Recipient the right to, receive benefits from this Plan, provided the Medical child Support Order clearly specifies:

A. The name and last known mailing address of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
B. A reasonable description of the type of coverage to be provided by the Plan to each such Alternate Recipient, or the manner in which such type of coverage is to be determined;
C. The period to which such order applies; and
D. The name of the Plan to which such order applies.

The medical child support order must not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of law relating to medical child support pertaining to Medicaid eligible children as described in Section 1908 of the Social Security Act as added by §13623 of OBRA 1993.

Section 1.45. Reasonable and Customary Expenses as applied to Eligible Charges under this Plan means expenses that are: (a) the most consistent expense by an individual Health Care Provider for a given procedure, (b) the usual and reasonable fee for a procedure by the majority of Health Care Providers with similar training and experience within the same locality, and (c) reasonable when it meets the criteria in (a) and (b) or when, in the judgment of the Administrative Manager, it merits special consideration based upon the complexity of treatment. The term "locality" means a county or such greater area that is necessary to obtain a representative cross section of the reasonable expenses.

Section 1.46. Room and Board Charges means all the charges customarily made by a Hospital on its own behalf at a daily rate for room and meals and all general services, supplies, and activities essential for Inpatient care (but not fees for professional services), determined solely by the class of accommodations occupied.

Section 1.47. Self-Payments means contributions to the Plan submitted by you or your spouse to secure continued coverage under the terms of the Plan and/or pursuant to applicable law.

Section 1.48. Subacute Care Facility (sometimes referred to as a specialty Hospital or long term care acute (LTAC) facility) means a public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care (sometimes called Specialty Care or post acute care or long term acute care), that primarily provides, immediately after or instead of acute care, comprehensive Inpatient care for an individual who has had an acute Illness, Injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets all of the following requirements:

A. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
B. It maintains on its premises all facilities necessary for medical care and treatment; and
C. It provides services under the supervision of Physicians; and
D. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
E. It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
F. It is not a hotel or motel.

Section 1.49. Trustees or Board of Trustees means, collectively, the individuals appointed from time to time to serve, and who are serving, in a trustee capacity for the Fund. The Trustees are the "administrator" of the Plan within the meaning of Section 3(16) (A) of ERISA, and the "named fiduciary" within the meaning of Section 402(a) (2) of ERISA.

Section 1.50. Union includes the Heat and Frost Insulators and Allied Workers Local 21 of Dallas and Fort Worth, Texas and Shreveport Louisiana, affiliated with the International Association of Heat and Frost Insulators and Allied Workers, and the International Association of Heat and Frost Insulators and Allied Workers Local 112, Lake Charles, Louisiana and Orange, Texas.

Section 1.51. USERRA means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

ARTICLE II – ELIGIBILITY RULES

Section 2.1. ELIGIBILITY RULES FOR EMPLOYEES

A. General Rule. You will become eligible for coverage when you satisfy the initial eligibility requirements, as described below.

B. Initial Eligibility

1. Eligibility Rules Based on Benefit Quarters through January 31, 2017. For a detailed description of the Quarterly Eligibility Rules, please refer to the Plan provisions in effect prior to January 31, 2017.

2. Eligibility Rules Based on Monthly Eligibility Effective for Benefit Months Beginning February 1, 2017. You will initially become eligible for benefits once you have worked at least 420 hours in Covered Employment in any one, two or three consecutive month period. All hours that you work in Covered Employment after October 1, 2016, up to a maximum of 420 hours, shall be credited to an "Hour Bank" maintained on your behalf. Once you have accumulated 420 hours in your Hour Bank, 140 hours will be deducted for the first month of coverage. In no event shall benefits be payable under the Plan for claims incurred prior to the date coverage begins under the Plan.

C. Continuing Employee Eligibility. After establishing initial eligibility, your continued coverage shall be determined on a monthly basis. You must work 140 hours in Covered Employment during a Work Month to be eligible for the corresponding Benefit Month.

1. Continuing Eligibility Due to Covered Employment. Hours worked each "Work Month" determine your eligibility for the "Benefit Month," which is the second calendar month following the "Work Month" as shown below. There is a lag in time between the last month in which you work and the month in which you are credited with that work.

Work Month	One-Month Lag Period	Benefit Month
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December

November	December	January
December	January	February

2. **Continuing Eligibility Due to Total Disability.** If after you became eligible under the Plan, you are unable to work in Covered Employment because of a Total Disability, you will be credited with 30 hours of Covered Employment for each full week of a certified Total Disability up to a maximum of 390 hours during a 12-month consecutive period. Disability credits will be held in your Hour Bank Account, subject to having the maximum of 420 hours in your Hour Bank at any one time, after deduction of the 140 hours for the current month of coverage.

   To continue Eligibility during Total Disability, you must: (i) notify the Fund Office of your disability; (ii) submit satisfactory proof that you are Totally Disabled to the Board of Trustees; and (iii) remain under the care of a Physician. The Board of Trustees may require subsequent proof of the continued Total Disability and reserves the right to have you examined by a Health Care Provider of the Trustees' choice at any time, at the Plan's expense, to determine the existence or continuation of such Total Disability.

3. **Continuing Eligibility through Hour Bank Deductions.** If you fail to work the required 140 hours in Covered Employment in a Work Month, but have enough hours in your Hour Bank to satisfy the shortfall, the excess hours needed to satisfy the 140-hour minimum when added to the hours that you worked during the Work Month will automatically be withdrawn from your Hour Bank and applied to continue coverage for the corresponding Benefit Month. The hours accumulated in your Hour Bank will continue to be utilized in this manner and withdrawn in each Work Month you fail to work 140 hours in order to continue coverage for the corresponding Benefit Month, until your Hour Bank has been depleted or forfeited.

   You shall be allowed to accumulate up to a maximum of 420 hours in your Hour Bank. Any hours in excess of 420 accumulated in your Hour Bank, including hours credited for a Total Disability shall be forfeited.

   Hour Bank Accounts are merely bookkeeping entries and neither you nor your Dependents have any right to any particular Fund assets or any vested or accrued right to your Hour Bank. The Trustees can modify, reduce or terminate your Hour Bank Account at any time.

4. **Self-Payment Option for Continued Eligibility.** Once you become eligible, if you fail to work the 140 hours required to continue your eligibility, you are permitted to make Self-Payments to continue your coverage. The amount of the Self-Payment is equal to the difference between any hours remaining in your Hour Bank at the end of the Work Month and 140 hours, multiplied by the prevailing

hourly Employer Contribution Rate. This Self-Payment option is limited to a maximum of three consecutive months. The hours applied towards Self-Payment cannot be applied towards your reinstatement. To elect this Self-Pay option, you must: (a) submit a written notice to the Plan's Administrative Manager that you want to Self-Pay and; (b) Self-Pay the needed number of hours to continue eligibility to the Plan before the beginning of the relevant Benefit Month.

D. **Eligibility of Non-Bargaining Unit Participating Employees**. You are a Non-Bargaining Unit Participating Employee if you are not a member of a collective bargaining unit represented by the Union, and are eligible to participate in the Plan pursuant to a Participation Agreement (not a Collective Bargaining Agreement) between your Employer and the Trustees. The applicable eligibility and enrollment requirements for eligible Non-Bargaining Unit Participating Employees is set forth in the Participation Agreement.

Section 2.2. ELIGIBILITY RULES FOR DEPENDENTS

A. **Eligibility and Enrollment**. Your Dependents are eligible for coverage under the Plan, provided you submit to the Fund Office a completed enrollment form and any additional required documentation, such as a marriage license or birth certificate within 60 days of the latest of the following dates: (i) the date your coverage becomes effective, (ii) the date you first acquire the Dependent, or (iii) if applicable, the date specified in a Qualified Medical child Support Order.

If you do not enroll your eligible Dependents within 60 days of the date on which the Dependent first qualifies for coverage, the Dependent will be eligible for coverage on the first day of the month after a completed enrollment form and required documentation is received by the Fund Office.

If your Dependent qualifies for coverage under the Plan in more than one capacity (for example, as a Dependent and Employee, or as a Dependent of more than one Employee), he will be covered under the Plan but only in one capacity (which will be at the higher level of coverage, if there is a difference).

No individual may be covered under this Plan both as an employee and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one Employee.

If, while your family coverage is in effect, any of your Dependent Children becomes eligible for coverage as an Employee, that child will cease to be a Dependent Child, and may enroll for coverage as an Employee. Coverage as a Dependent Child will terminate as of the date coverage as an Employee becomes effective.

B. **Special Enrollment Under HIPAA**. If you do not enroll a Dependent spouse or child(ren) for coverage under this Plan when they first become eligible because they have other group health coverage maintained by an Employer, and the other coverage terminates because of loss of eligibility or because the Employer stops contributing towards the other

coverage, or if the other coverage is COBRA coverage, because the COBRA coverage is exhausted, you may enroll such Dependent(s) for coverage under this Plan effective as of the date the other coverage terminates, provided the Fund Office receives a completed enrollment form and any required documentation for the Dependent(s) within 30 days after the date the other coverage terminates. If you fail to enroll your Dependent(s) during the 30-day special enrollment period, you may still enroll the Dependent(s) at any time. However, your Dependent(s)' coverage will be effective as of the first day for the month following the date the completed enrollment form is received by the Fund Office. These special enrollment rights will be interpreted and administered in accordance with the requirements of the federal law known as "HIPAA."

If you acquire a Dependent by reason of marriage, birth, adoption or placement for adoption, you may enroll the newly acquired Dependent and/or your Dependent spouse, if any, who is not already enrolled in the Plan. You must complete an enrollment form and any required documentation (including but not limited to a marriage license, birth certificates and medical information) for such Dependent(s) within 60 days after the date of the marriage, birth, adoption or placement for adoption. Upon receipt of the completed enrollment documents, your Dependent(s)' coverage will be effective retroactive to the date of the birth, adoption, placement for adoption or marriage. If the Fund Office receives a completed enrollment form and any required documentation more than 60 days after the marriage, birth, adoption or placement for adoption, the Dependent(s)' coverage will be effective as of the actual date of enrollment.

PLEASE NOTE: Your Dependent(s) must notify the Fund Office of all changes in address and family status (e.g., divorce, birth or adoption of a child, or a child no longer qualifying as a Dependent.)

C. **Children's Health Insurance Program (CHIP) Special Enrollment Rights**. If your Dependent (i) is eligible but not covered under this Plan, (ii) has coverage through Medicaid or a State Children's Health Insurance Program ("CHIP"), and (iii) either loses eligibility for coverage through Medicaid or CHIP or becomes eligible for a premium assistance program through Medicaid or CHIP, you will have a 60-day special enrollment period in which to enroll your Dependents in this Plan. To exercise this right, you must send a written request for enrollment with any required documentation to the Fund Office, within 60 days after the loss of Medicaid or CHIP coverage, or the determination of eligibility for the premium assistance program. If your enrollment request is received within this 60-day period, enrollment will be effective no later than the first day of the first calendar month after receipt of your request. If you fail to enroll your Dependent within this 60-day period, the general eligibility and enrollment rules will apply.

D. **Extended Coverage for Totally Disabled Children.** If a Dependent child, when he or she reaches the age limit as outlined in Section 1.17 is covered under the Plan, chiefly depends upon you for support and maintenance and is continuously unable to obtain self-sustaining work due to a physical or mental disability, the child will continue to be

considered an Eligible Dependent until the earlier of the following dates:

1. The date he or she recovers from the disability; or
2. The date he or she no longer chiefly depends upon you for support and maintenance.

You must provide proof of the Dependent child's incapacity to the Fund within 31 days after the date he or she reaches the limiting age.

Section 2.3. TERMINATION OF EMPLOYEE ELIGIBILITY

Your eligibility will terminate on the earliest of the following dates to occur, subject to the right under the Plan, if any, to continue coverage under COBRA:

A. The last day of the first Benefit Month for which you do not have sufficient hours remaining in your Hour Bank Account to satisfy the full required amount;
B. The date the Plan or Fund is terminated or amended to exclude your coverage, or the date there are not enough assets remaining in the Fund to pay benefits under the Plan;
C. The last date for which coverage has been timely paid in full, if coverage is being provided on a Self-Payment basis;
D. The date of your death.

To become covered under the Plan following termination, you must again satisfy the initial eligibility requirements for new Employees.

Section 2.4. NO RETROACTIVE CANCELLATION OF COVERAGE

The Plan will not retroactively cancel coverage, except when Self-Payments are not timely made, or in cases of fraud or intentional misrepresentation of material fact.

Section 2.5. TERMINATION OF DEPENDENT ELIGIBILITY

Your Dependent's eligibility will terminate on the earliest of the following dates to occur, subject to the right, if any, to continue coverage under COBRA:

A. The date your eligibility terminates other than by reason of death;
B. The last day of the month in which the Dependent ceases to qualify as a Dependent, as defined herein;
C. The date specified in a Qualified Medical child Support Order;
D. The date the Plan or Fund is terminated or amended to exclude coverage for the Dependent, or the date there are not enough assets remaining in the Fund to pay benefits under the Plan;
E. The last day of the month in which an Employee's Hour Bank eligibility is exhausted following the death of the Employee; or

F. The date of the Dependent's death.

Section 2.6. REINSTATEMENT OF ELIGIBILITY

A. Reinstatement of Eligibility for Actives. If your coverage ends because you failed to work the minimum hours in Covered Employment and do not have sufficient hours in your Hour Bank to make up for your shortfall, your coverage may be reinstated if during the three months following termination of your coverage, your unused hours in your Hour Bank combined with hours worked in Covered Employment equals at least 140 hours. In such an event, coverage will be reinstated on the first day of the Benefit Month in which you have at least 140 hours in your Hour Bank. After the three month period following termination of coverage, any hours in your Hour Bank will be forfeited. You must then meet the initial eligibility rules to become covered under the Plan again.

B. Dependents. In general, your Dependents will be reinstated at the same time your coverage is reinstated, as long as they continue to qualify as your Dependents.

Section 2.7. RECIPROCITY WITH OTHER PLANS

The Trustees have entered into Reciprocity Agreements with the Trustees of certain other plans in an effort to address the problem of Employees working in the Geographical Jurisdiction of other locals. Under these Agreements, contributions due on your behalf while working under another local's jurisdiction may be transferred from that local's fund to this Plan if you make written request on a proper form. For information regarding other funds that have Agreements with this Plan, contact the Administrative Manager.

If you are eligible under this Plan and work in another jurisdiction that has a signed Agreement with this Plan, you may continue your coverage under this Plan. Persons coming from other jurisdictions to work in the Geographical Area of this Plan and requesting reciprocity will not become eligible under this Plan, but will continue their coverage, if any, under their home Plan.

Reciprocity payments will be credited only after they are received by the Administrative Manager. Until payments have been confirmed to this Plan, you may be required to make timely Self-Payments to continue your eligibility. Self-payments made in excess of the amount required to maintain eligibility for a particular month are refundable to you when reciprocal payments are later received.

ARTICLE III – CONTINUATION COVERAGE RIGHTS UNDER COBRA

Section 3.1. YOUR RIGHT TO CONTINUE COVERAGE

This Plan offers up to 36 months of Continuation Coverage, which includes COBRA Coverage, and, Extended Self-Pay Coverage Rules for Employees. The Sections that follow shall generally apply to both COBRA Coverage and Extended Self-Pay Coverage, unless otherwise indicated.

Your right to COBRA Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Coverage provides continued Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed in Section 3.3. After a Qualifying Event, COBRA Coverage is offered to each person who is a "Qualified Beneficiary." Under the Plan, Qualified Beneficiaries who elect COBRA Coverage must pay the cost of the Continuation Coverage, as described in Section 3.10.

Section 3.2. QUALIFIED BENEFICIARY.

In general, a Qualified Beneficiary can be:

A. You and your Eligible Dependents who were covered by the Plan on the day before the Qualifying Event;

B. A Dependent child who is born to or placed for adoption with you during a period of COBRA Coverage;

C. Any Participant who is covered by the Plan as an Alternate Recipient under a Qualified Medical child Support Order.

If a Qualified Beneficiary on COBRA Coverage acquires a family member who could be enrolled in the Plan if the Qualified Beneficiary were an active Employee, the Qualified Beneficiary may add such family member to his or her COBRA Coverage for the remainder of the coverage period.

In addition, if a Qualified Beneficiary who is Self-Paying for COBRA Coverage has a Dependent who: (1) was eligible but did not enroll in the Plan at the time of the Qualified Beneficiary's initial enrollment because the Dependent had other group health plan or insurance coverage; and (2) lost the other coverage due to exhaustion of COBRA Coverage, loss of eligibility, or termination of Employer Contributions (but not due to a failure to pay timely any required premiums or because of termination of coverage for cause), the Qualified Beneficiary may add that Dependent to his or her COBRA Coverage, for the remainder of the coverage period, within 30 days after termination of the Dependent's other coverage, pursuant to Section 2.2(B), Special Enrollment, of this Plan.

Section 3.3. QUALIFYING EVENTS

A Qualifying Event is any of the following events that causes a loss of coverage under the Plan.

A. As an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan as a result of one of the following Qualifying Events:

    1. You do not work the required number of hours in Covered Employment to maintain coverage under the Plan; or
    2. Your Covered Employment ends for any reason, including retirement, other than

your gross misconduct;

B. Your Dependent(s) will become a Qualified Beneficiary if he or she loses coverage under the Plan as a result of one of the following Qualifying Events:

1. Your death;

2. You do not work the required number of hours in Covered Employment to maintain coverage under the Plan;

3. Your Covered Employment ends for any reason, including retirement or your work in Covered Employment, other than your gross misconduct;

4. You and your spouse divorce; or

5. For your Dependent children, the child stops being eligible for coverage under the Plan as a Dependent (for example, the child reaches the maximum age for dependency under this Plan).

Section 3.4. COBRA COVERAGE ELECTION PERIOD

You or your Qualified Beneficiary must elect COBRA Coverage within the 60-day Election Period in order to have your coverage continued.

The Election Period begins on the date you or your Qualified Beneficiary loses coverage on account of the Qualifying Event, and ends 60 days after the date you or your Qualified Beneficiary loses coverage on account of the Qualifying Event, or if later, the date notice is provided to you or your Qualified Beneficiary of the right to elect COBRA Coverage. If coverage is not elected within the 60-day Election Period, all rights to elect COBRA Coverage and, if applicable, any Extended Self-Pay Coverage thereafter, are forfeited.

Section 3.5. NOTIFICATION OF QUALIFYING EVENT

The Plan will offer COBRA Coverage to you and your Qualified Beneficiaries only after the Fund Office has been timely notified that a Qualifying Event has occurred. You or your Dependent must notify the Fund Office in writing no later than 60 days after the following Qualifying Events:

A. Your divorce;

B. Your Dependent child ceasing to be eligible for coverage under the Plan as a Dependent.

Failure to provide the proper notice within the required time frames described below may prevent you or your Dependents from obtaining COBRA Coverage.

The Fund Office will notify you and/or your Dependents of the right to COBRA Coverage within 30 days following the date coverage ends when the Qualifying Event is:

A. The termination of your employment, for any other reason other than for gross misconduct, including reduction of hours of employment; or

B. Your death.

Notice given to you or your spouse will be deemed to be notice to all affected Dependent children living with you or your spouse.

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the fund office listed below, at the following address:

Administrative Manager
Benefit Resources, Inc.
8441 Gulf Freeway, Suite 304
Houston, Texas 77017
Fax: (866) 316-4794

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state: the name and address of the Employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event, and the date it happened. If the Qualifying Event is a divorce, your notice must include a certified copy of the divorce decree.

Notice may be provided by you, your Dependent, or any representative acting on behalf of you or your Dependent. Notice from one individual will satisfy the notice requirement for all individuals affected by the same Qualifying Event.

Once the Fund Office receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Coverage. You may elect COBRA Coverage on behalf of your spouse and your Eligible Dependents.

For each Qualified Beneficiary who elects COBRA Coverage, COBRA Coverage will begin on the date that Plan coverage would otherwise have been lost, after all accumulated eligibility based on hours worked in Covered Employment has been exhausted.

If you, your spouse or Dependent children do not elect COBRA Coverage within the 60-day election period described above, the right to elect COBRA Coverage will be lost.

Section 3.6. MAXIMUM COVERAGE PERIOD FOR CONTINUED COVERAGE

COBRA Coverage is a temporary continuation of coverage. The COBRA Coverage periods described below are maximum periods of coverage. COBRA Coverage can end earlier than the maximum period of coverage for several reasons, as described under 3.9 of this Article, "Early Termination of COBRA Coverage before the Maximum Coverage Period Ends."

A. **COBRA Coverage for Termination of Employment or Reduction of Hours Qualifying Event.** When Plan coverage is lost due to the end of employment or reduction of the Employee's hours of employment, COBRA Coverage can last for up to a total of 18 months.

B. **COBRA Coverage if the Covered Employee Becomes Entitled to Medicare.** Under a special COBRA rule, if Plan coverage is lost due to a termination of employment or reduction of hours of employment and the Employee became entitled to Medicare benefits within 18 months before such Qualifying Event, COBRA Coverage for Qualified Beneficiaries (other than the Employee) who lose coverage as a result of the Qualifying Event, can continue for the longer of (i) 36 months from the date the Employee first became entitled to Medicare benefits, or (ii) 18 months from the termination of employment or reduction of hours Qualifying Event.

For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA Coverage for his Dependents who lose coverage as a result of his termination can last for up to 36 months after the date of Medicare entitlement. This equals 28 months of COBRA Coverage after the Qualifying Event (36 months minus eight (8) months). This special rule applies only if the covered Employee becomes entitled to Medicare within 18 months BEFORE the termination of employment or reduction of hours Qualifying Event.

C. **COBRA Coverage for Death, Divorce, Legal Separation or Loss of Dependent Status.** When Plan coverage is lost due to the covered Employee's death, divorce or legal separation, or a Dependent child losing Dependent child status, COBRA Coverage can continue for up to a total of 36 months.

D. **Disability Extension of COBRA Coverage**. If you or any of your Eligible Dependents are entitled to COBRA Coverage for an 18-month period, that COBRA period can be extended for a Participant who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of up to 29 months), provided all of the following conditions are satisfied:

1. the disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage;

2. the disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration; and

3. the Fund Office is notified in writing of the date of disability and the names of the Qualified Beneficiaries for whom a disability extension is requested, and is provided a copy of the disability determination within 60 days after issuance of the disability determination AND before the 18-month COBRA Coverage period ends.

This extended period of COBRA Coverage for disability will end at the earlier of:

1. the last day of the month that contains the 30th day after the Social Security Administration has determined that the formerly disabled individual is no longer disabled; or

2. the end of 29 months from the date of the COBRA Qualifying Event.

If the Social Security Administration issues a determination before the end of the 11-month extension that you or the Qualified Beneficiary are no longer disabled, the Qualified Beneficiaries receiving the extended coverage must provide the Fund Office with written notice of the termination of disability, the date it occurred, the names of the affected Qualified Beneficiaries and a copy of the determination, within 30 days after issuance.

Notice given by any one of the Qualified Beneficiaries or by any other individual on their behalf will satisfy the notice obligation of all such individuals. A form that may be used for giving notice of a determination of disability or termination of disability is available from the Fund Office upon request. Notice may be given by mailing or hand delivering a completed and signed form to the Fund Office no later than the due date. Alternatively, written notice of the required information may be provided in any other legible form, provided it is mailed or hand delivered to the Fund Office no later than the due date. Notice will be treated as having been given on the postmark date if mailed, or on the date received at the Fund Office, if hand delivered. Notice given in any other manner will not be effective notice to the Plan.

Section 3.7. EXTENDED SELF-PAY

If, during the 18-month period of COBRA Coverage, another Qualifying Event occurs by reason of your death, divorce, your becoming entitled to Medicare, or a Dependent child ceasing to qualify as a Dependent child under the Plan, your Dependents who are Qualified Beneficiaries may be eligible to elect to Self-Pay up to 18 additional months of COBRA Coverage, for a maximum of 36 months from the date coverage initially terminated.

This extended period of COBRA Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Coverage is available to any child(ren) born to, adopted by, or placed for adoption with

you (the active Employee) during the 18-month period of COBRA Coverage.

You must submit written notice of the second Qualifying Event to the Fund Office within 60 days after it occurs. This extension is available only if the event would have caused your Dependents to lose coverage under the Plan had the first Qualifying Event not occurred. A form that may be used for giving notice of a second Qualifying Event is available from the Fund Office upon request. Notice may be given by mailing or hand delivering a completed and signed form to the Fund Office no later than the due date. Alternatively, written notice of the required information may be provided in any other legible form, provided it is mailed or hand delivered to the Fund Office no later than the due date. Notice will be treated as having been given on the postmark date if mailed, or on the date received at the Fund Office if hand delivered. Notice given in any other manner will not be effective notice to the Plan.

Section 3.8. EXTENDED SELF-PAY COVERAGE RULES FOR EMPLOYEES

Upon expiration of the initial 18 months of COBRA Coverage for Qualifying Events in Section 3.3 (A), you and your Dependents will automatically qualify for an additional 18 months of Continuation Coverage on a Self-Payment basis.

This Extended Self-Pay Coverage will include the same benefits that you and your Dependents had under the COBRA Coverage provisions.

Section 3.9. TERMINATION OF COBRA COVERAGE

Early Termination of COBRA Coverage before the Maximum Coverage Period Ends. COBRA Coverage will automatically terminate before the end of the maximum 18, 29 or 36-month periods, upon the earliest of any of the following:

A. the first day of the period for which a required Self-Payment is not paid in full on time (if the failure to pay timely relates to the first Self-Payment, COBRA coverage will not take effect); or

B. the date, after electing COBRA coverage, on which a Qualified Beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both), or first becomes covered under another group health plan; or

C. the date the Plan terminates, and the Employer and Employee organization cease to provide any group health plan for Employees, as permitted under COBRA; and

D. during an 11-month disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to be no longer Totally Disabled, as described under the subsection entitled “Disability Extension of COBRA Coverage” (in this case, COBRA Coverage for all Qualified Beneficiaries, not just the disabled Qualified Beneficiary, will terminate).

NOTE: COBRA Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving COBRA Coverage.

You must notify the Fund Office in writing within 30 days after a Qualified Beneficiary first becomes entitled to Medicare (Part A, Part B or both) or first becomes covered under other group health plan coverage, after electing COBRA Coverage. The Plan will provide a written notice of termination to each Qualified Beneficiary whose COBRA Coverage terminates before the end of the maximum coverage period.

Section 3.10. COSTS AND PAYMENT FOR COBRA COVERAGE

A. **Cost of COBRA Coverage**. The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or in the case of an extension of COBRA Coverage due to a disability 150%) of the cost to the Plan for coverage of a similarly situated Plan Participant or Beneficiary who is not receiving COBRA Coverage. The Trustees will determine the amount of the required COBRA Coverage Self-Payment. The amount may change from time to time during the period of COBRA Coverage and will most likely increase over time. You will be notified of any changes in the required Self-Payment amount. If a COBRA Self-Payment is not paid in full within the grace period, eligibility for COBRA Coverage will end and cannot be reinstated.

B. **For first three months of COBRA, cost will be based on Formula**. If you lose eligibility and elect to continue coverage under COBRA, the amount you are required to contribute during the first three months of COBRA coverage is based on the following formula:

Cost to continue COBRA Coverage for each of the first three months	Equals	Applicable Monthly COBRA Premium Rate	Minus	Contributions for hours worked in the immediately preceding Eligibility Month divided by three months

Thereafter, the Employee must Self-Pay the full monthly COBRA premium rate to continue coverage.

C. **Payment for COBRA Coverage**. Your first Self-Payment must cover the cost of COBRA Coverage from the date your Plan coverage would have otherwise terminated through the end of the month before the month in which you make your first payment. For example, if your coverage under the Plan terminates on September 30, and you elect COBRA Coverage on November 15, your initial Self-Payment is due on or before December 30 (the 45th day after the date of your COBRA Coverage election). If you make your first Self-Payment in December, it must equal the amount due for October and November. You are responsible for making sure that the amount of your first Self-Payment is correct.

You may contact the Fund Office to confirm the correct amount of your first Self-Payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA Coverage and made the first Self-Payment. **If you do not make your first Self-Payment for COBRA Coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

1. **How Self-Payments Must Be Made.** All COBRA Coverage Self-Payments must be paid by check. Your first payment and all monthly payments must be mailed or hand-delivered to the Fund Office at the address specified in the Election Notice provided to you at the time of your Qualifying Event, or to any new address of which you are subsequently notified by the Plan.

2. **When Self-Payments Are Considered To Be Made**. If mailed, your Self-Payment is considered to have been made on the date it is postmarked. If hand-delivered, your Self-Payment is considered to have been made on the date it is received at the Fund Office. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

3. **First Self-Payment for COBRA Coverage.** You must make your first Self-Payment for COBRA Coverage no later than 45 days after the date of your election (this is the date your Election Form is postmarked, if mailed, or received by the Fund Office, if hand-delivered).

4. **Monthly Payments for COBRA Coverage**. You are required to make monthly Self-Payments for each subsequent month of COBRA Coverage. The amount due for each month for each Qualified Beneficiary will be set forth in the Election Notice provided to you at the time of your Qualifying Event. Each of these monthly Self-Payments is due on the first day of the month for that month's coverage. If you make a monthly Self-Payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. ***The Plan will not send you bills or notices of Self-Payments due for the coverage periods. It is your responsibility to pay your COBRA Self-Payments on time.***

5. **Grace Periods for Monthly COBRA Coverage Self-Payments**. Although monthly Self-Payments are due on the first day of each month of coverage, you will be given a grace period of 30 days after the first day of each month to make the monthly Self-Payment. Your COBRA Coverage will be provided for each month as long as payment for that month is made before the end of the grace period. However, if you make a Self-Payment later than the first day of the month to which it applies but before the end of the grace period, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated

(going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly Self-Payment in full before the end of the grace period for the month, you will lose all rights to COBRA Coverage under the Plan.

Section 3.11. NOTICE REQUIREMENTS

A. **Required Notice from Plan**. When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the covered Employee, the Plan will offer COBRA Coverage to the Qualified Beneficiaries. You do not have to notify the Plan of any of these Qualifying Events.

B. **Required Notice from Employees and Dependents**. When the Qualifying Event is divorce or legal separation of the Employee and Dependent spouse, or a Dependent child losing eligibility for coverage as a Dependent child, a COBRA Coverage election will be available to you only if you notify the Fund Office in writing, within 60 days after the later of (i) the date of the Qualifying Event, or (ii) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

The notice must include your name, the Qualified Beneficiary's name, the type of Qualifying Event, the date it occurred, and, if applicable, a copy of the divorce decree or written proof of legal separation. If you do not provide this required notice to the Fund Office during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE.**

If you provide the required notice of the Qualifying Event to the Fund Office in a timely manner, the Fund Office will notify you and all Qualified Beneficiaries, within 30 days after receiving the required notice, of your right to elect COBRA Coverage. Any notice that is given to you or your Dependent spouse will be treated as having been given to all affected Dependent children who live with you or your Dependent spouse.

The Employee or former Employee who is or was covered under the Plan, a Qualified Beneficiary who lost coverage due to the Qualifying Event described in the notice, or a representative acting on behalf of either, may provide the required notice. A notice provided by any of these individuals will satisfy the responsibility to provide notice on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying Event described in the notice.

C. **Financial Responsibility for Failure to Give the Required Notice**. If the Fund Office does not receive the required notice of the Qualifying Event in a timely manner, and the Fund pays a claim in error after coverage should have terminated due to the Qualifying Event, you will be obligated to reimburse the Fund for the claim paid in error. If you fail to do so,

the Fund may deduct the amount that is owed from other benefits that are payable for you or your Dependent.

D. **Notice of Unavailability of COBRA Coverage**. If you provide notice to the Fund Office of a Qualifying Event, but are not entitled to COBRA Coverage, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA Coverage. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

E. **Notice of Termination of COBRA Coverage**. If COBRA Coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the Fund Office's determination that COBRA Coverage will terminate. The Notice will set out why COBRA Coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Section 3.12. KEEP THE FUND INFORMED OF ADDRESS CHANGES

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

Section 3.13. QUESTIONS

Questions concerning this Plan, your COBRA Coverage rights or the Extended Self-Pay rules should be addressed to the Fund Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ARTICLE IV – FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you are covered under the Plan and eligible for Family and Medical Leave (FMLA leave) in accordance with the Family and Medical Leave Act of 1993 ("FMLA"), you are entitled to continue the Fund's health care coverage during the period of FMLA Leave to the extent required under FMLA.

In accordance with FMLA, *your Employer* must: (1) certify to the Fund that the Employer is subject to the FMLA requirements and that you are eligible for FMLA Leave; (2) timely notify the Fund of the type and duration of FMLA Leave you have requested; and (3) timely furnish the Fund with the necessary information to support your eligibility for FMLA Leave. In addition, *you* must timely notify the Fund of the type and duration of FMLA Leave requested, and must timely furnish the necessary information to support your eligibility for FMLA Leave.

During your FMLA Leave, the Fund will waive your Employer's obligation to contribute on your behalf for the period of FMLA Leave. The Fund shall assume the financial obligation of coverage and shall monitor the costs associated with this coverage. The Trustees in their sole discretion shall determine if this coverage will continue without the payment of contributions.

If you return to Covered Employment immediately following termination of FMLA Leave, you will continue eligibility as if your work in Covered Employment had continued without interruption.

While on FMLA Leave, you will be eligible to continue the same benefits as immediately before the FMLA Leave for yourself and your Eligible Dependents, subject to any Plan changes that may occur during the FMLA Leave.

ARTICLE V – QUALIFIED MILITARY SERVICE LEAVE OF ABSENCE (USERRA)

If you take a leave of absence for Qualified Military Service that is protected under the federal law known as "USERRA" (the Uniformed Services Employment and Re-Employment Rights Act of 1994), any service you have earned and any contributions credited to your benefit for initial or continuing eligibility will be kept on the Fund's records and protected during such absence. "Qualified Military Service" may include such service as active or inactive duty training or active duty in the United States Armed Forces or National Guard. For example, if you take a leave of absence for Qualified Military Service, are honorably discharged and return to Covered Employment within a certain time period, your pre-leave credited service, and coverage under the Plan (if you are covered when your leave began), will be reinstated upon your return without a waiting period or exclusions.

If you and your Dependents have coverage when your Qualified Military Service leave begins, you may continue such coverage for up to 24 months while you are performing Qualified Military Service. If your leave of absence is no longer than 30 days, this continued coverage will be provided on the same terms that were in effect before the leave began, which means there is no charge (unless you were required to Self-Pay before the leave began). If your leave is longer than 30 days, the right to continue coverage will be provided in the same way as COBRA Coverage. This means that you must make a timely election to continue coverage and make the required Self-Payments within the COBRA time periods. The continued coverage that is provided in satisfaction of your rights under USERRA will also apply to satisfy your rights under COBRA (i.e., they will run at the same time). See Article III, Section 3.1 "Continuation Coverage Rights Under COBRA" for a full explanation of COBRA.

Medical coverage under this Plan will be coordinated with any medical coverage provided to military personnel and their Dependents under TRICARE in a manner that complies with the law.

When you are discharged (honorably or with a protected status), you must return to Covered Employment in accordance with the following time periods in order to be protected under USERRA and have the rights described in this Section:

A. Within 90 days from the date of discharge for military service of more than 180 days;
B. Within 14 days from the date of discharge for military service of more than 30 days but less than 180 days; and
C. By the beginning of the first full regularly scheduled work period beginning after military service ends (plus travel time and an additional eight hours) if military service is 30 days or less.

If your Qualified Military Service consisted solely of a physical or medical examination to verify fitness, you must return to Covered Employment by the beginning of the next regular work period.

If you are hospitalized for or recovering from an Illness or Injury incurred during Qualified Military Service, these time periods will be extended for a recovery of up to two years.

If you have questions about taking military leave, please speak directly with your Employer. If you have questions about how a leave of absence will affect your coverage under the Plan, please contact the Fund Office. Your USERRA rights are subject to change as the law changes, and Plan coverage will be provided only as required by law. If you leave employment for military service, you should notify your Employer and the Fund Office as soon as possible to ensure protection of your USERRA rights.

ARTICLE VI – COMPREHENSIVE MEDICAL BENEFITS - COVERED EXPENSES

Section 6.1. WHAT THE PLAN PAYS FOR

The Plan helps you and your Dependents pay for Covered Expenses incurred for medical care, services, and supplies, as described in this Article. These benefits are self-insured by the Fund. An expense is incurred on the date the service or supply for which it is charged is furnished.

Section 6.2. THE CALENDAR YEAR DEDUCTIBLE

The "Calendar Year Deductible" is the amount of Covered Expenses, as shown in the Schedule of Benefits, that you and each of your Eligible Dependents must first incur and pay out-of-pocket during a Calendar Year, before your Covered Expenses that are incurred during the remainder of the Calendar Year are payable under the Plan. A separate Calendar Year Deductible will apply to you and to each of your Dependents.

Section 6.3. COPAYMENT PERCENTAGE, NETWORK PROVIDERS AND OUT-OF-POCKET LIMIT

A. **Copayment**: "Copayment" under this Plan means a sharing of Allowable Charges for Covered Services between the Plan and you. The sharing is expressed in the Schedule of Benefits as the percentage of an Allowable Charge that is payable by the Plan, after any deductible amount is satisfied. There are different copayment percentages for different categories of charges. If the percentage is less than 100%, the remaining percentage of the Allowable Charge is your responsibility. For example, if the applicable copayment

percentage is 85%, the benefits payable by the Plan will be based on 85% of the Allowable Charge (after any applicable deductible is satisfied). The remaining 15% of the Allowable Charge (and any deductible) is your responsibility. The benefits payable under the Plan will also be subject to any other exclusions or limitations that apply, as described in this SPD/Plan.

B. **Network Providers**: The Trustees may contract from time to time with a Preferred Provider Organization ("PPO"), to offer you and your Dependents discounted rates if you use a participating Hospital, Physician or other medical provider, described as a "Network Provider." Any other provider is described as a "Non-Network Provider." The copayment percentage payable by the Plan is higher if you use a Network Provider. A list of the providers participating in the Network will be furnished to you automatically, without charge, separately from this SPD/Plan. You may also locate a Network Provider by contacting the Administrative Manager at (713) 643-9300.

C. **Out-of-Pocket Limit**: The Plan has an "Out-of-Pocket Limit," as set forth in the Schedule of Benefits, which affects the copayment percentage that is payable. The "Out-of-Pocket Limit" is the maximum amount of out-of-pocket Covered Expenses that you are responsible for paying during a Calendar Year (in addition to the Calendar Year Deductible), before the copayment percentage for that Participant increases to 100% for the remainder of the Calendar Year.

For example, if you satisfy your Calendar Year Deductible and Out-of-Pocket Limit for a Calendar Year, any Allowable Charges incurred by you for the remainder of that Calendar Year will be subject to a 100% copayment percentage payable by the Plan.

There is also an Out-of-Pocket Limit per family for a Calendar Year as set forth in the Schedule of Benefits. Once you and your covered Dependents collectively satisfy the family Out-of-Pocket Limit for a Calendar Year, any Allowable Charges incurred by you or a covered Dependent during the remainder of the Calendar Year will be subject to a 100% copayment percentage payable by the Plan, provided that individual has satisfied the Calendar Year Deductible.

Expenses that are not covered by the Plan or that exceed the Allowable Charge will not be credited toward satisfaction of the Out-of-Pocket Limit. The types of expenses that may be used to satisfy the Calendar Year Deductible are the same types of expenses that may be used to satisfy the Out-of-Pocket Limit.

Section 6.4. UTILIZATION MANAGEMENT PROGRAM

The Plan has adopted a Utilization Management Program designed to help control increasing health care costs by avoiding: (i) unnecessary services; and (ii) high-cost services when there is a less costly option that can achieve the same or better result. If you follow the procedures of the

Plan's Utilization Management Program, you may avoid penalties for noncompliance that result in a benefit reduction.

The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company operating under a contract with the Plan (hereafter referred to as the "UM Company"). The name, address, and telephone number of the UM Company is shown in the Quick Reference Chart at the beginning of this document.

The Plan's Utilization Management Program consists of:

A. Precertification Review

Precertification Review is a procedure administered by the UM Company before services are rendered to assure that the proposed health care services meet or exceed accepted standards of care, and that admissions and lengths of stay in health care facilities are Medically Necessary. The following services must be precertified (pre-approved) by the UM Company BEFORE the services are provided:

1. All Hospital admissions, including partial Hospitalizations for mental health treatment (Note: for pregnant women, precertification is required only for Hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a cesarean section);
2. All admissions to a Skilled Nursing Facility, Subacute Care Facility, Hospice or other facility; and
3. All Home Health Care Services.

You or your Health Care Provider must call the UM Company at the telephone number shown in the Quick Reference Chart at the beginning of this document to request Precertification Review. Calls for elective services should be made prior to the expected date of service.

The UM Company will review the information provided and will let you, your Health Care Provider, the Hospital and the Fund Office know whether the proposed services have been certified as Medically Necessary.

B. Admission Certification Review

Admission Certification Review is a procedure administered by the UM Company to assure that Emergency Hospital admissions meet or exceed accepted standards of care and that admissions and lengths of stay are Medically Necessary. If you require Emergency Hospitalization and there is no time to contact the UM Company before you are admitted, the UM Company must be notified of the Hospital admission within 48 hours after admission.

You, your Health Care Provider, the Hospital, a family member or a friend can notify the UM Company. This will enable the UM Company to: (i) assist with discharge plans; (ii) determine the

need for continued medical services; and (iii) advise your Health Care Providers of any recommendations, options or alternatives for your medical care.

You or your Health Care Provider must call the UM Company at the telephone number shown in the Quick Reference Chart at the beginning of this document to request Admission Certification Review. **Calls for Emergency Hospital admissions must be made within 48 hours of the Emergency admission.**

The UM Company will review the information provided, and will let you, your Health Care Provider and the Hospital, and the Fund Office know whether the health care services have been certified as Medically Necessary.

1. Noncompliance Penalties for Failing to Request Precertification Review

If you fail to request Precertification Review in accordance with the above procedures and time frames, you will incur a penalty of 10% of Eligible Charges. That is, Eligible Charges for the following services will be reduced by 10% unless Precertification Review is received prior to the date of the admission/treatment: (i) Inpatient Hospital admissions; (ii) admissions to a Skilled Nursing Facility, Subacute Care Facility, Hospice or other facility; and (iii) Home Health Care Services.

2. Noncompliance Penalties for Failing to Request Admission Certification Review

If you fail to request Admission Certification Review in accordance with the above procedures and time frames, you will incur a penalty of 10%. That is, Eligible Charges for Emergency Hospital admissions will be reduced by 10% unless Admission Certification Review is received within 48 hours after the date of admission.

C. Continued Stay Review

Continued Stay Review is the ongoing assessment of the health care as it is being provided, especially, but not limited to continued duration of health care services in a Hospital, Skilled Nursing Facility, Subacute Care Facility, Hospice or other facility:

1. When you are receiving medical services in a Hospital or other Inpatient health care facility, the UM Company will monitor your stay by contacting your Health Care Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

2. Continued Stay Review may include such services as coordinating Home Health Care or Durable Medical Equipment, assisting with discharge plans, determining the need for continued medical services, and advising your Health Care Providers of various options and alternatives for your medical care available under this Plan.

3. If at any point your treatment is found not to be Medically Necessary or if it is determined that care could be safely and effectively delivered in another environment, such as through Home Health Care or in another type of health care facility, you and your Health Care Provider will be notified. This does not mean that you must leave the Hospital or stop receiving treatment. However, if you choose to stay or continue treatment, all expenses Incurred after the notification will be your responsibility. If it is determined that your Hospital stay or services were not Medically Necessary, no benefits will be paid in connection with any related Hospital, medical or surgical expense.

D. Restrictions and Limitations of the Utilization Management Program

1. The fact that your Health Care Provider recommends surgery, Hospitalization, or confinement in a health care facility, or that your Health Care Provider proposes or provides any other medical services or supplies does not mean that the recommended services or supplies will be considered Eligible Charges or be considered Medically Necessary for determining coverage under the Plan.

2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a treatment or service is Medically Necessary does not mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan, either in whole or in part.

3. **All treatment decisions rest with you and your Health Care Provider.** You should follow whatever course of treatment you and your Health Care Provider believe to be the most appropriate, even if the UM Company does not consider the treatment Medically Necessary or as an Eligible Charge. However, the benefits payable by the Plan may be affected by the determination of the UM Company.

Section 6.5. COVERED EXPENSES FOR COMPREHENSIVE MEDICAL BENEFITS

The following medical services and supplies are considered Covered Expenses for which comprehensive medical benefits may be payable. Covered Expenses must be Medically Necessary and must not exceed the Allowable Charge. Covered Expenses are subject to all the limitations and exclusions and other applicable terms and conditions of the Plan.

A. Hospital Benefits. Covered Expenses incurred during a Hospital stay include: Room and Board Charges for a semi-private room; confinement in an intensive care or coronary care room; medication ordered by a Physician; Physician visits; and charges for radiology, pathology, x-ray exams, and lab tests.

Covered Expenses for services rendered by a Hospital on an Outpatient basis include: pre-admission testing that is performed within seven days immediately preceding Hospital confinement, treatment of a Medical Emergency; chemotherapy, inhalation therapy, or radiation therapy ordered by a Physician, which is regularly scheduled at a Hospital Outpatient facility; and non-emergency surgery ordered by a Physician.

B. **Ambulatory Surgical Facility Benefits.** Covered Expenses for surgery performed at an ambulatory surgical facility include: services and supplies rendered by the ambulatory surgical facility; and Physician's charges for services rendered while you are at the facility for x-rays and lab tests, and for radiology and pathology.

C. **Outpatient X-Ray and Lab Benefits.** Covered Expenses include the following x-ray and diagnostic laboratory procedures performed while you are not confined to a Hospital: non-routine Pap smears and mammograms; charges for radiology and pathology to interpret the tests or studies; and x-ray, radium, and radioactive isotope therapy.

D. **Surgery Benefits**. Covered Expenses include: Physicians' surgery charges, including post-operative care; charges for the administration of anesthesia; charges for heart valve replacement, and implantable prosthetic lenses for cataracts, prosthetic bypass or replacement vessels.

Covered Expenses for oral surgery are limited to the following procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when the conditions require a pathological exam;
2. Surgery required to correct accidental Injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. Reduction of fractures and dislocation of the jaw;
4. External incision and drainage of cellulitis;
5. Incision of accessory sinuses, salivary glands or ducts; and
6. Frenectomy (cutting the midline tongue tissue).

Covered surgery Expenses include charges incurred for a second surgical opinion. If the second opinion differs from original Physician's opinion, then charges for a third opinion are also covered. The Physician providing the second (or third) opinion must be a specialist with respect to the patient's condition, must not be financially associated with the original Physician, and must not be the Physician that performs the surgery.

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the Reasonable and Customary Expense for the primary procedure and 50% of the Reasonable and Customary Expense for subsequent procedures if such procedures had been performed independently. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

E. **Organ and Tissue Transplant Benefits.** Covered Expenses include the following types of organ and tissue transplants, provided they are not Experimental or Investigational: cornea, kidney, liver, pancreas, kidney/pancreas, heart, lung, heart/lung, allogeneic bone marrow, autologous bone marrow, and stem cell. Covered Expenses payable for organ and tissue transplant services include evaluation, pre-testing, Physician fees, and Hospital charges.

Donor-related medical services are payable, but only for the donor who is selected for the organ or tissue transplant. These services include costs to procure and transport the organ or tissue to the transplant site. Procurement includes the cost of surgery for a living donor who has no available medical insurance or coverage for the surgery.

Covered Expenses do not include: transplant of any organ or tissue not listed above; transplant of an animal organ; an artificial organ (this does not include a mechanical or similar device to assist a human organ function); or any transplant services for an Covered Person as the selected organ donor if the recipient is not a Covered Person under the Plan.

F. **Ambulance Benefits.** Covered Expenses include emergency transportation to the nearest Hospital by a professional ambulance service, including air ambulance. When an Injury or Sickness requires special care not available at a local Hospital, Covered Expenses include ambulance transfer to the nearest Hospital that can provide the care.

G. **Skilled Nursing Facility Benefits.** Covered Skilled Nursing Facility services include Room Charges and Board and skilled nursing care, provided the patient meets each of the following requirements:

1. Confinement in the skilled nursing facility must begin within seven days immediately following Hospital confinement of at least five consecutive days.
2. The eligible individual's condition must require skilled nursing care.
3. A Physician must certify the skilled nursing facility confinement.
4. The eligible individual must remain under a Physician's care while confined.

H. **Home Health Care Benefits**. The Plan provides benefits for home health care, provided the eligible individual meets each of the following requirements:

1. Care must begin within fourteen days after discharge from a Hospital or skilled nursing facility.
2. A Physician must certify the care instead of a Hospital or skilled nursing facility confinement.
3. The skilled home health care services and supplies must be rendered by a licensed provider who is not a family member, and provided on a part-time basis under an established home health care plan.

I. **Hospice Care Benefits.** The Plan provides hospice care benefits when services are provided in lieu of all other care to treat a terminal Sickness. A "terminal Sickness" is a Sickness

with which the eligible individual has six months or less to live. The facility or agency providing care must be licensed on its own or as part of another facility and operate under the direction of a Physician. It must meet standards of the National Hospice Organization.

Hospice care must be furnished in a licensed facility or in the eligible individual's home and certified by a Physician. The care must be agreed upon in writing by the Physician and the facility or agency providing the care, and must meet the eligible individual's medical and social needs.

Covered Expenses include: Room and Board Charges at a hospice facility; services and supplies at a facility or in the eligible individual's home; part-time nursing care and home health aide services up to eight (8) hours a day; consultation and case management services by a Physician; physical therapy; medical supplies; and prescribed drugs and medicines.

Covered Expenses do not include: private or special duty nursing; care other than for pain control or to manage acute or chronic symptoms; funeral arrangements; financial or legal counseling; companion, homemaker or housekeeping services; volunteer services that are otherwise free; or counseling by a church pastor or minister.

J. **Breast Reconstruction Benefits.** In the case of an eligible individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, Covered Expenses include:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications at all stages of the mastectomy, including lymphedemas.

In accordance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), coverage will be provided in a manner determined in consultation with the attending Physician and the patient. Such coverage will be subject to annual deductibles and coinsurance provisions as are consistent with those established for other benefits under the Plan.

K. **Maternity Benefits.** Covered Expenses are payable for normal pregnancy and resulting childbirth for a covered Employee or the Employee's covered spouse. Dependent children are covered for certain pre-natal care and certain preventive services benefits. Covered Expenses are payable on the same basis as any other Illness, according to guidelines established by the American College of Obstetricians and Gynecologists or any other established professional medical association.

Complications of pregnancy, delivery by Cesarean section, and voluntary sterilization procedures for the covered Employee or the Employee's covered spouse are also considered Covered Expenses.

For purposes of this benefit, services may be rendered by a Physician, a nurse midwife or a Physician's assistant, provided he or she: is licensed under applicable state law to provide maternity care; is directly responsible for providing maternity care to the mother, and actually provides the care.

Benefits include Covered Expenses incurred at a birthing center. A birthing center is defined as a licensed, free-standing facility that provides pre-natal care, delivery and immediate postpartum care and care of the child born at the facility. Charges incurred after confinement in the birthing center are payable in full, not subject to any deductible, coinsurance or copayments.

The Plan will not, as required under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan will not require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery occurs outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital for the birth.

L. **Newborn Benefits - Well Baby Care.** Covered Expenses for newborn well baby care are payable on the same basis as any covered Sickness, according to guidelines established by the American Academy of Pediatrics or any other established professional medical association, and include: charges for Hospital nursery Room and Board; miscellaneous services and supplies provided and billed by the Hospital on its own behalf; Physician charges for circumcision; and Physician charges for initial routine exam of the child before discharge from the Hospital. The above Covered Expenses for well-baby care are payable even if the child is not an eligible individual. For other Covered Expenses, the child must be enrolled as an eligible individual for Dependent coverage.

M. **Newborn Benefits - Sick Baby Care.** A newborn is covered for the first 31 days from birth for sick baby care, which includes charges for Injury and Sickness, and care to treat diagnosed birth defects, congenital anomalies, and abnormalities. In order for benefits to be provided beyond the 31 days, the child must be enrolled as an eligible individual for Dependent coverage.

N. **Mental Health Benefits.** Mental health benefits are payable under the Plan for the treatment of Psychiatric Conditions. The term "Psychiatric Condition" means a

Sickness classified as a psychiatric condition in the most current edition of the International Classification of Diseases, or in the most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. For purposes of this benefit, a Psychiatric Condition also includes anorexia nervosa and bulimia, schizophrenia and depressive disorders, including but not limited to, manic depression. Psychiatric Condition does not include addiction or abuse of any drug, chemical or substance.

Covered Expenses for the treatment of Psychiatric Conditions include: Hospital Room and Board Charges, services and supplies; Physician's charges; services of a masters level psychologist, R.N., or social worker who is licensed in the state in which they are practicing and provide services under the direction or supervision of a Physician; treatment in a licensed facility other than a Hospital operating primarily for treatment of Psychiatric Conditions; and drugs and medicines that by law require a written prescription from a Physician. Coverage is also provided for a residential treatment facility and for intensive Outpatient treatment.

O. Inpatient Rehabilitation Benefits. Covered rehabilitation expenses include services and treatment for physical restoration of function following a covered Injury or Illness provided while Hospital confined in a facility accredited by the Joint Commission Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF), including:

1. Acute rehabilitation while Hospital confined for a condition that requires intensive interdisciplinary rehabilitation appropriate for an acute level of care; or
2. Sub-acute rehabilitation while Hospital confined for a condition that requires skilled nursing supervision and therapeutic intervention.
3. Services for physical rehabilitation while Hospital confined, but only when the eligible individual is able to actively participate in such programs, and there is documented continuous physical improvement.

P. Outpatient Physical, Occupational and Speech Therapy Benefits. Covered physical, occupational and speech therapy expenses include Outpatient therapy services and treatment by a licensed, qualified physical therapist, occupational therapist, or speech pathologist when ordered by the eligible individual's attending Physician.

1. Services and treatment must be rendered for acute, traumatic Injury or physical functional defect caused by a covered Injury or Sickness.
2. Services for Outpatient therapies are covered only when the eligible individual is able to actively participate in such therapies, and there is documented continuous physical improvement.
3. Programs, treatment, and services relating to community re-entry, transitional living, residential, school-based or vocational programs are not covered.

Q. **Manipulative Therapy Benefits (Chiropractic Treatment).** Services for manipulative therapies are covered only when: the eligible individual is not Hospital confined; the eligible individual is able to actively participate in such therapies, and there is documented continuous physical improvement. Covered Expenses include:

1. Services by a licensed, qualified provider for therapeutic restoration of an abnormal function of the nerve and/or muscle and/or spinal system by manipulation of structures of the human body.
2. Charges for manipulation and treatment for structural imbalance, distortion, dislocation, displacement, or subluxation of vertebrae of the spinal column.

R. **Clinical Trial Benefits**. Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial are covered provided the charges are:

1. Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Fund if the individual were not participating in the Approved Clinical Trial; and
2. Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You are eligible for payment of charges for participation in an Approved Clinical Trial if:

1. You satisfy the protocol prescribed by the Approved Clinical Trial provider; and
2. Either: (a) The individual's PPO provider determines that participation in the Approved Clinical Trial would be medically appropriate; or (b) the individual provides the Fund with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease.

The Approved Clinical Trial's study or investigation must be:

1. approved or funded by one or more of: (1) the National Institutes of Health (NIH), (2) the Centers for Disease Control and Prevention (CDC), (3) the Agency for Health Care Research and Quality (AHCRQ), (4) the Centers for Medicare and Medicaid Services (CMS), (5) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (6) a qualified non-governmental research entity identified by NIH guidelines for grants; or (7) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified

individuals who have no interest in the outcome of the review;

2. a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
3. a drug trial that is exempt from investigational new drug application requirements.

No benefits will be paid for:

1. Expenses incurred due to participation in an Approved Clinical Trial that are: (1) investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis; or
2. Expenses at a Non-PPO provider if a PPO provider will accept the patient in an Approved Clinical Trial.

S. Miscellaneous Covered Expenses. The following items are also Covered Expenses under the Plan:

1. Physician's house call and office visits.
2. Drugs and medicines that by law require a written prescription from a Physician and are dispensed by a licensed pharmacy.
3. Oxygen and rental of equipment for its administration, including IPPB (Intermittent Positive Pressure Breathing) equipment.
4. Devices (except for artificial organs) implanted by surgery into a body cavity to aid the function of an internal organ.
5. Rental (but not repairs) of a non-motorized wheelchair, Hospital bed, or other durable medical equipment, not to exceed the total purchase price of the item. The item is only covered if it is needed for therapeutic use and can withstand repeated use, is normally used only for medical reasons, and is not of general use, except to treat an Injury or Illness.
6. Initial prosthesis for replacement of a natural limb or eye that was lost, or replacement due to pathological change. Repairs to the prosthesis are not covered.
7. Initial replacement of natural teeth lost due to an Injury. Such replacement cost is covered only if incurred within six (6) months of the accident.
8. Casts (other than impressions), surgical dressings, trusses, splints and braces (other than orthodontic braces and splints to the teeth) and crutches when prescribed or ordered by a Physician.
9. Catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, when prescribed by a Physician.
10. Initial contact lenses or eyeglasses after cataract surgery, if they are prescribed by

a Physician.

Section 6.6. PREVENTIVE SERVICES

Charges for recommended preventive services are afforded under the Plan as required by the Patient Protection and Affordable Care Act of 2010 ("ACA"). Coverage is provided only for PPO providers, with no cost-sharing (Fund payment percentage is 100% with no deductible or co-payment). These recommended preventive services generally include the following:

A. Evidenced-based items or services with a rating of A or B, that are considered to be current recommendations of the United States Preventive Services Task Force (USPSTF) for purposes of ACA;

B. Immunizations for routine use in children and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);

C. For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

D. For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA.

If preventive services are received from a non-PPO provider, they will not be covered. If the federal guidelines are unclear about which preventive benefits must be covered, the Trustees will determine if a particular benefit is covered under this preventive services benefit. For recommendations in effect for less than one year, coverage of the newly recommended preventive service will become effective as of the first plan year beginning at least one year after the effective date unless otherwise required by law. The following is intended to be a list of the recommended preventive services that are current as of adoption of this Plan restatement; however, this list will automatically incorporate by this reference any applicable changes to recommended preventive services that the Plan is required to cover under ACA.

i. COVERED PREVENTIVE SERVICES FOR ADULTS

1. Abdominal aortic aneurysm one-time screening for men ages 65-75 who have ever smoked.
2. Alcohol misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.

3. Blood pressure screening for all adults aged 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a Physician's visit.
4. Cholesterol screening (lipid disorders screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.
5. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The test methodology must be medically appropriate for the patient. The Plan will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. The Plan will not impose cost sharing with respect to the following services when these services are provided in connection with a screening colonoscopy and the attending provider determines the service is medically appropriate: anesthesia services, a pre-procedure specialist consultation, or a pathology exam on a polyp biopsy.
6. Depression screening for adults.
7. Type 2 Diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
8. Diet counseling for adults at higher risk for chronic disease.
9. HIV counseling and screening once per year for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.
10. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for adults with a body mass index of 30 kg/m2 or higher.
11. Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
12. Tobacco use screening for all adults and cessation interventions for tobacco users.
13. Syphilis screening for all adults at increased risk of infection.
14. Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
15. Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
16. Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
17. Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.
18. Screening for hepatitis B virus infection in adults at high risk for infection.

ii. COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

1. Anemia screening on a routine basis for pregnant women.

2. Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation, or at the first prenatal visit, if later.
3. BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Plan will cover BRCA 1 or 2 genetic tests without cost sharing, if appropriate as determined by the woman's Health Care Provider, including for a woman who has previously been diagnosed with cancer, as long as she is not currently symptomatic or receiving active treatment for breast, ovarian, tubal or peritoneal cancer.

4. Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every year for women aged 40 and older.
5. Breast cancer chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
6. Comprehensive lactation support and counseling by a trained provider during pregnancy and for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Plan may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the Plan.
7. Cervical cancer screening for women ages 21 to 65 with Pap smear every three years.
8. Chlamydia infection screening for all sexually active non-pregnant women aged 24 and younger, and for non-pregnant women, aged 25 and older who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
9. Gonorrhea screening for sexually active women age 24 and younger and in older woman who are at increased risk for infection, provided as part of a well woman visit. The Plan will pay for the most cost-effective test methodology only.
10. Hepatitis B screening for pregnant women at their first prenatal visit.
11. Osteoporosis screening for women. Women aged 65 and older will be eligible for routine screening for osteoporosis. Younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year-old women. The Plan will pay for the most cost-effective test methodology only.
12. Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
13. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.

14. Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
15. Well-woman visit annually for adult women to obtain the covered preventive services that are age- and developmentally-appropriate, including preconception care and many services necessary for prenatal care. The Plan will cover additional well-woman visits if the Physician determines that the patient requires additional visits to obtain all necessary covered preventive services, subject to reasonable medical management techniques. In addition, the Plan will cover without cost sharing these preventive services for Dependent children where an attending provider determines that well-woman preventive services are age- and developmentally-appropriate for the Dependent.
16. Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
17. Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit.
18. Counseling for sexually transmitted infections, once per year as part of a well woman visit.
19. Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
20. Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.
21. Sterilization surgery for women and surgical sterilization implants for women. This coverage includes the clinical services, including patient education and counseling, needed for provision of the contraceptive method.
22. The following women's contraceptive agents that are approved by the Food and Drug Administration (FDA) and prescribed for a woman by her Health Care Provider. This coverage includes the clinical services, including patient education and counseling, needed for provision of the contraceptive agent:
    a. spermicides;
    b. cervical caps;
    c. female condoms;
    d. contraceptive sponges;
    e. diaphragms;
    f. generic oral contraceptives, including the combined pill, progestin-only pill and extended/continuous use pill (brand name oral contraceptives are only covered if the woman's Health Care Provider determines and notifies the Plan in writing that generic oral contraceptives would be medically inappropriate for the woman);
    g. generic transdermal patches (brand name patches, such as Ortho Evra®, are only covered if the woman's Health Care Provider determines and notifies the Plan in writing that generic transdermal patches would be medically inappropriate for the woman);

h. vaginal contraceptive rings;
i. generic injections (brand name injections, such as Depo-Provera® 150 mg. and Depo-SubQ Provera 104®, are only covered if the woman's Health Care Provider determines and notifies the Plan in writing that generic injections would be medically inappropriate for the woman);
j. emergency contraceptives, such as Plan B®, Plan B One-Step® and Next Choice One Dose®;
k. ella® emergency contraception;
l. intrauterine devices (IUDs) with progestin;
m. copper IUDs; and
n. implantable rods.

Over-the-counter contraceptives must be submitted with a prescription from your Physician.

Coverage for the above women's contraceptive agents is limited to women under 51 years of age.

iii. COVERED PREVENTIVE SERVICES FOR CHILDREN

1. Well baby and well child visits from birth through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits include the following age-appropriate screenings and assessments:

    a. Developmental screening for children under age 3, and surveillance throughout childhood;
    b. Behavioral assessments for children of all ages;
    c. Hearing screening;
    d. Height, weight and body mass index measurements;
    e. Autism screening for children at 18 and 24 months;
    f. Alcohol and drug use assessments for adolescents;
    g. Hematocrit or hemoglobin screening;
    h. Lead screening for children at risk of exposure;
    i. Tuberculin testing for children at higher risk of tuberculosis;
    j. Dyslipidemia screening for children at higher risk of lipid disorders;
    k. Sexually transmitted infection (STI) screening and counseling for sexually active adolescents;
    l. Cervical dysplasia screening at age 21;
    m. Oral health risk assessment;
    n. Medical history;
    o. Blood pressure screening;
    p. Depression screening for adolescents ages 11 and older;
    q. Vision screening; and

r. Critical congenital heart defect screening in newborns.

2. Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and children (such as hypothyroidism screening for newborns and sickle cell screening for newborns).
3. Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
4. HIV counseling and screening once per year for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
5. Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
6. Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
7. Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
8. Screening for hepatitis B virus infection in adolescents at high risk for infection.
9. Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices.

iv. IMMUNIZATIONS

Routine immunizations are covered for Participants who meet the age and gender requirements, and who meet the Center for Disease Control (CDC) medical criteria for recommendation.

1. Immunization vaccines for adults:

   a. Diphtheria/tetanus/pertussis (DTP);
   b. Measles/mumps/rubella (MMR);
   c. Influenza;
   d. Human papillomavirus (HPV);
   e. Pneumococcal (polysaccharide);
   f. Hepatitis A;
   g. Hepatitis B;
   h. Meningococcal;
   i. Zoster, beginning at age 60; and
   j. Varicella.

2. Immunization vaccines for children from birth to age 18:

   a. Hepatitis B;
   b. Rotavirus;
   c. Diphtheria, Tetanus, Pertussis;

d. Haemophilus influenzae type b;
e. Pneumococcal;
f. Inactivated Poliovirus;
g. Influenza;
h. Measles, Mumps, Rubella;
i. Varicella;
j. Hepatitis A;
k. Meningococcal; and
l. Human papillomavirus (HPV).

v. PREVENTIVE PRESCRIPTION DRUGS (OTHER THAN CONTRACEPTIVES)

1. Aspirin to prevent cardiovascular disease for men age 45 to 79 years and for women age 55 to 79 years.
2. Oral fluoride supplements for preschool children age 6 months to 5 years whose primary water source is deficient in fluoride.
3. Folic acid supplements containing 0.4 to 0.8 mg for women planning or capable of pregnancy.
4. Iron supplements for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
5. Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls. Over-the-counter supplements are covered only with a prescription.
6. Breast cancer risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.
7. Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia.

Preventive Prescription Drugs must be prescribed by a Health Care Provider. Over-the-counter preventive Prescription Drugs must be submitted with a prescription, in accordance with Plan rules.

vi. OFFICE VISIT COVERAGE

Preventive services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the preventive services benefit. The following conditions apply to payment for in-network office visits under the preventive services benefit. Non-network office visits are not covered under the preventive services benefit under any condition.

1. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost-sharing with respect to the office visit.

2. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
3. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost-sharing with respect to the office visit.

ARTICLE VII – COMPREHENSIVE MEDICAL BENEFITS - EXCLUSIONS AND LIMITATIONS

Section 7.1. GENERAL EXCLUSIONS

No medical benefits will be payable under the Plan for any of the following:

A. Hospital charges incurred on a Friday, Saturday or Sunday in connection with an admission on any of those days unless the admission is for:

   1. A "Medical Emergency," which means a severe condition that results in symptoms which occur suddenly and unexpectedly, and requires the immediate care of a Physician or surgery to prevent death or serious impairment of the Covered Person's health; or
   2. Surgery, or diagnostic tests or procedures performed in connection with surgery, if the surgery is scheduled to be performed within 24 hours from the time of admission;

B. Expenses in connection with bodily injuries arising from or in the course of employment;

C. Charges incurred as a result of any occupational Injury or Sickness or for any Injury or Sickness for which the Participant has received or is entitled to receive compensation for that particular Injury or Sickness under any Worker's Compensation or Occupational Disease Law;

D. Charges for or in connection with the pregnancy of an Eligible Dependent child, or in connection with an abortion for any Covered Person except (a) where the life of the mother would be endangered if the fetus were carried to term or (b) where medical benefits are provided for the complications, but not for the abortion itself except that Dependent children are covered for certain pre-natal care and certain preventive services benefits;

E. Medical charges or examinations which are not Medically Necessary for the treatment of an Injury or Sickness or other covered condition, or which are Experimental or Investigative in nature;

F. Charges for or in connection with hearing aids or the fitting of hearing aids;

G. Charges for or in connection with cosmetic surgery, except for the repair of accidental traumatic Injury or a congenital anomaly to the extent specifically covered under Article VI, "Comprehensive Medical Benefits – Covered Expenses";

H. Except as specifically listed under Article IV, "Comprehensive Medical Benefits – Covered Expenses," charges incurred for or in connection with any operation or treatment (a) of the teeth or gums, or (b) in connection with the fitting or wearing of dentures, or (c) for realignment due to atrophy of the lower jaw, occlusion, maxillofacial surgery or retrognathia;

I. Charges for or in connection with treatment of Injury or Sickness which is occasioned by war or act of war, declared or undeclared;

J. Charges incurred outside the United States or Canada, unless related to a Medical Emergency;

K. Charges for services or supplies received from or in facilities owned or operated by the United States Government, or for services and supplies for which the Covered Person is not required to pay, unless and to the extent this exclusion is otherwise prohibited by law;

L. Charges for treatment rendered for mental and nervous conditions that are not included in this Plan's definition of "Psychiatric Condition." Charges for treatment of for addiction or abuse of any drug, chemical or substance are not covered.

M. Charges arising from a self-inflicted Injury or Illness, including complications thereof. However, expenses shall not be excluded if the Injury or Illness results from an act of domestic violence, or arises as a result of a physical or mental health condition;

N. Charges for or in connection with any surgical operation or procedure to alter, reduce or enlarge the size or shape of a male or female breast except to the extent specifically listed under Article VI, "Comprehensive Medical Benefits – Covered Expenses";

O. Charges for or in connection with the treatment of sleep disorders except as listed under the Article VI, "Comprehensive Medical Benefits – Covered Expenses";

P. The portion of any charge determined to be in excess of the Reasonable and Customary Expense;

Q. Any charge, service or supply which is not specifically listed as covered under the Covered Medical Expenses;

R. Non-prescription drugs, except as specifically listed as covered under the Preventive Services Benefit;

S. Eye care, including but not limited to eye exams, eye refractions, eyeglasses and contact lenses, except as specifically listed under the Recommended Preventive Services;

T. Charges incurred for services or supplies that are not recommended by a Physician;

U. Charges incurred by an individual when he is not covered by the Plan;

V. Charges incurred for Custodial Care or rest cures; "Custodial Care" means any of the following: (1) non-health related care or services given mainly for personal hygiene or to perform or assist with the activities of daily living, including but not limited to bathing, feeding, dressing, walking and taking medicines that can be self-administered, regardless of where it is given or who recommends, provides or directs the care; (2) health-related services which do not seek to cure, or which are not likely to substantially reduce disability or enable the patient to live outside an institution providing care; and (3) care or services which do not require administration by trained medical personnel in order to be delivered safely and effectively;

W. Charges incurred for health examinations or tests not required for the treatment of Sickness or Injury or other covered condition, or for routine checkups, routine newborn care or routine pediatric care, except to the extent specifically provided under the Recommended Preventive Services;

X. Charges for services received by a Covered Person when rendered by a member of the Covered Person's immediate family;

Y. Charges incurred for the promotion of fertility or treatment of infertility, including but not limited to fertility tests, hormone therapy, reversal of surgical sterilization, and actual or attempted impregnation or fertilization by artificial insemination, in-vitro fertilization or embryo transfer, regardless of whether it involves a Covered Person as a surrogate, donor or recipient; and

Z. Charges for manipulative or spinal treatment except to the extent specifically listed under the Article VI, "Comprehensive Medical Benefits – Covered Expenses"; and

AA. Charges incurred as a result of any Injury or Sickness for which the Participant has received or is entitled to receive compensation or other monetary award for that particular Injury or Sickness from any third party or parties responsible for payment, including but not limited to the Participant's own uninsured motorist's insurance carrier and homeowner's insurance carrier.

Section 7.2. PREVENTIVE SERVICES COVERAGE LIMITATIONS AND EXCLUSIONS

A. Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are covered under the applicable medical benefits, not the preventive services benefit. A service is covered for diagnostic reasons if the Participant had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.

B. Services covered under the preventive services benefit are not also payable under other portions of the Plan.

C. The Plan will use reasonable medical management techniques to control costs of the preventive services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.

D. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered.

E. Examinations, screenings, tests, items, or services are not covered when they are Experimental or Investigational, as determined by the Plan.

F. Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:

1. When required for education, sports, camp, travel, insurance, marriage, adoption or other non-medical purposes;
2. When related to judicial or administrative proceedings;
3. When related to medical research or trials; or
4. When required to obtain or maintain employment or a license of any kind.

G. The following services will not be treated as preventive services but will otherwise be covered subject to the Plan's deductibles and coinsurance (but are excluded for Dependent children):

1. Radiology services (obstetrical ultrasounds);
2. High-risk prenatal services;
3. Delivery; and
4. Postnatal care.

H. Services related to male reproductive capacity, such as vasectomies and condoms, are not covered under the preventive services benefit.

ARTICLE VIII—COORDINATION OF MEDICAL BENEFITS

Section 8.1. GENERAL

Since it is not intended that greater benefits be received than the actual medical expense Incurred, this Plan has "coordination of benefit" rules that apply whenever you or your Dependent has "other plan" coverage in addition to coverage under this Plan. You and your Dependent must promptly notify the Fund Office of the other coverage so that the Plan can apply these rules in processing and paying claims for medical benefits. The amount payable under this Plan will take into account any coverage you or your Dependent has under any other group-type plan, and benefits will be coordinated to provide up to 100% reimbursement for expenses covered under either plan.

Coordination of benefits is a concept of anti-duplication. It provides that if an individual is covered by two or more group health plans, the amount of benefits payable under this Plan and the other plan(s) will be coordinated so that the total amount paid is not greater than 100% of the "Allowable Expense." An "Allowable Expense" is the necessary, Reasonable and Customary Expense for medical services, treatment or supplies, which is covered at least in part under this Plan and under the other plan(s).

Under coordination of benefits, payment is made on a primary-secondary basis. The primary plan will calculate its benefits and pay first without regard to the other plan. The secondary plan will then reduce benefits as needed, taking into account the amount paid by the primary plan, so that the total benefits paid or provided by all plans do not exceed 100% of the Allowable Expense. No plan will pay more than it would have paid if no other plan was involved. The following rules explain how this Plan coordinates payment of its benefits with other plans under which you or Dependents may be covered.

Section 8.2. HOW COORDINATION OF BENEFITS WORKS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense.

Section 8.3. DEFINITIONS

A. For purposes of this Section, the term "plan" includes any plan providing benefits or services for or by reason of, Hospital or medical care that is provided by:

1. Group, franchise or blanket coverage, whether insured or non-insured.

2. Group Blue Cross, Blue Shield, Hospital, HMO, PPO and other prepayment coverage provided on a group basis, except for which the subscription charge or premium payment is made directly by the person covered to the organization providing the coverage.

3. Any coverage under labor-management Trusteed plans, Union welfare plans, employer organization plans, employee benefit organization plans, or any other arrangements of benefits for individuals of a group.

4. Any coverage under governmental programs and any coverage required or provided by any statute, such as Medicare, Medicaid and Workers Compensation.

5. Any student coverage under a plan or program sponsored by or provided through a school educational institution.

6. Any coverage under an individual no-fault policy.

"Plan" shall be construed separately with respect to each policy, contract or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.
"This Plan" means the portion of the Southwest Health Benefits Plan that provides benefits for Hospital and medical and that are subject to this provision.

B. "Allowable Expense" means any Medically Necessary, Reasonable and Customary Expense, at least a portion of which is covered under one or more Plans that cover the individual for whom claim is made.

C. "Claim Determination Period" means a Calendar Year or any portion thereof during which you or your Dependent is covered under this Plan.

Section 8.4. ORDER OF DETERMINATION

A. When a Plan has no limitation against payments made under any other group plan, then it shall be considered the primary plan and render payment first.

B. In the event two or more of the plans involved do provide a limitation against duplicate benefits, then the following rules shall apply.

1. **Non-Dependent/Dependent**. The benefits of the Plan that covers the person as an Employee (that is, other than as a Dependent) are determined before those of the Plan that covers the person as a Dependent.

2. **Dependent child/Not Separated or Divorced**. The primary plan for children's expenses when the parents are not separated or divorced shall be determined by

the birth dates, excluding year of birth, of the parents. The plan of the parent whose month and day of birth is earlier in the year shall be the primary plan. If both parents have the same birthday, or if the other plan does not have a rule similar in intent to this, then the plan that covered the parent longer shall be the primary payer and the plan that covered the other parent for a shorter period shall be the secondary payer.

3. **Dependent child of Separated or Divorced Parents**. For children's expenses when the parents are separated or divorced, if there is a court decree that establishes responsibility for the financing of medical, dental, or other health care expenses with respect to children, the benefits are determined in accordance with the court decree. Otherwise, benefits for the child are determined in this order:

   a. The plan of the parent with custody of the child;

   b. The plan of the spouse of the parent with custody of the child; and

   c. the plan of the parent not having custody of the child.

4. **Joint Custody**. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering that child will follow the order of benefit determination rules described in item 2 above.

5. **Active/Inactive Employee**. If the rules above do not create an "Order of Benefit Determination," the primary plan will be the one that has covered the person for the longer period of time, with the following exception:

   The benefits of a plan covering the person as a laid-off or retired Employee, or Dependent of such person, shall be determined after the benefit of any other plan covering the person as an Employee.

6. **Continuation Coverage**. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the order of benefit determination will be as follows:

   a. The benefits of a plan covering the person as an Employee (or as that person's Dependent);

   b. The benefits under the continuation coverage.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. If the other plan lacks a Coordination of Benefits Provision, it is the primary plan.

8. **General Provisions**. When this Plan pays reduced benefits due to the Coordination of Benefits provision, only the reduced amount will be charged against the limits of the Plan.

   If another plan pays benefits that should have been reduced because of coordination of benefits, the Plan may, at its option, pay to the other plan the amount by which the benefits should have been reduced. Amounts so paid will be deemed benefits under this Plan, and will reduce the Plan liability to the extent of such payment.

   If the Plan has made payment of any expense that is in excess of that permitted by Coordination of Benefits, the Plan has the right to recover such amount from any party that has received such payment.

   If another plan is primary under this Plan's coordination of benefits rules and it contains a provision capping its benefits for an eligible individual or his Dependents having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation of the National Association of Insurance Commission's (NAIC's) and this Plan's coordination of benefit rules, this Plan will not be liable to provide benefits until the primary plan provides its customary benefits determined without regard to such a cap.

In no event will the amount paid under this Plan exceed the amount that would have been paid if there were no other plan involved. When a claim is made, the primary plan pays the benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the COB provision.

Section 8.5. COORDINATION OF BENEFITS WITH MEDICARE

A. "Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Medicare benefits are available only in the United States. Resident aliens are eligible for Medicare only if they are eligible for Social Security benefits or they have lived in the United States for at least five (5) years.

B. The Plan will be Primary Payer to Medicare only:

   1. For an active Employee who is age 65 or older;

   2. For an active Employee's spouse who is age 65 or older;

3. For the first 30 months of treatment for end-stage renal disease received by an Participant;

4. For Disabled, Eligible Dependents of active Employees; and

5. Where otherwise explicitly required by federal law.

The reference to active Employee throughout this Plan does not, however, include laid-off, retired, former Employees under COBRA or Self-Pay provisions of the Plan, or Participants who are not covered by reason of current employment status.

When the rules above do not apply, the Plan will pay its benefits only after Medicare has paid its benefits.

Note: If you are eligible for Medicare, the Plan will pay benefits only up to the amount that would be paid under the above rules, whether or not you have applied for Medicare Part A and Part B benefits. Because your benefits may be affected by Medicare, you may want to contact your local Social Security office for information about Medicare. This should be done before your 65th birthday or that of your spouse, or if you or one of your Dependents become Disabled. Medicare coverage, even on a secondary basis, can provide valuable benefits.

C. Because benefits may not be duplicated, benefits provided under this Plan may be coordinated with any Medicare benefits the Employee or Dependent actually receives by virtue of enrollment for Medicare benefits.

As long as the Employee or Dependent remains actively employed and eligible under this Plan, all other benefits provided under the Plan will remain fully in force, whether or not they are eligible for the health benefits provided by the Medicare Program.

Section 8.6. COORDINATION OF BENEFITS WITH MEDICAID

If you, your Dependent or Alternate Recipient are entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act, this Plan will be Primary.

Payment for benefits will be made in accordance with any assignment of rights made by or on your behalf or that of your Dependent or Alternate Recipient as required by Medicaid under §912(a)(1)(A) of the Social Security Act of 42 U.S.C §1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits, and to the extent that payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state has acquired the rights with respect to you, your Dependent or Alternate Recipient for payment of such benefits.

In the event Medicaid files a claim directly with the Plan for services provided to an eligible

Participant past the Fund's deadline for submission of claims, and the Plan is required to pay such claim under federal law, the Plan shall process such claim as an Out-of-Network claim, and shall pay the lesser of 100% of the Medicaid approved charges or the applicable Out-of-Network percentage Copay of the total billed charge.

The provisions of §1908 of the Social Security Act will apply to the extent such provisions are in accordance with state Medicaid law.

Section 8.7. COORDINATION OF BENEFITS WITH STATE AND FEDERAL PROGRAMS OTHER THAN MEDICARE OR MEDICAID

A. If an Employee or Dependent is eligible for coverage under a governmental health benefit program or program established under a state or federal statute, whether or not election has actually been made to obtain such coverage, the amount of benefits paid by both Plans will not exceed one hundred percent (100%) of the lesser of the Reasonable and Customary Expense or the PPO negotiated charges covered under this Plan.

B. Benefits will be paid first by the other Plan, unless otherwise declared by law, after which this Plan will make its coordinated benefit payment. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other Plan were involved.

Section 8.8. RIGHT TO RECOVERY

If the Plan pays more to or for a Participant than required under the Coordination of Benefits provisions set forth in this Article VIII, the Fund has the right to recover the excess payments from any person, provider or company to or for or with respect to whom such payments were made. The Participants shall cooperate fully with the Plan by providing documentation and taking whatever action is reasonably required by the Plan to assist with recovery of the overpayment.

ARTICLE IX—SUBROGATION AND REIMBURSEMENT

Section 9.1. SUBROGATION AND REIMBURSEMENT

A. If you are hurt or injured in any type of accident, as identified below, to the extent the Plan makes payment for benefits under the Plan, the Plan shall be fully subrogated to all of your rights of recovery arising out of:

1. Any claim or cause of action which may accrue because of the alleged negligent conduct of any third party and/or his insurers, including any claim against your own insurer arising under the Uninsured Motorists Coverage provisions of a Policy of Insurance or a Homeowner's Policy issued to you; and

2. Any claim or cause of action which may accrue because of an event giving rise to a claim under the Products Liability Laws of any state and, any claim or cause of action which may accrue because of an event giving rise to a claim under the Workers' Compensation law of any state.

B. The Fund shall be entitled to reimbursement or subrogation regardless of whether you have been made whole. The Fund's rights shall not be subject to reduction under any common fund doctrine, attorney's fund doctrine or any similar claims or theories.

C. Certification and Agreement

The Plan shall make payment of any such claims only upon your certification that no other sums have yet been paid in satisfaction thereof; that the claim assertable against a third party is disputed; that the tortfeasor and/or his insurer are withholding payment pending resolution of that dispute; and only upon your execution of the Fund's standard Subrogation and Reimbursement Agreement, and that of your attorney, if applicable, in which you agree, as follows:

1. To reimburse the Fund out of the proceeds of any recovery had from any third party, including your own Uninsured Motorist Insurer, whether by way of litigation, settlement or otherwise, prior to the payment of any other claims;

2. To reimburse the Fund from any gross amount recovered by you, before any payment of attorneys' fees and costs by you;

3. To provide to the Fund all information and documents necessary and reasonable in the Trustees' sole discretion, and to otherwise assist the Trustees in recovering all amounts paid out by the Fund that are subject to the Agreement;

4. To execute and deliver all necessary instruments as the Trustees may require to facilitate the enforcement of its rights;

5. To recognize that the Fund has no obligation to pay you or your attorney any amounts expended in attorneys' fees and costs of litigation in pursuing the claims against others, including your own Insurers;

6. To reimburse the Fund and otherwise make the Fund whole for any and all attorneys' fees and costs expended by the Trustees and/or the Fund in pursuing litigation or other actions, in whatever forum, to enforce the terms of the Plan and/or the Subrogation and Reimbursement Agreement executed by the claimant;

7. That no settlement shall be made with nor release granted to any third party or insurer without the written consent of the Trustees;

8. To protect the Fund's right to recovery under the Subrogation and Reimbursement Agreement and to do nothing that would in any way prejudice these rights. The Trustees shall have the sole discretion to determine the amount of recovery from any third party, insurer or Workers' Compensation Insurer;

9. To serve as constructive trustee over any and all proceeds recovered by you from a responsible third party, whether by settlement, award or judgment and recognize that a failure to hold such funds in trust will be deemed a breach by you of the duties set forth in this Article; and

10. In the event you fail to fully cooperate with the Trustees in accordance with this Section or the written Subrogation and Reimbursement Agreement, the Fund will stop making payments in connection with the accident or Injury giving rise to the Fund's subrogation and reimbursement rights, and all amounts previously paid by the Fund shall immediately become due and payable to the Fund.

D. Fund's Liens on Recovered Proceeds

The Fund has an equitable lien on any and all proceeds recovered by you up to the total amount of medical benefits that the Fund has paid to you or on your behalf. This equitable lien shall attach to any money or property that is obtained by any person or entity (including, but not limited to, you, any trust or your attorney(s)) as a result of an exercise of your right of recovery. The Fund shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. The Fund shall automatically have a first priority lien upon the proceeds of any recovery by you or your Dependent(s) from the third party to the extent of any benefits provided to you or your Dependent(s) by the Plan. You/your Dependent(s) or their representative shall execute such documents as may be required to secure the Plan's rights. The absence of a separate written Agreement shall in no manner invalidate the Plan's Rights of Subrogation and Reimbursement as set forth in this Article.

E. Right to Recover/Offset.

The Trustees may institute legal action against you to recover the benefits paid or, at their discretion, the Trustees may withhold payment of and/or implement a deductible against unrelated subsequent or previously existing claims to recoup amounts owed to the Fund, in the event you or your Dependent refuses or fails to reimburse the Fund upon recovery of any sums.

In the event the Plan pays benefits for claims not covered under the Plan, the Trustees are authorized to offset any such payment from any and all future claims submitted by you or your Eligible Dependents until such repayment is recouped in full. Alternatively, the Trustees may institute legal action against you or your Eligible Employees to recover overpaid benefits. If litigation is instituted for this purpose, the Trustees are authorized to recover, on behalf of the

Plan, all costs, expenses and attorney fees expended in obtaining the reimbursement of such overpaid benefits.

F. Upon reimbursement to the Fund of any or all amounts owed for claims paid relating to an accident or Injury, the Fund will have no obligation to pay any additional future related claims, and the Fund will impose a deductible in the amount of you or your Dependent's net recovery, if any, to offset any future related claims that may be submitted by you or your Dependent(s), or on your behalf.

Section 9.2. OVERPAYMENTS AND IMPROPER PAYMENTS

In the event the Plan pays a claim in error, overpays a claim or makes an improper payment on a claim, to or for a Participant or former Participant for any reason, the Trustees shall have the right to secure reimbursement for such payment directly from the Participant, former Participant or any third party to whom payment was made, and the Participant, former Participant or third party shall be obligated to reimburse the Plan for such payment.

The Trustees shall also have the right to secure reimbursement through an offset of any related or unrelated subsequent or previously existing benefits due to or for the Participant or former Participant. In addition, if a Participant fails to comply with the notification requirements described in Article X, including but not limited to the failure to notify the Plan timely of a change in address, change in Dependent status or other change affecting coverage under the Plan, and as a result the Plan (i) makes an erroneous payment, improper payment or overpayment, including but not limited to payment to or for an individual who is no longer covered or payment that is mailed to the wrong address and then cashed by an unauthorized person, and (ii) does not recover such payment after notice and demand, then the Participant and any third party receiving payment shall be obligated to reimburse the Plan for such payment, and the Trustees shall have the right to secure reimbursement for such payment directly from the Participant or third party or through an offset of any related or unrelated existing or future benefits due to the Participant or any covered family member.

Section 9.3. ERRONEOUS REPRESENTATIONS

The Trustees may withhold or deny payment of any claim which they reasonably believe is based on false or misstated facts or representations by any Participant or Beneficiary or provider of Covered Services or supplies, and shall have the right to secure reimbursement for any payments made on the basis of such false or misstated representations from the Participant or from any third party to whom payment was made on the Participant's behalf to the full extent described in Section 9.3 with respect to erroneous payments, improper payments and overpayments. In addition, if a Participant knowingly makes false statements on any document which is the basis for the Plan's payment of claims, the Trustees shall have the authority to declare such Participant ineligible for coverage under the Plan for a period not to exceed six (6) consecutive calendar quarters.

ARTICLE X – CLAIMS, APPEALS, AND REVIEW PROCEDURES

Section 10.1. CLAIMS RELATED DEFINITIONS

A. **Adverse Benefit Determination**. "Adverse Benefit Determination" means any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Fund. "Adverse Benefit Determination" also includes "rescissions" of coverage, regardless of whether there is an adverse effect on any particular benefit at the time of the claim. A "rescission" is generally a cancellation or discontinuance of coverage with a retroactive effect for reasons other than a failure by the claimant to timely pay premiums.

B. **Claim**. "Claim" means a request for a benefit made by a claimant in accordance with the Fund's reasonable procedures.

C. **Concurrent Claim.** "Concurrent Claim" means a Claim that is reconsidered after an initial approval is made that results in a reduction, termination or extension of a benefit.

D. **Disability Claim**. "Disability Claim" means a Claim that requires a finding of Total Disability as a condition of eligibility. This includes claims for the continuation of eligibility while Totally Disabled.

E. **Post-Service Claim.** "Post-Service Claim" means a Claim for benefits that is not a Pre-Service Claim.

F. **Pre-Service Claim.** "Pre-Service Claim" means a Claim for a benefit for which the Fund conditions coverage, in whole or in part, upon approval before receipt of the services or treatment.

G. **Urgent Claim.** "Urgent Claim" means a Claim for medical care or treatment where application of the normal time periods for pre-service authorization could seriously jeopardize the claimant's life, health of ability to regain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The opinion of the treating Physician that the claim qualifies under either condition described will be accepted by the Plan.

Section 10.2. CLAIM PROCEDURES

A. **Authorized Representatives**. A Participant or Beneficiary may appoint an Authorized Representative to file claims, request reviews, receive correspondence and otherwise act on behalf of the individual with respect to the Claims Procedure and Claims Review Procedure under the Plan, To do so, the Participant must complete and submit to the Plan an acceptable form. With respect to an Urgent Care Claim, a Health Care Provider with knowledge of the Participant's medical condition shall be permitted to act as the

Participant's Authorized Representative, even if the appropriate form has not been completed.

B. **Pre-Service Claims**. All Inpatient admissions, as described in the Schedule of Benefits, require pre-certification by the Plan's utilization review company. All emergency Hospital admissions require certification by the Plan's utilization review company within 48 hours of admission. These requirements apply regardless of whether a claim form has been or must be submitted.

1. Pre-Service Claim is a Claim for a benefit for which the Fund requires approval before medical care is obtained. The Fund requires that all Inpatient Hospital admissions be precertified. Obtaining precertification or prior approval of these services is treated as a Pre-Service Claim. Pre-Service Claims must be submitted by calling BlueCross BlueShield at 1-800-433-3232.

2. For properly filed Pre-Service Claims, the claimant will be notified of a decision within 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Fund. The claimant will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

3. If an extension is needed because the Fund needs additional information from the claimant, the claimant will be notified, before the end of the initial 15-day period, of the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of 45 days or the date the claimant responds to the request. The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

If a claimant improperly files a Pre-Service Claim, the claimant will be notified as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a Claim. Unless the claim is re-filed properly, it will not constitute a Claim.

C. **Urgent Claims**. Urgent Claims must be submitted by calling BlueCross BlueShield at 1-800-433-3232.

BlueCross BlueShield will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. BlueCross BlueShield will respond with a determination by telephone as soon as

possible, but not later than 72 hours after receipt of the Claim by BlueCross BlueShield. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, BlueCross BlueShield will notify the claimant not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Claimant must provide the specified information within 48 hours. If the information is not provided to BlueCross BlueShield within that time, the Claim will be denied.

Notice of the decision will be provided no later than 48 hours after BlueCross BlueShield receives the specified information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.

If a claimant improperly files an Urgent Claim, BlueCross BlueShield will notify the claimant as soon as possible but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing a Claim. Unless the claim is reified properly, it will not constitute a Claim.

With respect to an Urgent Care Claim, a Health Care Provider with knowledge of the eligible individual's medical condition will be permitted to act as an authorized representative.

D. **Concurrent Claims**. A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously-approved benefit (other than by Plan amendment or termination) will be made by BlueCross BlueShield as soon as possible. In any event, the eligible individual will be given enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend an approved Urgent Claim will be acted upon by BlueCross BlueShield within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to extend approved treatment that does not involve an Urgent Claim will be decided according to the guidelines for Pre-Service or Post-Service Claims, as applicable.

E. **Post-Service Claims**. In order for a request for benefits to be considered a Post-Service Claim, a completed claim form must be completed on behalf of the person for whom the claim is being made and submitted to the Fund Office with the itemized bill/s. The itemized bill/s must include the following information:

1. Patient's name;
2. date of service;
3. type of service or procedure code;

4. diagnosis or diagnosis code;
5. billed charges;
6. provider's Federal Taxpayer Identification Number (TIN); and
7. provider's billing name and address.

The claim must be submitted to the Fund Office within 90 days from the date that expenses were first incurred, unless it is shown by the Employee not to have been reasonably possible to give notice within such time limit. In no event will benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

Claims should be submitted to the Fund Office at the following address:

Southwest Health Benefits Fund
8441 Gulf Freeway, Suite 304
Houston, TX 77017

Ordinarily, claimants will be notified of decisions on Post-Service Claims within 30 days from the Fund's receipt of the Claim. This period may be extended one time by the Fund for up to 15 days provided the extension is necessary due to matters beyond the control of the Fund. In the event an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is required as a result of the Fund's need of additional information from the claimant, the Fund will issue a request for additional information that specifies the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the request for additional information until either 45 days or until the date the claimant responds to the request (whichever is earlier). The Fund then has 15 days to make a decision on the Claim and notify the claimant of the determination.

If the Fund determines that additional information is required from the claimant, the Fund may issue a combined request for additional information and notice of Adverse Benefit Determination. The notice of Adverse Benefit Determination would only be applicable in the event the claimant fails to provide any information within 45 days. In this case, the Fund would not issue a separate notice of Adverse Benefit Determination if the claimant failed to submit any information within 45 days. The combined notice will clearly state that the Claim will be denied in the event the claimant fails to submit any information in response to the Fund's request, and will satisfy the content requirements of both the request for additional information and the notice of Adverse Benefit Determination.

When the combined notice is used, the time frame for appealing the Adverse Benefit Determination begins to run at the end of the 45-day period prescribed in the combined notice for submitting the requested information.

F. **Disability Claims.** Disability Claims must be submitted to the Fund Office in writing, using the appropriate application form. An application form may be obtained by contacting the Fund Office.

The Fund will make a decision on the Claim and notify the claimant of the decision within 45 days. In the event the Fund requires an extension of time due to matters beyond its control, it will notify the claimant of the reason for the delay and indicate when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days from the time the Fund notifies the claimant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision.

In the event an extension is needed because the Fund needs additional information from the claimant, the extension notice will specify the information needed. In that situation, the claimant will have 45 days from receipt of the notification to supply the additional information. In the event the information is not provided within that time, the Claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of 45 days or until the date the claimant responds to the request. Once the claimant responds to the request for information, he or she will be notified of the decision on the Claim within 30 days.

G. **Notice of Initial Benefit Determination.** The claimant will be provided written notice of the initial benefit determination. In the event the determination is an Adverse Benefit Determination, the notice will include:

1. The specific reason(s) for the determination;

2. Reference to the specific Plan provision(s) on which the determination is based;

3. A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary;

4. A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;

5. A statement of the claimant's right to bring a civil action under ERISA Section

502(a) following the appeal of an Adverse Benefit Determination;

6. In the event an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;

7. In the event the determination was based on the absence of medical necessity or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

Section 10.3. APPEAL PROCEDURES

In the event a Claim is denied in whole or in part or the claimant disagrees with the decision made on a Claim, the claimant may appeal the decision.

A. Appeals of Adverse Benefit Determinations regarding Post-Service Claims and Disability Claims must be submitted in writing to the Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

1. the patient's name and address;
2. the claimant's name and address, if different;
3. the date of the Adverse Benefit Determination; and
4. the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

B. Appeals of Adverse Benefit Determinations regarding Urgent Claims and Pre-Service Claims may be made orally within 180 days after receipt of the notice of Adverse Benefit Determination by calling BlueCross BlueShield at 1-800-433-3232.

C. Appeals of Adverse Benefit Determinations regarding Concurrent Claims may be made orally by calling BlueCross BlueShield at 1-800-433-3232. For a Concurrent Claim that involves a termination or reduction of previously approved care, there is no set timeframe for appeal; however, the appeal must be completed before the care is terminated or reduced. For a Concurrent Claim regarding an extension of care, the appeal timeframe will be the timeframe for an Urgent, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

Section 10.4. THE APPEAL PROCESS

A. The claimant will have the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was submitted or considered as part of the initial benefit determination. The claimant will he provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

B. A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

C. If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was Experimental and Investigational), a Health Care Provider who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on his or her Claim, without regard to whether the advice was relied upon in deciding the Claim.

Section 10.5. EXTERNAL CLAIMS APPEAL PROCEDURES

In the event a claimant receives a final internal Adverse Benefit Determination and wishes to further appeal the claims denial, the claimant may request a review by an Independent Review Organization ("IRO"). The decision made by an IRO on a claims appeal will be binding on the claimant and the Plan.

A. Standard External Review

1. Request for External Review. A claimant may file a written request for an external review with the Plan within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

2. Preliminary Review. Within five business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

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

b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;

c. The claimant has exhausted the Plan's internal appeal process, if required; and

d. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan shall issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification shall describe the information or materials needed to make the request complete, and the Plan shall allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**. The Plan shall assign an IRO that is accredited by URAC. The Plan shall refer the claim to one of three (3) IROs with whom the Plan has contracted for such assignments, and shall rotate claims assignments among them. The IROs with whom the Plan has contracted are not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

a. The assigned IRO will utilize legal experts, where appropriate, to make coverage determinations under the Plan.

b. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice additional information that the IRO shall consider when conducting the external review.

c. Within five (5) business days after the date of assignment of the IRO, the Plan shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information shall not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. Within one (1) business day after making the decision, the IRO shall notify the claimant and the Plan.

d. Upon receipt of any information submitted by the claimant, the assigned IRO shall, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination that is the subject of the external review. The external review may be terminated as a

result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan shall provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall then terminate the external review upon receipt of such notice from the Plan.

e. The IRO shall review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim "de novo" and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process applicable. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

    i. The claimant's medical records;

    ii. The attending Health Care Provider's recommendation;

    iii. Reports from appropriate Health Care Providers and other documents submitted by the Plan, claimant, or the claimant's treating provider;

    iv. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

    v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

    vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

    vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. The assigned IRO shall provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO shall deliver the notice of final external review decision to the claimant and the

Plan.

g. The assigned IRO's decision notice shall contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation, including the specific overage provisions and evidence-based standards, considered in reaching its decision;

iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision, and any evidence-based standards that were relied on in making its decision;

v. A statement that the determination is binding, except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;

vi. A statement that judicial review may be available to the claimant; and

vii. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

viii. After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six (6) years. An IRO shall make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

4. Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan immediately shall provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited External Review

1. Request for Expedited External Review. The Plan shall allow a claimant to make

a request for an expedited review with the Plan at the time the claimant receives:

a. **An Adverse Benefit Determination,** if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

b. **A final internal Adverse Benefit Determination**, if the claimant has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination 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 a facility.

2. **Preliminary Review**. Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements set forth in paragraph (a)(2) above for Standard External Review. The Plan shall immediately send a notice that meets the requirements set forth in paragraph (a)(2) above for Standard External Review to the claimant of its eligibility determination.

3. **Referral to Independent Review Organization**. Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan shall assign an IRO pursuant to the requirements set forth in paragraph (a)(3) above for Standard Review. The Plan shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically, by telephone, facsimile, electronic means or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for Standard Review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. **Notice of Final External Review Decision**. The IRO shall provide notice of the final external review decision, in accordance with the requirements set forth in paragraph (a)(3)(vii) above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in

writing, within 48 hours after the date of providing that notice, the assigned IRO shall provide written confirmation of the decision to the claimant and the Plan.

Section 10.6. TIME LIMIT ON LEGAL ACTION

In no event may legal action be brought by or on behalf of any individual to recover benefits under the Plan unless the individual or legal representative has first fully complied with and timely exhausted all of the requirements of the Claims Procedure and Claims Review Procedure under the Plan, and in no event shall any such legal action be brought later than one (1) year following a final determination of the claim under the Plan.

Section 10.7. PHYSICAL EXAMINATIONS AND AUTOPSY

The Trustees at their own expense shall have the right and opportunity to examine any individual whose Injury or Sickness is the basis of claim when and as often as they may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not prohibited by law.

Section 10.8. TIMEFRAMES FOR NOTICES OF APPEAL DETERMINATIONS

A. **Pre-Service Claims.** Notice of the appeal determination for Pre-Service Claims will be sent within 30 days of receipt of the appeal by BlueCross BlueShield.

B. **Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by BlueCross BlueShield.

C. **Concurrent Claims.** Notice of the appeal determination for a Concurrent Claim that involves a termination or reduction of previously approved care will be sent by BlueCross BlueShield before the care is terminated or reduced. Notice of the appeal determination for a Concurrent Claim that involves an extension of care will be sent by BlueCross BlueShield based on the timeframes for an Urgent, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

D. **Post-Service Claims.** Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for appeal. However, if the request is received within 30 days of the next regularly scheduled meeting, it will be considered at the second regularly scheduled meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the appeal may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on the appeal has been reached, notice of the appeal determination will be sent as soon as possible, but no later than 5 days after the decision has been reached.

E. **Disability Claims.** Notice of the appeal determination for Disability Claims will be made in the same manner as for Post-Service Claims.

F. Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

1. the specific reason(s) for the determination;
2. reference to the specific Plan provision(s) on which the determination is based;
3. a statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
4. a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
5. if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
6. if the determination was based on medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
7. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

A decision on review of any Claim made under the Plan in accordance with the Claims Review Procedure will be final and binding on all persons.

ARTICLE XI – PRIVACY AND SECURITY RULE

The Plan has the right to release to or obtain from another person or entity, information relating to your claim or the claim of your Dependent which the Plan considers reasonably necessary for administering the Plan and determining and paying benefits that may be due. However, what the Plan does with your health information is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The federal law known as "HIPAA" resulted in federal privacy and security rules that require health plans, such as this Plan, to protect the confidentiality of your protected health information (also referred to as "PHI"). These privacy and security rules also apply to your Dependent's PHI. PHI is defined under HIPAA and generally includes health information, including demographic information, that is collected from you or created received by the Plan in any form (oral, written or electronic), from which it is possible to individually identify you. In addition, the information must relate to your past, present or future health or condition (physical or mental), to providing health care to you, or to paying for your health care. A complete description of your privacy rights can be found in the Plan's Privacy Notice, which was distributed to you upon enrollment. You may also request a copy of the Privacy Notice at any time by contacting the Fund Office.

We will not use or disclose your PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you. We have also required all of our business associates, such as the Claims Administrator, that create or receive PHI on our behalf to observe the privacy and security rules with respect to such PHI.

We will not, without your authorization, use or disclose PHI for employment-related actions and decisions or in connection with any of our other benefits or employee benefit plans. If someone other than you, even a friend or relative, contacts us and wants to discuss a claim or matter involving the information, your authorization will first be required unless the discussion is otherwise permitted under HIPAA. **Written explanations of benefits (EOBs) for Dependents under age 18 will be mailed to the participating Employee through whom the Dependent has coverage, unless the Dependent provides other written instructions to the Plan**.

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and to amend the information in certain circumstances. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Your rights are explained in greater detail in the Plan's Notice of Privacy Practices.

If you have questions about the privacy or security of your health information or wish to file a complaint under HIPAA, please contact the Administrative Manager at the Fund Office. The Administrative Manager also serves as the Plan's Privacy and Security Officer.

Written explanations of benefits (EOBs) for Dependent spouses and children age 18 or older will be mailed to the spouse or child unless he or she provides other written instructions to the Fund Office.

ARTICLE XII - IMPORTANT INFORMATION ABOUT THE PLAN

The following information concerning the Plan is being provided to you in accordance with the federal law known as ERISA.

A . Plan Name

The name of the Plan is the SOUTHWEST HEALTH BENEFITS FUND.

B . Type of Plan

The Plan is a group health plan that provides comprehensive medical benefits and prescription drug benefits.

C. Name and Address of Plan Sponsor and Plan Administrator

The Plan is sponsored and administered by a joint labor-management Board of Trustees consisting of an equal number of Union and Employer representatives. The address that may be used to contact the Board of Trustees is:

Union Trustees:

Kevin L. Smith, Chair
Business Manager, Insulators Local 112
3000 Highway 90 East, Suite 1
Lake Charles, LA 70605

Lucien Clark
President, Insulators Local 112
3000 Highway 90 East, Suite 1
Lake Charles, LA 70605

M. Monroe Norrid, Jr.
Business Manager, Insulators Local 21
11580 Reeder Road
Dallas, TX 75229

Thomas Kleinmann
6475 Trammel Drive
Dallas, TX 75214

Management Trustees:

Adrian Mendoza, Co-Chair
Performance Contracting Group
501 S. Wisteria Street
Mansfield, TX 76063

William G. McCraw
Alpha Specialty Contractors, Inc.
3000 Wichita Court
Fort Worth, TX 76140

Toby Landry
Atlantic Plant Services, Inc.
10343 Sam Houston Park Drive, Suite 200
Houston, TX 77064

A complete list of the Employers and/or employee organizations sponsoring or participating in the Plan is available for inspection without charge at the Fund Office, and a copy may be obtained by Employees, Dependents, retirees and Beneficiaries upon written request to the Plan Administrator for a minimal copying fee.

D. Type of Administration

The Plan is administered by a joint labor-management Board of Trustees consisting of an equal number of Union representatives and Employer representatives. The Board of Trustees is the named fiduciary charged with the responsibility to administer the Plan in accordance with the Plan documents and applicable law. The Board of Trustees may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services.

E. Agent for Service of Legal Process

In addition to the Plan Administrator, legal process may also be served on the Board of Trustees or any member of the Board of Trustees, as well as the following:

Maria Cangemi
Robein, Urann, Spencer, Picard & Cangemi
2540 Severn Avenue, Suite 400
Metairie, LA 70002

F. Employer Identification Number (EIN) and Plan Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 75-0355302. The Plan Number assigned to the Plan by the Board of Trustees is 501.

G. Plan Year

The Plan Year is the Calendar Year beginning January 1 and ending on the following December 31.

H. Identity of Funding Medium Used for Accumulation of Assets

All assets of the Plan are accumulated in a Trust Fund ("Fund") established and administered by the Board of Trustees for the purpose of providing benefits to the Participants and Beneficiaries and paying the administrative costs of the Plan. The Fund is governed by the Trust Agreement by which it was established and is maintained. The Board of Trustees has appointed, and may appoint from time to time, certain qualified investment advisors to assist with the investment of Plan assets. The Board of Trustees may, from time to time, contract with an insurance company to underwrite benefits under the Plan. All Plan benefits are payable solely out of the assets of the Fund. There is no obligation or liability of any Employer or Trustee or the Union to provide the benefits established under the Plan if the Fund does not have enough assets to make such payments.

I. Contribution Source

All contributions to the Plan are made by Employers in accordance with the Collective Bargaining Agreements between the Employers and sponsoring Local Unions, and any Participation Agreements between the Employers and Trustees. The Collective Bargaining Agreement and Participation Agreements require contributions to the Plan at a fixed rate per hour of Covered Employment.

Upon request, the Plan Administrator will provide you with information as to whether a particular Employer is contributing to the Plan on behalf of Participants working under a Collective Bargaining Agreement or Participation Agreement.

J. Collective Bargaining and Participation Agreements, Plan Documents and Reports

The Plan is maintained pursuant to one or more Collective Bargaining Agreements and Participation Agreements requiring the signatory Employers to make contributions to the Fund

on behalf of their Employees, at fixed rates for each hour in Covered Employment.

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;
2. Collective Bargaining and Participation Agreements;
3. SPD/Plan document and all amendments;
4. Form 5500 and full Annual Report filed with the Internal Revenue Service and Department of Labor; and
5. List of contributing Employers.

You may also obtain copies of these documents by making a written request to the Administrative Manager and paying a reasonable copying charge. You should ask what the charge will be before requesting copies. If you prefer, you can arrange to examine these documents, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Administrative Manager. A summary of the Annual Report, which gives details of the financial information about the Plan's operation, is furnished free of charge to all Participants.

ARTICLE XIII - STATEMENT OF ERISA RIGHTS

As a Participant in the Southwest Health Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended from time to time ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Section 13.1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

B. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Collective Bargaining Agreements and Participation Agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The Plan Administrator may assess a reasonable charge for the copies.

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

Section 13.2. CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue health care coverage for yourself, your Dependent spouse and children if there is a loss of coverage under the Plan as a result of a Qualifying Event. You and your Dependents will have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA coverage rights.

Section 13.3. ENFORCE YOUR RIGHTS

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, in all cases including those described in the above paragraph, you must first exhaust your administrative remedies under the Plan, by following the Plan's Claims Procedure and Claims Review Procedure described in this SPD/Plan, before you may file a lawsuit in any court. You will then have one year, from the date a final decision on appeal is reached under the Plan, in which to start a lawsuit (or, for fully insured benefits provided through a life insurance policy, the time period permitted under the life insurance policy, if different). In no event may legal action be brought in court, by you or on your behalf, later than this one-year period.

Section 13.4. ASSISTANCE WITH YOUR QUESTIONS

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

You can telephone the EBSA's toll-free Employee & Employer Hotline at 1-866-444-EBSA (3272), or write to the EBSA's Office of Participant Assistance at the following address:

Office of Participant Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210