CENTRAL TEXAS
HEALTH and BENEFIT TRUST FUND

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

2018 Edition

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IMPORTANT REMINDERS

You Must Notify the Fund Office if:

1. You change your address.
2. You get divorced or legally separated. You must also provide a court-certified divorce decree including any Qualified Medical Child Support Order ("QMCSO") or legal separation papers, if applicable. Any QMCSO must be in a form acceptable to the Trustees.
3. You get married. You must provide a certified copy of the marriage license or Declaration of Informal Marriage (for common-law marriages).
4. There is a birth, adoption, emancipation or death that changes the individual or family status in relationship to Plan benefits. You must provide a certified copy of the birth, adoption or death certificates.

How to Verify Benefits and File a Claim

To verify your benefits contact Central Texas Health and Benefit Trust Fund at:

Telephone: (972) 943-9559; Toll Free (866) 434-2200

The medical care service Provider should submit a Claim to the Plan for the Covered Person by sending it to:

Blue Cross Blue Shield of Illinois
300 E. Randolph – 26 NW
Chicago, IL 60601

If the Covered Person prefers to submit a Claim, that person may contact the Fund Office for medical Claims payment and to get the required Claim form at:

Central Texas Health and Benefit Trust Fund
Post Office Box 860007
Plano, TX 75086-0007
Telephone: (972) 943-9559
Toll Free: (866) 434-2200

The Covered Person or medical care Provider should complete the form. The Covered Person should then mail the completed Claim form, and all bills related to the Claim to the local Blue Cross Blue Shield office.

YOU MUST SUBMIT ANY CLAIM FOR BENEFITS WITHIN 90 DAYS FROM WHEN THE SICKNESS OR ACCIDENT OCCURRED. Failure to file a Claim within the 90 days will not invalidate the Claim if it is shown to the Fund's satisfaction that it was not reasonably possible to file the Claim within those 90 days. However, in that case, the Claim must be submitted as soon as is reasonably possible. In no event will benefits be provided if the Claim is submitted more than 12 months from the date on which the accident or sickness first occurred. Any decision concerning a Claim will be provided to you in writing or electronically.

NOTICE

This Fund is not a contract of employment and does not 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 Agreement or other Employment Agreement.

You MUST satisfy all of the eligibility provisions to be eligible for Plan benefits. Possession of this booklet does not, by itself, entitle you to Plan benefits.

The Trustees have full and exclusive authority in their sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits, and other related matters. The Trustees also have full power to construe the provisions of the Agreement and Declaration of Trust for this Plan and these Rules and Regulations. Any such determination and any such construction adopted by the Trustees will be binding on all persons, including all Participants and Beneficiaries of this Plan, including you and your Dependents.

This booklet is written to also function as the Fund's Summary Plan Description and to be as understandable as possible. This effort has resulted in simplified language that includes the Plan Rules and Regulations, also called the Plan document.

DEFINITIONS

Active Employee – Means an individual who is actively employed by a participating Employer and who is eligible to participate in the Plan.

Admission - Means an Inpatient stay in a Hospital or Other Facility Provider. Two successive Admissions will be considered one Admission if readmission is for the same or related condition for which the Covered Person was previously admitted and the readmission occurs within 90 days.

Alcoholism Treatment Facility - Means a facility that is primarily engaged in the treatment of alcoholism. The facility must have utilization and peer review plans in effect, and must maintain programs for alcoholism rehabilitation detoxification. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Ambulatory Health Facility - Means a facility that is organized and operated to provide medical care to Outpatients. The facility must provide preventive, diagnostic, therapeutic or rehabilitative services under the direction of a Physician. The facility must not be part of a Hospital.

Ambulatory Surgical Facility - Means a facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association, with an organized staff of Physicians, that:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

3. Does not provide Inpatient accommodations; and
4. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Other Professional Provider.

Beneficiary – Means your spouse, and if none, then your Children, and if none, then your parents, and if none, then your brothers and sisters, and if none, then your estate.

Brand-name drug – Means a pharmaceutical drug that has a trade name and is protected by a patent.

Calendar Year or Plan Year - Means January 1 through December 31.

Cardiac Rehabilitation Therapy - Means those Medically Necessary services that are rendered under the supervision of a Physician in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery. Therapy must be initiated within 12 weeks after the initial treatment for the medical condition ends and must be rendered in a Facility Provider covered by the Plan.

Child or Children – Means your natural child, step-child, foster child, adopted child, or a child placed with you for adoption. Grandchildren are covered provided they live with you for more than half the year and for whom you have provided over one-half of his or her financial support.

Chiropractic Treatment - Means the manipulation of the spine to relieve pain, restore maximum function, and to prevent disability following disease or Injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Professional Provider are required.

Chiropractor - Means a licensed practitioner of chiropractic medicine.

Claims

1. A "**Claim**" is a request for a benefit by or on behalf of a person who is eligible for benefits from this Plan, in accordance with the Plan's procedures. In addition, if a request for benefits is denied because the individual is not eligible for coverage under the Plan, the eligibility determination is considered a Claim for Appeal purposes.

   Casual inquiries about benefits or the circumstances under which benefits might be paid according to the terms of the Plan are not Claims. Nor is a request for a determination of whether an individual is eligible for coverage under the Plan considered a Claim.

2. A "**Pre-service Claim**" is a Claim for which the Plan requires approval before medical care is obtained. For example, a request to have a Hospital stay pre-authorized, as required by the Plan, is a Pre-service Claim. You can find more information about pre-certification under the section titled "Pre-certification and Case Management."

3. "**Urgent Care**" is medical care that, if normal Pre-service Claim response times were applied, would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of a physician with

knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of an Urgent Care Claim. An "Urgent Care Claim" is a Claim for Urgent Care. If an **Urgent Care Claim** is submitted without an opinion of a Physician stating that the situation does, in fact, involve an Urgent Care Claim, then the Covered Person or Provider must provide enough information so that the Plan can determine whether the Claim is an Urgent Care Claim.

4. A "**Post-service Claim**" is a Claim that concerns a service or supply that has already been provided for which a Covered Person has already incurred an expense. Most health, vision, dental, life insurance, accidental death and dismemberment, and weekly sickness and accident benefits Claims probably will be presented to the Plan as Post-service Claims.

5. "**On-going Treatment**" means a course of treatment that the Plan has approved for a specific period or number of treatments.

6. An "**Adverse Benefit Determination**" is any denial, reduction, termination of or failure to provide or make payment for a benefit, in whole or in part, under the Plan. It is also any denial, in whole or in part, of eligibility for coverage under the Plan. Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the individual pays the entire cost, is not an Adverse Benefit Determination.

7. "**Relevant Document**" means any document related to a Claim if it was relied upon in making the benefit determination; was submitted, considered or generated for making the benefit determination; or constitutes the Plan's policy or guidance with respect to the denied treatment option or benefit. Examples of what might be Relevant Documents include, but are not limited to, Plan rules, written medical opinions, and lists of covered services, drugs, products or supplies.

Coinsurance - Means a percentage of the Provider's Reasonable Charge that a Covered Person pays for Covered Services.

Community Mental Health Facility - Means a facility that is primarily engaged in the treatment of Mental Illness, including substance abuse. The facility must have utilization and peer review plans in effect. The facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the Department of Health.

Competitive Employment – Means any work as an electrical worker with an Employer that is not signatory to, or will have terminated its obligations under, a Collective Bargaining Agreement or Participation Agreement with any local union within the jurisdiction of the International Union of Operating Engineers.

Contributing Employer – Means any Employer who:

1. Has a Collective Bargaining Agreement or other written agreement with the Union or the Trustees requiring periodic contributions to be made to the Plan;

2. Has signed a copy of the Trust Agreement or a Participation Agreement;

3. Is accepted for participation in the Plan by the Trustees or was a party to the Trust Agreement; and

4. The Plan and the Union, provided it (1) becomes obligated pursuant to a Participation Agreement with the Trustees to contribute to the Plan on behalf of its Employees on substantially the same basis upon which other Employers are contributing to the Plan; or (2) is accepted for participation in the Plan by the Trustees; and (3) makes contributions to the Plan as required by the Participation Agreement.

Co-payment - Means the amount the Covered Person must pay each time the individual receives the Covered Service. The Co-payments are set forth in the Schedule of Benefits.

Coverage - Means the payment for Covered Services as specified and limited by the Central Texas Health and Benefit Trust Fund.

Covered Employee - Means: 1) a person who is an Active Employee, as defined in the Plan's eligibility rules; 2) a person who has elected COBRA continuation coverage and is still covered under COBRA continuation coverage; 3) a person who is covered as a Retired Employee making Retiree self-payments; or 4) a person who is Totally Disabled, as defined by the Plan, and is either a) covered under the Plan's Total Disability continuation provisions or b) making self-payments.

Covered Person - Means the Covered Employee and, under Family Coverage, Dependents.

Covered Services - Means the types of services or supplies for which the Plan provides payment. The Plan pays only for Covered Services that are Medically Necessary.

Deductible - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Calendar Year before benefits begin to be paid for that person under the Plan.

1. **Individual Deductible** - Is the amount that each Covered Person must pay during a Calendar Year before benefits begin to be paid by the Plan for that person.

2. **Family Deductible** - Is the maximum amount that all family members covered under the same Family Coverage must pay in Deductible expense in a Calendar Year. Once the Family Deductible for all combined family members is reached, the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Calendar Year.

3. The individual or family Deductible is not applicable to Co-payments and Preventive Care provided at no cost to the Covered Person.

Dependent – Means any person who meets the following requirements:

1. Your lawful spouse.

2. Your Child from birth to age 26.

3. Your Child of any age who is totally disabled, provided the Child was both disabled and eligible under the Plan before age 26, is solely dependent upon you for support, and provided you furnish proof of the Dependent Child's disability not later than 31 days after the Child's attainment of age 26. You may be requested by the Plan to furnish proof of the continued existence of such a disability from time to time. Totally disabled under this provision means that the Child is unable to engage in any substantial gainful activity on a full time sustained basis because of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

Diagnostic Services - Means tests and procedures performed when the Covered Person has specific symptoms to detect or to monitor the Covered Person's Illness or Injury. Diagnostic Services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; and cardiographic, encephalographic and radioisotope tests.

Effective Date - Means the date on which Coverage begins.

Eligible Expenses - Means expenses for Covered Services that are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Provider's Reasonable Charge.

Emergency Admission - Means an unplanned and unscheduled Admission through an emergency room or department.

Employee – Means an Employer's Employee who is covered by a Collective Bargaining Agreement presently in effect or that may be in effect from time to time in the future by and between the Union and the Employer requiring contributions to the Fund. An Employee includes any full-time Employees of the Employers for whom, pursuant to a Collective Bargaining Agreement with the Union or Participation Agreement with the Fund, and under such uniform and non-discriminatory rules, regulations, and rates as the Trustees may provide, contributions are required to be made to the Fund with respect to such employment for the purpose of providing benefits under the Plan.

Employer – Means any person, firm, association, partnership, or corporation having a Collective Bargaining Agreement with the Union, or a Participation Agreement with the Fund, that requires periodic contributions be made to the Fund on behalf of its Employees.

Experimental/Investigative - Means any treatment, procedure, facility, equipment, drug, device or supply, that the Plan does not recognize as accepted medical practice or that does not have required governmental approval when the Covered Person receives it, except as provided under applicable law.

ERISA - Means the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. Section 1001, *et seq.*

Facility Provider - Means Hospitals and Other Facility Providers.

Family Coverage - Means Coverage for the Covered Employee and one or more Dependents.

Generic Drug – Means a pharmaceutical drug that is equivalent to a brand-name product in actie ingredients, dosage, strength, route of administration, quality, performance, and intended use, but does not carry the brand name.

Home Health Care Provider - Means a facility that provides skilled nursing and other services on a visiting basis in the Covered Person's home, and that is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician. A Home Health Care Provider must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Hospice - Means a facility that provides medical, social, psychological and spiritual care as palliative treatment for terminally ill patients as Outpatients in the home and/or as Inpatients at Facility Providers using an interdisciplinary team of professionals. A Hospice must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by Medicare.

Hospital - Means an institution licensed as such by the jurisdiction in which it is located and approved as such by the Joint Commission on Accreditation of Health Care Organizations or certified under Medicare. It must provide Inpatient medical care and treatment, and maintain a staff of Physicians and nurses, facilities for diagnosis and major surgery. It cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction.

Illness - Means any physical disease or Mental Illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses.

Injury - Means bodily damage caused by external means or substances foreign to the body. Injury to the teeth as a result of biting or chewing is not considered an Injury.

In-network - Refers to Covered Services rendered by a Preferred Provider.

Inpatient - Means a Covered Person who is admitted to a Hospital or Other Facility Provider as a registered Inpatient and who remains in the Hospital or Other Facility Provider for 24 hours or more.

Laboratory - Means a facility that performs diagnostic tests and that is approved as such for Medicare reimbursement.

Maternity Services - Means services for normal pregnancy, complications of pregnancy, or miscarriage.

Maximum Benefit - Means the maximum amount the Plan will pay for a Covered Service.

Medical Emergency - Means the onset of an unexpected Illness or Injury that requires emergency treatment of such Illness or Injury when (1) such services are rendered in the emergency room or emergency department of a Hospital, and (2) failure to receive immediate treatment of such Illness or Injury would seriously jeopardize the Covered Person's life and/or health.

Medically Necessary or Medical Necessity - Means that a service or supply is:

1. Provided for an Injury or Illness;
2. Consistent with the diagnosis and treatment of the Covered Person's condition;
3. Consistent with the standards of good medical practice;
4. Not considered Experimental or Investigative;
5. Not for the Covered Person's convenience or the convenience of the Covered Person's Physician; and
6. Provided at the most appropriate level of care or in the most appropriate type of health care facility. Only the Covered Person's medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

Medicare - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Mental Illness - Means any Illness defined by the American Psychiatric Association as a mental or psychological illness or disorder.

Negotiated Rate - Means the rate for Covered Services established by a contract in effect between the PPO Network and the Preferred Provider.

Non-Preferred Provider - Means a Provider who is not participating in the PPO Network(s) to which the Covered Person has access under this Plan.

Nurse Practitioner - Means a registered nurse (R.N.) with advanced education and training who is licensed to practice medicine in collaboration with Physicians.

Occupational Therapy - Means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No Plan benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

Ophthalmologist - Means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) legally qualified to practice medicine, including diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

Other Facility - Means the following providers:

1. Ambulatory Health Facility;
2. Ambulatory Surgical Facility;
3. Home Health Care Provider;
4. Hospice;
5. Skilled Nursing Facility;
6. Community Mental Health Facility;
7. Alcoholism Treatment Facility; and
8. Specialized Hospital.

Other Professional Provider - Means any of the following providers:

1. Physical Therapist;
2. Speech Therapist;
3. Certified Registered Nurse Anesthetist (C.R.N.A.);
4. Registered Nurse (R.N.);
5. Licensed Practical Nurse (L.P.N.);
6. Licensed Occupational Therapist (O.T.);
7. Pharmacy or Pharmacist;
8. Certified Nurse Midwife (C.N.M.);
9. Chiropractor;
10. Laboratory (must be Medicare-approved);
11. Professional Ambulance Service;
12. Licensed Social Worker;
13. Licensed Professional Counselor (LPC) – Must be In-Network; and
14. Any other medical practitioner acting under a state medical license.

Out-of-Network - Refers to Covered Services rendered by a Non-Preferred Provider.

Out-of-Pocket Limit - Means the maximum Co-insurance, Deductibles and Co-payments that each Covered Person must pay in a Calendar Year.

1. **Individual Out-of-Pocket Limit** is the maximum amount each person is required to pay in Coinsurance, Deductibles and Co-payments in a Calendar Year.

2. **Family Out-of-Pocket Limit** is the maximum amount all family members covered under the same Family Coverage are required to pay in Coinsurance, Deductibles and Co-payments in a benefit period. Once the Family Out-of-Pocket Limit for all combined family members is reached, the Out-of-Pocket Limit will be considered satisfied for all family members under that Family Coverage during the remainder of the Calendar Year.

Outpatient - Means a Covered Person who receives medical care or treatment when the individual is not an Inpatient.

Partial Day Treatment (or Partial Day Treatment Program) - Means a program for psychiatric and/or substance abuse care that is accredited by the Joint Commission on Accreditation of Health Care Organizations, or in compliance with equivalent standards, for patients who require a skilled level of care in a Hospital, or other eligible Facility Provider, but who do not need treatment for an acute or life-threatening condition. A Partial Day Treatment Program is one provided in a treatment setting that is less than a 24-hour residential setting.

Participant – Means a Covered Person.

Participation Agreement – Means a written agreement in form and content acceptable to the Trustees that evidences commitment to be bound by the Trust Agreement and defines the Employer's contribution obligation to the Fund.

Pharmacy - Means a facility that is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

Physical Therapist - Means a licensed Physical Therapy practitioner.

Physical Therapy - Means treatment by physical means, including: modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, or to prevent disability following disease, Injury, or loss of a body part. Treatment must be for an acute condition where a rehabilitation potential exists and the skills of a Physician or other Professional are required.

Physician - Means one of the following professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.);
2. Doctor of Osteopathy (D.O.);
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.);
4. Dental Surgeon or Dentist (D.D.S.);
5. Chiropractor (D.C.);
6. Doctor of Optometry (O.D.);
7. Psychiatrist;
8. Psychologist; and
9. Ophthalmologist.

Plan - Means the Central Texas Health and Benefit Trust Fund, an employee welfare benefit plan established under ERISA and a health care payment program provided and jointly administered by the Board of Trustees. The Board of Trustees has sole discretion to modify and to interpret the Plan and the terms and conditions of the Plan Document. Any such interpretation is binding on all Covered Persons and their heirs, assignees and agents, and any other person.

Podiatrist - Means a professional licensed under the applicable state laws as a Doctor of Podiatric Medicine.

PPO - Means the Preferred Provider Organization selected by the Board of Trustees.

PPO Network - Means the network(s) of Preferred Providers to which the Covered Persons will have access under this Plan.

Preferred Provider - Means a Provider who is a member of the PPO Networks to which the Covered Person has access under this Plan.

Provider - A Facility Provider, Physician or Other Professional Provider defined in other sections of this Plan Document and Summary Plan Description who is licensed and is operating within the scope of that license.

Provider's Reasonable Charge - Means a charge by a Provider for a Covered Service that meets the Plan's criteria for reasonableness. The Plan does not pay more than a Provider's Reasonable Charge. For a Preferred Provider, the Provider's Reasonable Charge is based on the Negotiated Rate. For an Out-of-Network Physician or Other Professional Provider, the Provider's Reasonable Charge is the Usual, Customary and Reasonable Charge as determined by the PPO.

Serious Mental Illness - Means the following psychiatric illnesses as defined in the Diagnostic and Statistical Manual (DSM) III-R or its successor:

1. Schizophrenia;
2. Paranoia and other psychiatric disorders;
3. Bipolar disorders (hypomanic, manic depressive and mixed);
4. Major depressive disorders (single episodes or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive development disorders;
7. Obsessive-compulsive disorders; and
8. Depression in childhood and adolescence.

If, for any Illness listed above, any successor Diagnostic and Statistical Manual uses a different term or combines it with any other condition, the Illness shall still be regarded as a Serious Mental Illness.

Skilled Nursing Facility - Means a facility that mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care, or that provides treatment for Mental Illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

Specialized Hospital - Means a facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a Nurse Practitioner.

Speech Therapist - Means a licensed speech-language pathologist.

Speech Therapy - Means active treatment for improvement of an organic medical condition causing speech impairment. Treatment must be either post-operative or for the recovery stage of an active Illness.

Spouse - Means any individuals who are lawfully married under any state law, including individuals married to a person of the same sex who are legally married in a state that recognizes such marriages, but who are domiciled in a state that does not recognize such marriages. For a common law marriage, you must submit a copy of the registration of the informal marriage. The date of registration will be the effective date of eligibility.

TMJ - Means Temporomandibular Joint Dysfunction, a musculoskeletal disorder involving the jaw joint and/or associated soft tissues.

Trustees – Means fiduciaries of the Plan that are charged with the care and custody of the Plan assets and the administration and operation of the Plan. The Board of Trustees consists of equal representation of labor and management.

Usual, Customary and Reasonable (UCR) Charge – The term means the allowed charge, for purposes of coverage under the Plan, for services, treatments or supplies as determined by the Plan or its designee in accordance with a reasonable, uniform, consistent and non-discriminatory method. The Usual and Customary charge will be lowest of the following amounts: (1) for a PPO, the fee set forth in the agreement between the PPO and the Fund; (2) the provider's actual charge; (3) the suggested allowed amount as determined by the PPO; and (4) the usual charge by the provider for the same or similar service, treatment or supply.

You and Your - Refers to the Covered Employee in the Plan.

MESSAGE FROM THE BOARD OF TRUSTEES FOR BENEFIT PLAN A OF THE CENTRAL TEXAS HEALTH and BENEFIT TRUST FUND

To All Covered Persons who are eligible for **Benefit Plan A**:

We are pleased to provide you with this consolidated Plan Document and Summary Plan Description concerning **Benefits Plan A** under the Central Texas Health and Benefit Trust Fund. This document describes your current health, prescription drug, vision, life insurance, accidental death and dismemberment insurance, and sickness and accident benefits.

We have tried to explain all of the provisions of the Fund as clearly as possible. However, the Fund's provisions and the insurance contract that provides some of the benefits are complicated. The Board of Trustees has sole discretion to amend, modify, or discontinue all or part of the Fund and to interpret this Plan Document and Summary Plan Description. The Board's interpretation is binding on all Covered Persons and their heirs, assignees or agents, and on all Providers and all other persons and entities.

If you have questions after reading this document, you can call or write the Fund Office regarding the Plan and how any rules affect your Beneficiaries, and you. Please bear in mind that for your protection, only we, as the full Board of Trustees, are authorized to interpret the Plan. Information you receive from the Union or individual Employers or their representatives should be regarded as unofficial. Any information or opinion concerning your rights under the Plan, to be official, must be communicated to you in writing on our behalf.

Be sure to inform the Fund Office of any change in your mailing address to ensure that you receive all future communications about the Fund. We hope that you will find this document helpful and that you and your family will enjoy the protection of the Fund for many years to come.

Sincerely,

BOARD OF TRUSTEES

NOTE: Receipt of this document does not, by itself, entitle you to the benefits provided by this Plan. To be eligible for Plan benefits, you must be otherwise eligible as explained in this consolidated Plan Document and Summary Plan Description. If you have any questions, please contact the Fund Office at:

Telephone: (972) 943-9559
Toll-Free: (866) 434-2200

PLAN A

SCHEDULE OF MEDICAL BENEFITS – PLAN A		
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**	**OUT-OF-NETWORK**
GENERAL INFORMATION		
DEDUCTIBLES (Per Calendar Year)		
Annual Deductible* Per Individual Per Family (combined)	 $750 $2,250	 $750 $2,250
*Expenses incurred in the 4th quarter and applied toward your Calendar Year Deductible will also be given credit toward your next Calendar Year Deductible. The individual Deductible doesn't apply to certain preventive care for PPO and Prescription Drugs		
MAXIMUM OUT-OF-POCKET MEDICAL EXPENSES		
Per Individual Per Family	$6,000 $12,000	$8,000 $16,000
MAXIMUM OUT-OF-POCKET PHARMACY EXPENSES		
Per Individual Per Family	$600 $1,200	N/A N/A
*In-Network-Out-of-Pocket expenses include Medical Co-payments, Deductible, Co-Insurance, and Prescription Co-payments. Out-of-Network Deductibles and Co-payments are not included		
COVERED SERVICES – The Plan Pays The Following Amounts		
PHYSICIAN SERVICES		
Office Visit (primary and specialist care)	100% after $40 Co-payment	70% after Calendar Year Deductible
Minute Clinics	100% after $30 Co-Payment	N/A
Laboratory/Radiology Diagnostic Test (X-ray, Lab) Imaging (CT/PET Scans, MRIs)	100% of 1st $500 per Calendar Year and then 80% after the Calendar Year Deductible for charges over $500	100 % of 1st $500 per Calendar Year and then 70% after the Calendar Year Deductible for charges over $500
PREVENTIVE CARE SERVICES	100% as mandated by the Affordable Care Act	70% after Deductible See Covered Services
Surgery Inpatient Outpatient Office	 80% after Deductible 80% after Deductible 80% after Deductible	 70% after Deductible 70% after Deductible 70% after Deductible
HOSPITAL SERVICES		
Inpatient Services (semi-private room and related charges)	80% after Deductible	60% after Deductible
PHYSICIAN HOSPITAL SERVICES		
Inpatient Services	80% after Deductible	60% after Deductible

Emergency Room	$200 Co-payment then 80% Deductible Waived	$200 Co-payment then 80% Deductible Waived
Outpatient Services & Supplies	80% after Deductible	60% after Deductible
OTHER SERVICES		
Accidental Injury Services	100% of first $200 80% after Deductible	100% of first $200 60% after Deductible
Allergy Injections	100%	100%
Allergy Serum/Testing	80% after Deductible	60% after Deductible
Chiropractic Services	100% after $25 Co-payment per visit, 20 visit maximum per Calendar Year	
Durable Medical Equipment	80% after Deductible	60% after Deductible
Home Health Care Visits	80% after Deductible, max - 60 visits per Calendar Year	60% after Deductible; max - 60 visits per Calendar Year
Organ Transplants	80% after Deductible Travel & Lodging – 100%	60% after Deductible
PHARMACY - RETAIL		
Rx Calendar Year Deductible	$0	
Generic	100% after $15 Co-payment*	
Brand Name	100% after $35 Co-payment – When generic equivalent is available you also pay the difference in cost*	
*Maintenance drugs (Generic & Brand) after 2nd refill Mail Order is Mandatory		
Specialty (Mail order is mandatory after the first Rx is filled)	90% after Co-Payment of 10% of cost (Max $150)	
PHARMACY – MAIL ORDER		
Rx Mail Order Co-Payments (90-day supply)		
Generic	$0	
Brand Name	100% after $70 Co-payment - When generic equivalent is available you also pay the difference in cost	
Specialty (Mail order is mandatory after the first Rx is filled)	90% after Co-Payment of 10% of cost (Max $150)	
MAXIMUM OUT-OF-POCKET PHARMACY EXPENSES		
Per Individual Per Family	$600 $1,200	
VISION DISCOUNT BENEFIT		
For the Vision Discount Program, the contact information is listed on the back of your ID card		
PRE-CERTIFICATION AND CASE MANAGEMENT		
The Plan requires that prior to receiving services including Hospital In-patient and some Out-patient services a Covered Person must obtain pre-certification. **Failure to do so may reduce available benefits.**		

SCHEDULE OF LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
Covered Employee Life Insurance At the age of 70 years old, benefits reduce by 50%	$10,000
Eligible Dependents Life Insurance Spouse – until 65 years old Child – over 14 days old, but less than 25 years old	 $3,000 $3,000
WEEKLY ACCIDENT AND SICKNESS BENEFITS (Active Employee Only)	
Waiting Period	Weekly Benefit begins on the 8th day of the disability
Weekly Benefit	$250
Benefit Duration	Maximum of 26 weeks

Eligibility Rules-Plan A

Please refer to the Collective Bargaining Agreement you are working under to determine which plan of benefits apply to you and your Dependents.

Collectively-Bargained Employees

Initial Eligibility -You will become eligible on the first day of the second calendar month following a period of no more than six consecutive months during which you work in Covered Employment and you work at least 375 hours for a Contributing Employer.

Covered Employment - The term "Covered Employment" means your work for a Contributing Employer that is signatory to a Collective Bargaining Agreement or a Participation Agreement between your Employer and the Plan.

Lag Month – The "Lag Month" is the month between the month you initially accumulate 375 hours of employment and the first day of the month you actually become eligible for the benefits provided by the Plan. The purpose of the Lag Month is to allow sufficient time for your Employer to submit the required hours-of-employment form and related contributions to the Fund Office. Once the Fund Office enters the hours in your file your initial benefit month is determined.

Hour Bank Account - The term "Hour Bank Account" means an account of hours established in your name by the Plan. Subject to the maximum limit of 420 hours, all hours of Covered Employment for which contributions are made on your behalf will be credited to your Hour Bank Account. Your Hour Bank Account is updated monthly.

Your Hour Bank Account can be used to supplement required contributions that are less than the amount required by the Trustees to fund the Fund. If you have less than 140 hours in your Hour Bank Account at the end of a month, you may pay for the difference ("Short Pay") between the hours left in your hour bank and the 140 hours required at an hourly rate set by the Board of Trustees. To be eligible to Short Pay, you must be eligible for coverage the month before the month for which the Short Pay payment is applied.

Withdrawals for coverage from your Hour Bank Account will be made based on the Fund's current contribution rate. Whenever the Fund's contribution rate increases, the number of hours in your Hour Bank Account will be pro-rated.

Maintenance of Eligibility - Once you have established Initial Eligibility, 140 hours will be deducted from your Hour Bank Account for each month of coverage. You will continue to be covered for the benefits provided by the Fund as long as your Hour Bank Account contains at least 140 hours.

Whenever you work more than the required 140 hours, the excess hours will be added to your Hour Bank Account up to a maximum of 420 hours after the deduction of the 140 hours for the current month's coverage.

Example of Eligibility

Work Month	Hours Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	150	150			
May	180	330			
June	175	505	375	130	
July	180	310	140	170	July (Lag Month)
August	185	355	140	215	August (initial)
September	190	405	140	265	September
October	190	455	140	315	October
November	180	495	140	355	November
December	185	540	140	400	December
January	180	580	140	420	January
February	185	605	140	420	February
March	185	605	140	420	March

* Your Hour Bank Account will be limited to a maximum of 420 hours after the deduction for the current month's coverage.

Termination of Eligibility - Your eligibility will terminate on the earliest of the following:

1. The last day of the month in which you have less than 140 hours in your Hour Bank after the deduction for the current month's eligibility (see example below);

2. Except as otherwise required by applicable law, the last day of the month in which you enter full-time active duty in the Armed Forces of the United States;

3. The last day of the month following the day that the IBEW Local Union that represents you for the purpose of collective bargaining withdraws from participation in the Plan;

4. The date the Plan terminated, either in full or as to you or the group in which you belong.

If your IBEW Local Union and/or corresponding NECA Chapter chooses to leave the Plan, all hours in your Hour Bank Account will be forfeited immediately. If you are eligible for benefits under the Plan at the time of the withdrawal, whether as an Active Employee, by making self-payments under the Plan's COBRA or extended self-payment provisions for Totally Disabled or as a Retired Employee, your coverage will end on the last day of the month following the withdrawal.

If you are an Active Employee or any other employee covered under this Plan and you work in Competitive Employment, you will lose coverage and the hours in your Hour Bank Account will be forfeited, effective at the beginning of the month following the month in which you began work in Competitive Employment.

Example of Termination of Eligibility for Active Employee Due to Insufficient Hours

Work Month	Hours Worked	Reserved Account	Withdrawal	Reserve Account	Benefit Month
April	105	105		105	
May	0	105		105	
June	100	205		205	
July	110	315		315	September (Lag Month)
August	115	430	375	55	October (Initial)
September	150	205	140	65	November
October	160	225	140	85	December
November	105	190	140	50	January
December	100	150	140	10	February
January	80	90	0	90	March - COBRA

Reinstatement of Eligibility - If your eligibility terminates because you do not have the required hours in your Hour Bank Account, you will again become eligible when your Hour Bank Account shows a total of at least 140 hours within the six-month period immediately following the termination of your eligibility. The reinstatement will be effective on the first day of the second calendar month your Hour Bank Account balance returns to 140 hours. If you are not reinstated, your Hour Bank Account will be forfeited, and you will only become eligible for coverage upon completion of the eligibility requirements explained in the "Initial Eligibility" section.

Any change in eligibility for a specific plan of benefits as a result of a change in your job classification will be effective the 1st day of the month following the change in classification.

Non-Bargained Employees

Initial Eligibility - If you are a full-time or regular part-time (at least 30 hours/week) employee who is not subject to a Contributing Employer's collective bargaining agreement or letter of assent, or is not otherwise covered by any multiemployer health plan ("Non-Bargaining Employee"), or

you are a Non-Bargained Alumni Employee (an electrician who has in the past performed work under a collective bargaining agreement), you may be eligible for Plan benefits if your employer satisfies all of the following conditions:

1. Unless you are an employee of a Local Union, your employer must also be a Contributing Employer within six months of you beginning to receive coverage under the Plan;

2. Your employer must sign a Non-Bargaining Participation Agreement with the Plan, in a form approved by the Plan, that covers your employment;

3. If your Employer offers coverage to any of its Non-Bargaining Employees, your employer must agree to offer coverage to all of its regular full-time or part-time Non-Bargaining Employees who are not covered by any other multiemployer health plan. If your employer offers coverage to any of its Non-Bargained Alumni Employees, it must offer coverage to all of its Non-Bargained Alumni Employees. A Non-Bargaining Employee or Non-Bargained Alumni Employee may opt out of coverage, but only by filing a written notice with the Fund Office.

4. Your employer must make contributions to the Plan on your behalf for at least 160 hours per month, regardless of how many hours you actually work, at the rate established by the Trustees, in their sole discretion.

If your employer meets all of these conditions, and either you or your Contributing Employer has made contributions to the Plan on your behalf equal to three times the monthly amount described in Item 4, above, then you will be considered an "Active Employee", your benefits under the Plan will be the same as those for a collectively-bargained Employee, and an Hour Bank or Reserve Account will be maintained for you in the same manner as for a collectively-bargained employee. An individual who is making self-payments for coverage is NOT an Active Employee.

Termination of Eligibility - Your coverage under the Plan will terminate as provided in Maintenance and Termination of Eligibility section below, or if your Employer (1) is delinquent in its required contributions, (2) discontinues its contributions, (3) fails to employ for a period of six consecutive months any individuals under the terms of a collective bargaining agreement, or (4) otherwise ceases to cover its Non-bargained Employees or Collectively-bargained Employees under the Plan.

Maintenance and Termination of Eligibility

Your eligibility will terminate on the earliest of the following:

1. The last day of the month in which you have less than 140 hours in your Hour Bank after the deduction for the current month's eligibility;

2. Except as otherwise required by applicable law, the last day of the month in which you enter full-time active duty in the Armed Forces of the United States;

3. The last day of the month following the day that the IBEW Local Union that represents your Employer's bargaining unit Employees for the purpose of collective bargaining withdraws from participation in the Plan;

4. The date the Plan terminated, either in full or as to you or the group in which you belong.

MESSAGE FROM THE BOARD OF TRUSTEES FOR BENEFIT PLAN B OF THE CENTRAL TEXAS HEALTH and BENEFIT TRUST FUND

To All Covered Persons who are eligible for **Benefit Plan B**:

We are pleased to provide you with this document concerning **Benefits Plan B** under the Central Texas Health and Benefit Trust Fund. This document describes your current health, prescription drug, vision, life insurance, accidental death and dismemberment insurance, and sickness and accident benefits.

We have tried to explain all of the provisions of the Plan as clearly as possible. However, the Plan's provisions and the insurance contract that provides some of the benefits are complicated. The Board of Trustees has sole discretion to amend, modify or discontinue all or part of the Plan and to interpret the combined Plan Document and Summary Plan Description. The Board's interpretation is binding on all Covered Persons and their heirs, assignees or agents, and on all Providers and all other persons and entities.

If you have questions after reading this document, you can call or write the Fund Office regarding the Plan and how any rules affect your Dependents and you. Please bear in mind that for your protection, only we, as the full Board of Trustees, are authorized to interpret the Plan. Information you receive from the Union or individual Employers or their representatives should be regarded as unofficial. Any information or opinion concerning your rights under the Plan, to be official, must be communicated to you in writing on our behalf.

Be sure to inform the Fund Office of any change in your mailing address to ensure that you receive all future communications about the Plan. We hope that you will find this booklet helpful and that you and your family will enjoy the protection of the Plan for many years to come.

Sincerely,

BOARD OF TRUSTEES

NOTE: Receipt of this booklet does not, by itself, entitle you to the benefits provided by this Plan. To be eligible for Plan benefits, you must be otherwise eligible as explained in this consolidated Plan Document and Summary Plan Description. If you have any questions, please contact the Fund Office at:

Telephone: (972) 943-9559
Toll-Free: (866) 434-2200

PLAN B

SCHEDULE OF MEDICAL BENEFITS – PLAN B		
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**	**OUT-OF-NETWORK**
GENERAL INFORMATION		
DEDUCTIBLES (Per Calendar Year)		
Annual Deductible* Per Individual Per Family (combined)	 $1,000 $3,000	
***Expenses incurred in the 4th quarter and applied toward your Calendar Year Deductible will also be given credit toward your next Calendar Year Deductible. Your Deductible doesn't apply to certain preventive care for PPO and Prescription Drugs**		
MAXIMUM OUT-OF-POCKET MEDICAL EXPENSES		
Per Individual Per Family	**$6,000** **$12,000**	$10,000 $20,000
MAXIMUM OUT-OF-POCKET PHARMACY EXPENSES		
Per Individual **Per Family**	**$600** **$1,200**	
***In-Network-Out-of-Pocket expenses include Medical Co-payments, Deductible, Co-Insurance and Prescription Co-payments. Out-of-Network-Deductibles and co-payments are not included**		
COVERED SERVICES – THE PLAN PAYS THE FOLLOWING		
PHYSICIAN SERVICES		
Office Visit	100% after $40 Co-payment	70% after Calendar Year Deductible
Minute Clinic	100% after $30 Co-payment	N/A
Laboratory/Radiology Diagnostic Test (X-ray, Lab) Imaging (CT/PET Scans, MRIs)	100% of 1st $500 per Calendar Year and then 80% after the Calendar Year Deductible for charges over $500	70% after the Calendar Year Deductible
PREVENTIVE CARE SERVICES		
Regular preventive care	100%	70% after Deductible
Annual Physical	100%	60% after Deductible (max $250)
Immunizations	100%	70% after Deductible
Surgery		
Inpatient	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Office	80% after Deductible	60% after Deductible

HOSPITAL SERVICES		
Inpatient Services (semi-private room and related charges)	80% after Deductible	60% after Deductible
PHYSICIAN HOSPITAL SERVICES		
Inpatient Services	80% after Deductible	60% after Deductible
Emergency Room	80% after $200 Co-payment (Deductible waived)	80% after $200 Co-payment (Deductible waived)
Outpatient Services & Supplies	80% after Deductible	60% after Deductible
OTHER SERVICES		
Allergy Injections	100%	60% after Deductible
Allergy Serum/Testing	80% after Deductible	60% after Deductible
Home Health Care Visits	80% after Deductible; maximum of 60 visits per Calendar Year	60% after Deductible; maximum of 60 visits per Calendar Year
Organ Transplants	80% after Deductible	60% after Deductible

PHARMACY - RETAIL	
Rx Calendar Year Deductible Per Individual	$100 (applies to both Retail and Mail Order)
Generic	100% after $20 Co-payment * Mail Order is Mandatory after 2nd refill
Brand Name	100% after $40 Co-payment * When Generic equivalent is available you also pay the difference in cost between the Generic and Brand
*For maintenance drugs, Mail Order is mandatory after 2nd refill	
Specialty (Mail order is mandatory after the first Rx is filled)	100% after 10% of cost Co-Payment (Max $150)
PHARMACY - MAIL ORDER	
Rx Mail Order Co-Payments (90- day supply)	
Generic	100% ($0 cost to you)
Brand Name	100% after $80 Co-payment When generic equivalent is available you also pay the difference in cost between the generic and Brand
Specialty (Mail order is mandatory after the first Rx is filled)	100% after 10% of cost Co-Payment (Max $150)
MAXIMUM OUT-OF-POCKET PHARMACY EXPENSES	
Per Individual	**$600**
Per Family	**$1,200**
VISION DISCOUNT BENEFIT	
For the Vision Discount Program, the contact information is listed on the back of your ID card	

PRE-CERTIFICATION AND CASE MANAGEMENT
The plan requires that prior to receiving services including Hospital In-patient and some Out-patient services a Covered Person must obtain pre-certification. **Failure to do so may reduce available benefits.**

Eligibility Rules-Plan B

Please refer to the Collective Bargaining Agreement you are working under to determine which plan of benefits apply to you and your dependents.

Initial Eligibility - You will become eligible on the first day of the second calendar month following a period of no more than six consecutive months during which you work in Covered Employment at least 375 hours for a Contributing Employer.

Covered Employment - The term "Covered Employment" means your work for a contributing Employer who is signatory to a Collective Bargaining Agreement or a Participation Agreement between your Employer and the Plan.

Lag Month - The "Lag Month" is the month between the month you initially accumulate 375 hours of employment and the first day of the month you actually become eligible for the benefits provided by the Plan. The purpose of the Lag Month is to allow sufficient time for your Employer to submit the required hours-of-employment form and related contributions to the Fund Office. Once the Fund Office enters the hours in your file your initial benefit month is determined.

Hour Bank Account - The term "Hour Bank Account" means an account of hours established in your name by the Plan. Subject to the maximum limit of 420 hours, all hours of Covered Employment for which contributions are made on your behalf will be credited to your Hour Bank Account. Your Hour Bank Account is updated monthly.

Your Hour Bank Account can be used to supplement required contributions that are less than the amount required by the Trustees to fund the Plan. If you have less than 140 hours in your Hour Bank Account at the end of a month, you may pay for the difference ("Short Pay") between the hours left in your hour bank and the 140 hours required at an hourly rate set by the Board of Trustees. To be eligible to Short Pay, you must be eligible for coverage the month before the month for which the Short Pay payment is applied.

Withdrawals for coverage from your Hour Bank Account will be made based on the Plan's current contribution rate. Whenever the Plan's contribution rate increases, the number of hours in your Hour Bank Account will be pro-rated.

Maintenance of Eligibility - Once you have established Initial Eligibility, 140 hours will be deducted from your Hour Bank Account for each month of coverage. You will continue to be covered for the benefits provided by the Plan as long as your Hour Bank Account contains at least 140 hours.

Whenever you work more than the required 140 hours, the excess hours will be added to your Hour Bank Account up to a maximum of 420 hours after the deduction of the 140 hours for the current month's coverage.

Example of Eligibility

Work Month	Hours Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	150	150			
May	180	330			
June	175	505	375	130	
July	180	310	140	170	July (Lag Month)
August	185	355	140	215	August (initial)
September	190	405	140	265	September
October	190	455	140	315	October
November	180	495	140	355	November
December	185	540	140	400	December
January	180	580	140	420	January
February	185	605	140	420	February
March	185	605	140	420	March

* Your Hour Bank Account will be limited to a maximum of 420 hours after the deduction for the current month's coverage.

Termination of Eligibility - Your eligibility will terminate on the earliest of the following:

1. The last day of the month in which you have less than 140 hours in your Hour Bank after the deduction for the current month's eligibility (see example below);

2. Except as otherwise required by applicable law, the last day of the month in which you enter full-time active duty in the Armed Forces of the United States;

3. The last day of the month following the day that the IBEW Local Union that represents you for the purpose of collective bargaining withdraws from participation in the Plan;

4. The date the Plan terminated, either in full or as to you or the group in which you belong.

If your IBEW Local Union and/or corresponding NECA Chapter chooses to leave the Plan, all hours in your Hour Bank Account will be forfeited immediately. If you are eligible for benefits under the Plan at the time of the withdrawal, whether as an Active Employee, by making self-payments under the Plan's COBRA or extended self-payment provisions for Totally Disabled or as a Retired Employee, your coverage will end on the last day of the month following the withdrawal.

If you are an Active Employee or any other employee covered under this Plan and you work in Competitive Employment, you will lose coverage and the hours in your Hour Bank Account will

be forfeited, effective at the beginning of the month following the month in which you began work in Competitive Employment.

Example of Termination of Eligibility for Active Employee Due to Insufficient Hours

Work Month	Hours Worked	Reserved Account	Withdrawal	Reserve Account	Benefit Month
April	105	105		105	
May	0	105		105	
June	100	205		205	
July	110	315		315	
August	115	430	375	55	
September	150	205	140	65	September (Lag Month)
October	160	225	140	85	October (Initial)
November	105	190	140	50	November
December	100	150	140	10	December
January	80	90	0	90	January
February	0	90	0	90	February
March	0	90	0	90	March-COBRA

Reinstatement of Eligibility - If your eligibility terminates because you do not have the required hours in your Hour Bank Account, you will again become eligible when your Hour Bank Account shows a total of at least 140 hours within the six-month period immediately following the termination of your eligibility. The reinstatement will be effective on the first day of the second calendar month your Hour Bank Account balance returns to 140 hours. If you are not reinstated, your Hour Bank Account will be forfeited, and you will only become eligible for coverage upon completion of the eligibility requirements explained in the "Initial Eligibility" section.

Any change in eligibility for a specific plan of benefits as a result of a change in your job classification will be effective the 1st day of the month following the change in classification.

MESSAGE FROM THE BOARD OF TRUSTEES FOR BENEFIT PLAN C OF THE CENTRAL TEXAS HEALTH and BENEFIT TRUST FUND

To All Covered Persons who are eligible for **Benefit Plan C**:

We are pleased to provide you with this consolidated Plan Document and Summary Plan Description concerning **Benefits Plan C** under the Central Texas Health and Benefit Trust Fund. This document describes your current health, prescription drug, vision, life insurance, accidental death and dismemberment insurance, and sickness and accident benefits.

We have tried to explain all of the provisions of the Fund as clearly as possible. However, the Fund's provisions and the insurance contract that provides some of the benefits are complicated. The Board of Trustees has sole discretion to amend, modify, or discontinue all or part of the Fund and to interpret this Plan Document and Summary Plan Description. The Board's interpretation is binding on all Covered Persons and their heirs, assignees or agents, and on all Providers and all other persons and entities.

If you have questions after reading this document, you can call or write the Fund Office regarding the Plan and how any rules affect your Beneficiaries, and you. Please bear in mind that for your protection, only we, as the full Board of Trustees, are authorized to interpret the Plan. Information you receive from the Union or individual Employers or their representatives should be regarded as unofficial. Any information or opinion concerning your rights under the Plan, to be official, must be communicated to you in writing on our behalf.

Be sure to inform the Fund Office of any change in your mailing address to ensure that you receive all future communications about the Fund. We hope that you will find this document helpful and that you and your family will enjoy the protection of the Fund for many years to come.

Sincerely,

BOARD OF TRUSTEES

NOTE: Receipt of this document does not, by itself, entitle you to the benefits provided by this Plan. To be eligible for Plan benefits, you must be otherwise eligible as explained in this consolidated Plan Document and Summary Plan Description. If you have any questions, please contact the Fund Office at:

Telephone: (972) 943-9559
Toll-Free: (866) 434-2200

PLAN C

SCHEDULE OF MEDICAL BENEFITS – PLAN C		
COVERED SERVICE/PLAN CATEGORY	**IN-NETWORK**	**OUT-OF-NETWORK**
GENERAL INFORMATION		
DEDUCTIBLES (Per Calendar Year)		
Annual Deductible* Per Individual Per Family (combined)	 $2,500 $7,500	
***Expenses incurred in the 4th quarter and applied toward your Calendar Year Deductible will also be given credit toward your next Calendar Year Deductible**		
MAXIMUM OUT-OF-POCKET EXPENSES		
Per Individual Per Family	$7,500 $15,000	$10,000 $20,000
***In-Network-Out-of-Pocket expenses include Deductibles & Co-Insurance Out-of-Network-Deductibles and co-payments are not included**		
COVERED SERVICES		
PHYSICIAN SERVICES		
Office Visit* *Office visit benefit includes charge for pap smear, prostrate exam, gynecological exam and mammogram Laboratory/Radiology Diagnostic Test (X-ray, Lab) Imaging (CT/PET Scans, MRIs)	70% after Calendar Year Deductible See Covered Services 70% after Calendar Year Deductible	50% after Calendar Year Deductible See Covered Services 50% after Calendar Year Deductible
Well Child Care Immunizations Through Age 6 Over Age 6	70% after Calendar Year Deductible 100% 100%	50% after Calendar Year Deductible 100% 50% after Deductible
Surgery Inpatient Outpatient Office	 70% after Deductible 70 % after Deductible 70% after Deductible	 50% after Deductible 50% after Deductible 50% after Deductible
HOSPITAL SERVICES		
Inpatient Services (semi-private room and related charges)	70% after Deductible	50% after Deductible
PHYSICIAN HOSPITAL SERVICES		
Inpatient Services	70% after Deductible	50% after Deductible

Emergency Room	70% after Deductible	50% after Deductible
Outpatient Services & Supplies	70% after Deductible	50% after Deductible
OTHER SERVICES		
Allergy Injections	100%	50% after Deductible
Allergy Serum/Testing	70% after Deductible	50% after Deductible
Home Health Care Visits	70% after Deductible; Maximum of 60 visits per Calendar Year	50% after Deductible; Maximum of 60 visits per Calendar Year
Organ Transplants	70% after Deductible	50% after Deductible
VISION DISCOUNT BENEFIT		
For the Vision Discount Program, the contact information is listed on the back of your ID card		
PRE-CERTIFICATION AND CASE MANAGEMENT		
The plan requires that prior to receiving services including Hospital In-patient and some Out-patient services a Covered Person must obtain pre-certification. **Failure to do so may reduce available benefits.**		
Prescription Drugs are not covered by Plan C.		

Eligibility Rules-Plan C

Please refer to the Collective Bargaining Agreement you are working under to determine which plan of benefits apply to you and your Dependents.

Initial Eligibility - You will become eligible on the first day of the second calendar month following a period of no more than six consecutive months during which you work in Covered Employment at least 140 hours for a contributing Employer.

Covered Employment - The term “Covered Employment” means your work for a Contributing Employer who is signatory to a Collective Bargaining Agreement or a Participation Agreement between your Employer and the Plan.

Lag Month - The “Lag Month” is the month between the month you initially accumulate 140 hours of employment and the first day of the month you actually become eligible for the benefits provided by the Plan. The purpose of the Lag Month is to allow sufficient time for your Employer to submit the required hours of employment form and related contributions to the Fund Office. Once the Fund Office enters the hours in your file your initial benefit month is determined.

Hour Bank Account - The term "Hour Bank Account" means an account of hours established in your name by the Plan. Subject to the maximum limit of 420 hours, all hours of Covered Employment for which contributions are made on your behalf will be credited to your Hour Bank Account. Your Hour Bank Account is updated monthly.

Your Hour Bank Account can be used to supplement required contributions that are less than the amount required by the Trustees to fund the Plan. If you have less than 140 hours in your Hour Bank Account at the end of a month, you may pay for the difference ("Short Pay") between the hours left in your hour bank and the 140 hours required at an hourly rate set by the Board of Trustees. To be eligible to Short Pay, you must be eligible for coverage the month before the month for which the Short Pay payment is applied.

Withdrawals for coverage from your Hour Bank Account will be made based on the Plan's current contribution rate. Whenever the Plan's contribution rate increases, the number of hours in your Hour Bank Account will be pro-rated.

Maintenance of Eligibility - Once you have established Initial Eligibility, 140 hours will be deducted from your Hour Bank Account for each month of coverage. You will continue to be covered for the benefits provided by the Plan as long as your Hour Bank Account contains at least 140 hours.

Whenever you work more than the required 140 hours, the excess hours will be added to your Hour Bank Account up to a maximum of 420 hours after the deduction of the 140 hours for the current month's coverage.

Example of Eligibility

Work Month	Hours Worked	Reserve Account	Withdrawal	Reserve Account Max*	Benefit Month
April	130	130			
May	180	310	140		
June	175	345	140	205	
July	180	385	140	245	
August	185	430	140	290	August (Lag Month)
September	190	480	140	340	September (Initial)
October	190	530	140	390	October
November	190	530	140	420	November
December	190	470	140	420	December

* Your Hour Bank Account will be limited to a maximum of 420 hours after the deduction for the current month's coverage.

Termination of Eligibility - Your eligibility will terminate on the earliest of the following:

1. The last day of the month in which you have less than 140 hours in your Hour Bank after the deduction for the current month's eligibility (see example below);

2. Except as otherwise required by applicable law, the last day of the month in which you enter full-time active duty in the Armed Forces of the United States;

3. The last day of the month following the day that the IBEW Local Union that represents you for the purpose of collective bargaining withdraws from participation in the Plan;

4. The date the Plan terminated, either in full or as to you or the group in which you belong.

If your IBEW Local Union and/or corresponding NECA Chapter chooses to leave the Plan, all hours in your Hour Bank Account will be forfeited immediately. If you are eligible for benefits under the Plan at the time of the withdrawal, whether as an Active Employee, by making self-payments under the Plan's COBRA or extended self-payment provisions for Totally Disabled or Retired Employees, your coverage will end on the last day of the month day following the withdrawal.

If you are an Active Employee or any other employee covered under this Plan and you work in Competitive Employment, you will lose coverage and the hours in your Hour Bank Account will be forfeited, effective at the beginning of the month following the month in which you began work in Competitive Employment.

Example of Termination of Eligibility for Active Employee Due to Insufficient Hours

Work Month	Hours Worked	Reserved Account	Withdrawal	Reserve Account	Benefit Month
April	105	105		105	
May	0	105		105	
June	100	205	0	205	
July	110	175	0	315	July (Lag Month)
August	115	150	140	10	August (Initial)
September	140	150	140	10	September
October	40	50	0	50	October
November	0	50	0	50	November-COBRA

Reinstatement of Eligibility - If your eligibility terminates because you do not have the required hours in your Hour Bank Account, you will again become eligible when your Hour Bank Account shows a total of at least 140 hours within the six-month period immediately following the termination of your eligibility. The reinstatement will be effective on the first day of the second calendar month your Hour Bank Account balance returns to 140 hours. If you are not reinstated, your Hour Bank Account will be forfeited and you will only become eligible for coverage upon completion of the eligibility requirements explained in the "Initial Eligibility" section.

Any change in eligibility for a specific plan of benefits as a result of a change in your job classification will be effective the 1st day of the month following the change in classification.

Dependent Coverage for Plan C Benefits - Once you have established Initial Eligibility, you have 30 days to determine if you would prefer the Family Plan of benefits rather than the Single Plan of benefits. If you do not choose the Family Plan during the 30-day period, you will automatically be enrolled in the Single Plan.

After you make your initial selection, you will be allowed to request a change in your coverage only once each year. The change may be made only during the month of November. The change will become effective on January 1. You will not be allowed to change from Single to Family Plan or from Family to Single Plan at any other time.

OTHER ELIGIBILITY/PLAN ISSUES (APPLIES TO PLANS A, B, & C)

Qualified Medical Child Support Order ("QMCSO") - If an order is issued by a court or through an administrative process under state law concerning the provision of health care coverage for your Children, the Fund Office or its designee will determine if the court order is a Qualified Medical Child Support Order as defined by federal law, and that determination will be binding upon you.

To be qualified, an order must contain specific information, must be submitted to and approved by the Fund Office. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an individual who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if you are eligible for Plan benefits, the Fund Office or its designee will so notify the parents and each Child, and advise them of the Plan's procedures that must be followed to provide coverage of the Dependent Child.

Upon request, you may obtain from the Fund Office a copy of the Plan's procedures governing QMCSOs.

Special Rules for Military Service – If you enter into military service (such as active or inactive duty training or active duty in the United States Armed Forces, National Guard, Coast Guard or Public Health Service) for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA).

If you go into military service for more than 31 days, USERRA permits you to continue medical coverage for yourself and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA continuation coverage.

Your Dependent(s) may be eligible for health care coverage under TRICARE, the Department of Defense's health care program for members of the uniformed services, their family and survivors. This Plan will coordinate coverage with TRICARE.

Questions regarding your entitlement to this leave and to the continuation of medical coverage should be referred to the Fund Office.

Continuation During Total Disability – If you are an Active Employee and you become "**Totally Disabled**," as defined below, while covered by the Plan and you remain so disabled for 30 days or more, you will not have any hours deducted from your Reserve Account, if any, from the first day of the month in which your Total Disability commences.

If you: 1) lose your eligibility and are making self-payments under this Plan's self-payment rules, 2) you are an Active Employee or otherwise an eligible employee who is actively working when you become Totally Disabled, and 3) you remain so disabled for 30 days or more, then your coverage will be continued automatically during such Total Disability for up to six consecutive months, without your payment of your self-payment monthly premium. After that six-month period, if you are still Totally Disabled, the hours in your Reserve Account, if any, will be used to continue your coverage until you no longer have sufficient hours in your Reserve Account. After that six-month period, to continue your coverage, you will be required to resume self-payments under this Plan's self-payment provisions.

For purposes of this provision, you will be considered to be "**Totally Disabled**" when you are completely unable, due to a sickness or injury or both, as determined by two physicians practicing in a relevant practice field, to engage in a gainful occupation within your trade, provided you are working in Covered Employment or are a Non-Bargaining Employee when you become disabled.

Family and/or Medical Leave - If you have completed 12 months or 1,250 hours of employment, you are generally entitled under the federal Family and Medical Leave Act of 1993 ("FMLA") for up to 12 weeks each year of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a Child, or to provide care for a Spouse, Child or parent who is seriously ill, or for your own serious Illness.

While you are on FMLA leave, your employer may be required to continue making contributions on your behalf, which the Plan will credit to your Reserve Account, if any. You will be eligible to continue coverage for yourself and your Dependents under the Plan as long as you have sufficient hours in your Reserve Account. Please note, however, that your Reserve Account will not be credited while you are on FMLA leave unless your employer continues to make contributions to the Plan on your behalf, or you make self-payments.

Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your medical coverage will be reinstated without any additional limits or restrictions imposed on account of your leave, so long as you have sufficient hours in your Reserve Account for continued coverage. This is also true for any Dependent who was covered by the Plan when you took your leave.

Any changes in the Plan's terms, rules or practices that go into effect while you are on leave will apply to you and your Dependents in the same way they apply to all Active Employees and their Dependents. To find out more about your entitlement to family or medical leave as required by the FMLA and/or state law, and the terms on which you may be entitled to it, contact the Fund Office.

Important Note About the Eligibility Rules and Reserve Accounts

The Trustees can modify, reduce or terminate the Plan's eligibility rules, and the Reserve Accounts, at any time. The Reserve Account is merely a bookkeeping entry and neither you nor your Dependents have any right to any particular Plan assets or any vested or accrued right to your Reserve Account.

COBRA SELF-PAYMENT PROVISIONS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

Loss of Eligibility - You and your eligible Dependent(s) have the right to continue your medical coverage under this Plan on a self-pay basis, as described in this section, if coverage would otherwise terminate due to a Qualifying Event under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). This provision does not apply to Employee or Dependent Life Insurance or sickness and accident benefits.

Your Dependent(s) may continue coverage by making self-payments directly to the Fund Office if coverage also is lost because of one of the following reasons:

1. Your death or divorce;
2. Your legal separation;
3. Your entitlement to Medicare if you are continuing coverage in accordance with these provisions; or
4. In the case of a Child, the loss of that Child's status as a Dependent.

Notice - The Fund Office will notify you of your right to elect continued coverage under these special COBRA self-payment provisions when you have lost coverage because of insufficient hours.

If your Dependent loses coverage under the Plan as a result of: (1) your death; (2) your divorce or legal separation; (3) your entitlement to Medicare if you are continuing coverage in accordance with these provisions; or (4) the loss of that Child's status as a Dependent, then within 60 days of any of these events, **the Covered Person and the Dependent must notify the Fund Office** of any of these events. Once the Fund Office is timely notified of any of these events, it will then notify your Dependents of their rights under these provisions within 14 days. If neither you nor your Dependent notifies the Fund Office of any such event within 60 days, your Dependent will not be eligible to continue coverage under the Plan's self-payment provisions.

You and/or your Dependent(s) will have until the later of: (1) 60 days from the date of the notice from the Fund Office, or (2) 60 days from the date eligibility is lost, to notify the Fund Office of the election to continue eligibility by making self-payments.

Self-payment Amounts and Benefits Available - You will be notified by the Fund Office of the then-current premium rate(s) for your coverage when you receive notice of your right to elect continued coverage. The amount of the monthly self-payment(s) is established by the Board of Trustees and is subject to change.

If you and/or your Dependents choose to continue your coverage, you will be provided with the same benefits as those provided to Active Employees, excluding the accident and sickness benefits.

Acquiring a New Dependent While Covered by COBRA - If you acquire a new Dependent while you are continuing your coverage under these COBRA self-payment provisions, you may add that Dependent to your coverage for the balance of your available coverage period. To do so, you must notify the Fund Office and enroll the Dependent within 31 days of the eligibility event of that Dependent.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage - If, while you are enrolled in the self-pay continuation coverage under this section, your Dependent loses coverage under another group health plan, you may enroll the Dependent for coverage for the balance of the period of COBRA continuation coverage. The Dependent must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent must have been covered under another group health plan or had other health insurance coverage. To take advantage of this special right, you must enroll your Dependent within 31 days after the termination of the other coverage.

The loss of coverage under the other health plan must be due to exhaustion of COBRA continuation coverage under the other plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility for coverage under the other health plan must not have been due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Maximum Number of Self-payments - You and/or your Dependent's right to continue coverage under this section shall continue until the end of the month in which the earliest of the following events occurs:

1. The Plan ceases providing any benefits to any participants;

2. Your failure to timely make any self-payment required by the Trustees;

3. Covered Person becomes covered under any other group health care plan or becomes eligible for Medicare;

4. 18 months have passed since the loss of coverage, except as provided in item 5 below, concerning loss of coverage because of insufficient credited hours;

5. If a Covered Person is disabled for purposes of Social Security (or is found to be disabled within 60 days thereafter), when you lose coverage as a result of insufficient hours, the earlier of:

   (a) 11 months from the date the 18-month period described in Item 4 above ends; or

   (b) 30 days after the date that the Covered Person is found to be no longer disabled.

To take advantage of this 11-month extension, you must notify the Fund Office of your disability within 60 days of the Social Security Administration's determination of the disability and before the expiration of the 18-month period described in Item 4 above;

6. In the case of your death or divorce or legal separation, your entitlement to Medicare or a Child's ceasing to meet the definition of Dependent, 36 months have passed since the loss of regular coverage under the provisions of this Plan. If you become entitled to Medicare within 18 months before your loss of coverage, your Dependent's coverage ends no more than 36 months after your Medicare entitlement date;

7. In the case of multiple qualifying events described in "Self-pay Eligibility Affected by Multiple Events" below, COBRA coverage will be extended an additional 18 months for each qualifying event, however, in no case for more than 36 months from the date of initial loss of coverage; or

8. Except as otherwise required by COBRA, your local Union ceases participation or withdraws from the Plan, or your last employer is no longer required by a collective bargaining agreement, letter of assent or participation agreement to contribute to the Plan.

Termination of Self-payments - If you and/or your Dependent fails to make the required self-payment within the specified time, or you and/or your Dependent have made the maximum number of self-payments, you and/or your Dependent will no longer be permitted to make the self-payments described in this section and you must requa1ify for coverage under this Plan in accordance with the Initial Eligibility rules to regain eligibility for benefits.

Payment of Self-Payment Premium for Employee and Dependents - Your initial self-payment must be paid no later than the 45th day after the date you submit your election to make self-payments. Your initial payment must cover both the required self-payment premium for the month you submit the payment, plus the premiums for any prior months back to the date you lost coverage. Each subsequent self-payment is due on the 1st day of the month for which coverage is intended. Self-payments received at the Fund Office later than 30 days after the due date will not be accepted, and rights to self-payment will terminate. There will be no waivers granted.

Trustee Rights Concerning Self-pay Eligibility - Please note that if you and/or your Dependent is continuing coverage under these provisions, from time to time the Board of Trustees may request any pertinent information bearing on your eligibility for the benefits provided under these self-payment provisions. If you fail to promptly respond to the Trustees' request for such information, the Trustees may suspend or terminate your self-payment rights.

Self-Pay Eligibility Affected by Multiple Events - An additional 18-month extension of coverage will be available to Dependents who elect COBRA coverage if a second qualifying event occurs during the first 18 months of COBRA coverage. The maximum period of continuation coverage available when a second qualifying event occurs is 36 months from the first day COBRA coverage begins. A second qualifying event includes the death of a Covered Employee, divorce or legal separation from the Covered Employee, the Covered Employee's enrollment in Medicare, or a Child's ceasing to be eligible for coverage as a Dependent under the Plan. You must notify the Fund Office within 60 days after a second qualifying event occurs. If you fail to notify the Fund

Office within 60 days after the second qualifying event, you will not be eligible for the 18-month extension.

Notwithstanding anything to the contrary in this section, no person may continue a self-payment extension under the Plan beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred.

Condition for Self-Payment Rights - Please note that the self-payment provisions under this section are provided pursuant to a federal law known as COBRA. Thus, eligibility for self-payment is expressly conditioned on you and/or your Dependents' entitlement to COBRA health care continuation coverage under applicable law. For example, loss of eligibility due to an employer withdrawing from the Plan, an employer ceasing to be covered under the applicable collective bargaining agreement, a Local Union withdrawing from the Plan, an employer failing or refusing to make its required contributions, or any other act or omission that does not qualify as a "qualifying event" under COBRA, will not entitle you and/or your Dependents to self-payment rights.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When you and/or your Dependents' coverage ends, you and/or your covered Dependents are entitled by law to, and will be provided with, a certificate of coverage that indicates the period you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent has ended. In addition, such a certificate will be provided upon written request within two years after the date coverage ended.

Losing your job-based coverage is also a special enrollment event in the Health Insurance Marketplace (Marketplace). The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments), and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Eligibility for COBRA continuation coverage will not limit your eligibility for Marketplace coverage or for a tax credit, if available. You can apply for Marketplace coverage at HealthCare.gov or by calling 1-800-318-2596 (TTY 1-855-889-4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during an open enrollment period, anyone can enroll in Marketplace coverage. If you need health coverage in the time between losing your job-based coverage and beginning coverage through the Marketplace (for example, if you or a family member needs medical care), you may wish to elect COBRA coverage from your former employer's plan. COBRA continuation coverage will ensure you have health coverage until the coverage through your Marketplace plan begins. Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can apply for and enroll in Medicaid or CHIP any time of year. If you qualify, your coverage begins immediately. Visit HealthCare.gov or call 1-800-318-2596 (TTY 1-855-889-4325) for more information or to apply for these programs. You can also apply for

Medicaid by contacting your state Medicaid office and learn more about the CHIP program in your state by calling 1-877-KIDS-NOW (543-7669) or visiting insurekidsnow.gov.

PRE-CERTIFICATION AND CASE MANAGEMENT

The Plan has contracted with a medical management company to conduct and manage the pre-certification and emergency admission notification process. Failure to obtain pre-certification will result in a penalty of a 50% reduction of benefit payments for all Eligible Expenses incurred.

A Covered Person must obtain pre-certification before receiving certain services. In addition, a Covered Person must provide notification to the Plan after a Hospital admission when that admission is not scheduled and occurs through an emergency room or department of a Hospital. These requirements are described in detail in this section.

The purpose of these pre-certification and notification requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (such as whether the length of stay, the number of visits or treatments or other aspects of the services or procedures are appropriate). Compliance with the pre-certification and notification requirements is not a guarantee of benefit payment.

The Covered Person must contact the medical management company at the telephone number appearing on the Identification Card. The Covered Person may satisfy this requirement by having the Hospital, admitting Physician or a family member contact the medical management company to obtain the required pre-certification or provide the required notification.

Pre-certification for Scheduled Admissions - The Covered Person must obtain pre-certification for every scheduled Hospital Admission. To obtain pre-certification for a scheduled Hospital Admission, the Covered Person or a Provider must notify the medical management company of the scheduled Hospital Admission at least twenty-four (24) hours before the Admission. The medical management company will determine a certain number of inpatient Hospital days for the stay upon pre-certification. **Failure to obtain pre-certification will result in a penalty of a 50% reduction of benefit payments for all Eligible Expenses incurred during the Admission**. This penalty will be applied before any applicable Co-payment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all. Any amounts not paid because of this penalty may not be used to satisfy any Out-of-Pocket Limits.

Note: You do not need to obtain pre-certification for Maternity Services for Hospital Admission for a routine, vaginal delivery that does not exceed 48 hours or a cesarean section that does not exceed 96 hours. If a Provider determines that additional time is Medically Necessary, the Covered Person or the Provider must notify the Plan during the continued-stay review described below.

Hospital Retrospective Review - If a Covered Person is admitted to a Hospital for an unscheduled Admission (such as an Emergency Admission), the admitting Physician, the Hospital, the Covered Person, or a family member of the Covered Person must give notice of the Admission to the medical management company at the number on the identification card no later than 24 hours after the Admission.

The Admission will be reviewed within one working day from the date on which the Covered Person provides notification. The review will be performed with the Covered Person's Provider to determine if a continued Hospital stay is Medically Necessary. Failure to provide notice of a Covered Person's Emergency Admission will result in a penalty of a 50% reduction in the payment for all Eligible Expenses in connection with the Admission. Any amounts not paid by the Plan because of this penalty may not be used to satisfy any Out-of-Pocket Limits.

Continued-stay review - During any Covered Person's Hospital stay, the medical management company will conduct a continued-stay review. This review applies to all Hospital Admissions. The purpose of continued-stay review is to evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Covered Person's Hospital stay to conduct a continued-stay review.

Discharge Planning - During a continued stay review, the medical management company will consider Discharge Planning. Discharge Planning will identify patients requiring extended care following discharge and determine the most appropriate setting for continued care.

Pre-certification for Hospice services - The Covered Person must obtain pre-certification for each Hospice Admission and for each Hospice treatment. To obtain pre-certification for Hospice services, the Covered Person, a family member of the Covered Person or a Provider should notify the medical management company no later than 24 hours before the scheduled Hospice Admission or Hospice care. Failure to obtain pre-certification will result in a penalty of reduction of payment for covered Hospice services by 50%. This penalty will be applied before any applicable Co-payment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all. Any amounts not paid because of this penalty may not be used to satisfy any Out-of-Pocket Limits.

Pre-certification for Transplant Procedures - The Covered Person must obtain pre-certification for all Inpatient and Outpatient Services related to any Transplant services. All Inpatient and Outpatient Services related to Transplant services must be pre-certified no later than 24 hours before receiving such services for Coverage under the Plan.

Failure to follow the pre-certification guidelines concerning Transplant services, <u>except for covered travel and lodging expenses</u>, will result in a penalty of a 50% reduction of benefit payments for covered transplant services. This penalty will be applied before any applicable Co-payment, Deductible or Coinsurance. If services are not Medically Necessary, no benefits are payable at all. Any amounts not paid by the Plan because of this penalty may not be used to satisfy any Out-of-Pocket Limits.

For **covered travel and lodging expenses** in connection with a Covered Person receiving Transplant services, failure to follow the pre-certification guidelines will result in the penalty of the Plan limiting payment to 70%, instead of 100%, of the Provider's Reasonable Charge up to a maximum of $10,000 per covered transplant. Any amounts not paid by the Plan because of this penalty may not be used to satisfy any Out-of-Pocket Limits.

Case Management - Case management is a voluntary program that is designed to inform patients of cost-effective settings for treatment. Case management typically applies when a Covered

Person has a chronic, ongoing or catastrophic condition that is expected to result in significant costs. In this event, on an exception basis through case management, the Plan may cover certain settings and/or procedures not expressly covered under the Plan. All requests for case management will be individually reviewed by the Plan.

If a Covered Person requests an alternative setting or procedure in connection with case management services, the Plan has the right to deny Coverage for such setting or procedure, and to pay only Plan benefits under the terms of the Plan.

PREFERRED PROVIDER NETWORK

The Plan offers a large network of Providers within the PPO Network(s) selected by the Board of Trustees. The Identification Card states the PPO Network(s) to which the Covered Person has access under the Plan.

The Plan provides the highest level of benefits when Covered Persons use Preferred Providers. Preferred Providers are those who have contracts with the network identified on the Identification Card. Services provided by Non-Preferred Providers will generally be covered at a lower benefit level than services provided by a Preferred Provider. Preferred Providers must accept a reduced rate ("Negotiated Rate") as their payment for services charged and cannot bill the Covered Person for the difference between the rate before it is reduced and the Negotiated Rate. Some expenses or services provided by a Non-Preferred Provider will be covered at the In-network benefit level for:

1. Professional reading of a Radiologist;
2. Professional reading of a Pathologist;
3. Anesthesia services by an Anesthesiologist when the surgery is performed in a Hospital or Other Facility Provider that is a Preferred Provider;
4. Emergency room services; and
5. Ambulance services.

COVERED SERVICES

The following are the Plan's Covered Services in alphabetical order. The Plan pays for Covered Services only if they are Medically Necessary. Any services or supplies that are not Medically Necessary may be the Covered Person's liability.

Abortion Services - The Plan will cover Surgical services related to an abortion when such services are rendered and billed by a Physician in a covered setting, provided the abortion is performed to terminate a pregnancy that is the result of a rape or incest. In addition, the Plan will cover medical or surgical complications that are the direct result of the Covered Person having an abortion even if the abortion is not the result of rape or incest.

Accidental Injury - The Plan will cover Injuries that are the direct result of an accident when such services are rendered by a Physician, Hospital or Other Facility Provider in a covered setting. To be covered under the Plan, the Covered Person must seek treatment for the accidental Injury within 72 hours of the Injury.

Allergy Injections and Tests - The Plan will cover allergy injections, the serum and allergy testing when such services are performed by a Physician in the Physician's office or other covered setting. In addition, any diagnostic laboratory tests will be covered in accordance with the Plan's "Diagnostic Services – Outpatient" benefit.

Ambulance Service - Ambulance service is ground transportation by a vehicle designed, equipped and used only to transport the sick and injured:

1. from the Covered Person's home, scene of accident or medical emergency to a Hospital;
2. between Hospitals;
3. between Hospital and Skilled Nursing Facility; or
4. from a Hospital or Skilled Nursing Facility to the Covered Person's home.

Surface trips must be to the closest local facility that can give Covered Services appropriate for the Covered Person's condition. If none, the Covered Person is covered for trips to the closest such facility outside his/her local area.

Air transportation is only covered when such transportation is Medically Necessary because of a life-threatening Injury or Illness. **Air Ambulance** is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care.

Ambulatory Surgical Facility Services - The Plan will cover services rendered and billed by an Ambulatory Surgical Facility for the performance of a covered surgical procedure performed in such facility.

Anesthesia Services - The Plan will cover anesthesia services rendered and billed by a Physician or certified nurse anesthetist for a surgical procedure that is performed on an Inpatient or Outpatient basis. Under this benefit, the Physician who administers the anesthesia cannot be the surgeon or assistant at surgery.

Birthing Center Services - The Plan will cover the following Maternity Services provided to a Covered Person when such services are rendered and billed by a birthing center:

1. **Room and Board**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. If, during an Admission, the Covered Person is in a private room, the Plan will limit Coverage to the semi-private room rate unless the private room is Medically Necessary. Coverage includes a bed in a special care unit approved by the Plan. Use of a private room will be covered at the Birthing room's semi-private room rate;

2. **Ancillary services**. Ancillary services covered during an Admission in a Birthing Center include, but are not limited to:

    a. Operating room and equipment used in it;
    b. Delivery room and equipment used in it;
    c. Other treatment rooms and equipment used in them;
    d. Prescribed drugs;

e. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
f. Medical and surgical dressings, supplies, casts and splints;
g. Blood, blood transfusions and other blood-related services; and
h. Diagnostic Services.

Cardiac Rehabilitation Therapy - Outpatient - The Plan will cover Cardiac Rehabilitation Therapy for the rehabilitation of the Covered Person following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility.

Chemotherapy - Outpatient - The Plan will cover chemotherapy treatment rendered by a Physician or Other Professional Provider when such treatment is rendered in a covered setting.

Chiropractic Services - Outpatient - The Plan will cover Chiropractic Treatment when rendered by a Physician or a Chiropractor on an Outpatient basis and in a covered setting. Chiropractic Treatment means the manipulation of the spine to relieve pain, restore maximum function, and to prevent disability following disease or Injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Professional Provider are required. Treatments are covered for Plan A participants only and are limited to 20 visits per calendar year.

Colorectal Cancer Tests - The Plan provides Coverage for Covered Persons 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically-recognized, screening examination for the detection of colorectal cancer. Coverage includes either:

1. a fecal occult blood test performed annually and a flexible sigmoidoscopy performed once every five years; or
2. a colonoscopy performed once every 10 years.

Dental Services - The Plan will cover the following dental services when such services are rendered and billed by a Physician or Other Professional Provider:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. Excision of benign bony growths of the jaw and hard palate;
3. External incision and drainage of cellulitis;
4. Incision of sensory sinuses, salivary glands or ducts;
5. Emergency repair due to Injury to sound natural teeth within 12 months of the Injury.

Services must be performed in a covered Inpatient or Outpatient setting. In addition, any services rendered and billed by a Hospital for the dental services under this benefit will be covered under the Hospital benefit. Any services rendered and billed by an Ambulatory Surgical Facility for the dental services under this benefit will be covered under the Ambulatory Surgical Facility benefit.

Dermatology Services - The Plan will cover the diagnosis or treatment of conditions of the skin when such services are rendered by a Physician in a covered Outpatient setting, including a

Physician's office setting. Coverage will include charges for Outpatient screening examinations, evaluation procedures, medical care, treatment or services directly related to a specific condition of the skin that is known or reasonably suspected. "Treatment" does not include any surgical procedures performed for the removal of skin tissue or skin lesions.

Diagnostic Services – Outpatient - The Plan will cover Outpatient Diagnostic Services rendered in an Outpatient Facility or Physician office setting when the Covered Person has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Outpatient Diagnostic Services include, but are not limited to, related pre-admission testing and allergy testing. Specific services covered under this benefit include:

1. Laboratory examinations;
2. X-ray tests or examinations;
3. EKGs;
4. EEGs; and
5. MRIs, MRAs, and CAT Scans.

Drug Addiction Services - The Substance Abuse services section of the summary of medical benefits describes drug addiction services.

Durable Medical Equipment - The Plan will cover the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician. Rental costs must not be more than purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use.

Emergency Care in Emergency Department - The Plan will cover the emergency treatment of an Illness or Injury when (1) such services are rendered in the emergency room or emergency department of a Hospital, and (2) failure to receive immediate treatment of such Illness or Injury would seriously jeopardize the Covered Person's life and/or health. Emergency care services include those Medically Necessary services and supplies provided by the Hospital following the Covered Person's Admission to the emergency room or emergency department for an Illness or Injury and include the services provided by the Physician and Other Professional Providers who are Hospital employees and who are regular staff members of the emergency room and emergency department of the Hospital.

Home Health Care services - Home Health Care services may be provided to the Covered Person on a part-time basis in the Covered Person's home as a Medically Necessary alternative to Inpatient care. A Home Health Care Provider must provide the services according to a physician-prescribed course of treatment that has been previously approved by the Plan. Covered Services include the following:

1. Skilled nursing services
2. Medical social service
3. Nutritional guidance
4. Home health aide service
5. Diagnostic Services
6. Therapy services

Hospice services - Hospice services are the following services that are provided to a terminally ill patient with a life expectancy of six months or less:

1. Nursing care
2. Medical social services
3. Physical, Speech and Occupational Therapy
4. Inhalation therapy
5. Home health aide services
6. Dietary counseling
7. Medical/surgical supplies
8. Medical equipment
9. Laboratory services
10. Bereavement counseling - Must be furnished within the first six months following the patient's death.
11. Twenty-four hour continuous nursing care (up to three intervals of continuous care, five days per interval)

Hospice services must be provided by a Hospice according to a physician-prescribed plan of care that has been previously approved by the Plan. Hospice services are most often provided in the home and must be agreed to by the Covered Person.

Hospital Services During an Inpatient Confinement - When the Covered Person is admitted as an Inpatient to a Hospital, the following room and board expenses and ancillary services are covered:

1. **Room and Board**. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services (unless otherwise stated). If, during an Admission, the Covered Person is Admitted in a private room, the Plan will limit Coverage to the semi-private room rate, unless the use of the private room is determined to be Medically Necessary. Coverage includes a bed in a special care unit, if Medically Necessary.

2. **Ancillary services**. Ancillary services covered during an Admission include, but are not limited to:

    a. Operating room and equipment used in it;
    b. Delivery room and equipment used in it;
    c. Other treatment rooms and equipment used in them;
    d. Prescribed drugs;
    e. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
    f. Medical and surgical dressings, supplies, casts and splints;
    g. Blood, blood transfusions and other blood-related services;
    h. Diagnostic services;
    i. Radiation therapy;
    j. Intravenous chemotherapy;
    k. Kidney dialysis;

l. Inhalation therapy;
m. Physical Therapy;
n. Occupational Therapy; and
o. Speech Therapy.

Kidney Dialysis - Outpatient - The Plan will cover Outpatient kidney dialysis treatment; however, treatment must be provided in a Facility that is a Preferred Provider.

Laboratory Services - The Plan will cover Outpatient Laboratory services. Coverage for Laboratory services is addressed in the Schedule of Benefits.

Mammography Services - Outpatient - The Plan will cover routine mammograms and services necessary for such test on an Outpatient basis. The Plan will cover routine mammograms as required by the Affordable Care Act.

Mastectomy or Lymph Node Dissection - If, due to treatment of breast cancer, any Covered Person has either a mastectomy or a lymph node dissection, the Plan will provide coverage for Inpatient care for a minimum of 48 hours following a mastectomy, and 24 hours following a lymph node dissection, unless the Covered Person receiving the treatment and the attending Physician determine that a shorter period of Inpatient care is appropriate.

Maternity Coverage

1. **Inpatient Services**. Coverage will be provided for the services rendered by a Hospital, Physician or Other Professional Provider for maternity services for an eligible employee or Dependent Spouse. The Plan will not restrict benefits for any Hospital length of stay for childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier, the Plan will only pay for the actual length of stay.

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

   In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section.

2. **Nursery Care of Well Newborn**. The Plan will cover the routine nursery care of the newborn infant and the first Inpatient visit to examine the infant. When the mother is discharged from the Hospital, continued Coverage for the infant will only be provided if the infant has been enrolled for Coverage under the Plan pursuant to the Plan's enrollment requirements.

3. **Pre-natal and Post-natal Office Visits**. Coverage will be provided for office visits for pre-natal and post-natal care and treatment of the mother. Pre-natal and post-natal office visits will be treated as a Maternity Service and will be covered in the same manner as all

other Maternity Services. However, the initial pre-natal office visit may be covered under the Physician office visit benefit (refer to the "Schedule of Benefits") if the Physician does not bill the initial office visit as part of the overall obstetrical bill.

Medical Services During a Hospital Admission - When the Covered Person is Admitted as an Inpatient to a Hospital, the following services are covered during the Admission:

1. **Physician In-hospital Visits**. One Physician visit from the Covered Person's Physician per day during an Admission.

2. **Intensive Care**. Constant care and treatment while Admitted in an intensive care unit.

3. **Care by Multiple Physicians**. When a Covered Person's condition requires the skills of separate Physicians, the Plan will cover the medical care and treatment by two or more Physicians during the same Hospital Admission.

Medical and Surgical Supplies - The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Syringes and needles;
2. Oxygen;
3. Surgical dressings;
4. Casts and splints;
5. Braces;
6. Catheters;
7. Colostomy and ileostomy bags and supplies required for their use;
8. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye;
9. Allergy serum and intravenous solutions unless such serum and IV solutions are obtained from a Pharmacy (refer to Prescription Drug Coverage); and
10. Wigs, limited to wigs following chemotherapy treatment.

Covered Services do not include items usually stocked in the home for general use like adhesive bandages, thermometers and petroleum jelly.

Non-routine Diagnostic Care or Treatment (Office Visit) - The Plan will cover a Covered Person's visit to his or her Physician's office to receive treatment for a specific Injury or Illness that is known or reasonably suspected. Covered services include charges for screening examinations, evaluation procedures, medical care or treatment, including but not limited to any allergy injections and other therapeutic injections the Covered Person receives during such office visit. Under this benefit, the services described in this paragraph will be payable when rendered by a Physician, Nurse Practitioner, Physician Assistant, or other medical provider acting under the individual's state-issued medical license and billed by a Physician.

Surgical services rendered by a Physician in a Physician's office will not be covered as part of this benefit, but will be covered as part of the Surgical services benefit.

Occupational Therapy Services - Outpatient - The Plan will cover Occupational Therapy when rendered by an Occupational Therapist or Physician in a covered Outpatient setting. Occupational Therapy means treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

Orthotic Devices and Orthopedic Shoes - The Plan will cover orthotic devices and orthopedic shoes that are an integral part of a leg brace. An orthotic device means a rigid or semi-rigid supportive device that limits or stops motion of a weak or diseased body part.

Patient Education Programs - The Plan will cover patient education programs in a covered Inpatient or Outpatient setting, including services performed in an office visit setting, for patient education programs for diabetic education and ostomy care.

Physical Therapy Services - Outpatient - The Plan will cover Physical Therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. Such treatment does not include treatment of the spine that is covered under "Chiropractic Services."

Podiatry Services - The Plan will cover podiatry services rendered by a Podiatrist or a Physician in a covered setting. Covered services include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

Preventive Care Services – The Plan will pay 100% of PPO Covered Charges per Covered Employee and/or Dependent for Preventive Care benefits. For Non-PPO providers, the Plan will pay 70% after the applicable Deductible(s). The Wellness and Preventive benefits are provided for appropriate individuals only, and as required under the Affordable Care Act and its related guidance, including evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). If you have questions about the specific requirements for each service or treatment, please call the Fund Office for more information. The Plan's Wellness and Preventive benefits are summarized as follows:

1. Preventive Care Services for Adults

    (a) Screening for heart disease, high blood pressure, high cholesterol, some cancers, depression, diabetes, tobacco, alcohol and drug use disorders, annual checkups, and various infectious diseases;
    (b) Counseling for various diseases, medical conditions, and for individuals at high risk of such diseases and conditions; and
    (c) Immunization vaccines as appropriate and as follows: Diphtheria, Hepatitis A and B, Herpes Zoster, Human Papillomavirus, influenza (flu shot), measles, meningococcal, mumps, pertussis, pneumococcal, rubella, tetanus, and varicella (chicken pox),

2. Well Child Coverage includes the following:

   (a) Well baby and well child visits (as appropriate).
   (b) Screening for various diseases and cancers, Autism, behavioral and developmental assessments, depression, tobacco, alcohol and drug use disorders, hearing/vision/oral health, annual checkups, and various infectious diseases.
   (c) Immunization vaccines for children as appropriate for age and populations, as follows: ◦Diphtheria, Tetanus, Pertussis (Whooping Cough); Haemophilus influenza type b; Hepatitis A and B; Human Papillomavirus (HPV); Inactivated Poliovirus; Influenza (flu shot); Measles; Meningococcal; Pneumococcal; Rotavirus; and Varicella (Chickenpox).
   (d) Interventions, including education or grief counseling, to prevent initiation of tobacco, alcohol or drug use.

3. Well-woman visit annually for adult women, and Dependent Children as appropriate, 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. A summary of these benefits is as follows:

   (a) Screening for anemia, heart disease, high blood pressure, high cholesterol, some cancers (including breast and ovarian), depression, diabetes, Rh incompatibility, osteoporosis, tobacco, alcohol and drug use disorders, annual checkups, and various infectious diseases,
   (b) Education and counseling related to lactation, breast pumps, and breastfeeding, contraceptives methods, sterilization procedures, uses and application of supplements and related medications.
   (c) The Plan will cover at least one form of contraception in each of the FDA-approved contraceptive methods with no cost sharing.
   (d) Counseling and screening for various diseases and conditions, and for interpersonal and domestic violence, as part of a well-woman visit.

4. For Co-Insurance purposes, Physician office visits are handled as follows:

   (a) If a preventive care service is billed separately from an office visit, the patient must pay the normal coinsurance for the office visit.
   (b) If a preventive care service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such a service, the patient will not be required to pay any deductible or coinsurance for the office visit.
   (c) If a preventive care service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of such a service, the patient must pay the normal coinsurance for the office visit. The Plan will cover preventive care services as provided by the Affordable Care Act.

Private Duty Nursing Services - The Plan will cover services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician and when rendered on an

Inpatient basis in a Hospital or Other Facility Provider. The services will only be covered if they are determined to be of such nature or degree of complexity that the Provider's regular nursing staff cannot give them. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising, and feeding.

Prostate Cancer Detection Examinations - The Plan provides Coverage for each male Covered Person for an annual, medically-recognized, diagnostic examination for the detection of prostate cancer. Coverage includes (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test for each male Covered Person as recommended under nationally recognized standards for such tests.

Prosthetic Appliances - The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances and supplies that:

1. replace all or part of a missing body part and its adjoining tissues; or

2. replace all or part of the function of a permanently useless or malfunctioning body organ.

Covered prosthetic appliances include prostheses for breast reconstruction following a covered mastectomy procedure.

Psychiatric Services - The Plan will cover the care and treatment of a psychiatric condition in a covered Inpatient or Outpatient setting. In addition, the Plan will cover treatment in a Partial Day Treatment Program. Covered Services for a psychiatric condition include the same Covered Services that are available for any other Illness under this Plan. In addition, the following services are covered:

1. Psychotherapy and sessions during individual and groups sessions;

2. Psychological testing;

3. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling;

4. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Psychiatric Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, or Community Mental Health Facility.

Radiation Therapy - Outpatient - The Plan will cover radiation therapy when rendered by a Physician or Other Professional Provider in a covered setting on an Outpatient basis.

Routine/Well-care for Adult - See Preventive Care above.

Routine/Well-care for Dependent Child - See Preventive Care above.

Skilled Nursing Facility Services - The Covered Person must be admitted to the Skilled Nursing Facility within 24 hours following a Medically Necessary Hospital stay, and services must be Medically Necessary as a continuation of treatment for the condition for which the Covered Person was hospitalized.

Sleep Disorders - The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or Other Professional Provider in a covered setting. A "sleep disorder" is considered the same as any other Illness for Coverage.

Speech Therapy - Outpatient - The Plan will cover Speech Therapy when rendered by a Physician or Speech Therapist in an Outpatient setting. Speech Therapy means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active Illness.

Substance Abuse Services - The Plan will cover Substance Abuse services for the care and treatment of substance abuse in a covered Inpatient and Outpatient setting. In addition, the Plan will cover treatment in a Partial Day Treatment Program. Covered Services for a substance abuse condition include the same Covered Services that are available for any other Illness under this Plan. Substance abuse includes addictions to drugs or alcohol. In addition, the following services will be covered:

1. Psychotherapy in individual and group sessions.

2. Psychological testing.

3. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.

4. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Substance Abuse services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Alcoholism Treatment Facility or Community Mental Health Facility.

Surgical Services - The Plan will cover surgery performed by a Physician on an Inpatient or Outpatient basis. An Inpatient basis includes surgery performed by a Physician while the Covered Person is an Inpatient in a Hospital. An Outpatient basis includes surgical services performed in an Ambulatory Surgical Facility or a Physician's office. Surgical services also include:

1. **Surgical Assistance**. Services of a Physician who helps the Covered Person's surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Provider's Reasonable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon's charge for the surgery;

2. **Multiple Surgical Procedures**. When more than one surgical procedure is performed through the same body opening during one operation, the Covered Person is covered only

for the most complex procedure, unless more than one body system is involved or the procedures are needed for the handling of multiple trauma.

The Plan covers the following special types of surgery:

1. **Reconstructive Surgery** - Surgery to restore bodily function or correct deformity. Coverage is limited to problems caused by disease, Injury, birth or growth defects, or previous treatments.

2. **Mastectomy** -

    a. all stages of reconstruction of the breast on which the mastectomy has been performed;
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance;
    c. prostheses and treatment of physical complications, including lymphedemas, of mastectomy;
    d. physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Benefits for reconstructive breast surgery shall be covered as provided by the Women's Health and Cancer Rights Act of 1998 and in a manner determined in consultation with the attending Provider and the patient.

3. **Voluntary Sterilization Surgical Procedures** - Refer to the Sterilization Services benefit below.

Sterilization Services - The Plan will cover Surgical services for a voluntary sterilization procedure when such services are rendered and billed by a Physician. In addition, any services rendered by a Hospital, Ambulatory Surgical Facility or Other Facility Provider in which such procedure is performed and that are rendered and billed by such Facility Provider will also be covered by the Plan.

TMJ Treatment - Outpatient - The Plan provides limited Outpatient Coverage for Covered Persons with Temporomandibular Joint Dysfunction ("TMJ"). In addition to providing Coverage for Outpatient Diagnostic Services for TMJ, the Plan will cover the therapeutic IM injection into the temporomandibular joint and covered orthotic or orthopedic devices and the adjustment to such devices when such services are rendered and billed by a Provider.

Transplant services - The Plan covers services for the transplant procedures described in this section when such services are rendered and billed by a Physician and/or Hospital ("Transplant services") and provides all Covered Services performed in connection with the Transplant services as are available under the Plan for the treatment of any other Illness. In addition, the Plan covers expenses for the acquisition and transportation of the organ or tissue. Travel and lodging expenses are limited to the travel expenses of the Covered Person receiving the transplant procedure and one adult companion, or, if the Covered Person is a minor, two adult companions (such as the Covered Person's parents). Under the Plan, a Transplant service includes the following human organ and tissue transplants: Heart, Lung; Heart/lung, Liver, Kidney, Bone marrow, Intestines,

Pancreas, Pancreas/kidney, Cornea, and any organ transplant not listed above, if required by federal law. Any transplant not listed above will be covered if Medically Necessary.

Urgent Care Services in Urgent Care Facility - The Plan covers services rendered by an urgent care facility for the treatment and diagnosis of an Illness or Injury, and include the services provided by the Physician and Other Professional Provider who are Urgent Care facility employees. Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, treatment or services directly related to a specific Injury or Illness that is known or reasonably suspected.

EXCLUSIONS AND LIMITATIONS

1. **Admissions Primarily for Diagnostic Studies**. The Plan will not cover room, board and general nursing care for Hospital Admissions that are mainly for diagnostic studies, except as provided by law;

2. **Admissions Primarily for Physical Therapy**. The Plan will not cover room, board and general nursing care for Hospital Admissions mainly for Physical Therapy;

3. **Alternative Treatments**. The Plan will not cover treatments that are deemed to be "alternative treatments", including but not limited to the following: acupressure; acupuncture; biofeedback; naturopathy; psychosurgery; massage therapy; megavitamin therapy; nutritionally based alcoholism therapy; holistic or homeopathic care including drugs, ecological or environmental medicine; hypnotherapy or hypnotic anesthesia; hypnotherapy; and sleep therapy;

4. **Certain Counseling Services**. The Plan will not cover marriage counseling, family counseling, pastoral counseling, financial counseling, legal counseling and custodial care counseling, except as specifically set forth in the Plan;

5. **Certain Examinations and Services**. The Plan will not cover examinations or medical services the Covered Person receives specifically for employment, recreation, insurance, school attendance or licensure;

6. **Cosmetic Services**. The Plan will not cover expenses for or treatment only to improve appearance, except as specifically set forth herein. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes;

7. **Custodial Services**. The Plan will not cover expenses or services for custodial care or for services not needed to diagnose or treat an Injury or Illness, including Hospital Admissions;

8. **Drugs**. The Plan will not cover over-the-counter drugs or prescription drugs purchased and administered on an Outpatient basis, except as specified in "Prescription Drug Benefits" section beginning on page 66. Prescription drugs administered while an Inpatient in a Hospital will be covered under the Plan;

9. **Dental Services**. The Plan will not cover expenses for dentistry or dental processes;

10. **Educational or Training**. The Plan will not cover expenses or services or supplies primarily for educational, vocational or training purposes;

11. **Exercise Program**. The Plan will not cover expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan;

12. **Experimental/Investigative Services**. The Plan will not cover expenses for any services that are experimental or investigative, except as provided by Federal law;

13. **Eye Glasses.** The plan will not cover expenses except as required by Federal law;

14. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, "Immediate Family Member" means the Covered Employee's Spouse, or Dependent Child or Spouse's Dependent Child, brother, sister, or parent;

15. **Felony or Illegal Activity**. The Plan will not cover expenses incurred as a result of a Covered Person's voluntary involvement or participation in a felony or a riot, or act of civil disobedience;

16. **Governmental Unit or Program**. The Plan will not cover expenses to the extent governmental units or governmental programs provide benefits, except benefits will be coordinated with government programs as appropriate;

17. **Hearing Aids**. The Plan will not cover expenses for hearing aids or examinations for prescribing or fitting them;

18. **Inappropriate Charges**. The Plan will not cover expenses that are not Medically Necessary and any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the American Medical Association or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

19. **Infertility Services**. The Plan will not cover expenses for in-vitro fertilization, artificial insemination, reversal of sterilization and all other services in connection with an infertility condition, including but not limited to the following: any consultative services with a Physician to assess the infertility condition; any diagnostic tests or procedures in connection with diagnosing the infertility condition; and charges for assisted reproductive technologies, including but not limited to, in vitro fertilization, artificial insemination, gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT);

20. **Legal Obligation to Pay**. The Plan will not cover expenses for which the Covered Person has no legal obligation to pay in the absence of this or like coverage;

21. **Lifestyle Improvement Services**. The Plan will not cover lifestyle improvement services or charges, including but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage and dietary supplements;

22. **Marital Counseling**. The Plan will not cover services in connection with marital counseling;

23. **Medical Department/Clinic**. The Plan will not cover expenses incurred or services received from a medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;

24. **Medicare**. The Plan will not cover expenses for which benefits are payable under Medicare Part A, or that would have been payable if a Covered Person had applied for Part A, and for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except as specified in Coordination of Benefits;

25. **Non-covered Services**. The Plan will not cover services that are not specified in the Plan as Covered Services;

26. **Non-medically Necessary Services**. The Plan will not cover services or supplies that are not considered to be Medically Necessary;

27. **Podiatry Services**. The Plan will not cover expenses for foot care whose purpose is only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails, and the like;

28. **Before Effective Date or After Termination Date**. The Plan will not cover expenses incurred before the Covered Person's Effective Date or after the termination date, except as specified in the Plan;

29. **Private Room Charges**. The Plan will not cover charges for a private room while the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility unless such private room is deemed Medically Necessary;

30. **Preventive and Routine Services**. The Plan will not cover preventive services, routine office visits or routine periodical physical examinations for a Covered Person, except as specified in Covered Services above;

31. **Smoking Cessation Programs**. Plan C will not cover expenses for care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma;

32. **Sterilization Reversal**. The Plan will not cover expenses for the reversal of a sterilization procedure;

33. **Suicide**. The Plan will not cover expenses for attempted suicide or an intentionally self-inflicted Injury, while sane or insane, unless the Injury was sustained as a result of a medical condition or domestic violence. A medical condition includes a physical and mental health condition;

34. **Telephone Consultations, Missed Appointments, Claim Form Completion**. The Plan will not cover expenses for telephone consultations, missed appointments, or completion of Claim forms;

35. **TMJ Devices and Services**. The Plan will not cover services for TMJ except those described in "TMJ Treatment – Outpatient;"

36. **Transplant services**. The Plan will not cover transplant procedures other than those described in "Transplant Services;"

37. **Transsexual Surgery**. The Plan will not cover expenses for transsexual surgery or any treatment leading to or for transsexual surgery. This exclusion includes gender dysphoria or sexual reassignment or change, medications, implants, hormone therapy, surgery, medical or psychiatric treatment for such surgery or treatment;

38. **Veteran's Administration Facility**. The Plan will not cover services received by veterans for any Illness, disease or Injury suffered as a result of, or while in, military service to the extent that such services can be performed by a U.S. Department of Veteran's Affairs healthcare facility;

39. **Vision Services**. Except as required by Federal law;

40. **War**. The Plan will not cover expenses or charges for Injury or Illness that occurs as a result of any act of war, declared or undeclared;

41. **Weight Control or Related Treatments**. The Plan will not cover dietary products or supplies or treatment for controlling or reducing weight, obesity treatments, (including but not limited to any surgical procedures to correct obesity), and exercise programs;

42. **Wigs**. The Plan will not cover expenses for care and treatment for hair loss including wigs (other than wig(s) following chemotherapy treatment), hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

43. **Worker's Compensation**. The Plan will not cover expenses that are for Injury or Illness arising in the course of employment if whole or partial compensation is available under worker's compensation or any other laws of any governmental unit. This applies whether or not the Covered Person claims such compensation or recovers losses from a third party;

44. **X-ray Without Film**. The Plan will not cover expenses for x-ray examinations made without film.

PRESCRIPTION DRUG BENEFITS (Plans A & B)

The Plan provides prescription drug coverage for two sources of prescription drugs: 1) pharmacies; and 2) mail order from the Pharmacy Benefit Manager (PBM) listed on your ID card. The coverage provided for each of these sources is described below.

For both pharmacy and mail order coverage, there are two categories of drugs:

1. Preferred Drugs; and
2. Non-preferred Drugs.

A "**Preferred Drug**" is a Generic Drug or Brand-name Drug that is listed on the Plan's Formulary. A "**Formulary**" is a list of Brand-name and Generic Drugs that have been determined to be the best and most economical in each therapeutic category. A "**Brand-name Drug**" is one that is made by a particular company that has a patent on the drug. Usually, no other company can make a Brand-name Drug until the patent expires. A "**Generic Drug**" is a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand-name Drug, and generally is available after a Brand-name Drug's patent expires. You may obtain a copy of the Plan's Formulary from the Fund Office or by going online to the website listed on your ID card.

A "**Non-Preferred Drug**" is a Brand-name Drug or Generic Drug that is not on the Formulary. Non-Preferred, or non-Formulary drugs have the same Co-payment under the Plan as Preferred, or Formulary Drugs, but you will be required to pay the difference between the price of the Formulary/Preferred Drug and the cost of the Non-Preferred Drug.

The Plan provides coverage for prescription drugs dispensed by a licensed Pharmacy if the requirements described in the Introduction are met and if the Pharmacy is a Preferred Provider with the PBM. Each covered prescription dispensed by mail order is limited to a ninety-day supply of drugs. Each Covered Prescription dispensed from a Pharmacy is limited to a thirty-day supply of drugs.

Mail Order Prescription Drug Coverage

The Plan provides prescription drug coverage for drugs dispensed by mail order through the PBM listed on your ID card.

Covered Prescription Drugs

Covered Prescription Drugs include:

1. Formulary drugs prescribed by a Physician that require a prescription by federal law;

2. All compounded drugs containing at least one ingredient in a therapeutic quantity that requires a prescription under federal law, and covered under the Plan Formulary;

3. Insulin, insulin syringes, insulin injecting devices, and glucagon;

4. Diabetic supplies such as alcohol swabs, lancets, lancet devices, and test strips;

5. Diabetic supplies when prescribed by a Physician, when such supplies are available through the PBM. Diabetic supplies obtained through the PBM will not be subject to any Co-payment;

6. Oral contraceptives. However, if Seasonale, which is prescribed in a 91-day supply, is prescribed as the Covered Person's oral contraceptive, the Covered Person will be required

to pay three times the Co-payment that the Covered Person would pay for an oral contraceptive that is prescribed in a 30-day supply;

7. Contraceptive devices such as the contraceptive patch, diaphragm and ring;

8. Depo-Provera (injection not covered under the Prescription Drug Coverage);

9. Lunelle (injection not covered under the Prescription Drug Coverage);

10. Injectables that are covered under the PBM Specialty Pharmacy Program, limited to a 30-day supply when obtained through a Pharmacy or the PBM by Mail;

11. EpiPen and EpiPen, Jr.;

12. Medical supplies for aerochambers, aerochamber with mask, and nebulizer masks;

13. Pediatric Federal Legend vitamins (a Federal Legend Drug is one whose label must bear the legend: “CAUTION: Federal Law prohibits dispensing without a prescription”);

14. Prenatal Federal Legend vitamins;

15. Acne products even if used for cosmetic purposes only, but limited to Covered Persons to age 45. Prior authorization is required for all acne products for Covered Persons age 45 or older;

16. Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder drugs;

17. Immunosuppressants; and

18. Federal Legend non-sedating antihistamines, subject to all formulary provisions.

Prior Authorization

The Covered Person must obtain prior authorization for lost, stolen or damaged drugs, acne products for persons over 45, and to obtain refills or amounts in excess of the amounts allowed for a certain period due to travel or vacation. To obtain prior authorization, contact the PBM at the phone number appearing on the reverse side of the Identification Card. The Covered Person will be asked to provide certain information to assist in the determination of the drug’s Medical Necessity. Failure to obtain prior authorization for the Covered Drugs that require prior authorization will result in a loss of Coverage for drugs purchased without prior authorization.

PRESCRIPTION MEDICATION CLAIMS: Your pharmacy may submit a Claim for prescription drug benefits to the Plan for the Covered Person by sending it to the PBM the Trustees have hired to pay most prescription drug Claims for the Plan. Please refer to your ID Card for Pharmacy Benefit Manager information.

If the Covered Person prefers to submit a prescription drug Claim or is denied coverage at the Pharmacy, pays full price and wants to submit a Claim, the Covered Person should contact the prescription drug Claims payment office and get the required Claim form. The Covered Person

should complete the form, or have the pharmacy or medical care Provider complete the form. You should then mail the completed Claim form and all bills related to the Claim to the PBM. YOU MUST SUBMIT ANY CLAIM WITHIN 12 MONTHS OF THE DATE THAT THE EXPENSES WERE INCURRED.

The prescription drug Claims payment office will make an initial determination concerning your entitlement to prescription drug benefits.

Exclusions and Limitations

No Prescription Drug Coverage is provided for the following:

Administration Charges - Charges for the administration or injection of any drug.

Appetite Suppressants - The Plan will not cover appetite suppressants, unless specified otherwise.

Contraceptives - The Plan will not cover emergency contraceptives and pregnancy termination drugs.

Cosmetic Drugs - For any prescription used for treatment only to improve appearance, except as specified herein.

Drugs Without Prescriptions - The Plan will not cover drugs that do not require a prescription by federal law, other than insulin.

Excess Prescription Refills - The Plan will not cover any prescription refilled in excess of the number of times specified by the Physician.

Experimental/Investigative - The Plan will not cover any drugs labeled "Caution - limited by federal law to investigational use," or drugs that are experimental or investigational, even though a charge is made to the individual.

Fertility Medication - The Plan will not cover fertility medication used to treat infertility, unless specified otherwise.

Governmental Agency or Program - The Plan will not cover services for which benefits are payable by any governmental agency or program, but the Plan will coordinate benefits with such agency or program as applicable.

Growth Hormones - The Plan will not cover growth hormones, unless specified otherwise.

Immunization Agents and Blood Expenses - Prescription Drug Coverage does not include immunization agents except as required by the Affordable Care Act, biological sera, blood or blood plasma.

Inappropriate Charges - The Plan will not cover expenses that are not Medically Necessary for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by

the American Medical Association, or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice.

Inpatient Prescription Drugs - Prescription Drug Coverage does not include medication that is to be taken or administered, in whole or in part, while the Covered Person is a patient in a Hospital, a convalescent Hospital, rest home, sanitarium, Skilled Nursing Facility, nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Medicare - Prescription Drug Coverage does not include expenses for which benefits are payable under Medicare Part A or B or would have been payable if a Covered Person had applied for Part A or B, except as specified in coordination of medical and prescription drug benefits.

Non-covered Medical Condition - The Plan will not cover any prescription drug services or charges for any condition not covered under the Plan's Medical Benefits.

Non-covered Medication - The Plan will not cover any medication that is not included in the list of Covered Prescription Drugs above.

Physician/Provider Administered Medication - Prescription Drug Coverage does not include medication that is to be administered by a physician, nurse or anyone other than the patient in a normal home setting.

Refills After One Year from Order - The Plan will not cover any refill dispensed after one year from the Physician's original order.

Termination Date - The Plan will not cover any prescription filled or refilled after the termination of Coverage or termination of this Plan, whichever is earlier.

Therapeutic Devices - The Plan will not cover therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, unless specified otherwise.

Worker's Compensation - The Plan will not cover prescription drugs that the Covered Person is entitled to receive without charge under any Workers' Compensation Laws.

IMPORTANT NOTICE ABOUT MEDICARE PART D FOR PLANS A & B AND YOUR PRESCRIPTION DRUG COVERAGE

This section has important information about your current prescription drug Coverage with the Plan and the Medicare prescription drug coverage program. This section will also tell you where to find more information to help you make decisions about your prescription drug coverage.

Medicare prescription drug coverage is available to everyone with Medicare through Medicare prescription drug programs and Medicare Advantage Plans that offer prescription drug coverage.

The Board of Trustees has determined that the prescription drug Coverage offered by the Plan is, on average for all Plan participants, expected to pay at least as much under its prescription drug program as the standard Medicare prescription drug coverage will pay.

That means that the Plan has **creditable coverage** under the Medicare law.

Because your existing Coverage is creditable coverage, you can keep the Plan's Coverage and not pay extra if you wait to enroll in Medicare prescription drug coverage at a later date.

If you drop or lose your Coverage with the Plan, and do not enroll in Medicare prescription drug coverage after your current Coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you go 63 days or longer without creditable coverage, your Medicare prescription drug plan monthly premium will go up at least 1% per month for every month that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than what most other people pay as long as you have Medicare coverage.

Generally, an individual can only join a Medicare prescription drug plan when that individual first becomes eligible for Medicare and between November 15 and December 31 of any year. This means that if you lose Coverage under the Plan before November 15 in a given year, and you did not join a Medicare prescription drug plan during your Initial Eligibility period, you may have to wait to enroll in a Medicare prescription drug plan until November 15 of the year in which you lose Plan Coverage, which could make your Medicare prescription drug premium higher.

Your prescription drug Coverage is part of the overall health benefits of the Plan. **If you or any of your Dependents decide to enroll in a Medicare prescription drug plan, you can stay in the Plan and keep the Plan's Coverage. However, if you drop your Plan Coverage, be aware that you and your Dependents will not be able to get this Coverage back other than under the Plan's usual eligibility rules.**

You should compare the Plan's Coverage with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. You should also inform the Plan if you or any of your Dependents enroll in a Medicare prescription drug plan, for the Plan's coordination of benefits purposes.

For more information about this notice or your current prescription drug Coverage, you should contact the Fund Office at (866) 434-2200. You will receive this notice annually and at other times in the future, such as before the next enrollment period for Medicare prescription drug coverage, and if Coverage under the Plan changes. You may also request a copy at any time by contacting the Fund Office.

More detailed information about Medicare plans that offer prescription drug coverage can be found in the "Medicare & You 2006" handbook or any subsequent version, supplement or volume. If you are eligible for Medicare, you will get a copy of this handbook annually in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program at 1-888-834-7406; TTY users call (512) 407-3250; or
- Call 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213; TTY 1-800-325-0778.

Dismemberment Benefits - Applies to Plan A

The Plan's Covered Employee life and accidental death and dismemberment insurance and Dependent life insurance benefits are provided through a contractual arrangement between the Plan and United of Omaha Life Insurance Company, the Life Insurance provider.

Covered Employee Life Insurance Benefits - Applies to Plan A

Benefits - The Covered Employee life insurance benefit is ten thousand dollars ($10,000.00). Upon your death, payment of the benefits will be made to your designated Beneficiary. The Life Insurance provider will pay the benefit when it receives proof that your death occurred while eligible for benefits. This employee life insurance has no cash surrender or loan values.

Reduction for Age - The life insurance benefit is reduced by fifty percent (50%) if your death occurs after you reach 70 years of age. This reduction in benefits will be effective on the first day of the calendar month after you turn 70 years old.

Beneficiary(ies) - Subject to any applicable community property or other domestic relations laws that may require consent by your Spouse for you to elect another Beneficiary, you may name any individual as your Beneficiary. You may also change your Beneficiary at any time by notifying the Fund Office in writing. The Plan and the Life Insurance provider are not liable for any payments made before receiving any change of Beneficiary notice.

If you list two or more Beneficiaries, each Beneficiary will receive an equal share unless you specify otherwise. If you do not name a Beneficiary, or if a named Beneficiary is not alive at the time of your death, benefits will be paid in the following order: to your Spouse; your Children; your parents; or your estate. Any individual Beneficiary must be living on the tenth day following your death to receive a payment of benefits. Benefits payable to a minor will be made payable in a manner consistent with the applicable state law.

Proof of Death - A Claim will require written proof of death, such as a certified copy of a death certificate.

Acceleration of Benefits - If you are diagnosed with a terminal condition, you may request an acceleration of life insurance benefits. A terminal condition is an Injury or Illness that is expected to result in your death within six months, and from which there is no reasonable chance for recovery. The accelerated life insurance benefit will be paid in a one-time, lump sum to you or

your representative in the amount of 50% of the life insurance benefit. When accelerated life insurance benefits are paid to the Covered Employee or the Covered Employee's representative, that Covered Person's life insurance coverage is affected as follows:

- Life insurance benefits will be decreased by the amount paid in accelerated death benefits;
- Remaining life insurance benefits are subject to future age reduction;
- The Covered Employee may not reinstate coverage to its full amount in the event of recovery; and
- Accidental death and dismemberment benefits are not affected by acceleration of benefits.

Waiver of Premium - If you become Totally Disabled, you may request that your premiums for Employee life insurance be waived. To qualify for this waiver, you must be a Covered Employee and under the age of 60 when you become Totally Disabled. If your premiums are waived, you will continue to receive Employee life insurance coverage with the acceleration of death benefits option, but you will not continue to receive accidental death and dismemberment insurance, Dependent life insurance or any other benefits not specifically continued. Claims for this waiver of premium must be made within one year from the date your Total Disability began. This waiver will continue until your 65th birthday or you are no longer Totally Disabled, whichever occurs first.

THESE BENEFITS ARE PROVIDED UNDER AND SUBJECT TO THE CONTRACT BETWEEN THE LIFE INSURANCE PROVIDER AND THE PLAN.

Dependent Life Insurance Benefits - Applies to Plan A

Benefits - The Dependent life insurance benefit is three thousand dollars ($3,000.00). Benefits will be paid to you when the Life Insurance provider receives sufficient proof of your Dependent's death, subject to the terms described below.

Dependent Eligibility - You are eligible for this benefit if you are a Covered Employee and you have or acquire a Dependent. A newborn Child will be covered the day it is over 14 days old.

Termination for Age – The Dependent life insurance benefit terminates after a covered Spouse reaches 65 years of age. This termination in benefits will be effective on the first day of the calendar month after your Spouse turns 65 years old.

Conversion Privilege for Both Employee and Dependent Life Insurance - You may convert your life insurance or the Dependent's life insurance policy to an individual life insurance policy if any one of the following occurs:

1. You or your Dependent lose eligibility;
2. The Plan's life insurance is changed or canceled; or
3. Your life insurance benefit amount or Dependent life insurance benefit amount is reduced.

The Covered Person has 31 days from the date of the event that entitles the Covered Person to the right to convert to apply for conversion of the policy. If the Covered Person dies within the 31-day application period, the Life Insurance provider will pay a death benefit to the Covered Person's Beneficiary in the amount that individual was entitled to convert, whether or not applied for.

The face value of the new individual policy cannot be more than the amount under the Plan and will not include accidental death and dismemberment coverage or the accelerated death benefit. The premium you pay will depend on your age or your insured Dependent's age.

If Coverage ends because the Plan's contract with the Life Insurance provider ends, the Covered Person may convert the policy to an individual policy for no more than the benefit amount of the lesser of:

1. $5,000; or
2. The amount of the Covered Employee's life insurance benefit amount or Dependent's life insurance benefit amount listed in the Schedule of Benefits above, minus the amount of group insurance the Covered Employee or Dependent becomes eligible for through the Plan, if the new coverage begins within 31 days of the date the Life Insurance provider's group policy ended.

LIFE INSURANCE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS CLAIMS: Notice of a Claim for life insurance benefits or accidental death and dismemberment benefits must be submitted in writing to the Fund Office, within 91 days after the loss on which a Claim is based, or as soon as reasonably possible. This notice must include information to identify the Claimant and the Covered Person, such as name, address and Social Security number. Upon receipt of a notice of a Claim, the Fund Office will send proof of loss Claim forms to the Claimant, which must be completed and returned promptly. The Covered Person may then submit the Claim for life insurance or accidental death and dismemberment benefits to the Fund Office, at:

Central Texas Health & Benefit Trust Fund
P. O. Box 860007
Plano, TX 75086-0007
Telephone: (972) 943-9559
Toll Free: (866) 434-2200

THESE BENEFITS ARE PROVIDED UNDER AND SUBJECT TO THE CONTRACT BETWEEN THE LIFE INSURANCE PROVIDER AND THE PLAN.

Covered Employee Accidental Death and Dismemberment Benefits - Applies to Plan A

Benefits - If, while you are a Covered Employee, you have an accident and you lose your life, limb or sight within 180 days of the accident and the loss is due to the accident, you or your Beneficiary will receive the benefits described below.

Covered Employee - For purposes of these accidental death and dismemberment benefits section, a Covered Employee is an Active Employee as defined by the Plan's eligibility rules.

SCHEDULE OF LOSS AND BENEFITS

LOSS	BENEFIT AMOUNT
Loss of Life	$10,000
Loss of both hands, or both feet or entire sight in both eyes	$10,000

Loss of one hand and one foot	$10,000
Loss of speech and hearing in both ears	$10,000
Loss of one hand or one foot and entire sight of one eye	$10,000
Loss of one hand or one foot or entire sight of one eye	$ 5,000
Loss of speech	$ 5,000
Loss of hearing in both ears	$ 5,000
Loss of thumb and index finger of same hand	$ 2,500

Loss of hands or feet means that the limb is permanently, physically severed at or above the wrist or ankle. Loss of sight, speech and hearing means total and permanent loss of the ability. The loss of life benefit will be paid to your Beneficiary; all other benefits will be paid to you. For this Accidental Death and Dismemberment benefit, an "accident" is an unexpected, external, violent and sudden event.

Exclusions – The Life Insurance provider will not pay benefits for loss directly or indirectly caused by the following:

1. Suicide or intentionally self-inflicted Injury, while sane or insane;
2. Physical or Mental Illness;
3. Bacterial infection or bacterial poisoning, unless from a cut or wound caused by an accident;
4. Riding in or descending from an aircraft as a pilot or crew member;
5. Armed conflict, whether declared as war or not, involving any country or government;
6. Injury suffered while in the military service for any country or government;
7. Injury that occurs while you commit or attempt to commit a felony;
8. Use of any drug, narcotic or hallucinogenic agent that is illegal, unless prescribed by a doctor, or if not taken as directed by a doctor or the manufacturer; or
9. Intoxication, as defined by your blood alcohol content meeting or exceeding the legal presumption of intoxication under the laws of the state where the accident occurred.

Covered Persons may not take legal action to receive benefits until 60 days after the date proof of loss is submitted with all required information. Legal action must commence within three years after the date proof of loss has been submitted. The Life Insurance provider may contest the validity of a Covered Person's insurance coverage because of inaccurate or false information received relating to the Covered Person's insurability for up to two years from the effective date of coverage for a Covered Person.

THESE BENEFITS ARE PROVIDED UNDER AND SUBJECT TO THE CONTRACT BETWEEN THE LIFE INSURANCE PROVIDER AND THE PLAN.

WEEKLY ACCIDENT AND SICKNESS (A&S) BENEFITS - Applies to Plan A

Benefits - An Active Employee who: 1) is also actively working for a Contributing Employer; 2) who becomes disabled from a non-occupational Illness or Injury, as determined by the Trustees in their sole discretion; and 3) who is thereby prevented from performing any and all of the usual duties of his/her occupation, will receive a weekly benefit of two hundred and fifty dollars ($250).

Weekly benefits will begin with the eighth day of disability, and will continue as long as you remain disabled and qualify as an Active Employee for up to a maximum of 26 weeks for any one Period of Disability.

Period of Disability - In determining a "Period of Disability," successive periods of disability separated by less than two weeks of continuous active employment with a Contributing Employer will be considered as one continuous Period of Disability unless they arise from different and unrelated causes and are separated by a return to active employment with a Contributing Employer for at least one full work day.

Limitations and Exclusions - Benefits are not payable for:

1. Any Period of Disability during which you are not under the direct care of a Physician; or
2. Disability, in whole or in part, that either:
   a. Is covered by any workers' compensation or occupational disease law; or
   b. Arises from or is sustained in the course of any occupation or employment for compensation, profit and gain while working for anyone other than a Contributing Employer.
3. Any Period of Disability during which you are drawing unemployment benefits or are on the union's out-of-work list.

Claims must be filed on forms provided by the Fund Office and eligibility will be determined by the third party administrator, based upon plan rules and regulations established by the Board of Trustees. Appeals of eligibility determinations may be made under the Appeals procedures. To reduce the potential for benefit denials or the delay associated with Appeals, review your benefit applications for accuracy and provide all information requested in a timely and prompt manner.

COORDINATION OF MEDICAL AND PRESCRIPTION DRUG BENEFITS

What is Coordination of Benefits?

Frequently, members of a family are covered under more than one group health plan. Where there is more than one group health plan covering family members, there may be duplication of coverage when more than one plan is paying benefits for the same dollar of medical or prescription drug expenses. For that reason, this Plan has adopted a policy to coordinate medical and prescription drug benefits (but not life insurance, accidental death and dismemberment, or weekly sickness and accident benefits) with similar benefits payable under any other plan. This Plan will fully coordinate benefits with other plans, so that the combined benefits from all included plans can never exceed 100% of the Allowable Expenses (defined below). Deductible limits will still apply under all plans.

Definitions (For purposes of this "Coordination of Benefits" section only)

Allowable Expense - Means any Medically Necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the plans that covers the person for whom a Claim to This Plan is made. When the benefits from a plan are in the form of services, rather than cash

payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Plan - means:

1. Any group health plan that provides medical or prescription drug benefits;
2. A governmental program, including but not limited to Medicare, regardless of whether the person making a Claim under This Plan has enrolled in or registered for coverage;
3. Any service plan contract, group or other pre-payment coverage;
4. Any coverage under a labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
5. The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault"-type contracts; or
6. Any health maintenance organization coverage.

The term "plan" does not include coverage under an individual or any franchise policy or contract. Each plan or part of a plan that has the right to coordinate benefits is a separate plan.

This Plan - means the Central Texas Health and Benefit Trust Fund.

Order of Benefit Determination

The order in which any plan will pay its benefits is as follows:

1. A plan that does not contain a coordination of benefits provision pays benefits first. plans that purport to always pay after other plans, or to not pay benefits in a coordination of benefits situation, will pay first.
2. A plan that covers a person as an employee pays its benefits before a plan that covers a person as a dependent.
3. If a person who makes a Claim under This Plan is covered by more than one plan as a dependent Child, the plan that covers the parent whose birthday (month and day, only) occurs first in a calendar year pays its benefits before a plan that covers the parent whose birthday (month and day, only) occurs later in the calendar year. If any of the plans does not have this "birthday rule", then the plan without this provision pays its benefits before the plan that does contain this provision.
4. If a dependent Child makes a Claim under This Plan and is covered by more than one plan, and if the Child's parents are divorced or legally separated, the order of payment is as follow:
    a. If there is a court decree that establishes financial responsibility for a dependent Child's health care expenses, the plan of the parent with that responsibility pays its benefits before the plan of the parent without that responsibility.
    b. If there is no court decree, and the parent with custody of the Child has not remarried, the plan that covers the Child as a dependent of the parent with custody pays its benefits before the plan of the parent without custody.
    c. If there is no court decree and the parent with custody of the Child has remarried, then the order of benefit determination is as follows:
        1) the plan of the parent with custody or primary custody;

2) the plan of the step-parent;
3) the plan of the parent without custody or primary custody.

d. Notwithstanding any of the above, if there is no determinative court decree, and if a dependent Child is covered under a health maintenance organization ("HMO"), then the benefits of the HMO shall always be determined before the benefits of This Plan.

5. If the above rules do not establish the order of payment, then the plan that has covered the person claiming a benefit from This Plan for the longest time determines its benefits first.
6. If a person claiming benefits from This Plan is covered by a plan as an active employee and by another plan as a retired or laid-off person or the dependent of such a person, then, if both plans contain a coordination of benefits provision regarding retired or laid-off employees, the plan that covers the person as an active employee or the dependent of such a person pays its benefits before the plan that covers the person as a retired or laid-off employee or the dependent of such a person. If either one of the plans contains no coordination of benefits provision regarding retired or laid-off employees, and as a result, each plan would attempt to pay its benefits after the other, then the order of benefit determination shown above will determine the order of payment by the plans.
7. This Plan shall also coordinate benefits within itself when two or more Covered Persons who are members of the same immediate family and household are employees of one or more contributing employers and have coverage both as employees and as Dependents. In such a situation, an individual who is covered as an employee under This Plan will receive whatever additional benefits, if any, are available as a result of his or her status as a Dependent.

How Benefits are Coordinated

If, based on the order of benefit determination rules above, This Plan's benefits are payable first, then the benefits payable by the other plans are ignored when This Plan determines the amount payable by it. If This Plan's benefits are payable after those of any other plan, This Plan adds up the benefits payable by each of the plans in the order in which the other plans pay, and compares the total benefits to the total amount of Allowable Expenses. If This Plan's payments would result in benefits being paid that exceed the total Allowable Expenses, This Plan's benefits will be reduced so that the total amount paid by all plans does not exceed the Allowable Expenses. When coordination of benefits reduces the total amount otherwise payable in a calendar year for a person covered by This Plan, each benefit that would have been payable in the absence of coordination will be reduced in proportion. The reduced amounts will be charged against any applicable benefit limits of This Plan. Under no circumstances will This Plan pay more than it would have in the absence of other plans.

This Plan may, with your consent, release to or obtain from any other plan, organization or person, any information that the Trustees deem necessary for the purpose of coordinating benefits. Any person claiming benefits under This Plan shall provide This Plan with any information necessary to implement this provision. Failure to provide information requested by This Plan may result in This Plan discontinuing the payment of benefits.

Whenever a payment that should have been made by This Plan under this provision has been made under another plan, the Trustees have the right, in their sole discretion, to pay to any organization

that made such a payment any amount that the Trustees determine is warranted. Amounts paid in this manner are considered to be benefits paid by This Plan, and to the extent of that payment, This Plan, the Fund and the Trustees shall have no further liability under This Plan.

When This Plan has made an overpayment, This Plan has the right to recover that payment to the extent of the excess. This Plan may recover the overpayment from the person to whom it was made or from any other plan or appropriate organization.

SUBROGATION

What Are the Plan's Subrogation Rights?

In the event of any payment under or by and through this Fund, the Plan and its insurers shall be subrogated to all the rights of recovery of either you or your Dependent against any person or entity and you or your Dependent shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights including, but not limited to, an additional written Subrogation Agreement. Neither you nor your Dependent shall do anything after a loss to prejudice such rights. Prejudicing the Plan's subrogation rights may result in the denial of benefits or termination of your participation in the Plan.

If requested in writing by the Trustees, the Fund Office, or Legal Counsel, you or your Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity with said action to be taken in the name of you or your Dependent. In their sole discretion, the Trustees reserve the right to prosecute an action in the name of you or your Dependent against any third parties and/or entities potentially liable to you or your Dependent in an effort to recover monies paid by the Plan; or to intervene in the name of the Trustees into any legal proceeding initiated by you or your Dependent against any third parties and/or entities.

By virtue of any payment under this Plan, a lien shall be established upon any action on behalf of you or your Dependent against any person or entity legally responsible for the Injury or Illness for which such payment was made. In any action or actions by you or your Dependent against a third party (or multiple third parties), the Plan shall be subrogated to the right or rights of you or your Dependent to the extent necessary to reimburse it for 100% of all sums paid or assumed by the Plan under these Rules and Regulations, together with reasonable costs and expenses including attorneys' fees, if any, incurred by the Plan in enforcing the liability of a third party or you or your Dependent under this Agreement. Any sums recovered from the third party by you or your Dependent or by the Plan on behalf of you or your Dependent, either by judgment or compromise shall be applied first to reimburse the Plan for benefits paid or to be paid and pay its costs and expenses including attorney's fees, if any, without regard to any setoff or contribution for the payment of you or your Dependent's attorneys' fees and costs in pursuing and enforcing the liability of the third party or parties. The Plan shall not be responsible for the payment of your or your Dependent's attorneys' fees without its written consent, nor shall the Plan share any responsibility, pro-rata or otherwise, for you or your Dependent's attorneys' fees or expenses. However, this amount is limited to the amounts that you or your Dependent has, may, or could have reasonably recovered from any third party and that are related to the same Illness or Injury

or to the events giving rise to the Illness or Injury for which benefits are paid. In this connection, the Plan shall not be bound by the characterization of any recoveries given by any other person(s).

The Plan Administrator shall determine, in its sole discretion, what actual or potential recoveries from the third party or parties are related to the Illness or Injury or to the events giving rise to such Illness or Injury. This amount shall not be limited or reduced pro rata or otherwise because you or your Dependent is liable only in part, because you or your Dependent's resources or insurance are limited, or for any other reason. These obligations and rights supersede any laws or legal theories that purport to limit, reduce or eliminate the contractual Subrogation rights of the Plan including, but not limited to, the "make (or made) whole doctrine," "common fund" or other federal, state or local "common law" theories. Amounts recovered in excess of the Plan's reimbursement and costs and expenses including attorney's fees may be paid to you or your Dependent, but such excess shall apply as a credit against liability of the Plan for further payments to or on behalf of you or your Dependent under these Rules and Regulations, which has arisen or may arise from the Illness or Injury sustained by you or your Dependent referred to herein.

Amounts recovered in excess of the Plan's reimbursement and costs shall be paid to you or your Dependent, but such excess shall apply as a credit against liability of the Plan for further payment to or on behalf of you or your Dependent, which has arisen or may arise from the Injury or Illness that forms the basis of the Claim asserted by or on behalf of you or your Dependent.

With respect to Claims involving subrogation, payment of benefits may be delayed pending receipt of any and all of the requested documentation, including a completed and executed Subrogation Agreement and any other necessary paperwork from the Employee, Dependent, their legal or medical representative, medical providers and the like. The Trustees shall have the absolute discretion to settle Subrogation Claims on any basis they deem warranted and appropriate under the circumstances.

If the Covered Person recovers any amount and fails to reimburse the Plan for the full amount of the benefits paid by the Plan, the Plan has a lien on the amounts received and may take any available legal or equitable action against the Covered Person or against any entity that has possession, custody or control over the monies recovered. At its discretion, the Plan may withhold benefit payments or deduct the amounts owed from future Claims submitted by the Covered Person or eligible Dependents, including unrelated subsequent or previously-existing Claims, to satisfy its reimbursement and subrogation rights.

If the Covered Person, or any person acting on that person's behalf, does not attempt a recovery of the benefits paid by the Plan or which the Plan is obligated to pay, the Plan is entitled, but not required, to institute legal action against the responsible party in the Covered Person's name, the Plan's name or the Trustees' names. If the Covered Person asserts a legal Claim to recover for the Injury or Illness, the Covered Person must allow the Plan to intervene or join in any Claim, lawsuit or other legal action.

What Are Your Obligations?

The Covered Person must do whatever is reasonably requested by the Plan to secure the Plan's rights to subrogation and reimbursement. The Covered Person also must avoid doing anything that would prejudice the Plan's rights. Among other things, the Covered Person must:

1. Furnish all information requested by the Plan;
2. Notify the Plan in writing of any Claim for damages made for the Injury or Illness within 60 days;
3. Complete, sign and deliver to the Plan a Subrogation and Reimbursement Agreement provided by the Plan;
4. Complete, sign and deliver all other documents or papers requested by the Plan;
5. Take any action or give any other assistance requested by the Plan to enforce its subrogation and reimbursement rights;
6. Notify the Plan and obtain its prior written approval of any proposed settlement or release of your or your Dependents' Claims; and
7. Notify the Plan and obtain the Trustees' prior written approval of any agreement to distribute any recovery or payment to trusts, to third parties (including your attorneys), or to accounts or other entities.

If a Covered Person fails or refuses to complete and sign the subrogation and reimbursement agreement or any other document required by the Plan, fails or refuses to provide any requested information, fails to assist the Plan with its subrogation and reimbursement rights or otherwise fails to perform any obligations described in this section, the Plan may withhold payment of benefits or deduct the amounts owed, as described above. A Claim will be considered incomplete and may be denied if a subrogation and reimbursement agreement and/or any request for information is not timely returned. If your eligible Dependent is a minor, or if the Covered Person is incapacitated, a parent, legal guardian or legal representative is responsible for fulfilling the Covered Person's obligations.

CLAIMS REVIEW & APPEAL PROCEDURES

Claims Review

Urgent Care Claim - For any Urgent Care Claim, the Medical Management Company (MMC) will provide written notice of a coverage determination as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the MMC's receipt of the Claim. If the Urgent Care Claim is received without sufficient information to decide the Claim, the MMC will notify the Covered Person as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Covered Person must provide the specific information within 48 hours. The MMC will notify the Covered Person of the disposition of the Claim within 48 hours after the earlier of: (i) the receipt of the specified information; or (ii) the end of the period the Covered Person had to provide the specified information.

There are special time limits for responding to an Urgent Care situation that arises from On-going Treatment, as described below in the section on time limits for On-going Treatment.

For more information, refer to the Pre-Certification section of this Plan Document and Summary Plan Description and the back of the identification card.

Pre-service Claim - The Medical Management Company (MMC) will provide the Covered Person with written notice of denial or payment of a Pre-service Claim within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the Claim by the MMC, unless matters beyond the MMC's control, or failure to provide the MMC with sufficient information to decide the Claim, require an extension of the due date for providing the decision.

If the MMC needs an extension of the due date for providing a decision, the MMC will provide written notice before the end of the initial 15-day period. The extension notice will explain why the MMC needs an extension.

If the MMC needs an extension due to circumstances beyond the MMC's control, the extension notice will state the date by which the MMC expects to decide the Claim, and such an extension will be for no longer than 15 days. The MMC will not make more than one extension.

If an extension is needed because the MMC needs additional information from the Covered Person, the MMC will notify the Covered Person of the information needed. The Covered Person will then have 45 days to supply the additional information. If the information is provided within the 45 days, the MMC will notify the Covered Person as soon as possible of the decision, but in no case later than 15 days after it receives the information. If the information is not provided within the 45 days, the Pre-service Claim will be denied, and the MMC will notify the Covered Person of this denial within 15 days after the 45-day period ends.

On-going Treatment Claims - If the Medical Management Company (MMC) reduces or terminates payment for On-going Treatment before that treatment is finished (other than by Plan amendment or Plan termination), the MMC will notify the Covered Person sufficiently in advance of the reduction or termination to allow that person to Appeal the action and obtain a determination of that Appeal before the reduction or termination.

If the Covered Person requests an extension of the On-going Treatment beyond the period or number of treatments approved by the MMC, and that request does not constitute one involving Urgent Care, the request will be treated in the same manner as a new Claim for benefits.

If the Covered Person requests an extension of the On-going Treatment beyond the period or number of treatments approved by the Plan, and that request involves Urgent Care, the MMC will make the initial decision concerning the request as soon as possible, taking into account the medical circumstances, and the MMC will notify the Covered Person of its coverage determination within 24 hours of the MMC's receipt of the Claim, provided the Claim is received at least 24 hours before the expiration of the approved period or number of treatments. If such a request is received less than 24 hours before the end of the On-going Treatment, it will be processed as though it were a new Urgent Care Claim.

Post-Service Claims - For any Post-Service Claim, the Plan will provide the Covered Person with written notice of a coverage determination within 30 days after receipt of the Claim by the Plan.

This period may be extended one time for up to 15 days, if the Plan determines an extension is necessary due to matters beyond the control of the Plan.

If an extension is needed because the Plan needs additional information from the Covered Person, he or she will be notified of the information needed. The Covered Person will then have at least 45 days to supply the additional information. If the information needed is provided in full within the 45 days, the Plan will notify the Covered Person as soon as possible of the decision, but in no case later than 15 days after it receives the information. If the information is not provided within that time, the Claim will be denied, and the Plan will notify the Covered Person of this denial within 15 days after the 45-day period ends.

Weekly Sickness and Accident Benefits Claims - The Plan will make a decision on a Claim and notify the Covered Person of that decision within 45 days after it receives the Claim. This period may be extended one time for up to 30 days, if the Plan determines an extension is necessary due to matters beyond the control of the Plan. This notification will occur before the expiration of the initial 45-day period and will provide a date by which the Plan expects to render a decision. The Plan may extend its determination by a second, 30-day period, if the Plan determines another extension is necessary due to matters beyond the control of the Plan. Any notice of extension will explain the standards for determination of benefits, the unresolved issues that prevent a determination on the Claim, and the additional information needed to resolve the issues.

If an extension is needed because the Plan needs additional information from the Covered Person, the Plan will notify that person of the information needed. The Covered Person will then have 45 days to supply the additional information. If the information needed is provided in full within the 45 days, the Plan will notify the Covered Person as soon as possible of the decision, but in no case later than 30 days after it receives the information. If the information is not provided within that time, the Claim will be decided based on the available information. During the period for supplying 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 date the Plan receives a response to the request or the deadline for doing so (whichever is earlier).

Life Insurance and Accidental Death and Dismemberment Claims – The Fund Office will determine your Eligibility under the Plan. The insurance company will determine all non-Eligibility matters concerning your Claim. You will be notified in writing of a decision concerning your Claim within 90 days from receipt of your Claim by the office making the particular determination. The Plan may require an extension of 90 days if there are special circumstances, and will give written notice of any such extension, with an explanation of the special circumstances and the date a decision is expected.

Notice of Initial Benefit Determination – The Claimant will be provided with written notice of the initial benefit determination. In the event the determination is an Adverse Benefit Determination, the notice will be written in a culturally and linguistically appropriate manner. An initial benefit determination will include:

1. The specific reasons for the determination and a discussion of the decision including the basis for disagreeing with or not following the views of a treating physician or vocational

professional, the views of medical or vocational experts obtained by the plan, and/or a disability determination by the Social Security Administration;

2. Reference to the specific Plan provisions, guidance, or other criteria 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. A statement of the Claimant's right to receive access to and copies of all relevant documents 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;
8. For Urgent Care Claims, a description of the expedited review process applicable to Urgent Care Claims (for Urgent Care Claims, the notice may be provided orally and followed with written notification).

Appeal Procedures

You may have any other person whom you choose to represent you concerning a Claim or an Appeal, at your own expense, provided you provide written authorization to the Fund Office of who is authorized to represent you. An appointment-of-authorized-representative form, which may be obtained from the Fund Office, may be used to designate an authorized representative. The Plan may request additional information to verify that the designated person is authorized to act on your behalf or on behalf of your Dependent. However, in a situation involving Urgent Care Claims, a Provider who has knowledge of your medical condition may act as the authorized representative without you first providing written authorization to the Plan. If you give the Plan notice that you are being represented by another person, the Plan will provide any of its notices to that person, and not to you, unless you ask the Plan to provide notices to both you and your representative.

The Covered Person or an authorized representative may Appeal any Adverse Benefit Determination, including any decision concerning eligibility, within 180 days after the Covered Person's receipt of it. Except for Urgent Care Claim Appeals, the Appeal must be written and must include:

1. The patient's name and address;
2. The Covered Person's name and address, if different;
3. The date of the Adverse Benefit Determination; and
4. The basis of the Appeal (the reason(s) why the Claim should not be denied).

The Appeal may include any additional information the Covered Person or the Provider feel may be useful for the review of the Adverse Benefit Determination. The Appeal should be sent to the Fund Office at the following address:

Central Texas Health & Benefit Trust Fund
P. O. Box 860007
Plano, TX 75086-0007

For Urgent Care Claims, an Appeal may be submitted orally, by facsimile, electronically, or by any other method intended to expedite the process.

Upon request, the Covered Person may have reasonable access to, and copies of, all Relevant Documents at no charge. Upon request, the Plan will also provide the Covered Person or authorized representative with the identification of any medical expert whose advice was obtained by the Plan in connection with the Adverse Benefit Determination. The Claimant will also be automatically provided, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with the Claim; any new or additional rationale for a denial; and a reasonable opportunity to respond to new information by presenting written evidence and testimony. Except for Urgent Care Claims, any Appeal must be in writing and may include any information the Covered Person wishes to submit in support of the Appeal.

All Appeals will be reviewed by the Board of Trustees. The Trustees will give no deference to the determination previously made by the Claims payer. The decision on Appeal will be made on the basis of the record, including such additional documents and comments that the Covered Person or authorized representative may submit in connection with the Appeal. If an Appeal concerns a denial that was based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees will consult with a health care professional who has appropriate training and experience in the field of treatment involved in the medical judgment, and that professional will not be the one, or the subordinate of the one, who was consulted concerning the Adverse Benefit Determination.

Any denial of any Appeal, in whole or in part, will be written in a culturally and linguistically appropriate manner and include the specific reason(s) for the denial and a discussion of the decision including the basis for disagreeing with or not following the views of a treating physician or vocational professional, the views of medical or vocational experts obtained by the plan, and/or a disability determination by the Social Security Administration; the Plan provision(s), guidance, or other criteria on which the denial is based; a description of any applicable contractual limitations period and its expiration date; a statement of the Claimant's right to receive access to and copies of all relevant documents; will state the Claimant's right to bring a civil action under ERISA Section 502(a) following a denial of the Appeal; and any other information required by law under the circumstances.

Appeals Concerning Life Insurance and Accidental Death and Dismemberment Benefits

The Claimant must submit any Appeal concerning an Adverse Benefit Determination regarding life insurance or accidental death and dismemberment benefits, including any denial of Eligibility, in writing within 60 days of receiving an Adverse Benefit Determination. Any Appeal concerning Eligibility (whether the Covered Person met or meets the minimum requirements for coverage under the Plan, such as having sufficient hours) for these benefits must be submitted in writing to the Fund Office. Any Appeal concerning any issue other than Eligibility must be submitted to the

insurance company. You may obtain the current address for the insurance company from the Fund Office.

Upon request, the Covered Person may have reasonable access to, and copies of, all Relevant Documents at no charge, and will be provided with the identification of any medical expert whose advice was obtained in connection with the Adverse Benefit Determination.

The Trustees will decide Appeals concerning Eligibility, and the insurance company will decide Appeals concerning non-Eligibility aspects of the Adverse Benefit Determination.

Time Periods for Notice of Appeal Determinations

Urgent Care Claim Appeals - The Medical Management Company will decide any Urgent Care Claim Appeal. For these Appeals, the Plan will notify the Covered Person or an authorized representative of the Trustees' Appeal determination as soon as possible, considering the medical circumstances, but not later than 72 hours after the Plan receives the Appeal. The Plan will communicate regarding the Appeal, including providing its decision notice, by telephone, facsimile, electronically or other, similarly expeditious method available under the circumstances.

Pre-service Claim Appeal - The Trustees will decide any Pre-service Claim Appeal. The Plan will notify the Covered Person or an authorized representative of the Trustees' Appeal determination concerning any Pre-service Claim Appeal in writing or electronically not later than 30 days after the Plan receives the Appeal.

Post-service Claim or Claim for Weekly Accident and Sickness Benefits Appeal - The Trustees will decide any Appeal concerning a Post-Service Claim or weekly accident and sickness benefit Claim. They will review and decide the Appeal no later than the date of the next regularly-scheduled meeting of the Board of Trustees that immediately follows the receipt of the Appeal. However, if the Appeal is submitted within 30 days before the date of the next meeting, the Trustees will make a determination no later than the date of the Trustees' second meeting following the Plan's receipt of the Appeal. If special circumstances require a further extension of the due date for a decision, the Plan will provide written notice of the extension before the meeting at which the determination would otherwise be made, if possible. The notice will include an explanation of why the extension is needed and the date a determination is expected to be made. Any determination will be made no later than the third meeting of the Trustees following the receipt of the Appeal. The Plan will notify the Covered Person or an authorized representative of the Trustees' Appeal determination in writing or electronically within five days after the determination is made.

Life Insurance or Accidental Death and Dismemberment Benefits Appeal -The Trustees will decide any Appeal concerning Eligibility regarding life insurance and accidental death and dismemberment benefits. They will review and decide the Appeal no later than the date of the next regularly-scheduled meeting of the Board of Trustees that immediately follows the receipt of the Appeal. However, if the Appeal is submitted within 30 days before the date of the next meeting, the Trustees will make a determination no later than the date of the Trustees' second meeting following the Plan's receipt of the Appeal. If special circumstances require a further extension of the due date for a decision, the Plan will provide written notice of the extension before

the meeting at which the determination would otherwise be made, if possible. The notice will include an explanation of why the extension is needed and the date a determination is expected to be made. Any determination will be made no later than the third meeting of the Trustees following the receipt of the Appeal. The Plan will notify the Covered Person or an authorized representative of the Trustees' Appeal determination in writing or electronically within five days after the determination is made.

The insurance company will decide any non-Eligibility issue concerning the Appeal, and will provide a written decision concerning the Appeal within 60 days from receiving the Appeal. If special circumstances require an extension of the due date, the insurance company will provide written notice of the extension with an explanation of the special circumstances and the expected decision date, which may be no more than 60 days from the end of the first 60-day period. The insurance company's Appeal decision will be written in an understandable way, will state the specific reason(s) for the decision, and will make specific reference to the provision on which the decision is based.

Exhaustion of Claim and Appeal Review Procedures and Time Limit for Filing Any Lawsuit

No action or proceeding against the Plan, the Trust Fund, the Board of Trustees, or any person or entity acting on behalf of any of them, or any other person, for the recovery of any benefits under the Plan may be started until the Plan's Claims and Appeals procedures have been exhausted. In addition, all actions for the recovery of benefits must commence within 12 MONTHS after the Plan's Claim and Appeal review procedures have concluded. For these purposes, the Claim and Appeal review procedures conclude upon the Trustees' issuance of notice of their decision concerning the Appeal or, for an Appeal being reviewed by an insurance company, upon that insurance company's issuance of a decision concerning the Appeal. A Participant or Beneficiary can only file a lawsuit in connection with the Plan in the United States District Court for the Eastern District of Texas, Plano Division.

External Claim and Appeal Review Procedures - Plans A & B

Within four months after the date of receipt of a notice of a final Notice of Appeal Determination (or an Adverse Benefit Determination) you or your authorized representative may submit a written external review request ("Request") for your Claim to be reviewed by an Independent Review Organization (IRO). Within five business days of the receipt of your Request for external review, the Plan will complete the preliminary review of the Request to determine whether: (1) you are or were covered by the Plan at the time the health care service was requested or performed; (2) the health care service was a covered service under the Plan at that time; (3) you have exhausted your internal Claims and Appeals process; and (4) you have provided all of the information, including release forms, necessary to process your external review Request. Within one day after the Plan has made a determination on items (1-4) above, it will provide you with a notice in writing regarding whether your Request is complete and whether you are eligible to pursue an external review Request, or not. If your application is incomplete the notice will include any information that is needed to make your Request complete. If it is determined that your Request is not eligible for an external review, the notice will include the reasons you are ineligible and it will provide the

applicable contact information for the applicable Employee Benefits Security Administration office.

If your Request is complete and it is determined the Request is eligible for external review, the Plan will assign your Request to the next available Independent Review Organization, from among the three such certified Independent Review Organizations that review external Requests for the Plan. These three Independent Review Organizations are rotated for every new external Request, to assist in providing you with an Independent Review Organization analysis without any bias toward the Plan's final determination on your benefit Claim. Once your Request is assigned to the Independent Review Organization, the Plan will provide the Independent Review Organization with the documents and information it considered in making the adverse benefit determination. After the initial submission of your Request to the Independent Review Organization, you will receive a notice from the Independent Review Organization that you will have ten business days from the date of that notice to submit additional information that must be considered by the Independent Review Organization in its review of your Request. The Independent Review Organization will forward to the Plan any information you provide, within one business day, and the Plan may overturn its final Notice of Appeal Determination related to your Request within one business day of notice of your additional information. Otherwise the Independent Review Organization will proceed to make a final determination on your Request. The Independent Review Organization will review your Request de novo, meaning it will look at your Request without any preference for the decision made by the Trustees in your Appeal. Once the Independent Review Organization makes a determination on your Request, it shall notify you and the Plan within one business day of its decision on your Request. In making its decision on your Request, the Independent Review Organization shall consider the following:

1. Your medical records;
2. Your attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by you, or your treating provider or the Plan:
4. The Plan's terms, to ensure that Independent Review Organization's decision is not contrary to the Plan's terms;
5. Appropriate practice guides, including guidelines developed by the federal government, national or professional medical societies, boards and associations;
6. Any appropriate clinical review criteria developed and used by the Plan; and
7. The opinion of the Independent Review Organization's clinical reviewer(s) after considering the applicable and appropriate information and documents.

The Independent Review Organization's written decision on your Request shall be provided to you and the Plan within 45 days after the Independent Review Organization receives your Request. The Independent Review Organization notice shall contain the following:

1. A general description of your Request with all relevant information, including but not limited to the diagnosis and treatment codes and corresponding meanings and the reasons for the previous denials;
2. The date the Independent Review Organization received your Request for review and the date it issues its final decision;

3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason(s) and rationale for its decision, including any evidence-based standards relied upon in the decision.
5. A statement that the determination is binding except to the extent other remedies are available to you or the Plan;
6. A statement that judicial review may be available to the parties; and
7. The current contact information for healthcare consumer assistance and the Employee Benefit Security Administration.

The Independent Review Organization's records are available for review by the parties, as allowed by law. If your Request results in the Independent Review Organization overturning the Notice of Appeal Determination then the Plan will immediately provide coverage or payment for the disputed Claim.

Expedited External Review Request. You may file an Expedited Request with the Plan if you receive:

1. An Adverse Benefit Determination, you have filed a request for an expedited internal Appeal, and the delay involved in the internal Appeal process would seriously jeopardize your medical condition, your life or health, or your ability to regain maximum function related to your Illness or Injury; or
2. A final internal Notice of Appeal Determination and the delay involved in processing a normal Request would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or where the final Notice of Appeal Determination concerns an Admission, availability of care, continued stay, or health care items or services for which you received Emergency Services and you have not been discharged from the medical facility.

Once the final decision on your Request is made by the Independent Review Organization or by the insurance company, whichever is applicable, if you are still not satisfied with the outcome, you must commence a legal action under ERISA 502 for the recovery of benefits within 12 MONTHS after the Independent Review Organization's external Request decision is provided to you. The final decision is made on your benefit Request when the Independent Review Organization provides a notice of its final determination on your Request. For an Appeal being reviewed by an insurance company, that decision is final upon that insurance company's issuance of a decision concerning the Appeal.

Legal Compliance

The Board of Trustees intends that this Plan and the Fund, both in content and operation, comply in all respects with applicable law and government regulations including the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, the Children's Health Insurance Program Reauthorization Act (CHIRPA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Genetic Information Nondiscrimination Act (GINA), the Health Insurance Portability and Accountability Act (HIPAA), Michelle's Law; Medicare Part D, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Mental

Health Parity and Addiction Equity Act, the Patient Protection and Affordable Care Act (ACA), and all of their respective amendments. The Plan will be interpreted and applied to comply with all applicable laws.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Central Texas Health and Benefit Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan Document and Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later

portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information or pre-certification, contact your plan administrator.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For covered persons receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymph edemas. These benefits are subject to the same Deductible and Co-Insurance applicable to other medical and surgical benefits under Central Texas Health and Benefit Trust Fund. If you would like more information on the benefits under the Women's Health and Cancer Rights Act of 1998, please call the Fund Office at (866) 434-2200.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should: 1) contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; 2) call the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272); or 3) 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, Suite N-5625
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA's Toll-Free Employee & Employer Hotline at 1-866-444-EBSA (3272).

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THIS PLAN, WHENEVER IN THEIR SOLE DISCRETION CONDITIONS SO WARRANT.

HIPAA PRIVACY NOTICE

Central Texas Health and Benefit Trust Fund
P. O. Box 860007
Plano, TX 75086-0007

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations issued by the U.S. Department of Health and Human Services (the "Privacy Rules"), the Central Texas Health and Benefit Trust Fund (the "Plan") is required to take reasonable steps to ensure the privacy of your health information ("Protected Health Information" or "PHI") and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information;
2. Your rights to privacy with respect to your Protected Health Information;
3. The Plan's duties with respect to your Protected Health Information;
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services ("HHS"); and
5. The person you should contact for further information about the Plan's privacy practices.

The Plan is required to maintain the privacy of your PHI, provide you with this Notice of its legal duties and privacy practices, and to follow the terms of this Notice. The Plan, however, reserves the right to change its privacy practices and/or the terms of this Notice at any time, and to make new provisions effective for all PHI that it or any affiliate uses, maintains, discloses or requests. You will receive written notice of any changes that are made to the Plan's privacy practices and/or the terms of this Notice. You will also receive a revised Notice within 60 days after any material changes are made.

Please note that the Plan prepared this Notice, so any references to "we," "our," or "us" mean the Plan.

Your Protected Health Information

Important Definitions

Protected Health Information - The term "Protected Health Information" or "PHI" includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written, or electronic form.

Business Associates - Business Associates are individuals and companies who need access to your PHI to act on our behalf or to provide us with services. Examples of Business Associates include third-party administrators, managed care networks, preferred provider organizations ("PPOs"), health maintenance organizations ("HMOs"), dental networks, mental health insurers, pharmacy benefits managers, attorneys, consultants and auditors. We may disclose your health information to our Business Associates, and we may authorize them to use, disclose or request your health information for any or all of the same purposes for which we are permitted to use or disclose it ourselves, as well as for their own administrative purposes. Our Business Associates are contractually required not to use, disclose or request your health information for any other purposes.

When the Plan May Disclose Your PHI

The Privacy Rules provide that the Plan may not use or disclose your PHI without your consent, unless expressly permitted by the Privacy Rules and/or HIPAA. The following is a brief description of some of the situations where the Plan may use or disclose your PHI without your consent. Please note that when using or disclosing your PHI or when requesting your PHI from another entity covered by the Privacy Rules, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

A. **As required by law** - The Plan may use or disclose your PHI as expressly permitted or required by HIPAA, the Privacy Rules, a valid court order, or other statutory or governmental rule or regulation.

B. **As required by HHS** - The HHS Secretary may require the disclosure of your PHI to investigate or determine the Plan's compliance with the Privacy Rules.

C. **For treatment, payment or health care operations** - The Plan may use or disclose your PHI in order to carry out "Treatment," "Payment," or "Health Care Operations." Examples for each of these purposes are described below. These descriptions are only examples and are not intended to be complete descriptions of all of the ways in which we may use, disclose or request your health information within each of these three categories.

1. **Treatment** means the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose the name of your treating family practice physician to your surgeon so that the surgeon may ask for your blood work lab results from your family practice physician.
2. **Payment** includes but is not limited to the following:
   a. **Determining your eligibility for benefits** - For example, we may use information obtained from your employer to determine whether you have satisfied the Plan's requirements for active eligibility;
   b. **Obtaining contributions from you or your employer** - For example, we may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage;
   c. **Pre-certifying or pre-authorizing health care services** - For example, we may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure or request additional information from another provider to validate the reasons for the procedure or treatment;
   d. **Determining and fulfilling the Plan's responsibility for benefits** - For example, we may review health care Claims to determine if specific services that were provided by your physician are covered by the Plan;
   e. **Providing reimbursement for the treatment and services you received from health care providers** - For example, we may send your physician a payment with an explanation of how the amount for the payment was determined. Similarly, a detailed bill or an "Explanation of Benefits" ("EOB") may also be sent to you or to the primary insured that will typically include information that identifies you, your diagnosis, and the procedures you received;
   f. **Subrogation or reimbursement health Claim benefits for which a third party may be liable** - For example, we may exchange information about an accidental Injury with your attorney who is pursuing reimbursement from another party and request information updating the proceedings; and
   g. **Coordinating benefits with other plans under which you have health coverage** - For example, we may disclose information about your benefits to another group health plan in which you participate, or request information from such plan regarding coordination of the benefits between the two plans.
3. **Health Care Operations** include, but are not limited to, the following:
   a. **Business Management and Administration** - This includes business planning and development, cost management, and customer service;

b. **Conducting quality assessment and improvement activities** - For example, a supervisor or quality specialist may review health care Claims to determine the accuracy of a processor's work;

c. **Case management and care coordination** - For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need;

d. **Contacting you regarding treatment alternatives or other benefits and services that may be of interest to you** - For example, a case manager may contact you to give you information about alternative treatments that are neither included nor excluded in the Plan's benefits, but that may nevertheless be available in your situation;

e. **Contacting health care providers with information about treatment alternatives** - For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting;

f. **Employee training** - For example, training of new Claims processors may include processing of Claims for health benefits under close supervision;

g. **Accreditation, certification, licensing, or credentialing activities** - For example, a company that provides professional services to the Plan may disclose your health information to an auditor who is determining or verifying the company's compliance with standards for professional accreditation;

h. **Securing or placing a contract for reinsurance of risk relating to Claims for health care** - For example, your demographic information (such as age and sex) may be disclosed to carriers of stop-loss insurance to obtain premium quotes;

i. **Conducting or arranging for legal and auditing services** - For example, your health information may be disclosed to an auditor who is auditing the accuracy of Claim adjudications;

j. **Formulary development** - For example, benefit utilization information may be used to develop the formulary list of prescription drugs covered by the Plan;

k. **Management activities relating to compliance with privacy regulations** - For example, the Privacy Official may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy;

l. **Resolution of internal grievances** - For example, your health information may be used in the process of settling a dispute about whether a violation of our privacy policies and procedures actually occurred;

m. **Sale, transfer, merger, or consolidation** - For example, your health information may be disclosed if the Plan merges with another health plan;

n. **De-identification of Health Information** - We may use or disclose your health information for the purpose of creating health information that is no longer identifiable as pertaining to you. Such de-identified health data may then be used for purposes that are not described in this notice as either permitted or required; and

o. **Creation of a Limited Data Set** - We may use your health information to create a "limited data set" that excludes most identifiers but may include partial addresses (city, state, and zip code), dates of birth and death, and other dates that pertain to your health care treatment. Such a "limited data set" may be disclosed for purposes of research, public health, or health care operations.

D. **Public health purposes** - The Plan may disclose your PHI to an authorized public health authority if required by law or for public health and safety purposes. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

E. **Domestic violence or abuse situations** - The Plan may disclose your PHI when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

F. **Health oversight activities** - The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs.

G. **Legal proceedings** - The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a valid court order or a subpoena or discovery request that meets the Privacy Rule's requirements. In certain situations, the Plan may be required to make reasonable efforts to notify you about a request or to obtain a court order protecting your PHI.

H. **Law enforcement purposes** - The Plan may disclose your PHI when required for law enforcement purposes. For example, the Plan may disclose PHI about you to law enforcement officials if it is suspected that your death may have resulted from criminal activity.

I. **Determining cause of death and funeral purposes** - The Plan may disclose your PHI when it is required to be given to a coroner or medical examiner to identify a deceased person, determine cause of death or for that coroner's or medical examiner's other authorized duties. The Plan may also disclose PHI to funeral directors, consistent with applicable law, as necessary for them to carry out their duties with respect to decedents.

J. **Organ donation** - The Plan may disclose your PHI for cadaveric organ, eye or tissue donation purposes.

K. **Research** - The Plan may disclose your PHI for certain research, provided that certain restrictions set forth in the Privacy Rules are met.

L. **Health or safety threats** - The Plan may disclose your PHI when, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

M. **Specialized government functions** - The Plan may disclose your PHI when, consistent with applicable law, the disclosure is required for military purposes, national security, and other specialized governmental functions.

N. **Workers' compensation programs** - The Plan may disclose your PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law that provide benefits for work-related Injuries or Illness.

O. **Disclosure to the Plan's Board of Trustees** - The Plan will also disclose PHI to the Plan's Board of Trustees for purposes related to Treatment, Payment, and Health Care Operations. For example, the Plan may disclose information to the Board of Trustees to allow the Trustees to decide an Appeal or review a subrogation or reimbursement Claim.

The Plan may also disclose to the Board of Trustees "summary health information," which includes Claims totals without any personal identification except your zip code so the Trustees may, for example, obtain health insurance premium bids or in connection with their consideration of making amendments to the Plan's plan of benefits.

The Board will not disclose your Protected Health Information to your employer for general employment purposes.

P. **Health-Related Services That May Be of Interest** - The Plan or its Business Associates may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, you may be contacted by a case management coordinator if you suffer a serious Injury or Illness.

Q. **Disclosures to Your Family and Friends** - The Plan and/or its business associates may, in certain limited situations, disclose your PHI to your family members or friends. Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if the information to be disclosed is directly relevant to the family member's or friend's involvement with your care or payment for that care, and either 1) you are present and have had an opportunity to agree or disagree before the use or release of your PHI, and you have agreed to the disclosure, or when given the opportunity to object, you have not objected; or 2) if you are not present, or as a practical matter, are unable to consent when your PHI is to be disclosed, and such disclosure is in the your best interest as determined in the Plan's or its Business Associates' professional judgment based on common practice, their experience, and the circumstances surrounding the disclosure.

All other uses and disclosures not expressly authorized by HIPAA, the Privacy Rules and/or other applicable law, will not be made without your written authorization, which you may revoke at any time as long as you do so in writing. Written notice of your revocation must be sent to the Fund Office at the following address:

Central Texas Health and Benefit Trust Fund
P.O. Box 860007
Plano, TX 75086-0007

You may request that the Plan:

1. Restrict the uses and disclosures of your PHI to carry out Treatment, Payment or Health Care Operations; or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

If the Plan agrees to your request, except in certain situations such as an emergency, the Plan may not use or disclose your PHI in violation of the restriction. The Plan, however, is not required to agree to your request.

To make such a request, you must do so in writing and send it to the Fund Office at the above address.

You May Request Confidential Communications

The Plan will accommodate your reasonable requests to receive communications of PHI by alternative means or at alternative locations. For certain requests, the Plan may require your request to include a statement that, absent such change in delivery method or location, such disclosure could endanger you.

All requests must be submitted in writing to the Fund Office at the above address.

You May Inspect and Copy PHI

You have the right to inspect and obtain copies of your PHI contained in a "designated record set" for as long as such information is maintained in a designated record set. In certain situations, however, the Plan may deny you access to your PHI. In such case, the Plan will provide you with a written notice of the denial that includes the reason(s) for the denial, whether or not the decision is reviewable, a description of the review procedures if the decision is reviewable, and a description of how you may complain to the Plan or the HHS Secretary about the denial.

In most situations, the Plan must provide the PHI you request in both the form and the format you request. In certain situations, with your approval, the Plan may provide you with an explanation or summary of your PHI, provided that you agree in advance to the fee that may be imposed by the Plan for that summary. If you request copies of your PHI, the Plan may impose reasonable fees for the copies to cover the cost of the copies, labor, and postage.

The Plan must provide the requested access or its notice of denial within 30 days if the information you request is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline, provided that the Plan notifies you in writing of the reason for the extension and the date that the Plan will complete its action within the applicable initial 30 or 60-day period.

To request access to your PHI that is maintained in a designated record set, you must do so in writing and submit it to the Fund Office at the above address.

A **Designated Record Set** includes enrollment, payment, billing, Claims adjudication and case or medical management records maintained by or for the Plan, or other information used in whole or in part by or for the Plan to make decisions about you.

You Have the Right to Request Amendment of Your PHI

You have the right to request that the Plan amend your PHI or a record about you that is maintained in a designated record set for as long as the PHI is maintained in a designated record set.

The Plan has 60 days after receiving your request to act on it by either making the amendment or denying your request. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denies your request to amend your PHI in whole or in part, the Plan will give you a written notice that provides (i) an explanation of the basis for the decision, (ii) a statement of your right to submit a written statement disagreeing with the denial and how you may file this statement, (iii) a statement that if you do not submit a disagreement, you may request that your initial amendment request plus the denial be included with any future disclosures of the PHI that is subject to the request, and (iv) a description of how you may complain about the denial to the Plan or the HHS Secretary. If you file a written statement of disagreement (or request that your initial amendment request serve as such), the Plan has the right to issue and file a written rebuttal to your statement, in which case, a copy will be provided to you.

All requests to amend your PHI must be submitted in writing to the Fund Office.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will provide you with an accounting of certain disclosures by the Plan of your PHI made after January 1, 2004, and up to six years before your request. We do not have to provide you with an accounting of disclosures related to Treatment, Payment, or Health Care Operations, disclosures made to you or authorized by you in writing, or in certain other limited situations as provided for in the Privacy Rules. Generally, the accounting will include the date of the disclosure; the name of the person or entity that received the PHI and that entity's or person's address, if known; a brief description of the disclosed PHI; and a brief statement of the reason for the disclosure.

The Plan has 60 days to provide the accounting after receipt of your request. The Plan is allowed an additional 30 days if, within the initial 60-day period, the Plan gives you a written notice of the reasons for the delay and the date by which the accounting will be provided.

All accounting requests must be submitted in writing to the Fund Office at the above address. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Fund Office at the following address:

Central Texas Health and Benefit Trust Fund
P.O. Box 860007
Plano, TX 75086-0007

Your Personal Representative

You may exercise your rights described in this Notice through a personal representative. Your personal representative will generally be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1. Disclosures to or requests by a health care provider for treatment;
2. Uses or disclosures made to you;
3. Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA;
4. Uses or disclosures required by law; and
5. Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that:

1. Does not identify you; and
2. With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Plan. Summary information summarizes the Claims history, Claims expenses or type of Claims experienced by individuals covered by the Plan. Identifying information will be deleted from summary health information, in accordance with HIPAA and the Privacy Rules. If you believe that your privacy rights have been violated, you may file a complaint with the Fund Office at the address noted above. All complaints must be in writing.

You also may file a complaint with the U.S. Department of Health and Human Services at the address noted below. Your complaint must (i) be filed in writing, either on paper or electronically, (ii) include the Plan's name, (iii) contain a description of the acts or omissions you believe to be in violation of the Privacy Rules, and (iv) be filed within 180 days of when you knew or should have known that the acts or omissions giving rise to the complaint occurred. Your complaint should be filed at the following address:

Region VI
Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Phone: (214) 767-4056
Fax: (214) 767-0432
TDD: (214) 767-8940

The Plan will not retaliate against you in any way for filing a complaint.

If you have any questions regarding this Notice or the subjects addressed in it, or have a complaint to be lodged with the Plan regarding this notice or other HIPAA privacy issues, you may contact the following individual at the Fund Office:

Central Texas Health and Benefit Trust Fund
Matthew Friestman, Privacy Officer
P.O. Box 860007
Plano, TX 75086-0007
or call (866) 434-2200

Protected Health Information use and disclosure by the Plan is regulated under HIPAA and the Privacy Rules. You may find these rules at 45 Code of Federal Regulations ("CFR") Parts 160 and 164. This Notice is provided to you under 45 CFR §164.520 and it attempts to summarize some of the Privacy Rules and the Plan's privacy policies and procedures. The Privacy Rules and HIPAA will supersede this Notice if there is any discrepancy between the information in this Notice and the Privacy Rules and/or HIPAA.

PLAN INFORMATION

The following information concerning the Plan is being provided to you in accordance with Federal regulations:

1. The name and type of administration of the Plan:

   The Central Texas Health and Benefit Trust Fund is administered by the Joint Board of Trustees ("**Trustees**" or "**Board of Trustees**") consisting of equal numbers of Union Trustees and Employer Trustees.

   Type of Plan - This Plan is a multiemployer, employee group health benefit plan maintained for the purpose of providing medical benefits and Life Insurance benefits.

Employer Identification Number - The Employer Identification Number assigned by the Internal Revenue Services is 20-0400732.

Plan Number - The Plan Number assigned by the Board of Trustees is 501.

2. The type of administration of the Plan:

The Central Texas Health and Benefit Trust Fund is administered on a day-to-day basis by a contracted third party administrator ("TPA"). The name, address, and other contact information for the TPA are:

AmeriBen/IEC Group
P. O. Box 860007
Plano, Texas 75086-0007

Telephone: (972) 943-9559
Toll-Free: (866) 434-2200

The office of the TPA is referred to as the "Fund Office" in this SPD.

3. The names and business addresses of the Trustees are:

Union Trustees	**Management Trustees**
Mr. Matthew Friestman, (Secretary) IBEW Local Union No. 520 4818 E. Ben White Blvd., Suite 300 Austin, TX 78741	Mr. Les M. Moynahan (Chairman) NECA South Texas Chapter 16607 Blanco Road, Suite 1105 San Antonio, TX 78232
Mr. Paul Garza IBEW Local Union No. 60 814 Arion Parkway, Suite 120 San Antonio, TX 78216	Mr. Case Kanetzky 5516 Meg Brauer Way Austin, TX 78749
Mr. Rick Siskr IBEW Local Union No. 60 814 Arion Parkway, Suite 120 San Antonio, TX 78216	Mr. Don Kanetzky Central Texas Chapter, NECA 11161 FM 967 Buda, TX 78610
Mr. Mike D. Hernandez IBEW Local Union No. 60 814 Arion Parkway, Suite 120 San Antonio, TX 78216	Mr. Brad Hensel Hensel Electric Co. 501 Towne Oaks Drive Waco, TX 76710
Mr. Craig W. Miller IBEW Local Union No. 72 1813 Orchard Lane Waco, TX 76705	Mr. Glen Herring W.K. Jennings Electric Co. 1707 Dungan Lane Austin, TX 78754
Mr. David Heap 245 Gruetzner Lane Elgin, TX 78621	Mr. Robert Livar CDI Technology Services 590 Duncan Dr. San Antonio, TX 78226

Mr. Mark Guerra 5408 Rusk Court Austin, TX 78723	Mr. Denis St. Pierre South Texas Chapter, NECA 16607 Blanco Road, Suite 1105 San Antonio, TX 78727
Mr. Michael Murphy, Alternate IBEW Local Union No. 520 4818 E. Ben White Blvd., Suite 300 Austin, TX 78741	Mr. John Miller, Alternate Big State Electric 8923 Aero Street San Antonio, TX 78217
Mr. Stephen Teague, Alternate IBEW Local Union No. 72 1813 Orchard Lane Waco, TX 76705	

In addition to the Union and Employer Trustees designated above, you are entitled to receive from the Fund Office, upon written request, information concerning whether a particular employer organization or employee organization is a sponsor of the Plan and, if the employer organization or employee organization is a Plan sponsor, that sponsor's address.

4. THIRD PARTY ADMINISTRATOR

AmeriBen/IEC Group
Post Office Box 860007
Plano, TX 75086-0007
Telephone: (972) 943-9559
Toll-Free: (866) 434-2200

5. BENEFITS CONSULTANT

Ryan Benefits, Inc.
1100 Mira Vista Blvd., Suite 350
Plano, TX 75093

6. The following person has been designated as agent for the service of legal process:

Douglas M. Selwyn, Esq.
Conner & Winters, LLP
Niels Esperson Building
808 Travis Street, 23rd Floor
Houston, TX 77002

In addition, service of legal process may be served on any of the Trustees or on the Third Party Administrator.

7. The Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan's benefits include health, life insurance, accidental death and dismemberment, vision, prescription drugs and weekly sickness and accident benefits.

8. For purposes of maintaining the Plan's fiscal records, the year-end date is December 31. This means that the Plan Year is January 1 through December 31.

9. Funding Method: Benefits are provided from primarily employer contributions to the Central Texas Health and Benefit Trust Fund. Benefits are paid pursuant to provisions of collective bargaining and participation agreements, the Trust Agreement, and these Rules and Regulations. Contributions and any interest or other earnings are held in a trust fund for providing benefits to covered individuals and defraying reasonable operating expenses. Benefits for health, prescription drugs, vision, dental and weekly sickness and accident benefits are self-funded by the Trust Fund. Life insurance and accidental death and dismemberment benefits are provided under an insurance contract.

10. Contribution Source: Contributions to the Plan are made primarily by Employers, either under collective bargaining agreements between Employer associations and IBEW Local Unions 60, 72 or 520, or under participation agreements between Employers and the Trust Fund. In addition, the Trust Fund receives some contributions from Covered Employees in the form of Co-payments, Deductibles, self-payments and other payments, and it receives reciprocal contributions made on behalf of employees working in jurisdictions other than Locals 60, 72 or 520.

The TPA will provide you, upon written request, with information concerning whether a particular employer is contributing to this Plan on behalf of participants under a collective bargaining agreement or any participation agreement.

See the section entitled "Plan Documents and Reports", below, if you wish to obtain additional information about the collective bargaining and participation agreements.

11. Plan Information: The Plan's requirements concerning eligibility, as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefit, are described in this booklet.

12. Plan Regulations: All of the types of benefits provided by the Plan are described in this document. Complete terms of the benefits provided by separate contracts of insurance are provided in those agreements.

13. Plan Documents and Reports: You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

    A. Trust Agreement;
    B. Collective Bargaining and Participation Agreements;

C. This Plan Document and all Amendments; also referred to as the Summary Plan Description (SPD).
D. Form 990 filed with the Internal Revenue Service or full Annual Report filed with the Department of Labor; and
E. List of Contributing Employers.

14. Life Insurance Issuer

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

15. Plan Assets: The Plan's assets and reserves are held in the custody of a national bank and invested by the Board of Trustees under an investment management contract.

16. Funding Medium: Benefits are provided from the Plan's assets, which are accumulated in the Plan pursuant to contributions made by contributing Employers and Self-Payments made by eligible Participants to continue coverage when authorized by the Plan, as well as investment earnings related thereto. These assets are held by the Trustees in trust for the purpose of providing benefits to Participants and defraying reasonable administrative expenses of the Plan.

17. Selection of Physicians and Facilities: The Plan provides health care benefits, but does not purport to be a health care facility or contain licensed physicians or actually provide hospital or medical services or advice. Accordingly, the Plan is not responsible for any acts or omissions by Hospitals, Physicians, other medical facilities, or other medical professionals.

18. Qualified Medical Child Support Orders: Upon written request to the Fund Office, you may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations.

19. Procedure for Obtaining Additional Plan Documents: If you wish to inspect or receive copies of additional documents relating to the Plan, you may contact the Fund Office at the address or phone number listed above. You may be charged a reasonable fee to cover the cost of any materials you wish to receive. You should find out what the charge will be by calling the Fund Office before requesting copies. If you prefer, you can arrange to examine these reports, during normal business hours, at your Local Union Office. To make such arrangements, call or write the Fund Office. 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.