THE LOCAL 25 S.E.I.U. WELFARE FUND
PLAN OF BENEFITS

PROVIDED BY THE

LOCAL 25 S.E.I.U. WELFARE FUND

Restated Effective January 1, 2017

PREAMBLE

The purpose of this Plan Document is to set forth the terms and conditions under which benefits will be paid on behalf of Employees of Employers for whom Contributions are made to the Local 25 S.E.I.U. Welfare Fund. The benefits set forth in this Plan Document are, in some situations, supplemented by benefits provided by Union Health Service, Inc.

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ARTICLE 1- DEFINITIONS

Whenever a word or phrase defined in this Article is used in this Plan Document, it shall have the same meaning as defined unless a different meaning is plainly required by the context.

1.1 ASSOCIATION

The Building Owners and Managers' Association of Chicago, and any other association which, in the future, becomes a party to the Trust Agreement.

1.2 BENEFIT PLAN; PLAN OF BENEFITS; PLAN

The self-funded Benefit Plan of the Local 25 S.E.I.U. Welfare Fund as set forth herein.

1.3 CALENDAR YEAR

The 12-month period starting January 1 of any year and ending on December 31 of that year.

1.4 CHEMICAL DEPENDENCY

The abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol or any other chemical (except nicotine).

1.5 COLLECTIVE BARGAINING AGREEMENT; AGREEMENT

Any applicable collective bargaining agreement now existing between the Association or an Employer and the Union which provides for Contributions to the Trust Fund, as well as any extensions, amendments or renewals thereof, or any new collective bargaining agreement executed in the future which provides for the payment of Contributions into the Trust Fund as well as any extensions, amendments or renewals thereof.

1.6 CONTRIBUTIONS

Payments made by an Employer to the Fund on behalf of such Employer's Employees pursuant to the terms of an existing Collective Bargaining Agreement or Participation Agreement.

1.7 COVERED EMPLOYMENT

Work performed by an Employee for an Employer for which the Employer is required to make Contributions to the Fund on the Employee's behalf in accordance with the terms of a Collective Bargaining Agreement or Participation Agreement.

1.8 COVERED EXPENSE(S)

Covered Expenses are the actual Reasonable and Customary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies

which are Medically Necessary and required for care and treatment of the individual as a result of a Non-Occupational Injury or Non-Occupational Sickness for which benefits are payable by the Plan as specified on the applicable Schedule of Benefits, but only in accordance with all other applicable provisions, limitations and exclusions specified in this Plan Document.

1.9 COVERED UNDER THE PLAN

A term used to indicate that an individual is eligible to receive the applicable Plan benefits which apply to his status as an Eligible Employee or an Eligible Dependent.

1.10 CREDITED HOUR

Any hour of Covered Employment.

1.11 DEPENDENT

A. A Dependent is the legal spouse of an Eligible Employee, provided the spouse is not legally separated or divorced from the Eligible Employee.

B. A Dependent is an Eligible Employee's child as defined in Paragraph C below:

1. Who is 19 but less than 26 years of age

2. Who is age 26 or older who is incapable of self-sustaining employment because of mental retardation or physical handicap (hereafter called a "handicap" or "handicapped"), and who meets all of the requirements of the following provisions:

   a. The child must meet the definition of a child as defined in Paragraph C below.

   b. The child must have become so handicapped and incapable prior to the attainment of age 19.

   c. The child must remain handicapped.

   d. The child must be incapable of self-sustaining employment and continue to be incapable of such employment.

   e. The child must be dependent upon the Eligible Employee for the major portion of his support and maintenance.

   f. At no expense to the Trustees, the Eligible Employee must furnish proof of the child's handicap within 31 days prior to the date the Dependent child becomes age 19. If such proof is not received by the Trustees within such 31-day period, the child shall not be considered an Eligible Dependent beyond the date he attains age 19 even though the child continues to be handicapped.

   g. The Eligible Employee must furnish proof of the child's continued handicap if requested by the Trustees at any future time. If such proof is requested but not received by the Trustees on or before the date specified by the Trustees, the

child's eligibility for benefits shall terminate on that date.

C. Under this Plan, a child means:

1. A legitimate child born of a valid marriage of an Eligible Employee.

2. A natural child of the Eligible Employee's who is not a legitimate child born of a valid marriage, provided the Employee submits satisfactory proof of his parenthood (birth certificate, Voluntary Acknowledgement of Paternity, etc.);

3. A child legally adopted by an Eligible Employee or placed in the home of an Eligible Employee for the purpose of adoption.

4. A stepchild (of an Eligible Employee' meaning a child of an Employee's current spouse who was born to such spouse or who was legally adopted by the spouse before the Employee's marriage to that spouse).

5. An Eligible Employee's foster child, meaning a child who is placed with the Employee by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction; and

6. Any child determined by the Trustees to be an "alternate recipient" under the terms of a Qualified Medical Child Support Order (QMCSO). (The Fund Office will provide, upon request and free of charge, a copy of the Fund's QMCSO procedures.)

D. If a spouse or child of an Eligible Employee is eligible for benefits under this Plan as an Employee, the spouse or child is not considered a Dependent under this Plan.

E. If a spouse or child of an Eligible Employee is a full-time active member of the military service or armed forces of any country or nation, the spouse or child shall not be considered a Dependent under this Plan.

F. An Employee must provide the Fund Office with the following information, as applicable, before claims will be paid on behalf of an Eligible Dependent:

1. Birth certificate.

2. Marriage certificate.

3. Divorce decree.

4. The Employee must also notify the Fund Office if a Dependent loses Dependent status.

1.12 ELIGIBLE DEPENDENT

Any Dependent who is entitled to receive Plan benefits applicable to his status as the Dependent of an Eligible Employee.

1.13 ELIGIBLE EMPLOYEE

Any Employee who has met the eligibility requirements established by the Trustees for being eligi-

ble to receive the applicable benefits provided by the Plan for Eligible Employees.

1.14 ELIGIBLE FAMILY MEMBER

An Eligible Employee or any person in the Employee's family or household who meets the definition of a Dependent.

1.15 ELIGIBLE INDIVIDUAL

An Eligible Employee or an Eligible Dependent.

1.16 EMERGENCY

A. A medical condition which, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious medical consequences. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal or urinary system. In no event will a condition be considered an Emergency if the first treatment by a Physician is provided more than 24 hours after the onset of the symptoms.

B. If symptoms exist which reasonably may have been interpreted as an Emergency under the above definition, that condition will be considered an Emergency, even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are performed will be considered an Emergency even if the final diagnosis indicates that a heart attack did not actually occur.

C. In addition to medical conditions that are Emergencies as defined above, there are some conditions that result from accidents which appear to be serious and so threatening to a body part that emergency room treatment is indicated. These conditions will be considered Emergencies, even though they do not meet the above definition.

D. In addition to the foregoing, being taken for treatment to the nearest hospital or trauma center by police, fire department or ambulance, when such transportation is made under circumstances over which the person has no control, will be considered an Emergency.

1.17 EMERGENCY TREATMENT FACILITY

A free-standing facility, by whatever name called, which is engaged primarily in providing minor Emergency and episodic medical care to its patients. A Physician and an R. N. must be in attendance at all times that the Emergency Treatment Facility is open. The Emergency Treatment Facilities' facilities must include x-ray and laboratory equipment and a life support system.

1.18 EMPLOYEE

A. The term "Employee" shall mean:

1. Any person employed by a Contributing Employer on whose behalf such Employer is obligated to make Contributions to the Trust Fund pursuant to and under the terms of a Collective Bargaining Agreement between the Union and the Employer or pursuant to and under the terms of a Participation Agreement between the Union and the Employer.

2. Any employee who is employed full time by the Union, provided such employee is proposed by the Union and accepted by the Board, on whose behalf the Union, who shall be considered an Employer, is obligated to make Contributions to the Trust at the times and at the rate of payment equal to those Contributions made by any other Employer who is a party to the Trust.

3. Any employee who is employed full time by the Trust, upon acceptance by the Trustees, on whose behalf the Board, who shall be considered an Employer, is obligated to make Contributions to the Trust at the times and at the rate of payment equal to those Contributions made by any other Employer who is a party to the Trust.

4. Any employee who is employed full time by the Local 25 S.E.I.U. and Participating Employers Pension Trust, upon acceptance by the Board, on whose behalf each Trust Fund, each of which shall be considered an Employer, is obligated to make Contributions to the Trust at the times and at the rate of payment equal to those Contributions made by any other Employer who is a party to the Trust.

B. Also considered an Employee shall be any retired Employee of any Employer on whose behalf such Employer agrees to make Contributions to the Trust Fund on a uniform and non-discriminatory basis covering all retired employees of the Employer in accordance with the execution of a Participation Agreement with the Trustees; provided, however, that for the purpose of this Paragraph B, the Trust shall not be required to make Contributions to itself, and further provided that only the benefits provided under this Plan for retired Employees shall apply to any individual meeting such definition.

C. Individual owners, sole proprietors and partners shall not be considered Employees.

1.19 EMPLOYER; CONTRIBUTING EMPLOYER

Any employer of Employees as specified in Paragraphs A, B and C below:

A. The Association or any individual, firm, association, partnership, corporation or pension fund which has a Collective Bargaining Agreement with the Union or which has a Participation Agreement with the Trustees which requires periodic Contributions to the Trust Fund on behalf of its Employees.

B. The Union solely for the purpose of making Contributions to the Fund on behalf of its Employees pursuant to the provisions of a written Participation Agreement with the Trustees, provided that the Union in its role as an Employer shall have no voice in the selection of Employer Trustees nor any other rights granted to Employers hereunder.

C. The Board of Trustees, provided that the Board of Trustees in its role as an Employer shall

have no voice in the selection of Employer Trustees or any other rights granted to Employers hereunder.

1.20 EXPERIMENTAL AND INVESTIGATIVE

A treatment, procedure, facility, equipment, drug, device or supply will be considered to be experimental or investigative if it falls within any one of the following categories:

A. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition.

B. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.

C. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with medical experts of their choosing.

1.21 HOME HEALTH AGENCY

A public agency or private organization, or a subdivision of such agency or organization, which meet all of the following criteria:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services in the homes or places of residence of its patients.

B. It has established policies for governing the services which it provides, such policies being established by a group of professional personnel associated with the agency or organization, including one or more Physicians and one or more registered professional nurses.

C. It provides for the supervision of its services by a Physician or registered professional nurse.

D. It maintains clerical records of all its patients.

E. It is licensed according to the applicable laws of the state and of the locality in which it is located or provides services.

F. It is eligible to participate under Medicare.

1.22 HOSPITAL

An institution which is engaged primarily in providing medical care and treatment to sick and injured individuals on an inpatient basis at the patient's expense and which fully meets one of the requirements set forth in Paragraph A, B or C below:

A. It is a Hospital accredited by the Joint Commission on Accreditation of Hospitals.

B. It is a Hospital, a psychiatric Hospital or a tuberculosis Hospital, as those terms are defined in Medicare, which is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare.

C. It is an institution which fully meets all of the following tests:

1. It provides diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment and care of injured and sick individuals under the supervision of a staff of Physicians licensed to practice medicine.

2. It provides on the premises 24-hour-a-day nursing services by or under the supervision of R.N.s.

3. It is operated continuously with organized facilities for operative surgery on the premises.

4. It is not an institution which is primarily a clinic or, other than incidentally, a place for rest, for the aged, or a nursing or convalescent home or similar establishment.

1.23 IN-PLAN

With respect to the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits and the Plan 4 Schedule of Benefits, "In-Plan" as used herein means that health care services and supplies were received in or through UHS and that a UHS Physician provided, referred, approved or made arrangements for the health care services and supplies. Covered Expenses incurred as a result of care and treatment provided by or on the referral of UHS, the Plan shall pay, subject to any applicable Plan provisions, maximum benefits and limitations, an amount derived by multiplying the amount of such Covered Expenses by the applicable Plan co-payment percentage specified on the applicable Schedule of Benefits.

1.24 MEDICALLY NECESSARY

A term to describe those services, treatments or supplies provided by a Hospital or Physician that are required, in the judgment of the Trustees based on the opinion of a qualified medical professional, to identify or treat an injury or sickness. To be considered Medically Necessary, the service, treatment or supply must meet all of the following:

A. Must be consistent with the symptoms or diagnosis and treatment of the patient's condition, sickness, injury, disease or ailment.

B. Must be appropriate according to standards of good medical practice.

C. Must not be solely for the convenience of the patient, the Physician or the Hospital.

D. Must be the most appropriate which can safely be provided to the patient.

1.25 MEDICARE

The Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may later be amended.

1.26 MENTAL OR NERVOUS DISORDER

A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

1.27 NON-OCCUPATIONAL INJURY

An accidental bodily injury which does not arise out if or in the course of, and which is not caused or contributed to by or as a consequence of, any employment or occupation for compensation or profit.

1.28 NON-OCCUPATIONAL SICKNESS

A. A sickness which does not arise out of or in the course of, and which is not caused or contributed to by or as a consequence of, any employment or occupation for compensation or profit.

B. If the Trustees are furnished with satisfactory evidence that the individual concerned is covered as an employee under any Workers' Compensation law, Occupational Diseases law, any other legislation of similar purpose or under the Maritime Doctrine of maintenance, wages and cure, but that the sickness involved is one not covered under the applicable laws or doctrine, then such sickness shall, for the purpose of this Plan, be regarded as a Non-Occupational Sickness.

1.29 OUT-OF-PLAN

A. With respect to the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits or the Plan 4 Schedule of Benefits, an individual is considered to be Out-of-Plan if he receives medical care outside of a UHS Center that is not provided by a UHS Physician or that is not arranged by a UHS Physician.

B. An individual who is entitled to the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits or the Plan 4 Schedule of Benefits may also be Out-of-Plan if UHS is not notified as soon as possible.

C. If an individual who is entitled to the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits or the Plan 4 Schedule of Benefits incurs Covered Expenses and such expenses are in excess of any applicable deductibles, the Plan shall pay, subject to any applicable Plan provi-

sions, maximum benefits and limitations, an amount derived by multiplying the amount of such Covered Expenses by the applicable Plan co-payment percentage specified on the applicable Schedule of Benefits.

1.30 PARTICIPATION AGREEMENT

A written agreement executed by an Employer desiring to become a party to the Trust Agreement, which Agreement is approved by the Trustees and evidences the commitment of such Employer to be bound by the Trust Agreement as if an original party thereto, and whereby the Employer agrees to make and the Trustees agree to accept Contributions to the Fund on behalf of the Employer's employees who are members of the bargaining group.

1.31 PHYSICIAN

A legally qualified Physician or surgeon, who is a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.). With respect to services provided by a practitioner whose license limits the scope of his practice, such as a Doctor of Dentistry (D.D.S.), such individual shall be considered a Physician only for services or treatment rendered within the scope of such individual's license and to the extent that such benefits are specified as provided under the Plan.

1.32 PLAN

The self-funded program of health and welfare benefits provided by the Local 25 S.E.I.U. Welfare Fund established by, and as it may from time to time be amended by, the Board of Trustees pursuant to the provisions of the Trust Agreement.

A. Plan 1

An Employee and his Dependents will be Covered Under Plan 1 if he is employed by a Contributing Employer who is making Contributions to the Plan on the Employee's behalf at the rate set forth in the Collective Bargaining Agreement between S.E.I.U. Local 1 and the Building Owners and Managers Association of Chicago.

B. Plan 2

An Employee and his Dependents will be Covered Under Plan 2 if he was eligible for benefits under Plan 2 prior to June 1, 1985.

C. Plan 3

An Employee and his Dependents will be Covered Under Plan 3 if he is employed by a Contributing Employer who is making Contributions to the Plan on the Employee's behalf at the rate set forth in the respective Suburban Collective Bargaining Agreements (CBAs).

D. Plan 4

An Employee will be Covered Under Plan 4 if he is employed by a Contributing Employer who is making Contributions to the Plan on his behalf for employee only eligibility. Dependents of Employees Covered Under Plan 4 will not be entitled to Plan benefits.

1.33 PLAN ADMINISTRATOR

The Local 25 S.E.I.U. Welfare Fund Board of Trustees which, as named fiduciary, shall have the authority to control and manage the operation and administration of the Plan of Benefits and which may, at its discretion, delegate responsibilities for the operation and administration of the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

1.34 PLAN DOCUMENT

This document, setting forth the Plan of Benefits provided by the Local 25 S.E.I.U. Welfare Fund, effective June 1, 1985.

1.35 PLANYEAR

The12-month period starting October 1 of any year and ending September 30 of the following year.

1.36 PREFERRED PROVIDER ORGANIZATION (PPO)

The Trustees have entered into an agreement with a Preferred Provider Organization (PPO) which will make its network of provider Hospitals available for use by Plan participants at negotiated rates to the Fund.

1.37 R.N.

A Registered Nurse.

1.38 REASONABLE AND CUSTOMARY; REASONABLE AND CUSTOMARY CHARGE

A. The amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, circumstances and medical condition.

B. The result of such comparison shall determine the amount that is the maximum allowable charge to be considered a Covered Expense under this Plan. If a particular charge is more than the amount the Trustees consider to be Reasonable and Customary, any amount over the Reasonable and Customary Charge will not be recognized by the Plan as a Covered Expense.

1.39 SELF-PAYMENTS

Payments made to the Plan by Employees and Dependents to maintain coverage under the Plan.

1.40 SKILLED NURSING FACILITY

A nursing facility by whatever name called, which meets all of the following criteria:

A. It is an institution, or a distinct part of an institution, which has in effect a transfer agreement

with one or more Hospitals.

B. It is primarily engaged in providing inpatient Skilled Nursing Facility care and related services for individuals who require medical or nursing care.

C. It is duly licensed by the appropriate governmental authorities.

D. It has one or more Physicians and one or more R.N.'s responsible for the care of inpatients.

E. It requires that every patient be under the supervision of a Physician.

F. It maintains clinical records on all patients.

G. It provides 24-hour-a-day nursing services.

H. It provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

I. It has in effect a utilization review plan.

J. It is eligible to participate under Medicare.

K. It is not an institution which is primarily for the care and treatment of mental diseases or tuberculosis.

1.41 SURGICAL CENTER

A. To be approved for the purposes of this Plan, a Surgical Center is a facility which meets all of the following criteria:

1. It is a health care institution or facility, either freestanding or as part of a Hospital, which is equipped and operated with permanent facilities for the primary purpose of performing surgical procedures on patients on an outpatient basis and to which a patient is admitted to and discharged from within a 24-hour period;

2. It must be regularly licensed by the government or other agency which has the responsibility for such licensing;

3. It must keep medical records on all patients.

4. It must employ a licensed anesthesiologist and an R.N.

5. It must be supervised by a full-time Doctor of Medicine or Doctor of Osteopathy.

6. It must have at least two operating rooms and a recovery room.

7. It must be equipped to take care of emergencies.

8. It must have an agreement with at least one local Hospital to take patients who develop problems.

9. Any Physician performing surgery on the premises must also be allowed to perform surgery in a local Hospital.

B. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered a Surgical Center.

1.42 TOTALLY DISABLED; TOTAL DISABILITY

A. With Respect to an Employee

An Eligible Employee is considered Totally Disabled if he is prevented, solely as a result of Non-Occupational Injury or Non-Occupational Sickness, from engaging in his regular or customary occupation and is not performing any work of any kind for compensation or profit.

B. With Respect to a Dependent

An Eligible Dependent is considered Totally Disabled if he is prevented, solely as a result of Non-Occupational Injury or Non-Occupational Sickness, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

1.43 TREATMENT FACILITY FOR CHEMICAL DEPENDENCY

A rehabilitation facility for the treatment of individuals suffering from Chemical Dependency. To be considered an approved Treatment Facility for Chemical Dependency for the purposes of this Plan, the facility must be accredited by a recognized credentialing organization.

1.44 TRUST

The Local 25 S.E.I.U. Welfare Fund existing under a Restated Agreement and Trust dated January 1, 2017.

1.45 TRUST FUND; FUND

All property of whatever nature which shall be in said Trust, including but not limited to all Contributions to the Trust Fund which are received by the Trustees, together with all income, increments, earnings and profits therefrom, and all assets or claims, accrued or contingent, held by the Trustees for the uses, purposes and trusts set forth in the restated Agreement and Declaration of Trust and any amendments thereto.

1.46 TRUSTEES; BOARD OF TRUSTEES

The Union and Employer Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

1.47 UNION

Local No. 1, Service Employees International Union, including any local union affiliated with the Service Employees International Union which has entered into a Collective Bargaining Agreement requiring Contributions to be made to this Trust.

1.48 UNION HEALTH SERVICE; UHS

The Trustees of the Welfare Fund have made arrangements with Union Health Service, Inc. (UHS) to provide Eligible Individuals with a full range of medical care provided at UHS facilities. A UHS Center is a facility in which UHS Physicians provide medical care and services.

1.49 UNION HEALTH SERVICE PHYSICIAN; UHS PHYSICIAN

A Physician whose services are provided to Eligible Individuals by, through, or in connection with, Union Health Service Inc.

1.50 UNION PHARMACY SERVICES

The Trustees of the Welfare Fund have made arrangements with Union Pharmacy Services (UPS) to provide Eligible Individuals with discounted prescription drugs.

ARTICLE 2- GENERAL PLAN PROVISIONS

2.1 GENDER AND NUMBER

Any reference to the masculine gender in this documents shall be deemed to apply to the feminine gender and vice versa, unless the context requires otherwise. Any references to the singular may also apply to the plural and vice versa, unless the context requires otherwise or the result would be unreasonable.

2.2 GOVERNING LAW

This Plan is created and accepted in the State of Illinois. All questions pertaining to the validity and construction of the Trust Agreement, the Plan an of the acts and transactions of the Trustees or of any matter affecting the Fund shall be determined under Federal law where applicable Federal law exists; where no applicable Federal law exists, the laws of the State of Illinois shall apply.

2.3 SEVERABILITY CLAUSE

A. Should any provision contained in the Trust Agreement or in the Plan or any Plan Document or any amendment thereto be deemed or held to be unlawful, such illegality shall not adversely affect the other provisions herein and therein contained, unless such illegality shall make impossible or impracticable the functioning of such Agreement, Plan or Document.

B. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

2.4 PLAN AMENDMENT

This Plan and the benefits provided hereunder may be amended from time to time at the discretion of the Trustees without the consent of any Participant or Eligible Family Member. Any such amendment shall be without prejudice to any valid claim for benefits originating prior thereto.

2.5 TRUSTEE AUTHORITY AND RIGHT

A. The Trustees shall, subject to the requirements of the law, be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan, and decisions of the Trustees shall be final and binding. Benefits under this Plan will be paid only when the Board of Trustees or person delegated by them decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

B. All questions or controversies of whatsoever character arising in any manner or between any parties or persons in any manner or between any parties or persons in connection with this Plan or its operation, whether as to any claim for benefits, as to the construction of the lan-

guage of this Plan or any rules and regulations adopted by the Trustees, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Trustees for decision, or where appropriate, decisions of those acting for the Trustees. In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure. The decision on review shall be binding upon all persons dealing with the Plan or claiming any benefits hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matter.

C. The Trustees shall have the responsibility for the administration of this Plan and the Trust Fund, and the power to amend or terminate the Plan, in whole or in part.

D. The Trustees shall have the power and authority to increase, decrease or change benefits, eligibility rules or other provisions of the Plan of Benefits as may in their discretion be proper or necessary for the sound and efficient administration of the Trust Fund, provided that such changes are not inconsistent with law or with the provisions of this Plan or with the provisions of the Trust Agreement and are in the best interests of Plan participants and beneficiaries.

E. The Plan is maintained for the exclusive benefit of the Plan's participants and their Eligible Dependents. All rights and benefits granted under the Plan are legally enforceable.

2.6 PROVISIONS GOVERNING PAYMENT OF BENEFITS

A. Any of the following provisions which apply to the Weekly Disability Benefit shall apply only to Eligible Employees; and any of the following provisions which apply to charges incurred for medical benefits shall apply only to those Eligible Employees and their Dependents who are entitled to payment or reimbursement for such benefits according to the applicable provisions governing such benefits:

B. Benefits for charges incurred by an Eligible Individual shall automatically be assigned to the provider unless the Eligible Employee submits paid receipts for such charges with his claim form.

C. Benefits are payable to the Eligible Employee whose injury or sickness or whose Dependent's injury or sickness is the basis for a claim under the Plan.

D. Subject to due proof of disability, the benefits payable for any disability for which this Plan provides periodic payments shall be paid to the Eligible Employee at the expiration of each week payable, and any balance remaining unpaid upon termination of such period shall be paid immediately upon receipt of due proof of disability.

E. If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual.

F. If an individual should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of the individual's estate or to his surviving spouse, parent, child or children or to any other person or persons who, in the Trustees' opinion, are entitled to such payments, except that, with respect to the Weekly Disability Benefit, application must be made to the Trustees and payment of such due amounts must be approved by the Trustees before such payment shall be made.

G. Any payments made by the Trustees in accordance with these provisions shall fully discharge the liability of the Trustees to the extent of such payment.

H. Discharge by the Fund of its liability for Hospital or medical expenses for an amount less than the full balance due shall not incur to the benefit of any person or entity other than the Fund.

I. In determining the satisfaction of any applicable Plan deductible and the payment of benefits, a charge for any service, treatment or supply shall be considered to have been incurred on the date that the service or treatment was rendered or the date that the supply was provided.

2.7 LEGAL PROCEEDINGS

A. No action at law or in equity hall be brought to recovery under the Plan after three years from the expiration of the time by which written proof of loss is required to be furnished. Any action brought against the Fund or the Trustees shall be filed in Cook County, Illinois.

B. No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Administrator, the Trustees, or any of them unless all of the required claim procedures and appeal procedures shall first have been followed and exhausted.

C. This provision, permitting court action, shall not be deemed to extend or reinstitute any claim or cause of action which has expired under the time limits set forth in the Trust Agreement, or in any Plan Document or regulations of the Trustees or under any statute if such time limit has already expired.

D. This Section 2.7 shall not apply to matters covered, or purportedly covered, by the terms of any insurance policy procured by the Trustees.

E. In the event the Plan is required to pursue legal action to enforce the terms of the Plan and/or an agreement arising out of the Plan, the Plan's recovery will not be diminished by the common-fund doctrine, the make-whole doctrine, or any other defense traditionally available at equity.

2.8 TIME LIMITATION

If any time limitation of the Plan, with respect to giving notice of claim or furnishing proof of loss or disability or the bringing of an action at law or in equity, is less than that permitted by any law to which the Plan is subject, such limitation is hereby extended to conform with the min-

imum period permitted by such law.

2.9 WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Law or Occupational Diseases Law or similar law. Benefits which would otherwise be payable under the provisions of such laws shall not be paid by the Plan merely because an Eligible Individual fails or neglects to file a claim for benefits under the provisions of such laws.

2.10 RELEASE OF INFORMATION

An Eligible Employee making application for benefits shall be required by the Trustees to authorize any Physician, Hospital, Employer, government agency or any other person, corporation or organization having information which may be required for a proper determination of the claim by the Trustees to release such information to the Trustees. Such Eligible Employee shall, at the request of the Trustees, execute written authorizations necessary to accomplish this purpose.

2.11 RIGHT OF SUBROGATION AND AUTHORIZATION OF REIMBURSEMENT

A. It is the intent of the Trustees that no individual shall receive any profit from the payment of insurance or other benefits, or from the payment of any compensation for injuries. The purpose of the Plan is to pay Covered Expenses if they are not paid or payable by anyone else, whether or not such payments are the legal responsibility of the Eligible Employee or the injured Eligible Individual.

B. For the purposes of this Section 2.11:

1. A "Third-Party Incident" is any incident in which a Third Party is or may be responsible or liable for paying all or part of the expenses for which a claim is filed with the Plan.

2. A "Third Party" could be, but is not limited to: a third party tortfeasor or other individual or other entity of any kind who causes harm, such as the driver of another automobile or motor vehicle in an automobile or motor vehicle accident; an employee welfare plan or arrangement; a medical or hospital benefit plan; a no-fault or other automobile or motor vehicle insurance policy; an uninsured or underinsured motorist provision or medical pay provision of an automobile or motor vehicle insurance policy; a homeowners insurance policy; or a liability insurance policy of any kind or nature.

3. "Subrogation" is a term for a rule that gives the Plan the right to be repaid for benefits it pays on a claim if a Third Party is responsible for paying the expenses for which the claim is made.

4. "Compensation" for injuries includes any judgment, award or any settlement, whether or not the terms of the judgment, award or settlement specifically includes or excludes medical expenses and disability recovery. It is specifically intended to give the

Plan the right to recover all benefits it paid on a claim, whether or not the claimant had been made whole.

C. If a claim is submitted for expenses for which a Third Party is or may be legally responsible:

1. The Eligible Employee (and any adult injured individual for whom reimbursement of Covered Expenses is claimed under the Plan), must agree to and execute a "Repayment and Subrogation Agreement" in a form acceptable to the Trustees or Legal Counsel for the Trustees before benefits will be payable under the Plan; and

2. Such Eligible Employee or other adult injured individual must agree that:

   a. The Plan will have a lien on the proceeds of any recovery arising out of the Third Party Incident to the full extent of its Subrogation rights and to the full extent of its rights to repayment under the Repayment and Subrogation Agreement that may be independent of its Subrogation rights;

   b. To the full extent of benefits paid pursuant to the Plan, such recovery will be held in trust for the sole use and benefit of the Plan, and that the Plan shall have the right to obtain payment of such recovery being thus held in trust; and

   c. The Plan may sue in any court of competent jurisdiction to enjoin the use of such proceeds for any purpose other than their payment to the Plan; and

3. The attorneys for all such persons must sign an agreement that they will honor and enforce the terms of the Repayment and Subrogation Agreement before disbursing the proceeds of any recovery arising out of the Third Party Incident; and

4. If the injured individual is a minor or is otherwise legally incompetent, the Eligible Employee and the legally incompetent person's parent, legal guardian or "next friend" must sign a legally binding Repayment and Subrogation Agreement on behalf of the injured incompetent person as a condition precedent to the Plan's obligation to pay any benefits arising out of the Third Party Incident.

D. The Repayment and Subrogation Agreement specifies, among other things, that the Eligible Employee and/or the injured individual, agree that:

1. The Eligible Employee and/or the injured individual will repay to the Plan the amount of such assets held in trust for the Plan, whether or not the claimant is made whole by any subsequent recovery; and

2. The Trustees may participate in any legal action filed against a third party by or on behalf of the Eligible Employee and/or injured individual to recover the expenses; and

3. The Trustees may file suit in the name of the Eligible Employee and/or injured individual to recover the expenses the Plan pays on the claim if the responsible party does not pay for the expenses voluntarily if the Eligible Employee and/or the injured individual does not sue the responsible party for recovery of the expenses; and

4. The Eligible Employee and/or the injured individual will notify the Trustees before accepting any payment prior to the initiation of a lawsuit. If the Plan is not notified, and less than the full amount of the benefits that the Plan advanced to the Eligible Employee and/or the injured individual have been accepted, the Eligible Employee and/or injured individual will still be required to repay the Plan, in full, for any benefits paid. The Plan may withhold benefits from the Eligible Employee and/or his Eligible Dependent if the Eligible Employee and/or the injured individual waive any of the Fund's rights to recover, or fail to cooperate with the Plan in any respect regarding the Fund's reimbursement or subrogation rights. If the Eligible Employee and/or the injured individual refuses to reimburse the Plan from any recovery or refuses to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against future benefit payments under the Plan. Non-cooperation includes the failure of any party to respond to the Plan's inquiry concerning the status of any claim, request for any information or any other inquiry relating to the Plan's rights.

5. The subrogation amount shall not be diminished by the common-fund doctrine, the make-whole doctrine, or any other equitable defenses.

E. The Plan shall not be liable for, nor shall it have any obligation to pay, any benefit arising out of a Third Party Incident unless and until a Repayment and Subrogation Agreement in a form satisfactory to the Trustees executed by all persons to the full satisfaction of the Trustees has been received by the Plan.

F. No individual will be required to repay the Plan more than the benefits the Plan pays on the claim, nor more than the gross amount the injured individual receives in recovery, whichever is less, without regard to attorneys' fees and expenses incurred in obtaining any such recovery; however, the Plan may agree to share in the payment of the injured individual's attorney's fees if the Trustees determine it is in the Plan's interests to do so.

G. The Repayment and Subrogation Agreement, the Plan's right of Subrogation, and the Plan's right to recover assets held in trust for its benefit are separate and distinct rights and obligations, and the failure or invalidity, in whole or in part, of one such right or obligation shall not impair or otherwise adversely affect any other such right or obligation.

H. If a judgment or settlement is received by or on behalf of the injured individual, the individual on whose behalf the Plan paid benefits shall repay to the Plan the lesser of the full amount of benefits the Plan paid, or the amount of any recovery, whether or not that individual was legally responsible for the payment of those expenses. If such repayment is not made to the Plan, the Plan shall have the right, in addition to any other legal rights it may have, to reduce future benefits on claims made by the Eligible Employee and any Eligible Dependent, until the full amount of the agreed-upon repayment has been paid to the Plan.

I. Notwithstanding the foregoing, no benefits will be paid under the Plan if the law or public policy of the state in which the person lives, or in which the claim against the third person

has been or may be filed, prohibits the Fund from being reimbursed in the event the person, whether or not a minor, recovers from the third person, unless such prohibition is unenforceable because it is preempted by the Employee Retirement Income Security Act of 1974, as amended.

2.12 PAYMENT OF BENEFITS FOR COMPENSATED INJURIES

A. "Compensated Incident" shall mean any occurrence taking place at any time or over a period of time from which any settlement, award or recovery is or was granted to an Eligible Individual. "Compensated Incident" shall include a single act or a number of acts occurring over a period of time which result in injury to the Eligible Individual (such as, but not limited to, continued exposure to a harmful agent, prolonged misdiagnosis of a condition, etc.).

B. Notwithstanding any provision of the Plan to the contrary, no benefit shall be payable under the Plan for any Covered Expense which arises out of or is attributable to a Compensated Incident, either directly or indirectly, unless and until the total of benefits payable under the Plan's terms arising out of or related to such Compensated Incident equals or exceeds the total amount of compensation paid from another source to or on behalf of the Eligible Individual with respect to the Compensated Incident for injuries incurred in the Compensated Incident, or for medical services provided or rendered as a result of or in connection with an Injury, Sickness, accident or condition arising out of or related to the Compensated Incident, whether the compensation is in the form of a judgment, settlement or otherwise, and however such compensation is described or designated.

C. This provision shall apply irrespective of the designation or description of such compensation or recovery (i.e., loss, punitive damages, pain and suffering, medical expenses, attorneys' fees, costs, etc.). For the purpose of this provision, any and all compensation and recovery shall first be applied to compensation for medical expenses.

D. This provision shall apply regardless of who institutes the action against another source and regardless of who pays the compensation or recovery to the Eligible Individual, and whether recovery is in the form of a judgment, settlement or otherwise, and whether the Eligible Individual is an Eligible Employee or an Eligible Dependent, or a legally competent or incompetent person, or a representative of any such person.

E. The determination of whether a Covered Expense is within the purview of treatment and/or service attributable to a Compensated Incident is a question of fact which shall be determined by the Trustees in their sole discretion.

F. The Eligible Individual (or in the case of an incompetent Eligible Individual, his or her representative) shall assist and cooperate with representatives designated by the Trustees in making a determination as to whether the treatment and/or service can be attributable to the Compensated Incident. The Eligible Individual, (or in the case of an incompetent Eligible Individual, his or her representative) shall sign any and all necessary documents, releases and waivers reasonably requested by the Trustees or their representatives in making their determinations of whether the treatment and/or service can be attributable to the Com-

pensated Incident. No benefit shall be payable for any Covered Expense incurred in the treatment of a condition or injury which may be attributable to a Compensated Incident, whenever incurred, to or on behalf of an Eligible Individual during any period of time during which the Eligible Individual or, if applicable, the representative, fails or refuses to render reasonable aid, or sign any document, waiver or release reasonably related to furthering the intent of this provision.

G. This provision shall in no way affect or otherwise diminish the Plan's right to subrogation or recovery under a repayment agreement for medical expenses incurred prior to, or if applicable, subsequent to, the Eligible Individual's recovery.

H. This provision shall not be deemed waived by reason of satisfaction or release of the Plan's claim or lien under the Plan's subrogation rights without the express written agreement by the Trustees of such waiver. Any purported waiver of this provision by an Eligible Individual (or, in the case of an incompetent Eligible Individual, his or her representative) shall be null and void insofar as it applies to the Fund or Trustees or to any benefits claimed to be due and owing under the Plan.

2.13 FREE CHOICE OF PHYSICIAN

An Eligible Individual shall have free choice of any Physician, and the Trustees shall in no way disturb the Physician-patient relationship. However, this provision in no way implies reimbursement under this Plan for charges of any Physician beyond the coverage specifically provided herein.

2.14 TRUSTEE RIGHT OF EXAMINATION AND AUTOPSY

A. The Trustees shall have the right and opportunity to employ a Physician to examine the person whose injury or sickness is the basis of a claim hereunder when and so often as they may reasonably require during pendency of a claim hereunder.

B. The Trustees shall have the right and opportunity to examine any and all Hospital or medical records relating to a claim under this Plan.

C. The Trustees shall have the right to require an autopsy in the event of the death of an Eligible Individual whose injury or sickness is the basis of a claim hereunder, provided an autopsy is not forbidden by law.

2.15 PRECEDENCE OF PLAN DOCUMENT PROVISIONS OVER A SUMMARY

If any discrepancy exists between the provisions contained in a summary (Summary Plan Description or Summary of Material Modifications) of this Plan of Benefits and the provisions contained in this Plan Document, the provisions of this Plan Document shall take precedence.

2.16 CIRCUMSTANCES RESULTING IN CLAIM DENIALS OR LOSS OF BENEFITS

A. The Trustees, or their representative(s), have the authority to deny payment of a claim, in

whole or in part, and the reasons for denial of all or part of a claim may include one or more of the following:

1. The individual on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.
2. The claim was not filed within the Plan time limits.
3. The expenses that were denied are not considered Covered Expenses under this Plan.
4. The expenses for which the claim was filed were not actually incurred.
5. The individual for whom the claim was filed had already received the Maximum Benefit allowed for that type of expense during the stated period of time.
6. Another plan was primarily responsible for paying benefits for the expenses.
7. No payment was made, or a reduced payment was made, because some or all of the expenses for which the claim was filed were applied against a deductible.
8. No payment or a reduced payment was made because the individual who incurred the expenses received such expenses Out-of-Plan.
9. The individual did not receive medical services at or through UHS, or did not arrange medical care through UHS, when required to do so.
10. A third party was responsible for paying the expenses for which the claim was filed and the individual on whose behalf the claim was filed did not submit the required subrogation agreement or otherwise cooperate in a manner which would permit the Plan to process the claim and recover payment from the third party or his insurance company.
11. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
12. The Trustees reduced or temporarily suspended future benefit payments to an Eligible Individual in order to recover an overpayment of benefits previously made on that individual's behalf or on behalf of an Eligible Dependent.
13. The Plan of Benefits was discontinued or terminated and there were no further assets available for paying benefits.
14. If utilization review was required for a Hospital confinement, and the Hospital Utilization Review Program procedures were not followed, benefits for Hospital expenses may be reduced.

B. The list specified above is not an all-inclusive listing of the circumstances which may result in a claim denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the Plan's regular eligibility requirements for coverage under the Plan, that may result in denial of claims or loss of benefits.

C. Other provisions governing the payment of benefits and/or the limiting or exclusion of benefits are specifically set forth in the benefit Articles of this Plan Document.

2.17 PLAN DISCONTINUANCE

This Plan may be discontinued or terminated at any time by the Trustees under certain circumstances, for example if future Collective Bargaining Agreements and Participation Agreements do not require Employer Contributions to the Fund, if the Plan or Fund is merged into another plan or fund, or if the Trustees determine, for any reason, to terminate the Plan. If the Plan is terminated, benefits for Covered Expenses incurred before the termination date fixed by the Trustees will be paid on behalf of eligible family members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees in accordance with the Trust Agreement.

2.18 REVIEW ORGANIZATION

The following provisions apply to all care received under the Plan 2 Schedule of Benefits, and to Out-of-Plan care and treatment received under the Plan 1 Schedule of Benefits, Plan 3 Schedule of Benefits and Plan 4 Schedule of Benefits.

A. The Trustees, in their efforts to contain Plan costs, have entered into an agreement with a professional health care review organization (hereafter referred to as "Review Organization") to provide certain health care cost management services to Plan participants.

B. In accordance with the program of health care cost management activities adopted by the Trustees, the Review Organization will work with the Eligible Individuals, UHS, Hospitals and Physicians to provide recommendations regarding Hospital admissions, Hospital stays, and certain other types of health care as specified in this Section. 2.18.

C. Under the Hospital Review Program administered by the Review Organization, an Eligible Individual, someone acting on his behalf or his Physician, is required to contact the Review Organization prior to each non-emergency Hospital admission to initiate a review of the appropriateness and length of stay of the Hospital confinement. Any contact of the Review Organization to provide information about a Hospital admission is acceptable contact, whether the contact is performed by the Eligible Individual who is admitted to the Hospital, someone acting on his behalf or his Physician. However, it is ultimately the responsibility of the Employee to see that the contact is made on his own behalf or on behalf of his Dependent. With respect to Plan 1, Plan 3 and Plan 4 participants, this rule will not apply if a UHS Physician has recommended the non-emergency Hospital admission.

D. If an Eligible Individual is admitted to a Hospital on an emergency basis, the Eligible Individual, someone acting on his behalf or his Physician is required to contact the Review Organization at the time of the admission or immediately after the admission with information regarding the admission. Treatment in a Hospital's emergency room is not considered an admission and does not require a call to the Review Organization unless the individual is admitted to the Hospital as an inpatient.

E. If an Eligible Individual, someone acting on his behalf or his Physician does not comply

with the provisions of this Section 2.18, as the case may be, the Hospital Review Noncompliance Deductible specified on the Schedule of Benefits shall be applied to the Covered Expenses incurred as a result of each such Hospital confinement before the Plan shall pay its normal benefits for such expenses.

F. If the Hospital Review Noncompliance Deductible is applied to the Covered Expenses incurred with respect to a Hospital confinement, such Deductible shall be in addition to any Calendar Year Individual or Family Deductible, and Covered Expenses used to satisfy the Hospital Review Noncompliance Deductible may not be used to satisfy any part of any Calendar Year Individual or Family Deductible.

2.19 ASSIGNMENT AND ALIENATION OF BENEFITS

A. All benefits provided under this Plan are automatically assigned to the provider of service unless a paid-in-full receipt is furnished to the Fund where claim is made.

B. Except so far as may be contrary to the laws of any State having jurisdiction in the premises, the coverages and other benefits under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process for the debts of the Employees or their Dependents.

2.20 CONFORMITY WITH LAW

If any provision of this Plan Document is in conflict with any State or Federal law to which it is subject, it is hereby amended to conform to the minimum requirements of such law.

2.21 EFFECT OF FEDERAL LAW ON PLAN BENEFITS

In the event that any Federal law to which this Plan is subject requires any particular change in the way benefits are paid, this Plan shall comply with such law, subject to all other applicable Plan provisions and limitations.

2.22 ENROLLMENT AND TRANSFERS

A. An Eligible Employee Covered Under the Plan 2 Schedule of Benefits may transfer to coverage under the Plan 1 Schedule of Benefits for himself and his Eligible Dependents, if any. The following provision shall apply to the transferring participants:

1. The effective date of such change in coverage will be the first day of the calendar month following thirty days after the Fund Office receives the Employee's written request to transfer except as follows:

   a. If the Employee is hospitalized on the date his coverage under the Plan 1 Schedule of Benefits would otherwise start, coverage under the Plan 1 Schedule of Benefits for such Employee and his Dependents will be delayed until the Employee is no longer disabled.

b. If a Dependent is hospitalized on the date that his coverage under the Plan 1 Schedule of Benefits would otherwise start, his coverage under the Plan 1 Schedule of Benefits will be delayed until he is no longer hospitalized.

2. Once an Employee has transferred from the Plan 2 Schedule of Benefits to the Plan 1 Schedule of Benefits, he shall not be entitled to transfer back to the Plan 2 Schedule of Benefits at any future date.

3. For the first six months after the transferring Employee's and Dependents becomes Covered Under the Plan 1 Schedule of Benefits, the following provisions shall apply to the payment of benefits under the Plan 1 Schedule of Benefits:

a. Any benefits payable under the Plan 1 Schedule of Benefits for an Eligible Employee or his Eligible Dependents, if any, as a result of any disability or condition which began while such Employee or Dependent was Covered Under the Plan 2 Schedule of Benefits and prior to his effective date of benefits under the Plan 1 Schedule of Benefits shall be limited to the benefits that would have been payable for such disability or condition under the provisions and limitations governing the Plan 2 Schedule of Benefits.

b. After an Employee has been Covered Under the Plan 1 Schedule of Benefits for six months, benefits payable under the Plan 1 Schedule of Benefits for the Employee and his Eligible Dependents, if any, shall be payable in accordance with provisions and limitations governing the Plan 1 Schedule of Benefits.

2.23 RECORDS AND REPORTS

The Trustees shall exercise such authority and responsibility as they deem appropriate in order to comply with the Employee Retirement Income Security Act if 1974 and governmental regulations issued thereunder relating to disclosure to participants and annual reports to the Department of Labor.

2.24 RULES AND DECISIONS

A. The Trustees may adopt such rules as they deem necessary, desirable or appropriate.

B. All rules and decisions made by the Trustees shall be uniformly and consistently applied to all Plan participants in similar circumstances. When making a determination, the Administrator or the Trustees shall be entitled to rely upon information furnished by an Employee, a Dependent or a beneficiary, the Employers, or the legal counsel of the Trustees.

2.25 CERTIFICATES OF COVERAGE

A. When an individual ceases to be eligible for Plan benefits (including eligibility for Continuation Coverage), he will receive a certificate of coverage from the Fund Office. This certificate provides evidence of his prior health care coverage and may need to be furnished if he

becomes eligible under another group health plan that excludes coverage for pre-existing conditions, or if the individual buys an individual insurance policy with a pre-existing condition exclusion or limitation.

B. If an individual ceases to be eligible for Plan benefits, the Fund Office will automatically send such certificate of coverage to the individual's last known address.

C. The individual has the right to request, free of charge, a certificate of coverage for any reason, including not receiving a certificate from the Fund Office, any time within twenty-four months of when the individual was last Covered Under the Plan.

2.26 CLAIM FILING TIME LIMIT

Claims must be filed within one year of the date the claim was incurred.

ARTICLE 3- GENERAL EXCLUSIONS AND LIMITATIONS

This Article does not provide an all-inclusive listing of the Plan's limitations and exclusions with respect to charges incurred for various procedures, services and supplies or with respect to circumstances that may cause other loss. It is only representative of the types of charges for which Plan benefits are limited or not payable, of the types of situations in which charges are incurred for which Plan benefits are limited or not payable, or of the types of circumstances that may cause other loss. This list of exclusions and limitations applies to all of the benefits described in this Plan of Benefits except where specifically stated otherwise.

3.1 BENEFITS NOT PROVIDED UNDER THE PLAN

A. The exclusions and limitations described in this Section 3.1 apply to all Schedules of Benefits.

B. In no event shall any Plan payment or reimbursement be made nor, shall any Plan benefit be provided for:

1. Any treatment, care, procedure, service or supply which, in the opinion of the Trustees, based on the opinion of a professional medical consultant, is not Medically Necessary.

2. Any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a congenital defect or a specific Non-Occupational Injury or Non-Occupational Sickness unless specifically identified as being a Covered Expense under the Plan as a whole or unless specifically identified as being a Covered Expense for certain participants.

3. Any amount of an incurred charge which is in excess of the amount considered to be a Reasonable and Customary Charge.

4. Any care, service, supply or procedure which is Experimental or Investigative.

5. Any care, treatment, service or supply received from a physician who does not meet this Plan's definition of a Physician, or any care, treatment, service or supply provided in or by a Hospital, a Skilled Nursing Facility, a Home Health Agency, a Surgical Center, an Emergency Treatment Center or a Treatment Facility for Chemical Dependency which does not meet the applicable definition as specified in Article I, DEFINITIONS.

6. Charges incurred by a person who is not an Eligible Individual.

7. Any care, treatment, service or supply which is not recommended or approved by the attending Physician.

8. Any charges incurred for services of technicians not employed by the Hospital, Skilled Nursing Facility, Treatment Facility for Chemical Dependency, Surgical Center or Emergency Treatment Center; or for services of special nurses and their board, group nursing services, or services of Physicians other than those specifically included as Covered Expenses.

9. Charges incurred for any treatment or surgical procedure or service that is of an elective nature, or any non-Emergency plastic, beautifying or cosmetic surgery on the body, including but not limited to such areas as the eyelids, nose, face, breasts or abdominal tissue, except as specified in the following exception:

   Exception: This exclusion shall not apply to:

   a. Cosmetic surgery which is performed for the correction of defects caused by a Non-Occupational Injury, disease or birth defect.

   b. The correction of congenital defects.

   c. Corrective surgical procedures on organs of the body which perform or function improperly.

   d. Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

   e. Medically Necessary therapeutic abortion procedures performed on female Eligible Employees or female Eligible Dependent spouses.

   f. Vasectomies and other sterilization procedures performed on Eligible Employees and Eligible Dependent spouses.

   g. Reconstructive surgery performed primarily to restore or improve bodily functions or to correct damage caused by disease, injury or birth defects.

10. Charges incurred, with respect to x-ray, laboratory and pathology tests and examinations:

   a. For any x-ray or laboratory procedures or for services of any facility which are used in surveys, case-finding programs or research studies.

   b. For a Physician's services rendered in connection with any x-ray or laboratory test if such charges are included in any bill from a Hospital, Surgical Center, Emergency Treatment Center, clinic, or other facility.

   c. For any x-ray or laboratory rest which is performed as part of a routine physical examination or periodic checkup.

   d. For any x-ray or laboratory test which is performed as a result of or in connection with any condition other than the condition for which the individual is confined in a Hospital or other than the Emergency or surgery for which the individual seeks outpatient care and treatment.

11. Pre-admission tests performed prior to a Hospital admission if the admission is cancelled (unless the cancellation is due to circumstances beyond the control of the patient).

12. Charges incurred for diagnostic or therapeutic services not related to the condition for which a hospitalization or outpatient care is required.

13. With respect to a non-Emergency Hospital admission, charges incurred for Hospital daily room and board charges or Hospital services and supplies rendered to an Eligible Individual on any day prior to inpatient surgery where the primary reason for the admission is the performance of x-ray examinations, laboratory tests, or other studies or tests which could have been performed on an outpatient basis prior to admission for the surgery.

14. Maternity, pregnancy or pregnancy-related conditions for any person other than an Eligible Employee or an Eligible Dependent spouse.

15. Charges incurred for outpatient family planning services, well-baby care or wellness care of children and adults (including health and diet advice).

Exception: This exclusion does not apply to services provided through UHS.

16. Reversal or attempted reversal of vasectomies or other sterilization procedures.

17. Services rendered for the treatment of infertility.

18. Services or supplies received from a Physician, an R.N. or other individual who is a relative in any way to the Employee or to his Dependent who is receiving the care, or who ordinarily resides in the Employee's home or in the home of his Dependent who is receiving the care.

19. Charges incurred for services, supplies, treatments or surgical procedures which are provided or rendered in connection with care or treatment of an overweight condition or condition of obesity.

20. Food or food supplements.

Exception: With respect to the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits and the Plan 4 Schedule of Benefits, this exclusion does not apply to intravenously administered food and food supplements prescribed by a UHS Physician, provided such food or food supplements are the only form of nourishment that can be given to the patient.

21. Charges incurred for hearing aids, including the fitting or repair of hearing aids, eye examinations, eye refractions, eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), dental prosthetic appliances or any charges made for the fitting of any of these appliances, unless the service or supply was rendered as a result of a Non- Occupational Injury.

22. Any special education rendered to any individual regardless of the type of education, the purpose of the education, the recommendation of the attending Physician, or the qualifications of the individual or individuals rendering the special education.

23. Education, training or room and board while the individual is confined to an institution which is primarily a school or other institution for training, a place for rest, or a place for the aged.

24. Care or treatment provided for rest or custodial care. "Custodial care" means services and supplies, including room and board and other institutional services which are provided to an individual, whether disabled or not, to assist him in the activities of daily living Such services and supplies are considered custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

25. Charges incurred for any psychiatric consultation with or treatment of an Eligible Family Member when such treatment is unsupported by a diagnosis of sickness for such Eligible Family Member and which is rendered primarily in connection with the treatment of another Family Member.

26. Any organ transplant, except cornea or bone marrow transplants.

27. Charges incurred for services provided in connection with a surgical procedure performed by a Physician other than services provided by an anesthesiologist, services provided by the primary operating Physician(s), and services provided by a Physician as an assistant surgeon, provided however, that Covered Expenses incurred for the services of an assistant surgeon shall be limited to 20% of the Covered Expense incurred for the primary operating Physician's services.

28. Charges incurred for administration of anesthesia by anyone other than a Physician or a Certified Registered Nurse Anesthetist; or for charges incurred for administration of anesthesia in connection with a surgical procedure for which Plan payment is excluded.

29. Charges incurred for drugs, dressings or other supplies taken home or away from a Hospital, Skilled Nursing Facility, Emergency Treatment Center, Surgical Center or any other facility from which the individual has received any care or treatment.

30. Charges incurred for provision of special braces, appliances, ambulatory apparatus or specialized equipment unless the necessity of the item is certified by a Physician.

31. Charges incurred for surgical treatment of corns, calluses or the trimming of toenails.

32. Charges incurred for travel unless otherwise specified in the Covered Medical Expenses provisions of this document, whether or not recommended by a Physician.

33. Charges incurred for the services of blood donors.

34. Charges incurred for the first three pints of blood, blood plasma or other human blood derivatives.

35. Charges incurred for any private duty or special nursing services (including intensive nursing care by whatever name called) which are provided in connection with care and treatment provided in the outpatient or emergency department of a Hospital, in a Surgical Center or in an Emergency Treatment Center, regardless of whether such services are rendered under the direction of the facility or otherwise.

36. Care, treatment, services or supplies provided during confinement in a nursing home, rest home, convalescent home or similar establishment or facility unless it is an approved confinement in a Skilled Nursing Facility as specified in Article X, MEDICAL EXPENSE BENEFIT.

37. Treatment for chronic illness, including tuberculosis, in any institution other than a licensed Hospital, except as may be provided under a hospice care program to a person with a terminal medical condition.

38. Charges incurred for radium rental or radium treatments.

39. With respect to radiation therapy, charges other than charges incurred for treatment of a proven case of cancer or for a specific thyroid or heart condition.

40. Charges incurred for prescribed drugs or biologicals, except for prescription oral chemotherapy drugs and related supportive drugs that are prescribed by a UHS Physician or prescribed as part of a course of treatment arranged by a UHS Physician and administered under the supervisions of a home health care nurse, or drugs administered in a Hospital, Skilled Nursing Facility, Emergency Treatment Center, Surgical Center or any other facility from which the individual has received care or treatment. Charges will also be excluded for prescription drugs not on UHS's formulary list or that are not obtained through a participating retail pharmacy.

41. Charges incurred for administration of drugs or medicines.

42. Charges incurred in connection with dental or orthodontic services or for a Physician's services in connection with mouth conditions due to periodontal or periapical disease, or surgical preparation of gums or jaws for artificial teeth or removal of tooth root or infected and diseased gum tissues, or involving any of teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue or the extraction or filling of teeth.

Exception: This exclusion shall not apply to:

a. Dental services provided through the professional dental insurance company for Eligible Employees and their Eligible Dependents.

b. Services rendered for the repair of Non-Occupational Injury to sound natural teeth. For the purposes of this provision, sound natural teeth are natural teeth in an individual's mouth that are free of defect or decay.

43. Charges incurred for hospice care, except as provided in Article X, MEDICAL EXPENSE BENEFIT, Section 10.9, Hospice Care.

44. Charges incurred for physical therapy or speech therapy unless a treatment plan is submitted to the Fund Office by the prescribing Physician, and the Fund Office approves continued treatment. The approval for continued treatment must be provided by the Fund Office on a monthly basis and must be based on monthly progress reports documenting improvement.

45. Charges incurred for any items such as rental of a radio or TV, a telephone, cosmetics or toiletries, slippers, newspapers or magazines, telegrams, personal laundry, guest trays, beds or cots for guests or family members, or any other personal comfort items, or any other services or supplies which are not Medically Necessary.

46. Any treatment, care, procedure, service or supply which is not rendered or provided within any applicable time limitations.

47. Charges that would not have been made if this Plan did not exist.

48. Care, treatment, services or supplies which are provided by reason of the past or present service of an individual in the armed forces of any government, or which are provided while an individual is confined in a Hospital operated by the U.S. government or its agency, or which are provided under any legislation covering war veterans or merchant seamen, except that the Plan, to the extent required by law, will reimburse a VA Hospital for treatment of a non-service-related condition if the treatment would be a Covered Expense under the Plan if the VA were not involved.

Exception: If an Eligible Individual is a reservist who is called up to active military duty for more than 30 days and continues coverage for himself and/or any of his Dependents through Continuation Coverage Self-Payments, this exclusion will not apply to the extent that the Plan is required by law to provide coverage for non-service-related sicknesses and injuries.

49. Any Hospital confinement, medical care or service for which an Eligible Individual would not be legally required to pay.

50. Treatment, services or supplies provided as a result of any bodily injury or sickness caused by war or any act of war, whether war is declared or undeclared; any act of international armed conflict; any conflict involving the armed forces of any international body; insurrection; or participation in a riot.

51. Charges incurred for the completing of claim forms (or forms required by the Plan for the processing of claims) by a Physician or other provider of medical services or supplies.

52. Care or treatment of, or benefits provided as a result of, any disability resulting from injury, sickness or disease sustained while the person is performing any act or duty pertaining to any occupation or employment for compensation or profit, or for which benefits are or would be payable in whole or in part under any Workers' Compensation Act, Occupational Diseases Act, Employers' Liability Act, or similar law.

Exception: This exclusion does not apply to the Dismemberment Benefit.

53. Any care, treatment, service or supply for which payment under the Plan is specifically limited or excluded in any other provision of this document or which are specifically limited or excluded on any applicable Schedule of Benefits unless an exception is specifically set forth in this document.

54. Charges incurred for any type of care, treatment, service or supply once the applicable maximum benefit for such care, treatment, service or supply has been paid on behalf of an individual.

3.2 BENEFITS NOT PROVIDED UNDER PLANS 1, 3 AND 4 SCHEDULES OF BENEFITS

A. The list of exclusions and limitations described in this Section 3.2 is in addition to the list in Section 3.1, and applies to the Plan 1 Schedule of Benefits, the Plan3 Schedule of Benefits and the Plan 4 Schedule of Benefits.

B. In no event shall any Plan payment or reimbursement be made under the Plan 1 Schedule of Benefits, the Plan 3 Schedule of Benefits or the Plan 4 Schedule of Benefits, nor shall any Plan benefit be provided for any of the following:

1. Physician visits or surgery or any expenses incurred as a result of or in connection with surgery that is not provided by or arranged for by a UHS Physician other than in connection with an Emergency.

2. Charges incurred for surgeons' fees, outpatient facility expenses, preadmission testing or any other expenses incurred as a result of, or incurred in connection with, such surgery if the surgery is not performed by a UHS Physician or a Physician referred by a UHS Physician.

3. Any type of charges, other than inpatient Hospital or Skilled Nursing Facility or Treatment Facility for Chemical Dependency charges, incurred for services or supplies which are not provided by a UHS Physician when such services or supplies would or could otherwise have been furnished by or through the Union Health Service, Inc.

4. Pre-admission testing that is not recommended by a UHS Physician.

5. Hospital admission for routine check-ups, diagnosis or laboratory tests or other tests made prior to surgery if the tests could have been performed at UHS or at the Hospital on an outpatient basis.

6. Any charges incurred for any type of physical examination, employment physical examination, premarital examination, school physical examination, or any other medical examination or test for check-up purposes and where not necessary for treatment of a sickness or injury. This exclusion applies to cancer prevention examinations and cancer detection center examinations, Pap smears, tuberculosis examinations, sickle cell anemia examinations or any other type of physical examination or test which is given primarily to determine whether an individual has a specific sickness or injury where no symptoms are present.

   Exception: This exclusion shall not apply to preventive health care and examinations provided through UHS.

7. Charges incurred for services, supplies or treatments which are preventive in nature. This

exclusion applies to items such as flu shots and other inoculations and treatments which an individual may receive as a result of being exposed to a particular disease or to prevent the contraction of any disease.

Exception: This exclusion shall not apply to immunizations provided through UHS.

8. Charges incurred for outpatient care or treatment of Chemical Dependency except as provided through UHS.

9. Any Hospital admission for treatment of Chemical Dependency, except for Medically Necessary detoxification, UHS-approved evaluation, or other UHS-approved treatment when the patient has complicating medical or psychiatric conditions.

10. Charges incurred for outpatient treatment of a Mental or Nervous Disorder other than treatment rendered by a Physician, or for outpatient treatment that is not arranged by a UHS Physician.

11. Charges incurred for consultations, including Physician charges.

12. Care, treatment, services or supplies provided during confinement in a nursing home, rest home, convalescent home or similar establishment or facility unless it is an approved confinement in a Skilled Nursing Facility as specified in Article X, MEDICAL EXPENSE BENEFIT, Section 10.5, Covered Expenses under Plans 1, 3 and 4.

13. Home health care services, except as specified in Article X, MEDICAL EXPENSE BENEFIT, Section 10.5, Covered Expenses under Plans 1, 3 and 4.

14. With respect to Out-of-Plan Covered Expenses, charges incurred for inpatient or outpatient Physician visits.

3.3 BENEFITS NOT PAYABLE UNDER THE PLAN 2 SCHEDULE OF BENEFITS

A. The list of exclusions and limitations described in this Section 3.3, is in addition to the list in Section 3.1, and applies only to the Plan 2 Schedule of Benefits.

B. In no event shall any Plan payment or reimbursement be made under the Plan 2 Schedule of Benefits, nor shall any Plan benefit be provided for any of the following:

1. Hospital admission for routine checkups, diagnosis or laboratory or other tests made prior to surgery if the tests could have been performed at the Hospital on an outpatient basis.

2. Any charges incurred for any type of physical examination, employment physical examination, premarital examination, school physical examination, or any other medical examination or test for check-up purposes and where not necessary for treatment of a sickness or injury. This exclusion applies to cancer prevention examinations and cancer detection examinations, Pap smears, tuberculosis examinations, sickle cell anemia examinations or any other type of physical examination or test which is given primarily to determine whether an individual has a specific sickness or injury where no

symptoms are present.

Exception: The Plan will pay 100% of the charges for one routine physical examination for an Eligible Employee or Eligible Dependent spouse provided at UHS once every 12 months.

3. Charges incurred for services, supplies or treatments which are preventive in nature. This exclusion applies to items such as flu shots and other inoculations and treatments which an individual may receive as a result of being exposed to a particular disease or to prevent the contraction of any disease.

4. Charges incurred for any type of chronic illness, including tuberculosis, in any institution other than a licensed facility that meets this Plan's definition of a Hospital.

5. Charges incurred for care or treatment provided by a chiropractor.

6. Charges incurred for care or treatment provided by a podiatrist.

7. Charges incurred for prescribed drugs or biologicals, except for drugs administered at UHS, in a Hospital, Skilled Nursing Facility, Emergency Treatment Center, Treatment Center for Chemical Dependency, Surgical Center or any other facility where the individual is receiving covered care or treatment.

8. Charges incurred for any inpatient treatment provided in connection with any surgical operation or post-operative surgical care that is rendered on and after the date of a surgical operation.

9. No Plan benefits shall be provided for care, treatment, services or supplies provided during confinement in a nursing home, rest home, convalescent home or similar establishment or facility unless it is an approved confinement in a Skilled Nursing Facility as specified in Article X, MEDICAL EXPENSE BENEFIT, Section 10.6, Covered Expenses under Plan 2.

10. Home health care services, except as specified in Article X, MEDICAL EXPENSE BENEFIT, Section 10.6, Covered Expenses under Plan 2.

ARTICLE 4- COORDINATION OF BENEFITS

4.1 BENEFITS SUBJECT TO THIS ARTICLE

The provisions of this Article shall apply to all of the medical expense benefits provided under This Plan. The provisions of this Article shall not apply to the Weekly Disability Benefits provided under the Plan.

4.2 DEFINITIONS APPLICABLE TO THIS ARTICLE

A. The term "Plan," as used in this Article, means any plan providing benefits or services for or by reason of medical or vision care or treatment, which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage,
2. Service plan contracts, group practice, individual practice and other prepayment coverage,
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
4. Any coverage under governmental programs and any coverage required or provided by any statute. This does not include a state plan under Medicaid.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans and that portion which does not. Notwithstanding the foregoing, the term "Plan" shall be deemed to include any Plan which is paid for entirely by an Employee only if such Plan contains a provision coordinating its benefits with This Plan.

B. The term "This Plan," as used in this Article, means that portion of This Plan which provides the benefits subject to the provisions of this Article.

C. The term "Allowable Expense," as used in this Article, means any necessary, Reasonable and Customary item of Covered Expense. When a Plan provides benefits in the form of furnishing services or supplies rather than cash payments, the reasonable cash value of each service or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid. The Trustees shall not be required to determine the existence of any Plan or the amount of benefits payable under any Plan except This Plan, and the payment of benefits under This Plan shall be payable under any and all other Plans only to the extent that the Trustees are furnished with information relative to such other Plans by the Employer or Employee or any insurance company or other organization or person.

The difference between the cost of a private Hospital room and the cost of a semiprivate

Hospital room shall not be deemed to be an "Allowable Expense," except for the period of time during which the patient's confinement to a private Hospital room is deemed Medically Necessary in terms of generally accepted medical practice.

D. If another Plan has procedures which must be followed by a participant in order to obtain maximum reimbursement under that Plan, benefits shall be coordinated as if those rules or procedures had been followed even if they were not, e.g., if the Plan requires an individual to use certain providers, assesses a utilization review penalty for noncompliance or requires the individual to follow other procedures, expenses represented by that penalty, in dollars or other reduction in benefits, shall not be considered "Allowable Expenses" under this Article.

E. If this Plan is secondary to Plan that determines its benefits on the basis of negotiated fees, any amounts in excess of such negotiated fees are not reimbursable by this Plan, except when This Plan and another Plan have negotiated fee arrangements with the same provider, in which case This Plan may make reimbursement up to the lower of the two negotiated fees.

4.3 EFFECT ON BENEFITS

A. Except as specifically provided otherwise in this Plan Document, the benefit that would be payable under This Plan in the absence of this provision shall be reduced by the benefits payable under all other Plans for the expenses covered in whole or in part under This Plan.

B. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be a benefit payable.

1. The primary Plan, which is the Plan which pays benefits first, pays the benefits that would be payable under its terms in the absence of this provision.

2. Under this Section 4.3, the secondary Plan, which is the Plan which pays benefits after the primary Plan, may limit the benefits it pays so that the sum of its benefit and all other benefits payable by the primary Plan will not exceed the amount of benefits it would have paid had it been the primary Plan.

3. Under Section 4.3, the secondary Plan may limit the benefits it pays to:

   a. the amount of benefits it would have paid had it been the primary Plan;

   less

   b. all other benefits payable for the same expenses by the primary Plan.

C. If

1. another Plan which is involved in Paragraph B of this Section 4.3 and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and

2. the rules set forth in Paragraph D of this Section 4.3 would require This Plan to determined its benefits before such other Plan,

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under This Plan.

D. This Plan will determine its order of benefits using the first of the following rules which apply:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.

2. The benefits of a Plan which covers the person on whose expenses claim is based other as an active Employee will be determined before the benefits of a Plan which covers such person as an inactive or retired Employee. The benefits for claims submitted on behalf of a Dependent of an active Employee will be determined before the benefits of a Plan which covers such person as a Dependent of an inactive or retired Employee.

3. If a person on whose expenses the claim is based has Continuation Coverage or any other coverage provided under a right of continuation, pursuant to federal or state law, and is also covered under another Plan, the benefits of the Plan covering the person as an employee (or as the employee's dependent) shall be determined before the benefits of a Plan that is providing benefits under the Continuation Coverage.

Exception: If the Plan covering the person as an employee, member, subscriber or retiree (or a dependent of such person) is primary, as determined above, and if such Plan has a pre-existing condition exclusion, the Plan providing Continuation Coverage will be primary with respect to the Allowable Expenses incurred as a result of treatment for the pre-existing condition.

4. With respect to establishing the order of benefit determination on claims for Dependents, the following rules apply:

a. If the parents of the child are not divorced or separated, or if a court decree awards joint custody of the child without specifying that one parent has the responsibility to provide health care coverage, the benefits of the Plan which covers the child as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in a Calendar Year shall be

the primary plan. If both parents have the same month and day of birth, the Plan that has covered either of the parents longer is the primary Plan.

b. If the other Plan does not have the rule described in No. 2-a) above, but instead has a rule based on the gender of the parent, and if, as result, the Plans do not agree on the order of benefits, the rule of the other Plan will determine the order of benefits.

c. In the case of a child whose parents are divorced or separated, or if the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, then the responsible parent's plan is primary (provided the Plan is aware of the terms of the court decree).

d. If the parents are separated or divorced and no court decree allocates responsibility for the child's health care expenses or health care coverage, or if a court decree states that the custodial parent is responsible for the child's health care expenses or health care coverage, the order of benefits for all possible Plans is:

(1) The Plan of the custodial parent;

(2) The Plan of the spouse of the custodial parent;

(3) The Plan of the noncustodial parent; and

(4) The Plan of the spouse of the noncustodial parent.

e. In the event a husband and wife are both Eligible Employees under This Plan, or in the event the parents of a Dependent child Covered Under This Plan are both Eligible Employees under This Plan, This Plan will coordinate with itself on claims submitted on behalf of such Employees and Dependent children as follows:

(1) With respect to expenses incurred by a Dependent child whose parents are both Eligible Employees under This Plan:

(a) Both Employees must file a claim for benefits on behalf of the child;

(b) This Plan will first determine its primary benefits on the child's claim based on the child being a Dependent child of the parent whose Plan is determined to be primary in accordance with the applicable provisions of Nos. 2-a), 2-b), 2-c) and 2-d) of this Paragraph D; and

(c) After such primary benefits have been determined, the Plan will then determine its secondary benefits on the child's claim based on the child being a Dependent of the other

parent. Such secondary benefits will be determined only on Allowable Expenses not payable by the Plan as the primary payor, and in no event will such secondary benefits, when added to the primary benefits payable, exceed any limitation or maximum benefit specified on the applicable Schedule of Benefits.

(2) With respect to a claim incurred by an Employee Covered Under This Plan whose spouse is also an Employee Covered Under This Plan:

(a) The Employee on whose behalf the expenses are incurred must submit a claim for the expenses on his/her own behalf, and the spouse of the Employee must submit a claim for the expenses as a claim for his/her Dependent

(b) This Plan will first determine its primary benefits on the Employee's claim as the claim of an Employee; and

(c) After such primary benefits have been determined, the Plan will then determine its secondary benefits on the claim based on the Employee being a Dependent of the other Employee. Such secondary benefits will be determined only on Allowable Expenses not payable by the Plan as the primary payor, and in no event will such secondary benefits, when added to the primary benefits payable, exceed any limitation or maximum benefit specified on the applicable Schedule of Benefits.

f. For a Dependent child, the plan covering the child as an Employee will be primary over a plan covering the child as a Dependent. A plan covering the child as a spouse will be primary over a plan covering him as a child.

5. If the above rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

E. When the provisions of this Article operate to reduce the total amount of benefits otherwise payable as to a person Covered Under This Plan, each benefit that would be payable in the absence of this Article shall be reduced proportionately or in such other equitable manner as the Trustees shall determine and such reduced amount shall be charged against any applicable benefit of This Plan.

F. The Fund has the right to recover the cost of benefits provided to an Eligible Individual if that cost has also been paid by another person or company.

4.4 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this Article of This Plan or any provision of similar purpose of any other Plan, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Trustees deem to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Trustees such information as may be necessary to implement the provisions of this Article.

4.5 FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under This Plan in accordance with this Article have been made under any other Plans, the Trustees shall have the right, exercisable alone and in their sole discretion, to pay over to any organization making such payments any amounts they shall determine to be warranted in order to satisfy the intent of this Article, and amounts so paid shall be deemed to be benefits paid under This Plan, and to the extent of such payments, the Trustees shall be fully discharged from liability under This Plan.

4.6 RIGHT OF RECOVERY

Whenever payments have been made by the Trustees with respect to Allowable Expenses in a total amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Trustees shall have the right to recover such payments, to the extent of such excess, from one or more of the following, as the Trustees shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations.

4.7 COORDINATION WITH MEDICARE

All benefits provided under This Plan for medical care and treatment are subject to this provision.

A. Definitions

1. "Medicare," as used herein, means benefits provided under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such Program is currently constituted and as it may later be amended.

2. "Allowable Expenses," as used herein, means any necessary, Reasonable and Customary item of expense at least a portion of which is covered under Medicare or This Plan.

B. Provisions

If, for any person while Covered Under This Plan who is also covered under Medicare, the sum of the benefits payable under This Plan together with the benefits payable under Medicare exceeds the Eligible Individual's Allowable Expense, then the benefits otherwise payable under Medicare and This Plan with respect to such individual shall be reduced so that the benefits payable under Medicare and This Plan shall not exceed his Allowable Expenses for such period except as specified below:

1. Active Eligible Employees Age 65 or Older Who Continue Working

a. If an Eligible Employee who is age 65 or over and eligible to participate in Medicare continues to work as an Employee for a Contributing Employer who employs 20 or more employees and such Employee continues to maintain his eligibility for benefits under This Plan as an Employee, benefits shall be payable under This Plan without regard to the Eligible Employee's entitlement or potential entitlement to Medicare if the Employee is not entitled, and could not upon application become entitled, to Medicare as an End Stage Renal Disease beneficiary.

b. If an Eligible Employee who is age 65 or over and eligible to participate in Medicare continues to work as an Employee for a Contributing Employer who employs less than 20 employees and such Employee continues to maintain his eligibility for benefits under This Plan as an Employee, This Plan shall pay its benefits secondary to Medicare unless This Plan is legally required to pay first.

2. The Plan Primary to Medicare for Eligible Dependent Spouses Age 65 or Older

If an Eligible Employee, regardless of his age, has a Dependent spouse who is age 65 or older and eligible to participate in Medicare, benefits shall be payable under This Plan without regard to the Dependent spouse's entitlement or potential entitlement to Medicare if the spouse is not entitled, and could not upon application become entitled, to Medicare as an End Stage Renal Disease beneficiary.

3. End Stage Renal Disease (ESRD) Beneficiary

Benefits shall be payable under the Plan without regard to an Eligible Individual's entitlement to Medicare if the Eligible Individual is entitled to Medicare as an ESRD beneficiary and not more than thirty months has elapsed since the earliest of the following months:

a. The month in which the Eligible Individual began a regular course of renal dialysis;

b. The month in which the Eligible Individual received a kidney transplant;

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

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

4. In All Other Cases

a. If at least one Employer contributing to the Fund normally employed 100 or more employees on a typical business day during the previous Calendar Year, the provisions of subparagraph b) below shall apply to payment of benefits under This Plan during the current Calendar Year.

b. Benefits shall be payable under This Plan without regard to an Eligible Individual's entitlement or potential entitlement to Medicare if such Eligible Individual is:

(1) Under age 65; and

(2) An Employee, an Employer, an individual associated with an Employer in a business relationship, or an Eligible Dependent of any of these persons; and

(3) Entitled or potentially entitled to Medicare as a disabled beneficiary other than as an End Stage Renal Disease beneficiary.

C. All Persons Eligible for Medicare Considered Enrolled in Medicare

For the purposes of this Section 4.7, benefits shall be considered payable by Medicare whether or not an Eligible Individual who is eligible for Medicare has enrolled in or applied for benefits under Medicare Parts Aand B.

ARTICLE 5- CLAIM PROCESSING AND APPEAL

1.1 CLAIM PROCESSING PROCEDURES

A. Claim Processing Time Limits

1. In general, UHS processes doctor bills and the Fund Office processes all other claims, including hospital bills. Hospital bills are processed by the PPO, but the explanation of benefits is issued by the Fund Office. For ease of explanation, when used in the following explanation, the term "claims office" can apply to UHS or the Fund Office, depending on which office is responsible for the claim.

2. The amount of time the applicable claims office can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

   a. A claim is "post-service" if the treatment or supply for which payment is now being requested has already been received.

   b. A "disability claim" is a claim for Weekly Disability Benefits.

   c. A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining medical care.

   d. An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize the patient's life, health, or ability to regain maximum function, or that could subject the patient to severe pain that cannot be adequately managed without the proposed treatment.

3. A "concurrent care claim" is a request to extend a course of treatment beyond the period of time or number of treatments previously approved.

4. If all the information needed to process the claim is provided to the Fund Office, the claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

   a. Within thirty days for post-service claims.

   b. Within forty-five days for disability claims.

   c. Within fifteen days for pre-service claims.

   d. Within seventy-two hours for urgent care claims.

   e. Within twenty-four hours for concurrent care claims if the concurrent care is urgent and if the request for the extension is made within twenty-

four hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

5. An authorized representative may act on behalf of the Eligible Individual, although the Trustees may verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of the individual's medical condition as his representative.

B. When Additional Information Is Needed

1. If additional information is needed from the Eligible Individual, his doctor or the medical provider, the necessary information or material will be requested in writing. If the request goes to the medical provider, the Eligible Individual will receive a copy of the request. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within twenty-four hours.

2. It is the Eligible Individual's responsibility to see that the missing information is provided to the Fund Office. The normal processing period will be extended by the time it takes to provide the information, and the limit will start to run once the claims office has received a response to its request. If the missing information is not provided within forty-eight hours for an urgent care claim or forty-five days for any other claim, the Fund Office will make a decision on the claim without it, and the claim could be denied as a result.

C. Plan Extension

The normal time periods may be extended if the claims office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information). The Eligible Individual will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

1. Fifteen days for post-service claims.

2. Fifteen days for pre-service claims.

3. Thirty days for disability claims. A second 30-day extension may be needed in special circumstances.

D. Claim Denials

If all or a part of a claim is denied after the claims office has received a completed claim form and all other necessary information, the individual will be sent a written notice giving the reasons for the denial. The notice will include reference to the Plan provisions on which the denial was based and an explanation of

the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following those procedures, including a statement of the individual's right to bring a civil action under section 502(a) of ERISA. If the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the denial notice will state that the Plan will provide the specific internal rule, guideline, protocol or criterion used upon request free of charge. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent care claims, a description of the Plan's expedited review process will be provided.

5.2 CLAIM APPEAL PROCEDURE

A. Concurrent Care Claims

If the individual has a concurrent care claim and the claims office terminates or reduces a previously approved period of treatment, the individual will have the right to appeal that termination or reduction. The individual will be given advance notice the termination or reduction and allowed to appeal the determination before the termination or reduction. The rule allowing the treatment to continue pending an appeal does not apply if the individual's benefits terminate because he has lost eligibility under the Plan or if the termination or reduction is the result of a Plan amendment.

B. Physician Bills

If the Eligible Individual disagrees with the denial of payment of a Physician's bill, he should write to UHS within 180 days of the denial requesting a review to determine whether the denial was proper. The Eligible Individual should send the request for review along with the reasons why the denied claim for payment or services should have been paid to UHS. The Eligible Individual may also orally request a review of a denied urgent care claim by calling UHS.

C. All Other Claims, Including Hospital Bills

The Eligible Individual may also request the Appeals Committee of the Board of Trustees to review a claim after a denial of benefits by writing to the Board of Trustees. The Eligible Individual should attach to the written request for review any additional information that may help a favorable decision to be made on the claim. The letter should be submitted within 180 days after the date the denial was mailed. The Eligible Individual may also orally request a review of a denied urgent care claim by calling the Fund Office.

D. Full and Fair Review

1. UHS or the Appeals Committee (as applicable) will conduct a full and fair review of all the material submitted with the claim, the action taken by the claims office, the additional information the Eligible Individual has provided, and the reasons the Eligible Individual believes the claim should be paid. The review will be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party. It will not afford deference to the initial adverse benefit determination, and will take into account all comments, documents, records and other information submitted, without regard to whether such information was previously submitted or relied upon in the initial determination.

2. The Eligible Individual whose claim was denied has the right, upon request and free of charge, to have copies of all documents, records and other information relevant to the claim for benefits.

3. The Plan will not preclude an authorized representative (including a health care provider) from acting on the patient's behalf, although UHS or the Appeals Committee will verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of the medical condition as the patient's representative.

4. With respect to a review of any determination based on a medical judgment, UHS or the Appeals Committee must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment.

E. Personal Appearances

The Eligible Individual and/or his representative can also make a personal appearance before the Appeals Committee. If the Eligible Individual and/or his representative does so, it must be done at the Eligible Individual's expense.

5.3 NOTIFICATION FOLLOWING REVIEW

A. If the appeal is for an urgent care claim, the Eligible Individual will be notified of UHS' or the Appeals Committee's decision about the appeal as soon as possible, taking into account the medical circumstances, but not later than seventy-two hours after receipt of the request for review. In the case of pre-service claims, the Eligible Individual will be notified no later than thirty days after receipt of the request for review.

B. A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Appeals Committee that immediately

follows the Plan's receipt of a request for review. The Committee generally meets on a quarterly basis. If the request for review has been received by the Committee at least 30 days before its next scheduled meeting, a decision on the request for review will normally be made at the next quarterly meeting. If the request for review is not received by the Committee at least thirty days before the next quarterly meeting date, the decision may be delayed one additional quarter. In addition, in unusual circumstances, the decision may be delayed until the third meeting of the Committee after it has received the request for review. If such circumstances require such a delay, the Eligible Individual will be informed.

C. After a decision has been made on a disability or post-service claim, the Eligible Individual will be informed in writing of the decision, normally within five calendar days of the review. When the Eligible Individual receives the decision on the appeal, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that the Eligible Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; a statement describing any voluntary appeal procedures offered by the Plan and the Eligible Individual's right to obtain the information about such procedures; and a statement of the Eligible Individual's right to bring an action under section 502(a) of ERISA. If applicable, the Eligible Individual will also be informed that the specific internal rule, guideline, protocol or similar criterion relied on to make the decision will be provided free of charge upon request. If the decision was based on a medical judgment, the Eligible Individual will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

5.4 ENFORCEMENT OF RIGHTS

A. If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the Eligible Individual may go to court to enforce his rights.

B. For services provided at or by UHS, the Consumer Services Division of the Department of Insurance may be contacted.

ARTICLE 6- ELIGIBILITY

6.1 INITIAL ELIGIBILITY

A. Employees

An Employee will become initially Covered Under the Plan on the first day of the month coincident with or next following the earliest of:

1. The completion of ten months of employment in which the Employee has averaged 120 hours per month in each of the ten months, provided the Employee has earned at least one hour in each of those ten months.

2. The completion of the eligibility requirements set forth in special Participation Agreements, approved by the Trustees, if the Employee is covered by a non-standard Collective Bargaining Agreement.

3. With respect to Employees of the Welfare Fund, immediately upon becoming Employees of the Welfare Fund.

B. Dependents

1. Each individual who is a Dependent of an Employee on the Employee's initial eligibility date shall be eligible for and entitled to receive benefits under this Plan on and after such date.

2. Each individual who becomes a Dependent of an Employee while such Employee is eligible for benefits under this Plan shall be eligible for and entitled to receive benefits under this Plan on the date on which such individual becomes a Dependent of such Employee.

3. Notwithstanding the above, Dependents of an Employee covered by a Participation Agreement will be eligible for Plan coverage only if such coverage is specified in the Participation Agreement between the Trustees and the Covered Employer. If the Participation Agreement does not cover Dependents, none of the provisions of this Section 6.1 shall be applicable to the Employee's dependents whether or not they meet the Plan's definition of a Dependent.

6.2 CONTINUING COVERAGE

A. An Employee and his Dependents, if any, will continue to be Covered Under the Plan as long as the Employee works an average of 120 hours per month for Contributing Employers over a ten-month period. Every month the Employee's hours worked for a Contributing Employer during the previous ten months are totaled. If these hours add up to 1,200 or more, the Employee's coverage, and his Dependents' coverage, if any, will continue for one more month.

B. However, if an Employee has no Credited Hours in two consecutive months, his eligibility will terminate as stated in Section 6.3, Termination of Employee Eligibility.

6.3 TERMINATION OF EMPLOYEE ELIGIBILITY

An Employee's eligibility for benefits under the Plan shall terminate automatically at midnight on the first to occur of the following dates:

A. The first day of any month for which the Employee fails to have at least 1,200 Credited Hours in the ten preceding months, unless a correct and on-time Continuation Coverage Self-Payment is made by or on behalf of the Employee.

B. The first day of the month following a two-month period during which the Employee failed to have any Credited Hours, unless a correct and on-time Continuation Coverage Self-Payment is made by or on behalf of the Employee.

C. The sixteenth calendar day following the date the Employee's employment with a Contributing Employer terminates, provided the Employee does not become reemployed with another Contributing Employer within two months of the termination date, unless a correct and on-time Continuation Coverage Self-Payment is made by or on behalf of an Employee.

D. If Continuation Coverage Self-Payments are being made by or on behalf of an Employee in accordance with the provisions of Section 6.6, Eligibility Maintained Through Self-Payments, at the end of the last day of the last month of his allowable Maximum Coverage Period or on the date of occurrence of any of the events specified in Section 6.6, Eligibility Maintained Through Self-Payments, Paragraph E, "Termination of Continuation Coverage," whichever occurs first.

E. The date the Trustees terminate this Plan of Benefits.

F. The date the Employee enters the armed forces of any country on a full-time basis, unless the Employee is entitled to make and does make correct Continuation Coverage Self-Payments as specified in Section 6.6, Eligibility Maintained Through Self-Payments, or such Self-Payments are made on his behalf.

G. The date of the Employee's death.

6.4 TERMINATION OF DEPENDENT ELIGIBILITY

An Employee's Dependent's eligibility for benefits under the Plan shall terminate automatically at midnight on the first to occur of the following dates:

A. The date on which the Trustees terminate this Plan of Benefits.

B. The date on which the Trustees terminate benefits for Dependents under this

Plan.

C. The date on which the Dependent enters the armed forces of any country on a full-time basis, unless the Dependent is entitled to make and does make correct Continuation Coverage Self-Payments as specified in Section 6.6, Eligibility Maintained Through Self-Payments, or such Self-Payments are made on his behalf.

D. The date on which the Dependent child becomes Covered Under this Plan as an Employee.

E. The date on which the Dependent becomes covered under another plan as an employee.

F. The date on which the Employee ceases to be eligible for coverage under the Plan for reasons other than the Employee's death, or the date of the Employee's death, unless a correct and timely election of and Self-Payment for Continuation Coverage is made by or on behalf of the Dependent.

G. With respect to a Dependent spouse, on the date of divorce or legal separation of the Employee and spouse, unless a correct and timely election of and Self-Payment for Continuation Coverage is made by or on behalf of the spouse.

H. With respect to a Dependent child, the date on which the child fails to meet this Plan's definition of a Dependent, unless a correct and timely election of and Self-Payment for Continuation Coverage is made by or on behalf of the Dependent child; provided, however, that for a Dependent attaining the maximum age, eligibility will terminate on the last day of the month in which the Dependent attains age 26.

I. If Continuation Coverage Self-Contributions are being made by or on behalf of the Dependent in accordance with the provisions of Section 6.7, Eligibility Maintained Through Self-Payments, at the end of the last day of the last month of the Maximum Coverage Period to which the Dependent is entitled and for which a correct and timely Continuation Coverage Self-Payment was made by or on behalf of the Dependent, or on the date of occurrence of any of the events specified in Section 6.6, Eligibility Maintained Through Self-Payments, Paragraph E, "Termination of Continuation Coverage," whichever occurs first.

6.5 REINSTATEMENT OF ELIGIBILITY

A. If an Employee's eligibility for coverage terminates because he fails to meet the Continuing Coverage requirements specified in Section 6.2, Continuing Coverage, and such Employee does not elect to make Continuation Coverage Self-Payments, the Employee must once again satisfy the Continuing Coverage requirements specified in Section 6.2, Continuing Coverage, before he once again becomes Covered Under the Plan.

B. If an Employee's eligibility for coverage would terminate because he fails to meet the Continuing Coverage requirements specified in Section 6.2, Continuing Coverage, and such failure continues for two consecutive months, and if such Employee maintains coverage by making proper and timely Self-Contributions for Continuation Coverage, such Employee's eligibility for coverage under the Plan will be reinstated on the first day of the month following any month during which the Employee works a minimum of 120 hours for a Contributing Employer. The provisions of this Paragraph B shall not apply if the Employee's Continuation Coverage has been terminated for any reason before the date on which his eligibility for coverage would otherwise be reinstated.

C. If an Employee's eligibility for coverage would terminate because he fails to meet the Continuing Coverage requirements specified in Section 6.2, Continuing Coverage, he remains ineligible for two consecutive months, and he does not make appropriate Continuation Coverage Self-Payments, such Employee will regain his Coverage Under the Plan under the regular eligibility provisions on the first day of the month following the date the Employee's Contributing Employer makes Contributions on such Employee's behalf for 1,200 hours or more over a ten-month period.

D. An Employee shall not earn "Credited Hours" or "pay hours" by making Self-Contributions for Continuation Coverage except when such Employee qualifies for reinstatement of eligibility for coverage under the provisions of Paragraph B above. If an Employee qualifies for reinstatement of eligibility for coverage under the provisions of Paragraph B above, such Employee shall be credited with 120 Credited Hours for each month for which he has made a proper and timely Self-Contribution for Continuation Coverage, up to but not to exceed a total of nine months.

6.6 ELIGIBILITY MAINTAINED THROUGH SELF-PAYMENTS (CONTINUATION COVERAGE)

If Plan coverage terminates or is going to terminate for an Employee and/or any of the Employee's Dependents, the Employee or his Dependents shall be entitled to make Self-Payments to the Fund for continued Plan coverage, subject to the following:

A. Continuation Coverage

If a Qualifying Event occurs, each Qualified Beneficiary (other than a Qualified Beneficiary for whom the Qualifying Event will not result in any immediate or deferred loss of coverage) shall be offered an opportunity to elect to make Self-Payments to the Fund to continue to receive the health Plan coverage that he or she received immediately before the occurrence of the Qualifying Event. This continued coverage is "Continuation Coverage," and the rules governing such coverage are specified in the following provisions of this Section 6.6.

B. Qualified Beneficiary

1. A Qualified Beneficiary is any individual who, on the day before a Qualifying Event, is Covered Under the Plan by virtue of being on that day either:

   a. The Eligible Employee;

   b. The spouse of the Eligible Employee; or

   c. The Dependent child of the Eligible Employee.

2. An Eligible Employee can be a Qualified Beneficiary only in connection with a Qualifying Event that consists of the termination of the Employee's employment or reduction in the Employee's hours.

3. An individual is not a Qualified Beneficiary if, on the day before the Qualifying Event, the individual is Covered Under the Plan solely by reason of another individual's election of Continuation Coverage and is not already a Qualified Beneficiary by reason of a prior Qualifying Event.

C. Qualifying Event

1. A Qualifying Event is any of the following events which, under the terms of the Plan, causes an Eligible Employee, or the spouse or a Dependent child of the Eligible Employee, to lose coverage under the Plan (for this purpose, to "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event):

   a. The termination of the Eligible Employee's employment (other than by reason of the Employee's gross misconduct), or reduction in the Employee's hours;

   b. The divorce or legal separation of the Eligible Employee from the Employee's spouse;

   c. A Dependent child ceasing to meet the Plan's definition of a Dependent and thereby losing Dependent status; or

   d. The death of the Eligible Employee.

2. It is the responsibility of the Employee, the spouse, or the child, as applicable, to notify the Plan of the date of a divorce or legal separation, of the date a child loses Dependent status, or of the Employee's death. If such notice is not provided within 60 days of the occurrence of such an event, or within 60 days after Plan coverage would terminate for the affected Dependent(s), whichever date is later, the Dependent(s) who would lose coverage due to such a Qualifying Event shall not be entitled to elect Continuation Coverage.

D. Maximum Coverage Period

1. Except as specified in Paragraph E below, Continuation Coverage that has been elected by a Qualified Beneficiary shall extend for a period beginning on the date on which coverage would otherwise terminate for such individual because of the Qualifying Event and ending not before the earliest of the following dates:

   a. Eighteen (18) months after coverage would otherwise terminate for the Qualified Beneficiary if the Qualifying Event that gives rise to Continuation Coverage election rights is an Employee's termination of employment or reduction in hours, provided, however, that if the Social Security Administration determines that a Qualified Beneficiary is disabled, for the purposes of receiving Social Security disability benefits, on the date of the Employee's loss of employment or reduction in hours, the 18-month period may be extended to twenty-nine (29) months for the Qualified Beneficiary and his Eligible Family Members, provided that the Qualified Beneficiary:

      (4) Notifies the Fund Office within sixty (60) days of the date of the disability determination by the S ocial Security Administration and before termination of the original 18-month continuation; and

      (5) Notifies the Fund Office within thirty (30) days after Social Security makes a final determination that the Qualified Beneficiary is no longer disabled for Social Security disability benefits purposes;

   b. Thirty-six (36) months after the date coverage would terminate because of any other type of Qualifying Event, provided, however, that if a Dependent's child's coverage terminates due to loss of Dependent status on a date other than the last day of a month, the child's Maximum Coverage Period shall begin on the date on which the child loses Dependent status and shall end at the end of the thirty-sixth month following the month in which the child loses Dependent status; or

   c. If an Eligible Employee becomes entitled to Medicare while he is still Covered Under the Plan, either as an active Employee or under Continuation Coverage, the Employee shall lose the right to Continuation Coverage but his Eligible Dependents, if any, shall be entitled to Continuation Coverage for a Maximum Coverage Period of 36 months from the date of the Employee's entitlement to Medicare or, if longer, 18 months from the termination of the Employee's entitlement to Continuation Coverage.

2. In the case of a Qualifying Event that gives rise to an 18-month Maximum Coverage Period and is followed, within that 18-month period, by a second Qualifying Event (e.g., the Employee's death, a divorce or legal separation,

or a child's loss of Dependent status), the original 18-month period shall be expanded to 36 months, but only for those individuals who were Qualified Beneficiaries under the Plan as of the first Qualifying Event and who were Covered Under the Plan at the time of the second Qualifying Event. It is the Qualified Beneficiary's responsibility to notify the Benefit Office within 60 days after a second Qualifying Event occurs. If the Benefit Office is not notified within 60 days, the Qualified Beneficiary will lose the right to extend Continuation Coverage beyond the original 18-month period.

3. No Qualifying Event(s) can give rise to a Maximum Coverage Period that ends more than 36 months after the date coverage would otherwise have terminated because of the first Qualifying Event.

E. Termination of Continuation Coverage

Continuation Coverage under this Plan for an Eligible Individual may be terminated prior to the end of the applicable Maximum Coverage Period specified above on the first to occur of any of the following events with respect to that Eligible Individual:

1. The first day of any month for which timely payment is not made to the Plan with respect to Continuation Coverage for the Eligible Individual.
2. The date upon which the Fund ceases to maintain any group health plan (including successor plans).
3. The date after the date of the election of Continuation Coverage that the Eligible Individual becomes entitled to Medicare benefits.
4. The first date after the date of the election of Continuation Coverage upon which the Eligible Individual is covered (i.e., actually covered, rather than merely eligible to be covered) under another group health plan that is not maintained by the Fund, provided, however, that, if an Eligible Individual has a pre-existing medical condition that would cause benefits to be excluded or limited under the other group health plan, then Continuation Coverage will not be terminated on account of such other coverage.
5. If the Eligible Individual extended coverage for up to 29 months due to his or his family member's disability and there is a final determination by the Social Security Administration that the disabled person is no longer disabled, on the first day of the month that begins more than 30 days after the date of such final determination.

F. Continuation Coverage Benefits and Options

The Plan benefits provided for an Employee and/or for Dependents who are Covered Under the Plan on the date of the Qualifying Event and who are affected by an election of Continuation Coverage shall be the same medical and dental

coverage for which the Employee and/or Dependents were eligible on the day before the occurrence of the Qualifying Event and shall be the same as any such benefits provided to Eligible Employees and Dependents to whom a Qualifying Event has not occurred, provided an appropriate Continuation Coverage Self-Payment is made by or on behalf of the Employee and/or Dependent for the type of benefit coverage elected.

1. Plan 1 and Plan 3

An Employee or Dependent may elect to make Continuation Coverage Self-Payments for one of the following benefit coverage options:

a. The benefits set forth in Article VII, SCHEDULES OF BENEFITS, Section 7.1, Plan 1 Schedule of Benefits, Paragraphs C, D, and E.

b. The benefits set forth in Article VII, SCHEDULES OF BENEFITS, Section 7.1, Plan 1 Schedule of Benefits, Paragraphs C, D, E and F.

2. Plan 2

An Employee or Dependent may elect to make Continuation Coverage Self-Payments for one of the following benefit coverage options:

a. The benefits set forth in Article VII, SCHEDULES OF BENEFITS, Section 7.2, Plan 2 Schedule of Benefits, Paragraphs C, D and E.

b. The benefits set forth in Article VII, SCHEDULE OF BENEFITS, Section 7.2, Plan 2 Schedule of Benefits, Paragraphs C, D, E and F.

3. Plan 4

An Employee may elect to make Continuation Coverage Self-Payments for the same benefit coverage options as Plan 1 Employees may elect.

G. Monthly Self-Payment Amount for Continuation Coverage

1. The monthly Continuation Coverage Self-Payment amount for each benefit coverage option specified in Paragraph F above shall be determined by the Trustees in accordance with the law governing such determination.

2. Such Continuation Coverage Self-Payment amounts shall be subject to change, but not more often than once during the Plan's fiscal year unless there is a substantial change in the Benefit Plan.

H. Provisions Governing Election of Continuation Coverage

1. When the Fund Office is notified that a Qualifying Event has occurred, an election notice and an election form shall be sent to the Qualified Beneficiary(ies) affected by the Qualifying Event. The election notice shall inform the affected individuals of their right to elect Continuation Coverage and of

the Continuation Coverage Self-Payment amounts required for the benefit coverage options if Continuation Coverage is elected.

2. If Continuation Coverage is desired, the Qualified Beneficiary electing the coverage must fill in and return the election form to the Fund Office within 60 days after the election notice is mailed by the Fund Office to the Qualified Beneficiary(ies) or within 60 days after Plan coverage would otherwise terminate for the Qualified Beneficiary(ies), whichever date is later.

3. An election of Continuation Coverage is considered to be made on the date that the completed election form is mailed (postmarked) to the Fund Office (unless the election is made in person at the Fund Office).

4. If the completed election form is not mailed to the Fund Office within the applicable period of time specified above, Continuation Coverage shall be considered to have been declined with respect to all Qualified Beneficiaries affected by the Qualifying Event.

5. Each Qualified Beneficiary must be offered the opportunity to make an independent election to receive Continuation Coverage. However, if a Qualified Beneficiary who is either an Eligible Employee or the Dependent spouse of the Employee makes an election to provide any other Qualified Beneficiary with Continuation Coverage, the election shall be binding on such other Qualified Beneficiary.

6. An Employee may not decline Continuation Coverage on behalf of his Eligible Dependents. If the Employee does not elect Continuation Coverage on behalf of his Dependents who are entitled to Continuation Coverage, his Dependents are entitled to make a separate and independent election of Continuation Coverage.

7. An election on behalf of a minor child may be made by the child's parent or legal guardian.

8. Continuation Coverage may be elected for an individual who, as of the individual's election date, is already covered under another group health care plan that is not maintained by the Fund, provided however that if, after the date of the election of Continuation Coverage, such individual becomes covered under another group health plan not maintained by the Fund, Continuation Coverage will terminate unless the individual has a preexisting medical condition that would cause benefits to be excluded or limited under the other group health care plan.

9. Continuation Coverage may be elected for any individual who, as of the individual's election date, is already entitled to Medicare, provided however, that if, after the date of the election of Continuation Coverage, an individual becomes entitled to Medicare, Continuation Coverage will terminate.

10. In order to protect his and his family's rights, the Employee should keep the Fund Office informed of any changes in the addresses of family members. The Employee should also keep a copy, for his records, of any notices sent to the Fund Office or that the Fund Office sends to him.

11. No individual shall be required to prove that he is insurable in order to be entitled to Continuation Coverage.

I. Continuation Coverage Self-Payment Due Dates

1. Continuation Coverage Self-Payments may be made in person at the Fund Office or may be mailed to the Fund Office.

2. An individual making an election of Continuation Coverage shall have 45 days after the date of the election to make his initial payment.

3. Continuation Coverage Self-Payments must be made monthly; and each monthly Self-Payment is due on or before the first day of each month.

4. A Continuation Coverage Self-Payment shall be considered to have been made on a timely basis if the payment is received by the Fund Office within 30 days of the due date.

5. If a Continuation Coverage Self-Payment is not made within the 30-day grace period specified above and Continuation Coverage terminates for all affected individuals, the overdue payment may not be made up nor may coverage be reinstated by the making of further payments.

J. Continuation Coverage During Military Service

If an Eligible Employee or an Eligible Dependent is in the Military Reserve and is called up to active duty for at least thirty days, the call-up is considered a Qualifying Event under Continuation Coverage. The Employee or Dependent is entitled to elect Continuation Coverage, subject to all applicable provisions of this Section 6.6, regardless of any coverage provided by the military or government.

6.7 CERTIFICATES OF COVERAGE

A. When an individual is no longer eligible for Plan benefits (including eligibility for Continuation Coverage), the Fund Office will send a certificate of coverage to such individual at his last known address. This certificate provides evidence of the individual's prior health care coverage under the Plan.

B. Any individual who loses eligibility for Plan benefits has the right to request a certificate of coverage free of charge from the Fund Office anytime within twenty-four months of the date such individual was last Covered Under the Plan.

6.8 MILITARY LEAVE

A. If an Employee leaves employment with a Contributing Employer to enter active duty in the uniformed services of the United States, his eligibility will be frozen during his active duty. After the Employee's release from active duty under circumstances entitling him to re-employment under federal law, the Employee's eligibility and accumulated Credited Hours will be reinstated on the date he returns to work with a Contributing Employer, provided his return to work is within the time prescribed by federal law.

B. The Employee is also entitled to make self-payments for continued coverage for up to 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are very similar to Continuation Coverage. This Plan will pay primary benefits before the military/government pays except for service-related disabilities.

ARTICLE 7- SCHEDULES OF BENEFITS

7.1 PLAN 1 SCHEDULE OF BENEFITS

A. WEEKLY DISABILITY BENEFITS (Eligible Employees Only)

1. Amount of weekly benefit per Period of Disability:
   a) For the first 13 weeks $200
   b) For the second 13 weeks $100
2. Maximum period that weekly benefits are payable per Period of Disability ..... 26 weeks
3. Day of disability that benefits start:
   a) Disabilities due to Non-Occupational Injury ..... First day
   b) Disabilities due to Non-Occupational Sickness:
      (1) If inpatient Hospital-confined and if confinement begins before the eighth day ..... First day of confinement
      (2) If outpatient surgery is performed before the 8th day ..... Day of surgery
      (3) Other disabilities due to sickness ..... Eighth day

B. DISMEMBERMENT BENEFIT (Eligible Employees Only)

1. For loss of both hands, both feet, sight of both eyes, one hand and one foot, or one hand and sight of one eye $1,000
2. For loss of one hand, one foot, or sight of one eye $500
3. For loss of thumb and index finger of either hand $250

C. MEDICAL BENEFITS

All treatment must be arranged or approved by a UHS Physician.

1. Payment percentage for Covered Medical Expenses provided at a UHS Center ..... 100% of Covered Expenses

		In-Plan	Out-of-Plan
1.	Deductibles:		
a)	Deductible for inpatient treatment of each sickness ...	$0	$500
b)	Deductible for inpatient treatment of all injuries sustained in one accident	$0	$500
c)	Noncompliance deductible per confinement when the Hospital Review Program procedures are not followed	$0	$100
d)	Deductible per visit for treatment at an emergency room or emergency treatment center for a condition that does not meet the definition of Emergency	$0	$500
2.	Plan Co-Payment Percentages:		
a)	Inpatient Hospital, Skilled Nursing Facility and Treatment Facility for Chemical Dependency.....	100%	80%
b)	Outpatient Hospital.....	100%	not covered
c)	Emergency treatment.....	100%	80% facility only
d)	All other Covered Expenses, including Physicians and other non-Hospital expenses.....	100%	not covered

	In-Plan	Out-of-Plan
3. Special Limitations:		
(4)		
a) Chiropractic Treatment:		
(1) Maximum benefit payable per Calendar Year	$1,000	not covered
b) Speech Therapy:		
(1) Maximum benefit payable per Calendar Year for treatment of a congenital defect	$2,000	not covered
c) Hospital Room and Board:		
(1) Maximum Covered Expense, including intensive care units	--- semi-private room rate ---	
d) Hospice Care:		
(1) Lifetime maximum benefit payable	$10,000	not covered
e) Home Health (Nursing) Care:		
(1) Calendar Year maximum benefit	$10,000	not covered

Benefits paid for non-self-administered injectable drugs and portable oxygen supply units do not apply to this Calendar Year maximum benefit.

UHS may, on a case-by-case basis, authorize additional days of home health (nursing) care as specified in Article X, MEDICAL CARE EXPENSE BENEFIT, Section 10.8, Additional Days of Certain Types of Special Care, if, in the absence of such care, the person's medical condition would require him to be confined as a Hospital inpatient, and if the cost to the Fund for the Hospital confinement would be more than the cost of the additional authorized days of care. In no event, however, will benefits be paid for home health care.

f) Skilled Nursing Facility Care:		
(1) Calendar Year maximum allowable days of confinement	---- 30 ----	

UHS may, on a case-by-case basis, authorize additional days of Skilled Nursing Facility care as specified in Article X, MEDICAL CARE EXPENSE BENEFIT, Section 10.8, Additional Days of Certain Types of Special Care, if, in the absence of such care, the person's medical condition would require him to be confined as a Hospital inpatient,

and if the cost to the Fund for the Hospital confinement would be more than the cost of the additional authorized days of care. In no event, however, will benefits be paid for Skilled Nursing Facility Care.

D. PRESCRIPTION DRUG BENEFITS

Plan benefits will only be paid for prescription drugs that have been purchased at a participating pharmacy and that are on the UPS formulary list.

The Eligible Individual will be responsible for the following co-pay per UPS formulary drug or refill purchased at a participating pharmacy:

Formulary generics	$10
Formulary brand name drug	$20

The Eligible Individual will be responsible for the full cost of any prescription drug that is not on the UPS formulary, although the cost of such drugs may be discounted through a participating pharmacy.

If the discounted price for a Covered Prescription Drug is less than the fixed co-pay amount shown above, the Eligible Individual will be responsible only for the discounted price.

E. EYE CARE SERVICES

UHS will provide the following eye care services under the Plan 1 Schedule of Benefits:

1. Eye examinations.
2. Prescriptions for eyeglasses and contact lenses.
3. Treatment of eye disease.
4. Eye surgery.

F. DENTAL BENEFITS

Dental Benefits are provided for Eligible Employees and their Eligible Dependents through a contract between the Fund and a professional dental insurance company. The Eligible Individual must enroll in the dental plan and choose a participating dental center by contacting the dental insurance company.

7.2 PLAN 2 SCHEDULE OF BENEFITS

A. WEEKLY DISABILITY BENEFITS (Eligible Employee Only)

1. Amount of weekly benefit per Period of Disability:
   a) For the first 13 weeks $200
   b) For the second 13 weeks $100
2. Maximum period that weekly benefits are payable per Period of Disability ..... 26 weeks
3. Day of disability that benefits start:
   a) Disabilities due to Non-Occupational Injury ..... First day
   b) Disabilities due to Non-Occupational Sickness:
   c) If inpatient Hospital confined and if Hospital confinement begins before the eighth day ..... First day of confinement
   d) If outpatient surgery is performed before the 8th day ..... Day of surgery
   e) Other disabilities due to sickness ..... Eighth day

B. DISMEMBERMENT BENEFIT (Eligible Employee Only)

1. For loss of both hands, both feet, sight of both eyes, one hand and one foot, or one hand and sight of one eye $1,000
2. For loss of one hand, one foot, or sight of one eye $500
3. For loss of thumb and index finger of either hand $250

C. ROUTINE PHYSICAL EXAMINATION BENEFIT

Provided only at UHS, and only for Eligible Employees and Eligible Dependent spouses.

1. One exam per person in a 12-month period ..... Provided in full at UHS

D. COMPREHENSIVE MEDICAL EXPENSE BENEFIT

1. Deductibles:
   a) Hospital Review Noncompliance Deductible for each Hospital confinement when the Hospital Review Program procedures are not followed $100
   b) Emergency Care Deductible per visit to a Hospital emergency room or Emergency Treatment Center $50

      The Emergency Care Deductible will be waived if the visit to a Hospital emergency room or Emergency Treatment Center results in an inpatient admission, or if the condition meets the definition of an Emergency.
   c) Calendar Year Deductible(s):

d) Per individual $500

e) Per family ..... 2 Individual Deductibles

2. Maximum Out-of-Pocket Amounts:

Maximum Out-of-Pocket Amounts include only Calendar Year Deductibles, and the Eligible Individual's 20% co-payment amounts. Non-Compliance Deductibles, Emergency Care Deductibles, and the Eligible Individual's 50% co-payment amounts are not included.

a) Per individual each Calendar Year $1,500

b) Per family each Calendar Year $3,000

3. Plan payment/co-payment percentages:

c) For Covered Expenses incurred after all applicable deductibles are satisfied:

(1)Before the Maximum Out-of-Pocket Amount is reached 80%

(2)After the Maximum Out-of-Pocket Amount is reached 100%

4. Special Limitations:

a) Hospital daily room and board maximum Covered Expense, including intensive care units ..... Semi-private room rate

b)..... Maximum benefit payable for an assistant surgeon..... 20% of primary surgeon's Reasonable and Customary fee

c) Skilled Nursing Facility maximum allowable days of confinement per person per Calendar Year 30

The utilization review firm may, on a case-by-case basis, authorize additional days of Skilled Nursing Facility care as specified in Article X, MEDICAL CARE EXPENSE BENEFIT, Section 10.8, Additional Days of Certain Types of Special Care, if, in the absence of such care, the person's medical condition would require him to be confined as a Hospital inpatient, and if the cost to the Fund for the Hospital confinement would be more than the cost of the additional authorized days of care..

d) Home health nursing care (provided by a Home Health Agency) maximum amount payable per person per Calendar Year $5,000

Benefits paid for non-self-administered injectable drugs and portable oxygen supply units do not apply to this maximum amount

payable per Calendar Year.

The utilization review firm may, on a case-by-case basis, authorize home health (nursing) care in excess of the maximum benefit as specified in Article X, MEDICAL CARE EXPENSE BENEFIT, Section 10.8, Additional Days of Certain Types of Special Care, if, in the absence of such care, the person's medical condition would require him to be confined as a Hospital inpatient, and if the cost to the Fund for the Hospital confinement would be more than the cost of the additional authorized days of care..

e) Speech therapy provided for treatment of a congenital defect:

(1) Maximum allowable sessions per person per Calendar Year 50

(2) Maximum allowable Covered Expense per session $20

E. PRESCRIPTION DRUG BENEFITS

Plan benefits will only be paid for prescription drugs that have been purchased at a participating pharmacy and that are on the UPS formulary list.

The Eligible Individual will be responsible for the following co-pay per UPS formulary drug or refill purchased at a participating pharmacy:

Formulary generics $10

Formulary brand name drug $20

The Eligible Individual will be responsible for the full cost of any prescription drug that is not on the UPS formulary, although the cost of such drugs may be discounted through a participating pharmacy.

If the discounted price for a Covered Prescription Drug is less than the fixed co-pay amount shown above, the Eligible Individual will be responsible only for the discounted price.

F. DENTAL SERVICES

Dental Benefits are provided for Eligible Employees and their Eligible Dependents through a contract between the Fund and a professional dental insurance company. The Eligible Individual must enroll in the dental plan and choose a participating dental center by contacting the dental insurance company.

7.3 PLAN 3 SCHEDULE OF BENEFITS

The Plan 3 Schedule of Benefits are the same benefits provided under the Plan 1 Schedule of Benefits as specified in Section 7.1, Plan 1 Schedule of Benefits.

7.4 PLAN 4 SCHEDULE OF BENEFITS

The Plan 4 Schedule of Benefits are the same benefits provided under the Plan 1 Schedule of Benefits as specified in Section 7.1, Plan 1 Schedule of Benefits, except that the Plan 4 Schedule of Benefits does not include Weekly Disability Benefits or Dismemberment Benefits. Dependents will not be eligible for any benefits under the Plan 4 Schedule of Benefits.

ARTICLE 8- DISMEMBERMENT BENEFITS

Only active Eligible Employees Covered Under the Plan 1 Schedule of Benefits, the Plan 2 Schedule of Benefits, and the Plan 3 Schedule of Benefits are eligible for Dismemberment Benefits. Dependent spouses and children, and Employees Covered Under the Plan 4 Schedule of Benefits, are not eligible for Dismemberment Benefits, nor are Employees who are Covered Under the Plan because they are making Continuation Coverage Self-Payments.

8.1 BENEFIT PROVISION

Subject to the following provisions of this Article, if an Eligible Employee sustains accidental bodily injury while Covered Under this Plan, and as a result thereof, directly and independently of all other causes, suffers within 90 days from the date of the accident, any of the losses described below, the Plan will pay to such Eligible Employee, on receipt of due proof of such loss, the amount specified on the applicable Schedule of Benefits.

8.2 DEFINITION OF "LOSS"

A. With respect to hands and feet, "loss" shall mean actual severance at or above the wrist or ankle joints and

B. With respect to eyes, entire and irrecoverable loss of sight; and

C. With respect to index fingers, actual severance at or above metacarpophalangeal joints.

8.3 EXCLUSIONS AND LIMITATIONS

No benefits are payable under this Article:

A. For any disability resulting from accidental bodily injury, sickness or disease for which the Employee is not under the direct and continuing care of a Physician.

B. For any disability arising out of war, declared or undeclared, or any act or hazard of war.

C. For any disability incurred during or as a result of the commission (or attempted commission) of a felony by the Employee.

ARTICLE 9- WEEKLY DISABILITY BENEFIT

Only active Eligible Employees Covered Under the Plan 1 Schedule of Benefits, the Plan 2 Schedule of Benefits and the Plan 3 Schedule of Benefits are eligible for Weekly Disability Benefits. Dependent spouses and children, and Employees Covered Under the Plan 4 Schedule of Benefits, are not eligible for Weekly Disability Benefits. Employees who are Covered Under the Plan because they are making Continuation Coverage Self-Payments are not eligible for Weekly Disability Benefits.

9.1 PAYMENT OF BENEFITS

A. If an Eligible Employee, as a result of a Non-Occupational Sickness or Non-Occupational Injury, becomes Totally Disabled and is thereby prevented from performing any and every duty pertaining to his occupation or employment, the Plan shall pay to the Employee during the period of such Total Disability a weekly benefit up to but not to exceed the applicable maximum benefit amount specified on the Schedule of Benefits.

B. Benefits for part of a week of disability are paid at the rate of one-fifth of the weekly benefit for each day of disability, excluding Saturdays and Sundays.

C. Benefits shall not be payable for more than the maximum period that benefits are payable during any one Period of Disability as specified on the applicable Schedule of Benefits./

D. For the purposes of this Article, disabilities due to pregnancy, childbirth and related medical conditions will be considered a "sickness."

E. Federal income tax and Social Security (FICA) taxes will be deducted from benefits payable under this Article.

9.2 COMMENCEMENT OF BENEFITS

A. Benefits shall commence on the first to occur of the following dates, provided that the Eligible Employee is under the direct care of a Physician on that day:

1. On the first day of disability resulting from Non-Occupational Injury.
2. On the earlier of the eighth day of disability or the first day of hospitalization for a disability resulting from Non-Occupational Sickness.
3. On the earlier of the eighth day of disability or the first day of outpatient surgery for a disability resulting from a Non-Occupational Sickness.

B. If the Employee is not under the direct care of a Physician on the day on which benefits would normally commence, benefits shall not commence until the day on which the Employee is under the direct care of a Physician.

9.3 PERIODS OF DISABILITY

A. All successive Periods of Disability resulting from or contributed to by the same or related cause or causes shall be considered one continuous Period of Disability unless the periods are separated by the Employee's return to active full-time Covered Employment for at least two consecutive weeks.

B. Successive Periods of Disability resulting from or contributed to by entirely unrelated causes shall be considered one Period of Disability unless the Periods of Disability are separated by the Employer's return to active full-time Covered Employment for at least one full day.

9.4 SUCCESSIVE PERIODS OF DISABILITY

A. Successive Periods of Disability resulting from or contributed to by the same or related causes shall be considered one continuous Period of Disability unless the second Period of Disability commences after the Employee has returned to active full-time Covered Employment for at least two (2) consecutive weeks.

B. If the second Period of Disability is due to an injury, sickness or disease entirely unrelated to the cause of the first disability and begins after an Employee has returned to Covered Employment on a full-time basis for one full day, then the second disability shall begin a new Period of Disability.

C. Successive periods of disability due to injuries received in the same accident shall be considered one Period of Disability.

9.5 CONCURRENT DISABILITIES

If an Employee has concurrent disabilities (two or more disabilities existing at the same time) while receiving the benefits provided under this Article, the benefits payable shall be limited to a maximum of twenty-six weeks for such concurrent disabilities.

9.6 BENEFITS DURING TREATMENT FOR CHEMICAL DEPENDENCY

A. If an Eligible Employee is undergoing a UHS-approved inpatient, partial inpatient or intensive outpatient course of treatment in a Hospital or in an approved Treatment Facility for Chemical Dependency and Plan Benefits are payable for such a course of treatment, Weekly Disability Benefits shall be payable during such course of treatment for a period of time up to but not to exceed the period of time for which benefits are payable by the Plan, but in no event shall benefits be payable beyond the date on which the course of treatment is completed or beyond the date that the Employee has received maximum benefits allowable under the Weekly Disability Benefit, whichever date occurs first.

B. With respect to Out-of-Plan treatment, Weekly Disability Benefits shall be payable

only when Out-of-Plan benefits are payable for a period of Medically Necessary inpatient detoxification.

9.7 EXCLUSIONS AND LIMITATIONS

No benefits are payable under this Article:

A. For any disability resulting from accidental bodily injury sickness or disease for which the Employee is not under the direct and continuing care of a Physician.

B. For any disability resulting from accidental bodily injury, sickness or disease sustained while performing any act or duty pertaining to any occupation or employment for compensation or profit.

C. For any disability resulting from accidental bodily injury, sickness or disease for which benefits are or would be payable in whole or in part in accordance with the provisions of any Workers' Compensation Act, Occupational Diseases Act, Employers' Liability Act or similar law.

D. For any disability arising out of war, declared or undeclared, or any act of hazard of war.

E. For any disability incurred during or as a result of the commission (or attempted commission) of a felony by the Employee.

F. With respect to Chemical Dependency, benefits will not be payable under this Article except as specified in Section 9.6.

G. Any disability resulting from an injury, sickness or disease which occurred before the Employee became Covered Under the Plan.

ARTICLE 10- MEDICAL EXPENSE BENEFIT

10.1 BENEFIT PAYMENT PROVISIONS

A. Schedules of Benefits

1. Plan benefits shall be payable on behalf of an Eligible Individual in accordance with the Schedule of Benefits applicable to the Plan for which his eligibility status entitles him.

2. The co-payment percentages, deductibles, maximum benefits payable per lifetime, and other limitations and maximum amounts are specified in Article VII, SCHEDULES OF BENEFITS, under the applicable Plan 1, Plan 2, Plan 3 or Plan 4 Schedules of Benefits.

B. Payment Responsibilities of Employees

An Employee, on behalf of himself and his Eligible Dependents, shall be responsible for paying incurred charges in the amount of all applicable Deductibles, the percentage of Covered Expenses not payable by the Plan, expenses not considered to be Covered Expenses, and any other amounts not paid by the Plan.

C. Employees Transferring From the Plan 2 Schedule of Benefits To the Plan 1 Schedule of Benefits

If, on or after July 1, 1991, an Eligible Employee transfers from coverage under the Plan 2 Schedule of Benefits to coverage under the Plan 1 Schedule of Benefits, Plan benefits paid under the Plan 1 Schedule of Benefits for the Employee and his Eligible Dependents, if any, shall be subject to the provisions of Article II, GENERAL PLAN PROVISIONS, Section 2.22, Enrollment and Transfers.

D. Benefit Payment Limitations

1. Plan benefits shall be payable up to but not to exceed any maximum benefit or other benefit limitation specified on the applicable Schedule of Benefits or specified in this or any other Article of this Plan Document. For each Eligible Individual, whether or not there has been an interruption in the continuity of his eligibility or change in his status or Plan, the maximum amount of benefits available during any specified period of time shall be equal to the amount by which the maximum benefit specified for that period of time exceeds the sum of the benefits previously paid or provided on his account during that period of time.

2. Plan benefits shall be payable only for expenses incurred by Eligible Individuals.

3. Plan benefits shall be payable for expenses incurred by an individual only if the expenses are incurred within any applicable time limitations.

4. Plan benefits shall be payable only for the Covered Expenses specified in the applicable Sections of this Article and only in accordance with any applicable provisions governing such Covered Expenses.

5. Plan benefits shall be payable only for expenses which are actually incurred.

6. Plan benefits shall be payable only for expenses which are Medically Necessary and required in connection with the care and treatment of an individual as a result of a Non-Occupational Injury or Non-Occupational Sickness.

7. Plan benefits shall be payable only for expenses which are incurred upon the recommendation of, or with the approval of, a Physician.

E. Maternity Admissions

An Eligible Employee or an Eligible Dependent spouse is entitled to at least 48 hours of inpatient Hospital care for a normal delivery and at least 96 hours of inpatient Hospital care for a Caesarean section. The Plan will provide benefits for the Covered Expenses incurred by such individual during the prescribed time periods, subject to all applicable deductibles, co-payment percentages and maximum benefits set forth on the Schedule of Benefits. The Hospital Review Non-compliance Deductible will not apply to maternity admissions which are within these time limits.

10.2 DEDUCTIBLES

A. Out-of-Plan Deductibles under the Plan 1 Schedule of Benefits

With respect to the Plan 1 Schedule of Benefits, deductibles will apply only to benefits paid for treatment received Out-of-Plan.

1. Deductible for Treatment of Sicknesses

a. If an Eligible Individual goes Out-of-Plan for an inpatient confinement for treatment of a Non-Occupational Sickness and such individual incurs Covered Expenses as a result of charges made by such institution for such confinement, the Deductible for Treatment of Sickness in the amount specified on the Plan 1 Schedule of Benefits will be applied to such Covered Expenses per occurrence of such inpatient care before the Plan will pay its applicable co-payment percentage of such Covered Expenses. For the purpose of this provision, "per occurrence" means that the Deductible for Treatment of Sickness applies to Covered Expenses incurred by an Eligible Individual for each inpatient confinement resulting from each different sickness during a Calendar Year.

b. If the Deductible for Treatment of Sickness is applied to an individual's Covered Medical Expenses, such deductible shall be in addition to any other applicable deductible.

2. Deductible for Treatment of Injuries

a. If an Eligible Individual goes Out-of-Plan for an inpatient confinement for treatment of a Non-Occupational Injury and such individual incurs Covered Expenses as a result of charges made by such institution for such confinement, the Deductible for Treatment of Injuries in the amount specified on the Schedule of Benefits will be applied to such Covered Expenses per occurrence of such inpatient care before the Plan will pay its applicable co-payment percentage of such Covered Expenses. For the purposes of this provision, "per occurrence" means that the Deductible for Treatment of Injuries applies to Covered Expenses incurred by an Eligible Individual for each period of inpatient care provided as a result of all injuries sustained in one accident during a Calendar Year.

b. If the Deductible for Treatment of Injuries is applied to an individual's Covered Medical Expenses, such deductible shall be in addition to any other applicable deductible.

3. Emergency Care Deductible

a. If an Eligible Individual receives treatment in a Hospital emergency room or Emergency Treatment Center and does not contact UHS either before the treatment is received, or in cases of Emergency, as soon as medically possible but not later than forty-eight hours if the Eligible Individual is hospitalized, the Emergency Care Deductible in the amount specified on the Plan 1 Schedule of Benefits shall apply to the Covered Expenses incurred for each visit to a Hospital emergency room or Emergency Treatment Center before the Plan will pay its applicable co-payment percentage for such Covered Expenses.

b. The Emergency Care Deductible shall be waived if the condition for which the individual seeks the treatment meets the Plan's definition of an Emergency.

c. If the Emergency Care Deductible is applied to an individual's Covered Medical Expenses, such deductible shall be in addition to any other applicable deductible.

4. Hospital Review Noncompliance Deductible

a. If the Hospital Review Program procedures are not followed with respect to an Eligible Individual's inpatient Hospital admission, the amount of the Hospital Review Noncompliance Deductible specified on the Plan 1

Schedule of Benefits shall be deducted from the Covered Medical Expenses incurred by such individual before the Plan will pay its applicable co-payment percentage of the individual's remaining Covered Medical Expenses incurred as a result of each such inpatient Hospital admission.

b. If the Hospital Review Program Noncompliance Deductible is applied to Covered Medical Expenses incurred as a result of an inpatient Hospital confinement, such deductible shall be in addition to any other applicable deductible, and will not be applied to satisfy such other applicable deductible.

B. Deductibles under the Plan 2 Schedule of Benefits

The following deductibles apply to the Plan 2 Schedule of Benefits.

1. Emergency Care Deductible

a. If an Eligible Individual receives treatment in a Hospital emergency room or Emergency Treatment Center, the Emergency Care Deductible specified on the Plan 2 Schedule of Benefits shall apply to the Covered Expenses incurred for each visit to a Hospital emergency room or Emergency Treatment Center.

b. The Emergency Care Deductible shall be waived if the Eligible Individual is admitted to a Hospital as an inpatient, or if the condition for which treatment was sought meets the Plan's definition of an Emergency.

c. If the Emergency Care Deductible is applied to an individual's Covered Medical Expenses, such deductible shall be in addition to any other applicable deductible.

d. Payments made by or on behalf of an Eligible Individual to satisfy any Emergency Treatment Deductible shall not apply toward the satisfaction of any applicable Maximum Out-of-Pocket Amount.

2. Hospital Review Noncompliance Deductible

a. If the Hospital Review Program procedures are not followed with respect to an Eligible Individual's inpatient Hospital admission, the amount of the Hospital Review Noncompliance Deductible specified on the Plan 2 Schedule of Benefits shall be deducted from the total Covered Medical Expenses incurred by such individual before the Plan will pay its applicable co-payment percentage of the individual's remaining Covered Medical Expenses incurred as a result of each such inpatient Hospital admission.

b. If the Hospital Review Program Noncompliance Deductible is applied to Covered Medical Expenses incurred as a result of an inpatient Hospital

confinement, such deductible shall be in addition to any other applicable deductible, and will not be applied to satisfy such other applicable deductible.

c. Payments made by or on behalf of an Eligible Individual to satisfy any Hospital Review Program Noncompliance Deductible shall not apply toward the satisfaction of any applicable Maximum Out-of-Pocket Amount.

3. Calendar Year Deductibles

a. Satisfaction of the Individual Calendar Year Deductible

The Individual Calendar Year Deductible is the amount of Covered Medical Expenses which is deducted from an Eligible Individual's total Covered Medical Expenses incurred during a Calendar Year before the Plan will pay its applicable co-payment percentage of the individual's remaining Covered Medical Expenses. When the amount of such Covered Medical Expenses aggregates the Individual Calendar Year Deductible, the individual will be considered to have satisfied his Individual Calendar Year Deductible for that Calendar Year.

b. Satisfaction of the Family Calendar Year Deductible

Once two Eligible Family Members in one family incur Covered Medical Expenses which are applied toward their Individual Calendar Year Deductibles and which aggregate the Family Calendar Year Deductible, no further Individual Calendar Year Deductibles shall be required of any Eligible Family Member in that family for Covered Medical Expenses incurred during that Calendar Year.

c. Provisions Governing Calendar Year Deductibles

(1) The amounts of the Individual and Family Calendar Year Deductibles are specified on the Plan 2 Schedule of Benefits.

(2) Calendar Year Deductibles are based on an accumulation period of a Calendar Year.

(3) Only Covered Expenses actually incurred during a Calendar Year may be used to satisfy the Individual Calendar Year Deductible of the Family Calendar Year Deductible.

(4) If an Eligible Individual suffers from a condition for which Covered Medical Expenses are incurred in two or more Calendar Years, his Individual Calendar Year Deductible must be satisfied each Calendar Year, except as specified in No. (5) below.

(5) If any part of an Eligible Individual's Individual Calendar Year De-

ductible is satisfied during October, November or December of a Calendar Year, that individual's Individual Calendar Year Deductible for the following Calendar Year will be reduced by the amount so applied.

10.3 MAXIMUM OUT-OF-POCKET AMOUNT UNDER PLAN 2 SCHEDULE OF BENEFITS

Maximum Out-of-Pocket Amounts apply only to the Plan 2 Schedule of Benefits.

A. Provisions Governing Maximum Out-of-Pocket Amounts

1. The amounts of the individual Maximum Out-of-Pocket Amount and the family Out-of-Pocket Amount are specified on the Plan 2 Schedule of Benefits.

2. Once the out-of-pocket payments made by or on behalf of an Eligible Individual for his co-payment share of Covered Medical Expenses equals the amount of the individual Maximum Out-of-Pocket Amount, the individual will be considered to have met his individual Maximum Out-of-Pocket Amount for that Calendar Year.

3. Once out-of-pocket payments made by or on behalf of two or more Eligible Family Members in the same family for their co-payment share of Covered Medical Expenses equals the family Maximum Out-of-Pocket Amount, all members of that family will be considered to have met their family Maximum Out-of-Pocket Amount for that Calendar Year.

4. After the individual Maximum Out-of-Pocket Amount or the family Maximum Out-of-Pocket Amount has been reached, the Plan will pay, subject to all maximum benefits and limitations and other Plan provisions, 100% of most Covered Medical Expenses incurred by that individual or that family during the remainder of that Calendar Year.

B. Expenses that Do Not Apply to Maximum Out-of-Pocket Amounts

In no event shall any individual or family Maximum Out-of-Pocket Amounts include any of the following:

1. Amounts paid out-of-pocket to satisfy any Hospital Review Program Noncompliance Deductibles.

2. Amounts paid out-of-pocket to satisfy any Emergency Care Deductible.

3. Any expenses not considered Covered Expenses.

4. Charges in excess of any maximum allowable expense, specified on the applicable Schedule of Benefits.

5. Amounts paid out-of-pocket by an individual for a particular type of treatment or cause after the individual has received Plan benefits for that type of treatment or cause totaling any applicable maximum benefit or limitation.

10.4 COVERED EXPENSES UNDER PLANS 1, 3 AND 4

Covered Expenses are the actual Reasonable and Customary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services, supplies and types of treatment which are Medically Necessary and required for care and treatment of the individual as a result of a Non-Occupational Injury or Non-Occupational Sickness for which benefits are payable by the Plan as specified on the applicable Schedule of Benefits, but only in accordance with all other applicable provisions, limitations and exclusions specified in this Plan Document, and subject to any applicable maximum benefits and limitations.

A. In-Plan Covered Expenses Arranged by UHS

The following Covered Expenses are paid under the Medical Expense Benefit only when they are arranged by UHS:

1. Room and board charges incurred in a Hospital, Skilled Nursing Facility or a Treatment Facility for Chemical Dependency up to the semi-private room rate.

2. The following services and supplies provided on an inpatient or on an outpatient basis by or at a Hospital, a Skilled Nursing Facility, a Treatment Facility for Chemical Dependency, or an Emergency Treatment Center:

   a. Operating room, fracture room service, and other rooms for surgical services.

   b. Anesthetic supplies and administration of anesthetics, including services of a Physician or a Certified Registered Nurse Anesthetist (C.R.N.A.).

   c. Oxygen and oxygen administration.

   d. Diagnostic x-rays, clinical laboratory and pathological laboratory examinations, including services of a Physician or pathologist for the interpretation and supervision of such x-rays and laboratory examinations.

   e. X-rays and radioisotope treatments and examinations.

   f. Electrocardiograms, electroencephalograms and basal metabolism determination.

   g. General nursing care provided by Hospital staff on an inpatient basis.

   h. Bandages, dressings, casts, splints, braces, trusses, crutches, medicines and drugs.

   i. Blood, blood plasma and other blood derivatives (except the first three pints during each Hospital confinement).

   j. Physical therapy provided on an inpatient basis.

   k. Radiation therapy for proven cases of cancer or for a patient who has a specific thyroid or heart condition.

3. Medically Necessary local professional ambulance service to transport an individual to the nearest Hospital qualified to provided the necessary treatment.

4. Physical medicine (physical therapy, occupational therapy, restorative therapy and cardiac rehabilitation therapy) following trauma, stroke, heart attack or surgery, provided that the Fund Office approves the treatment plan submitted by the attending UHS Physician, and further provided that such Fund Office approval is provided monthly based on monthly progress reports documenting improvement.

5. Chiropractic treatment that has been arranged by a UHS Physician.

6. Services and supplies provided in a Hospital outpatient or emergency department or in an Emergency Treatment Center as a result of Emergency care or treatment of a condition that meets the Plan's definition of an Emergency.

7. Services and supplies provided for and in connection with an outpatient surgery performed by a UHS Physician in a Hospital outpatient department or in an approved Surgical Center when the Eligible Individual has surgery that does not require an overnight Hospital stay.

8. The following services and supplies provided to an Eligible Individual by a Home Health Agency, provided the attending UHS Physician makes the arrangements for such services and supplies:

   a. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

   b. Part-time or intermittent home health aide services.

   c. Medical supplies (other than drugs and biologicals) and the use of medical appliances.

   d. Equipment, services and supplies which are provided on an outpatient basis at a Hospital or Skilled Nursing Facility under arrangements made by the Home Health Agency, excluding transportation.

   e. Non-self-administered injectable drugs and portable oxygen supply units. Benefits paid for Covered Expenses incurred for these items shall not apply to an Eligible Individual's Calendar Year Maximum Benefit for home health care.

9. Rental, up to the purchase price, of Hospital-type equipment, including Hospital beds, oxygen equipment, wheelchairs or similar therapeutic equipment or, with prior Fund Office approval, purchase of such equipment if the total rental fee would be more than the purchase price.

10. Prosthetic devices such as artificial eyes and limbs ordered by a UHS Physician to replace natural eyes and limbs. Only the initial purchase charge of such items shall be a Covered Expense, except that one replacement device will be covered if UHS determines the replacement to be Medically Necessary and provides the referral to obtain such replacement.

11. Services and supplies rendered by a psychiatrist.

12. Services and supplies rendered in connection with the following types of elective surgery:

    a. Cosmetic surgery for the correction of defects caused by a disease, Non-Occupational Injury or birth defect.

    b. The correction of congenital defects.

    c. Corrective surgical procedures on organs of the body which perform or function improperly.

    d. Vasectomies, tubal ligations, and other sterilization procedures for Employees and Dependent spouses.

    e. Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

    f. Medically Necessary therapeutic abortions for female Eligible Employees and female Eligible Dependent spouses.

    g. Reconstructive surgery performed primarily to restore or improve bodily functions or to correct damage caused by disease, injury or birth defects.

13. Intravenously administered food and food supplements prescribed by a UHS Physician, provided such food or food supplements are the only form of nourishment that can be given to the patient.

14. Services and supplies for speech therapy due to a congenital defect, provided such therapy is arranged by a UHS Physician.

15. Services and supplies provided during an approved confinement in a facility which meets the definition of a Skilled Nursing Facility when full-time skilled nursing care is Medically Necessary following a Hospital confinement and meets all of the following criteria:

    a. The attending UHS Physician must certify that such confinement and nursing care is essential for recuperation from an injury or sickness; and

    b. The attending UHS Physician makes the arrangements for the Skilled Nursing Facility care.

16. Hearing aids, eye examinations, eye refractions, eyeglasses, contact lenses, dental prosthetic appliances, or any charges made for the fitting of these appliances, when required as a result of a Non-Occupational Injury.

17. Services and supplies provided under a Hospice Care Program in accordance with the provisions of Section 10.9.

18. Chemotherapy for cancer, including prescription oral chemotherapy drugs and related supportive drugs, that are prescribed by a UHS Physician or prescribed as part of a course of treatment arranged by a UHS Physician

and administered under the supervision of a home health care nurse.

19. Cornea and bone marrow transplants.

B. Out-of-Plan Covered Expenses

Out-of-Plan Covered Expenses are Covered Expenses incurred for inpatient services in a Hospital or Skilled Nursing Facility, and Hospital emergency room or Emergency Treatment Center charges for outpatient treatment of a condition that does meet this Plan's definition of an Emergency, including:

1. Room and Board charges incurred in a Hospital, Skilled Nursing Facility or a Treatment Facility for Chemical Dependency up to the semi-private room rate.

2. The following services and supplies provided on an inpatient or on an outpatient basis by or at a Hospital, a Skilled Nursing Facility, a Treatment Facility for Chemical Dependency, or an Emergency Treatment Center:

   a. Operating room, fracture room service, and other rooms for surgical services.

   b. Anesthetic supplies and administration of anesthetics, including services of a Physician or a Certified Registered Nurse Anesthetist (C.R.N.A.).

   c. Oxygen and oxygen administration.

   d. Diagnostic x-rays, clinical laboratory and pathological laboratory examinations, including services of a Physician or pathologist for the interpretation and supervision of such x-rays and laboratory examinations.

   e. X-rays and radioisotope treatments and examinations.

   f. Electrocardiograms, electroencephalograms and basal metabolism determination.

   g. General nursing care provided by Hospital staff on an inpatient basis.

   h. Bandages, dressings, casts, splints, braces, trusses, crutches, medicines and drugs.

   i. Blood, blood plasma and other blood derivatives (except the first three pints during each Hospital confinement).

   j. Physical therapy provided on an inpatient basis.

   k. Radiation therapy for proven cases of cancer or for a patient who has a specific thyroid or heart condition.

3. Inpatient treatment of Chemical Dependency, in a Hospital or Treatment Facility for Chemical Dependency must be upon the recommendation of a Physician, unless it is an Emergency.

4. Inpatient treatment of Mental and Nervous Disorders.

5. Services and supplies provided in a Hospital emergency room or Emergency Treatment

Center for treatment of a condition that meets the Plan's definition of an Emergency.

6. Services and supplies provided during an approved confinement in a facility which meets the definition of a Skilled Nursing Facility when full-time skilled nursing care is Medically Necessary following a Hospital confinement and meets all of the following criteria:

   a. The attending Physician must certify that such confinement and nursing care is essential for recuperation from an injury or sickness; and

   b. The attending Physician makes the arrangements for the Skilled Nursing Facility care.

10.5 COVERED EXPENSES UNDER PLAN 2

Covered Expenses are the actual Reasonable and Customary Charges incurred by an Eligible Individual upon the recommendation and approval of the attending Physician for services and supplies which are Medically Necessary and required for care and treatment of the individual as a result of a Non-Occupational Injury or Non-Occupational Sickness for which benefits are payable by the Plan as specified on the applicable Schedule of Benefits, but only in accordance with all other applicable provisions, limitations and exclusions specified in this Plan Document, and subject to any applicable maximum benefits and limitations. Such Covered Expenses include:

A. Daily room and board charges incurred in a Hospital, Skilled Nursing Facility, or Treatment Facility for Chemical Dependency up to the semi-private room rate.

B. Services and supplies provided on an inpatient or outpatient basis by a Hospital, a Skilled Nursing Facility, a Treatment Facility for Chemical Dependency, a Surgical Center or an Emergency Treatment Center, including, but not limited to:

   1. Operating room, fracture room service, and other rooms for surgical services.

   2. Anesthetic supplies and administration of anesthetics, including services of a Physician or a Certified Registered Nurse Anesthetist (C.R.N.A.).

   3. Oxygen and oxygen administration.

   4. Diagnostic x-ray, clinical laboratory and pathological laboratory examinations, including Physician's services for interpretation of such x-ray, laboratory and pathology tests or examinations.

   5. X-ray and radioisotope treatments and examinations.

   6. Electrocardiograms, electroencephalograms and basal metabolism determination.

   7. General nursing care provided by Hospital staff on an inpatient basis.

   8. Bandages, dressings, casts, splints, braces, trusses, crutches, drugs and medicines.

   9. Blood, blood plasma and blood derivatives (except the first three pints of during a period of disability).

10. Radiation therapy for proven cases of cancer or for a patient who has a specific condition of hyperthyroidism, chronic angina pectoris or chronic cardiac decompensation.

C. Medically Necessary local professional ambulance service provided to transport an individual to the nearest Hospital qualified to provided the necessary treatment.

D. Services and supplies for physical therapy, restorative therapy and cardiac rehabilitation therapy following trauma, stroke, heart attack or surgery, provided that the Fund Office approves the treatment plan submitted by the attending Physician, and further provided that such Fund Office approval is provided monthly based on monthly progress reports documenting improvement.

E. Services and supplies for providing speech therapy due to a congenital defect.

F. Services and supplies provided in a Hospital outpatient or emergency department or in an Emergency Treatment Center for care or treatment of a condition that meets the Plan's definition of an Emergency as defined in Article I, DEFINITIONS.

G. Physicians' services as follows:

1. Non-surgical non-Emergency care provided during an inpatient confinement in a Hospital, Skilled Nursing Facility or a Treatment Facility for Chemical Dependency on any day for which Plan benefits are payable for room and board charges, or provided in a clinic, a doctor's office, or in the patient's home.

2. Non-surgical Emergency care provided in a Hospital outpatient or emergency department, in an Emergency Treatment Center, in a clinic, in a doctor's office, or in the patient's home.

3. Surgical services and supplies provided for and in connection with surgery performed on an outpatient basis in a hospital outpatient department or in an approved Surgical Center. (The maximum payable for an assistant surgeon will be 20% of the Covered Expense incurred for the primary surgeon's fee.)

H. Necessary pre-admission tests (x-ray examinations and/or laboratory tests) made prior to a Hospital inpatient confinement subject to the following requirements:

1. The test must be ordered by the attending Physician or surgeon.

2. The tests must be performed on an outpatient basis.

3. The tests must be performed prior to, and in connection with, the condition requiring the Hospital confinement.

4. The inpatient Hospital confinement for which the tests are performed must begin within seven days after the tests are performed.

5. The tests must be medically valid at the time of the Hospital admission.

6. No payments shall be made for charges incurred for diagnoses, research, case findings or surveys.

7. No payments shall be made if the individual refuses to undergo, cancels or postpone a surgical procedure or cancels or postpones the confinement unless the cancellation or postponement is due to one of the following:

   a. The development of a medical condition which delays a surgical procedure.

   b. The unavailability of a Hospital bed.

   c. A condition being revealed which requires treatment prior to confinement or which makes a surgical procedure or the confinement medically inadvisable.

   d. Other circumstances beyond the control of the individual.

I. Services and supplies rendered in connection with the following types of elective surgery:

   1. Cosmetic surgery for correction of defects caused by an accident.

   2. The correction of congenital defects.

   3. Corrective surgical procedures on organs of the body which perform or function improperly.

   4. Vasectomies, tubal ligations and other sterilization procedures for Eligible Employees and Eligible Dependent spouses.

   5. Reconstructive breast surgery following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

   6. Medically Necessary therapeutic abortions for female Eligible Employees and female Eligible Dependent spouses.

   7. Reconstructive surgery performed primarily to restore or improve bodily functions or to correct damage caused by disease, injury or birth defects.

J. Inpatient treatment of Mental or Nervous Disorders.

K. Outpatient treatment of Mental or Nervous Disorders, provided such treatment is provided or rendered by a Physician.

L. Inpatient treatment of Chemical Dependency, provided the course of treatment is received in an accredited Hospital or in a Treatment Facility for Chemical Dependency.

M. Artificial eyes and limbs to replace natural eyes and limbs, provided that only the initial purchase charge of such items shall be a Covered Expense.

N. Second surgical opinions on proposed surgery, when obtained from a UHS Physician. The UHS Physician's fee and any related x-ray, laboratory, and diagnostic services and supplies required in obtaining the second opinion will be provided by the Plan at no cost to the individual.

O. Oxygen and rental of oxygen equipment.

P. Rental, up to the purchase price, of hospital-type equipment, such as a hospital bed, wheel-

chair, iron lung, or similar therapeutic equipment.

Q. Services and supplies provided during an approved confinement in a facility which meets the definition of a Skilled Nursing Facility. An approved confinement is one which meets all of the following criteria:

1. The attending Physician must certify that such confinement and nursing care is essential for recuperation from an injury or sickness,

2. The confinement must be preceded by at least three consecutive days of a Hospital confinement for which Plan benefits are payable,

3. The confinement must be due to the injury or sickness which required the previous Hospital Confinement,

4. The confinement must commence within three days after termination of a Hospital confinement or within three days after termination of a Skilled Nursing Facility confinement for which Plan benefits are payable.

R. The following services and supplies provided to an Eligible Individual during a course of home health care provided by a Home Health Agency and provided the Fund Office has precertified such services and supplies:

1. Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

2. Part-time or intermittent home health aide services.

3. Medical supplies (other than drugs and biologicals) and the use of medical appliances.

4. Medical services of interns and residents in training.

5. Services and supplies, excluding transportation, which are provided on an outpatient basis at a Hospital or Skilled Nursing Facility under arrangements made by the Home Health Agency.

6. Non-self-administered injectable drugs and portable oxygen supply units.

Benefits paid for Covered Expenses incurred for these items shall not apply to an Eligible Individual's Calendar Year Maximum Benefit for home health care.

10.6 ADDITIONAL DAYS OF CERTAIN TYPES OF SPECIAL CARE

A. Authorization for Additional Days of Skilled Nursing Facility Care

1. If an Eligible Individual has received Plan benefits during a Calendar Year for the maximum allowable number of days of Skilled Nursing Facility care specified on the applicable Schedule of Benefits and continues to require such care, the Trustees may, on a case by case basis and upon the recommendation of the UHS Medical Coordinator or the Review Organization, as applicable, authorize additional days of Skilled Nursing Facility Care during that Calendar Year if, in the absence of such additional Skilled

Nursing Facility care, the individual would require Hospital confinement for the care of the condition requiring the Skilled Nursing Facility care and if the cost to the Fund for such Hospital confinement would be more than the cost of additional authorized days of Skilled Nursing Facility care.

2. In no event, however, will benefits be paid for Skilled Nursing Facility care after an Eligible Individual has received Plan benefits not to exceed 30 days per calendar year, unless authorized by UHS.

B. Authorization for Additional Home Health Nursing Care Benefits

1. If an Eligible Individual has received Plan benefits during a Calendar Year totaling the Calendar Year maximum amount payable for home health nursing care specified on the applicable Schedule of Benefits and continues to require such care, the Trustees may, on a case by case basis and upon the recommendation of the Medical Coordinator or the Review Organization, as applicable, authorize additional home health nursing care during that Calendar Year if, in the absence of such additional home health nursing care the individual would require Hospital confinement for care or treatment of the condition requiring home health nursing care, and if the cost to the Fund for such alternative care would be more than the cost of additional authorized home health nursing care.

2. In no event, however, will benefits be paid for home health nursing care after an Eligible Individual has received Plan benefits totaling the applicable $10,000 maximum per calendar year, unless authorized by UHS.

10.7 HOSPICE CARE

The following provisions apply to the Plan 1, 3 and 4 Schedule of Benefits and the Plan 3 Schedule of Benefits only.

A. Payment of Hospice Benefits

1. The Hospital Care Program is a special program of care provided for Eligible Individuals with Terminal medical conditions.

2. Each Eligible Individual is entitled to the Hospice Care Lifetime Maximum Benefit specified on the applicable Schedule of Benefits. Once an Eligible Individual has received benefits totaling this Lifetime Maximum Benefit, no further Hospice care benefits will be payable. Expenses incurred for any further treatment of the individual's Terminal condition shall be payable under Comprehensive Medical Expense Benefit, subject to all applicable provisions and limitations.

3. Hospice care benefits are payable only under the Comprehensive Medical Expense Benefit.

4. Hospice care benefits are automatically assigned to the Hospice. The Hospice sends its bill to the Fund Office and is paid directly by the Fund Office. The Eligible Employee shall be responsible for incurred charges not paid by the Plan.

B. Special Definitions Applicable to Hospice Care

1. Hospice

A public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of specified services at home or in outpatient or institutional settings for individuals suffering from conditions that have a Terminal prognosis. The agency or organization must meet all of the following criteria in order to be considered an approved Hospice for the purposes of this Plan:

a. It must be eligible to participate in Medicare.

b. It must be duly licensed by the appropriate state agencies of the state in which it operates.

c. It must have an interdisciplinary group of personnel that includes the services of at least one Physician and one R.N.

d. It must maintain central clinical records on all patients.

e. It must meet the standards of the National Hospice Organization.

f. It must provide, either directly or under arrangements, the "core services" listed as Hospice Care Program Covered Expenses in Paragraph D below.

2. Terminal

An Eligible Individual's medical prognosis indicates a life expectancy of six months or less.

3. Palliative Care

Care which is provided to a Terminally ill individual for the purpose of relieving or alleviating symptoms without curing.

4. Respite Care

Short-term inpatient care provided to a Terminally ill person only when necessary to relieve family members caring for him.

5. Periods of Crisis

A period during which a Terminally ill person requires continuous care which is primarily provided by a licensed nurse. This care must be necessary to achieve palliation or management of acute medical services.

C. Eligibility for the Hospice Care Program

The attending UHS Physician must arrange the Hospice care.

D. Hospice Care Program Covered Expenses

Hospice Care Program Covered Expenses include certain types of services and supplies that are not normally considered Covered Expenses, but shall only include the following services

and supplies provided for Hospice care of an Eligible Individual's Terminal condition:

1. Nursing care by an R.N. or an L.P.N. and services of homemakers and home health aides (such services may be furnished on a 24-hour basis during a Period of Crisis or if the care is necessary to maintain the individual at home).
2. Medical social services under the direction of a Physician.
3. Counseling services and/or psychological therapy by a social worker or a psychologist.
4. Physical therapy.
5. Non-prescription drugs used for Palliative Care.
6. Medical supplies, bandages and equipment, and drugs and biologicals used for pain and symptom control.
7. Skilled Nursing Facility short-term inpatient care to provide respite care, palliative care, or care in periods of crisis, limited to five days per confinement and to ten days lifetime.
8. Skilled Nursing Facility inpatient care for longer terms if the necessary level of care is not available at home.

E. Terms and Conditions

The terms, conditions and limitations of the overall Plan of Benefits also apply to charges incurred and benefits paid under the Hospice Care Program, except where the provisions of the Hospice Care Program specifically state otherwise. The Coordination of Benefits provisions of the Plan shall also apply, both to other plans and to Medicare.

10.8 EXTENSION OF BENEFITS

If an Eligible Individual is Totally Disabled due to a Non-Occupational Injury at the time his coverage terminates, his benefits under this Plan will be continued according to the following provisions:

A. Benefits will be payable only for Covered Expenses incurred in connection with treatment of the injury or sickness that caused the Total Disability.

B. Benefits will be payable only to the extent that benefits would have been payable if the Eligible Individual's coverage had not terminated.

C. A Physician who is a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) must certify the Total Disability.

D. The extension of benefits will terminate on the first to occur of the following events:

   1. The date the individual ceases to be Totally Disabled.
   2. The last day of the three-month period of the individual's extension of benefits.

10.9 MEDICAL EXPENSE BENEFIT EXCLUSIONS AND LIMITATIONS

Covered Expenses shall not include, and no Plan benefits shall be payable or provided for, charges

incurred for any treatments care, services or supplies which are in excess of any specified limitation in, or which are specified as not payable in, Article III, GENERAL EXCLUSIONS AND LIMITATIONS, or which are in excess of any maximum benefits or limitations specified on any applicable Schedule of Benefits.

ARTICLE 11- SERVICES PROVIDED BY UNION HEALTH SERVICE (UHS)

This Article 11 provides a summary of the services and supplies provided by UHS to Eligible Individuals Covered Under the Plans 1, 3, and 4 Schedules of Benefits. The UHS Certificate of Coverage, available upon request by Eligible Individuals, provides a full description of services and supplies provided by UHS, and a full description of exclusions and limitations. If there is any discrepancy between this Article and the UHS Certificate of Coverage, the Certificate of Coverage will govern.

11.1 MEDICAL SERVICES PROVIDED AT OR THROUGH UHS

Unless otherwise specified, the following types of Covered Expenses are provided at no charge to an Eligible Individual:

A. UHS-ordered transportation for authorized transfers from a Hospital to the patient's home, or from the patient's home to a clinic.

B. Anesthesiology provided at UHS.

C. Audiometry (hearing screening) when provided at UHS or arranged by UHS.

D. Chemical dependency or mental or nervous disorder treatments that are arranged by UHS.

E. Chemotherapy provided at UHS.

F. Colon cancer screening provided or arrangeded by UHS.

G. Diabetes self-management training and education provided at UHS.

H. Physician consultations when arranged by UHS.

I. Drugs, excluding prescription drugs, administered to an Eligible Individual, including immunizations, booster shots and flu shots when administered at UHS.

J. Family planning services, excluding treatment of or services for infertility, provided at UHS.

K. Hemodialysis outpatient services arranged by UHS.

L. Laboratory tests provided at UHS or as an outpatient at another facility when arranged by UHS.

M. Maternity and obstetrical care.

N. Newborn care provided at UHS.

O. Ophthalmology provided at UHS.

P. Pathology provided at UHS.

Q. Podiatry provided at UHS.

R. Preadmission testing provided at UHS.

S. Preventive health care and examinations provided at UHS.

T. Physician and facility fees for outpatient radiation therapy arranged by UHS.

U. Radiology tests performed at UHS or performed on an outpatient basis when arranged by UHS.

V. Speech evaluation and recommendations (up to three outpatient visits for initial), when arranged by UHS.

W. Physician's fees for surgical services, on an inpatient or outpatient basis, performed at UHS or arranged by UHS, including Medically Necessary assistant surgeon's fees.

11.2 EYE CARE SERVICES PROVIDED BY UHS

The following eye care services are provided to all Eligible Individuals, including Plan 2 Eligible Individuals, from the Polk Street UHS Center only:

A. Eye examinations.

B. Prescriptions for eyeglasses and contact lenses.

C. Treatment of eye disease.

D. Eye surgery provided by eye specialists.

ARTICLE 12- DENTAL BENEFITS

The Fund has contracted with a professional dental insurance company to provide dental benefits to Eligible Employees and their Eligible Dependents. The Eligible Individual must enroll in the dental plan and choose a participating dental center. If the Eligible Individual chooses to change participating dental centers, he must re-enroll in the dental plan.

Dental plan benefits are described in a separate booklet.

ARTICLE 13- UNION PHARMACY SERVICES

Union Pharmacy Services are provided by the Fund through an arrangement with UHS.

13.1 PAYMENT OF BENEFITS

A. When an Eligible Individual purchases a drug on the UPS formulary from a participating pharmacy, the Eligible Individual will be responsible for paying the co-pay specified on the applicable Schedule of Benefits for each prescription drug or refill directly to the participating pharmacy. No claim forms will need to be completed.

B. If an Eligible Individual purchases a short-term supply of an emergency medication from a non-participating pharmacy, he should file a claim with UPS. If the medication is on the UPS formulary, he may be reimbursed for all or part of the cost of the medication.

C. No Plan benefits will be payable for drugs that are not on the UPS formulary.

13.2 UPS FORMULARY

The UPS formulary is a list of covered medications developed by UHS. Plan benefits are payable only for prescription drugs and medications that are on the UPS formulary. The list of drugs and medications on the UPS formulary may change from time to time and at any time.

ARTICLE 14- PRIVACY POLICY

14.1 ROLE OF THE TRUSTEES

The Board of Trustees serves as both the Plan Sponsor and the Plan Administrator. As Plan Sponsor, the Board exercises functions of the settlor of the Trust. As Plan Administrator, the Board supervises the administration of the Trust and all facets of the operation of the Plan, including the Plan's compliance with applicable laws and regulations. In this Article, unless otherwise specified, all references to the Trustees shall be deemed a reference to the Trustees in their capacity as Plan Administrator.

14.2 PRIVACY RULE

The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the Administrative Simplification subtitle of 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 Rule"). The term "Protected Health Information" shall have the meaning set forth in the Privacy Rule.

14.3 PRIVACY POLICY

The Trustees shall adopt a Privacy Policy statement which shall be consistent with the Privacy Rule and shall set forth procedures to accomplish the following functions:

A. Designate a Privacy Officer for the Fund.

B. Designate a Security Officer for the Fund.

C. Specify the purposes for which PHI will be collected, used and disclosed.

D. Establish a procedure for permitting participants and beneficiaries to authorize the disclosure of PHI.

E. Specify the rights of participants and beneficiaries to have access to their PHI and an accounting of the disclosures of their PHI, and the conditions that participants and beneficiaries are permitted to impose on the use and disclosure of their PHI.

F. Establish a procedure for recognizing personal representatives of participants and beneficiaries.

G. Provide that Fund employees or representatives who fail to act in accordance with the Privacy Rule shall be subject to appropriate discipline.

14.4 PROHIBITION ON UNAUTHORIZED USE OR DISCLOSURE OF PHI

The Trustees and their employees and agents will not use or disclose any PHI created or received by the Plan, except as permitted in this Article or as required by law.

14.5 TRUSTEES' CERTIFICATION

By adopting this Article, the Trustees certify, in accordance with Section 164.504(f)(2)(ii) of the Privacy Rule, that the Plan has been amended to conform to the Privacy Rule. In furtherance of that conformity, the following principles shall be observed:

A. The Trustees' and the Plan's use and disclosure of PHI shall be in accordance with the Privacy Rule, the Plan and the Trustees' Privacy Policy Statement.

B. Any agents, contractors or subcontractors of the Fund or the Trustees who receive PHI from the Plan shall agree to the same restrictions and conditions that apply to the Trustees' and the Plan's use of PHI. If those agents, contractors or subcontractors are "Business Associates" as defined in the Privacy Rule, their agreement shall be in a written document that satisfies the requirements of Section 164.504(e) of the Privacy Rule.

C. The Trustees and their agents shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit plan.

D. The Trustees shall report to the Plan's Privacy Official any use or disclosure of PHI that is inconsistent with the Privacy Rule, the Plan or the Trustees' Privacy Policy Statement.

E. The Trustees shall ensure that the right of participants and beneficiaries to access their PHI, as set forth in the Trustees' Privacy Policy Statement, shall be consistent with the requirements of Section 164.524 of the Privacy Rule.

F. The Trustees shall ensure that the right of participants and beneficiaries to amend their PHI, as set forth in the Trustees' Privacy Policy Statement, shall be consistent with the requirements of Section 164.526 of the Privacy Rule.

G. The Trustees shall ensure that the right of participants and beneficiaries to an accounting of disclosures of their PHI, as set forth in the Trustees' Privacy Policy Statement, shall be consistent with the requirements of Section 164.528 of the Privacy Rule.

H. The Trustees will make the Plan's and the Trustees' internal practices, books and records relating to the use and disclosure of PHI available to the Department of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA.

I. When PHI is no longer needed for the purpose for which disclosure was made to the Trustees, the Trustees, or any of them, shall, if feasible, return such PHI to the Plan or destroy such PHI.

14.6 SEPARATION OF FUNCTIONS

The Trustees shall responsible for seeing to it that the Plan maintains adequate separation of functions, to satisfy the requirements of Section 164.504(f)(2)(iii) of the Privacy Rule. To that end, the following rules shall apply:

A. The Trustees' Privacy Policy Statement or, in the alternative, a procedural statement that may be adopted by the Trustees or by the Plan's Privacy Official, shall include a description of the

Fund's employees or classes of employees who, in the performance of their jobs, are to be given access to PHI.

B. Fund employees who have access to PHI shall have such access solely in their capacity as Fund employees. If any Fund employee has responsibilities that are unrelated to the administration of the Plan then, in that capacity, the employee shall have no access to PHI.

C. Any Fund employee or representative who fails to act in conformity with the Privacy Rule or the Trustees' Privacy Policy Statement shall be subject to appropriate discipline, in accordance with the Fund's personnel policies. If a Trustee fails to act in conformity with the Privacy Rule or the Trustees' Privacy Policy Statement, the Plan's Privacy Official shall advise the other Trustees, who shall in an appropriate case report such conduct to the entity that has power of appointment over the Trustee.

14.7 SAFEGUARDS

The Trustees will implement administrative, physical and/or technological safeguards that reasonably and appropriately protect the confidentially, integrity, and availability of PHI that is created, received, maintained, or transmitted on behalf of the Plan. The Trustees or their representatives shall also implement reasonable and appropriate safeguards to protect PHI maintained in electronic form ("ePHI"), which safeguards shall address both the physical security of equipment on which ePHI is processed and stored and measures to protect ePHI from unauthorized access.

14.8 MINIMUM NECESSARY REQUESTS

The Trustees will use their best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

THE LOCAL 25 S.E.I.U. WELFARE FUND PLAN OF BENEFITS DESCRIBED AND SET FORTH HEREIN SHALL BECOME EFFECTIVE ON JANUARY 1, 2017.

IN WITNESS WHEREOF, AS THE TRUSTEES OF THE LOCAL 25 S.E.I.U. WELFARE FUND, HAVE EXECUTED THIS DOCUMENT ON 12/14/2016.

Employer Trustees

Union Trustees

12/14/16

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