Regional District Council Welfare Trust

PLAN AND SUMMARY PLAN DESCRIPTION

March 21, 2017

Regional District Council Welfare Trust

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March 21, 2017

Regional District Council Welfare Trust

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A MESSAGE FROM THE BOARD OF TRUSTEES OF THE
REGIONAL DISTRICT COUNCIL WELFARE TRUST

Dear Participant:

We are pleased to present you with the Plan and Summary Plan Description ("Plan") of the Regional District Council Welfare Trust ("Fund"). This booklet provides you with an explanation of how the Fund works its eligibility provisions, the benefits provided and your rights as a Participant. The benefits are effective as of March 21, 2017. We urge you to read this Plan and familiarize yourself with the Fund's rules and benefits provided.

If you have any questions about your health benefits or your rights under the Plan, please call or write the Fund Office. They will be happy to assist you.

Sincerely,
BOARD OF TRUSTEES

To Obtain a Spanish Version: This booklet explains your rights and benefits from the Fund. If you have difficulty understanding any part of this booklet, you may obtain a Spanish version by contacting the Fund Office by mail at 3140 NE Broadway, P.O. Box 4148, Portland, Oregon 97208 or by telephone at (800) 846-0611 between the hours of 9 a.m. and 5 p.m. Eastern Time, Monday through Friday.

Para obtener la versión en español: Este folleto del Fund le explica sus derechos y beneficios. Si usted tiene dificultad para entender cualquier parte de este folleto, puede escribirle a la oficina del Fund al P.O. Box 4148, Portland, Oregon 97208, o llamar de lunes a viernes en horas regulares (9 am a 5 pm EST) al (800) 846-0611 para obtener la versión en español.

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1 INTRODUCTION

This booklet describes the benefits under the Regional District Council Welfare Trust (the "Fund") as of March 21, 2017. It applies to You if You are an eligible Participant or eligible Dependent on or after March 21, 2017, unless a specific effective date is set forth in the text.

Defined terms are capitalized throughout this booklet. These terms have special meaning with respect to the benefits outlined in this booklet and are defined in the Definitions section.

The Trustees have provided this booklet, which is the Plan and Summary Plan Description ("Plan") for the Fund to give You the detailed rules for the Fund. This booklet serves as the official Plan Document and it is referred to as the "Plan" throughout this booklet. Save this booklet. Put it in a safe place. If You lose Your copy, You can ask the Fund Office for another.

Do not rely solely on the Union, Your employer or others for health benefit information. The detailed rules of the Plan can be complex and the Fund is not bound by their statements or interpretations. Only the full Board of Trustees is authorized to interpret the rules and provisions of the Plan. If You have questions about Your personal benefit entitlement, write or contact the Fund Office for more information. You can contact the Fund Office toll free at (800) 846-0611.

GRANDFATHERED PLAN

The Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted.

Being a grandfathered health plan means that the Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply to a grandfathered health plans and which do not, and what might cause a plan to change from grandfathered health plan status, can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

DEFINITIONS

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The following definitions, although not all-inclusive, are used throughout this booklet to help You understand Your benefits.

Calendar Year means January 1 through December 31 of the same year.

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance. Chemical Dependency does not include an addiction to, or dependency on, tobacco, tobacco products or foods.

Child or Children means a Participant's biological child, adopted child (including a child placed with the Participant for adoption), step-child, or eligible foster child.

Co-Payment or Co-Pay means the dollar amount of covered expenses the Covered Person is required to pay under the terms of the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations thereunder, as amended from time to time.

Collective Bargaining Agreement or Agreement means a written agreement between the Union and an employer which requires Contributions to the Fund.

Contributions mean payments made by a Contributing Employer to the Fund.

Contributing Employer or Employer means any person, firm, association, partnership or corporation entering into a Collective Bargaining Agreement or Special Agreement that requires Contributions to the Fund on behalf of its Employees.

Cosmetic Surgery or Treatment means surgery or Treatment that is performed primarily to change appearance or improve self-esteem.

Covered Person means You and/or Your Dependent(s) who are covered by the Plan.

Covered Services means services or supplies for which benefits are payable under the Plan. A Covered Service is considered incurred on the date the service or supply is provided. Covered Services do not include any charge:

(a) For a service or supply that is not Medically Necessary; or

(b) Which exceeds the Usual and Customary Charge for a service or supply.

Custodial Care includes any skilled or non-skilled health services or personal comfort and convenience services that provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:

- walking, transferring or positioning in bed and range of motion exercises;
- self-administered medication;
- meal preparation and feeding, by utensil, tube or gastrostomy; oral hygiene, skin and nail care, toilet use, routine enemas;
- nasal oxygen application, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastrostomy, tracheostomy and casts.

Deductible means the covered expenses incurred by a Covered Person that must be paid during a Calendar Year before benefits are payable under this Plan.

Dependent means any of the following individuals who are not Participants, provided the Fund Office receives the required documentation:

1. A Participant's Spouse (A covered Spouse will cease to qualify as an eligible Dependent under the Plan when the Spouse and Participant are divorced); and
2. A Participant's Child(ren) under the age of 26.

Dependent Contributions means the contribution rate set by the Board of Trustees to be paid by a Contributing Employer to the Fund to obtain Dependent Coverage for a General Foreman under the Plan.

Doctor means a legally qualified physician or surgeon and includes a Doctor of Chiropractic (DC), a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Psychology (Dps/PsyD), a Medical Doctor (MD), a Licensed Certified Midwife (LCMW), and a Doctor of Optometry (OD).

Elective Abortion means any abortion other than one where the mother's life would be endangered if the fetus was carried to term.

Emergency means the sudden and unexpected onset of a health condition with symptoms of sufficient severity to make the prudent lay-person with average knowledge of medicine and health believe that immediate medical care is required. This may include, but is not limited to, a condition that places the person's health in significant jeopardy, a serious impairment to a bodily function, a serious dysfunction of any bodily organ or part, inadequately controlled pain, or, with respect to a pregnant woman having contractions, there is inadequate time to make a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the mother or unborn child.

Employee is an individual employed by an Employer who is covered by a Collective Bargaining Agreement or Special Agreement, and for whom the Employer makes Contributions to the Fund.

ERISA means the Employee Retirement Income Security Act of 1974 and the regulations issued thereunder, as may be amended from time to time.

Experimental, Investigational or Unproven means a Treatment, drug, device, medical procedure, service or supply which:

- Cannot be lawfully marketed without the approval of the US Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
- Is the subject of a current investigational new drug or new device application on file with the FDA; or
- Is being provided pursuant to:
- A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
- A written protocol which describes among its objective; determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives; or
- Is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS):or
- In the predominant opinion among experts:
- As expressed in the published, authoritative literature, is substantially confined to use in research settings; or
- Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
- Is experimental, investigational, unproven or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Centers for Medicare and Medicaid Services (CMS) of HHS; or
- Is provided in connection with a Treatment, procedure, device or drug which is Experimental, Investigational or Unproven; or
- Has not been performed at least ten (10) times and reported in the United States peer review medical literature.

Fund means the Regional District Council Welfare Trust.

Gender - The term "he"/"his" or "she"/"her" as used in this document means he or she, his or hers, whichever is applicable.

General Foreman means an individual who:

- performs work covered by a Collective Bargaining Agreement between an Employer and the Union on a full-time basis;
- supervises the work of other Employees of the Employer covered by the Collective Bargaining Agreement;
- is an Employee for whom the Employer pays all working assessments (to the extent permitted by law) and benefits required by the Collective Bargaining Agreement for every hour under which the Employee is performing work;
- is identified as a General Foreman by the Employer on the Fund's designation form; and
- is accepted as a General Foreman by the Fund.

Hospital means a legally constituted institution which meets all of these tests:

1. it is licensed as an accredited hospital by the proper authority of the state in which it is situated (if hospital licensing is required in the state where it is situated);
2. it is engaged primarily in providing medical care and Treatment of sick and injured persons on an in-patient basis and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and Treatment of such persons by or under the supervision of a staff of legally qualified Physicians; and
3. it continuously provides 24-hour a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery.

When Treatment is needed for a Mental or Nervous Condition or Chemical Dependency, Hospital can also mean a place that meets all of these tests:

1. it is licensed as a mental hospital or chemical treatment facility by the proper authority of the state in which it is located;
2. it has rooms for resident inpatients;
3. it is equipped to treat Mental or Nervous Conditions or Chemical Dependency disorders;
4. it has a resident psychiatrist on duty or on call at all times; and
5. as a regular practice, charges the patient for the Expense of confinement.

The term "Hospital" does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

Illness or Sickness means a bodily disorder, disease, physical or mental infirmity, or functional nervous disorder or condition that requires Treatment by a Doctor. All Illnesses existing simultaneously resulting from the same or related causes shall be considered the same Illness. For a Participant or eligible Dependent Spouse only, Illness also includes pregnancy, childbirth or any maternity-related condition.

Injury or Accident means a sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body, which results neither from criminal activity engaged in by the Participant or eligible Dependent, nor from any employment for wage or profit, and which causes loss commencing while the benefits of the Participant or eligible Dependent are in force.

Medically Necessary or Necessary means that the service, supply, procedure, therapy or Treatment received is required to identify or treat the Illness or Injury that a Doctor has diagnosed or reasonably suspects. The service, supply, procedure, therapy or Treatment must be consistent with the diagnosis and treatment of the patient's condition(s), be in accordance with local standards of accepted medical practice, be required for reasons other than the convenience of the patient or the Doctor, not be regarded as Experimental, Investigational or Unproven, and be performed in the least costly setting required by the patient's condition. The fact that a service, supply, procedure, therapy or Treatment is ordered, recommended, approved or prescribed by a Doctor does not necessarily mean that such service is a Necessary or a Covered Service, even though it is not listed as an exclusion.

Medicare means the benefits program established under Title XVIII of the Social Security Act of 1965 and the regulations thereunder, as amended.

Mental or Nervous Condition means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Participant means any person who has attained and maintained eligibility under the Plan through active employment with a Contributing Employer in an eligible class of Employees.

Physician see definition for "Doctor."

Plan means the benefits described in this booklet and any appendices and amendments adopted by the Trustees that are applicable to a Covered Person.

Plan Administrator means the Board of Trustees for the Fund.

Preferred Provider Organization (PPO) means a network of health care providers who have contracted with the Fund to provide health care while controlling costs.

Premium means the monthly fee set by the Board of Trustees to be paid to the Fund by the Participant or Dependent Child for Dependent Child coverage under the Plan. Dependents of Participants in the category of General Foreman are not responsible for this Premium so long as the monthly Dependent Contributions are made on the Participant's behalf by his Employer.

Protected Health Information means individually identifiable health information that is not subject to specific exclusions.

Room and Board means room, board, general duty nursing, intensive care in an intensive care unit, as defined, and any other services regularly rendered by a Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit.

Schedule of Benefits means the specific benefits, waiting periods, maximums, Deductibles, out-of-pocket expenses, Co-Payments, limitations or allowances applicable to Covered Persons as adopted from time to time by the Board of Trustees.

Special Agreement means a participation agreement or other written agreement which requires an Employer to make Contributions to the Fund on behalf of its Employees.

Spouse means a person to whom a Participant is considered married under applicable state law, including an individual of the same sex if the laws of the state where the marriage took place authorize the marriage of two individuals of the same sex. The term "Spouse" does not include individuals who have entered into a registered domestic partnership, civil union, or other similar formal relationship recognized under state law that is not denominated as a marriage under the laws of that state.

TMJ/Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex muscles, nerves and tissues related to that joint). It includes TMJ or Temporomandibular joint dysfunction, arthritis or arthrosis; other craniomandibular joint disorders; and myofascial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an Injury.

Treatment means a treatment or course of treatment, which is ordered and/or provided by a Doctor to diagnose or treat an Injury or Illness, including:

- confinement and inpatient or outpatient services or procedures; and
- drugs, supplies, equipment, or devices.

The fact that the Covered Person's Doctor approves services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan.

Trustees and/or Board of Trustees means the persons selected under the trust agreement to administer the Plan and the Fund, together with their successors,

Union means the Regional District Council, Local 846 and/or Local 847. The Union may be a Contributing Employer under the Plan with regard to its Employees covered by a Special Agreement.

Urgent Claim means any claim for services for which the Plan requires the Covered Person to obtain pre-authorization before receiving Treatment, if a delay in receiving the requested Treatment could seriously jeopardize the life or health of the Covered Person or his/her ability to regain maximum function, or, in the opinion of a Doctor with knowledge of the Covered Person's medical condition, could subject the Covered Person to severe pain that cannot be managed without the Treatment that is the subject of the claim. This Plan does not require pre-authorization for Urgent Claims.

Usual, Customary and Reasonable Charge or UCR Charge – For Out-of-Network Covered Services, UCR Charge means that portion of any charge for a Covered Service, which is not in excess of the charge made for similar services and supplies to individuals of similar age, circumstances and medical condition in the locality concerned, as determined by the use of a national database at the 90th percentile. The Plan does not pay for Out-of-Network Covered Services in excess of the UCR Charge. Covered Persons who incur expenses for Out-of-Network Covered Services, are subject to balance billing by the provider (i.e. the amount billed by the provider in excess of the amount the Plan determines is the UCR Charge).

In some situations, the charge will be limited to a specific percentage of the Usual, Customary and Reasonable Charge. For example, for multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, the Charge will be:

- 100% of the UCR Charge for the primary procedure;
- 50% of the UCR Charge for the secondary procedure, including any bilateral procedure; and
- 25% of the UCR Charge for each additional covered procedure.

For surgical assistance by a:

- Physician, the Charge will be 20% of the UCR for the corresponding surgery:
- Physician's Assistant or a registered nurse when used in lieu of surgical assistant, the Charge will be 10% of the UCR for the corresponding surgery.

All Out-of-Network Covered Services are subject to this UCR Charge definition. In no event will the UCR Charge exceed the billed amount or the amount for which the Covered Person is responsible.

You or Your as used throughout this document means the Participant and/or his/her eligible Dependents.

ELIGIBILITY

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A Participant and in limited circumstances, his/her eligible Dependent(s) will become eligible for benefits under the Plan upon meeting the below eligibility requirements, provided Contributions are made on the Participant's behalf as required under the Collective Bargaining Agreements between the Union and Contributing Employers or a Special Agreement, and Dependent Contributions/Premiums are made as set out herein.

INITIAL ELIGIBILITY-EMPLOYEE

In order to qualify for Initial Eligibility, an Employee must work a total of at least 240 or more hours, at the Plan's current contribution rate, within any two consecutive months. Once the Employee works a total of at least 240 hours in two consecutive months, the Employee becomes eligible for coverage on the first day of the second month following the month in which the 240th hour was worked. For example:
An Employee who works a minimum of 240 hours during January and February, will be eligible for benefits under this Plan on April 1.

MAINTAINING ELIGIBILITY-PARTICIPANTS

After initial eligibility is established, a Participant will continue to be eligible each month that the Participant works a minimum of 120 hours at the Plan's current contribution rate. Please note: there will always be a delay of one month between the month the hours are worked and the eligibility month. For example:

- 120 hours worked in **March** will earn eligibility for **May**;
- 120 hours worked in **April** will earn eligibility for **June**;
- 120 hours worked in **May** will earn eligibility for **July** and so forth.

Hours worked in excess of 150 hours per month will accumulate and will be "banked" to supplement any month that a Participant works less than the 120 hours to maintain the Participant's eligibility. If You lose eligibility with the Plan for 12 consecutive months, Your hour bank will be forfeited and you will need to re-establish eligibility by meeting the initial eligibility requirement of 240 or more hours, at the Plan's current contribution reate, within any two consecutive months. A Participant can bank up to a maximum of 360 hours total. For example:

Hours Worked	Cummulative Hours Banked
If a Participant works 120 hours in March, he will maintain his eligibility for May, but he will not accumulate any banked hours	0
If the Participant then works 160 hours in April, he will maintain his eligibility for June and will accumulate 10 banked hours	10
If the Participant then works 200 hours in May, he will maintain his eligibility in July and will accumulate an additional 50 banked hours	60 (50 + 10)
If the Participant then only works 100 hours in June, he will need to use 20 of his banked hours to maintain his eligibility in August	40 (50 - 20)
If the Participant then only works 110 hours in July, he will need to use 10 of his banked hours to maintain his eligibility in September	30 (40 - 10)

Generally speaking, an Employee's Employer(s) will report to the Fund Office the number of hours the Employee worked for which the Employer(s) is required to make Contributions, and will then make Contributions based on the reported hours.

ELIGIBILITY DURING MILITARY DUTY

A Participant and in limited circumstances, his/her eligible Dependent(s)' right to health coverage from the Fund during and following any periods of military service are governed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). In order to prevent unnecessary disruptions in health coverage, a Participant should notify the Fund Office before the Participant leaves work. If a Participant is off work for no more than 30 days, coverage will not be affected. If a Participant is off work for more than 30 days and the Participant's total time off work from all separate periods of military service is less than five years, in general, the Participant's leave under USERRA, and in limited circumstances that of his eligible Dependent(s), will be administered under the regular COBRA rules outlined in Article 4 below, except that the maximum period of continuation coverage will be 24 months. For more information on Your rights under USERRA, contact the Fund Office or the local office of the Veterans' Employment and Training Service of the Department of Labor.

TYPES OF DEPENDENT COVERAGE AVAILABLE

Dependent Spouse and Dependent Child coverage are available for any Participant who is a General Foreman, so long as the monthly Dependent Contributions are made on the General Foreman's behalf.

A Participant who is not a General Foreman may nevertheless enroll his eligible Dependent Child(ren) in coverage under the Plan if the Dependent Child(ren) are enrolled during the open enrollment period or during a special enrollment period under HIPAA, and the required monthly Premiums are submitted on time on their behalf each month. No Dependent Spouse coverage is available for Participants who are not General Foremen.

DEPENDENT SPOUSE AND DEPENDENT CHILD COVERAGE FOR GENERAL FOREMEN

Beginning with the month an Employee becomes a General Foreman, the Employer is required to make Dependent Contributions on the General Foreman's behalf. Coverage for the General Foreman's eligible Dependents begins on the first day of the second month following two consecutive months in which an Employer makes Dependent Contributions on the General Foreman's behalf. Dependent Contributions can only be submitted for months in which the Employee has hours worked as a General Foreman. Dependent Coverage is effective on the first day of the month whether or not the General Foreman is still working, so long as the General Foreman is a Participant in the Fund during that month. Dependent Eligibility is maintained thereafter on a month to month basis. **Please note:** there will always be a "skip month" between the month the Dependent Contribution is paid for and the coverage month. For example:

Initial Eligibility - If a General Foreman worked in April and May, and the General Forman's Employer makes Dependent Contributions on his behalf for April and May, eligibility for the General Foreman's eligible Dependents will begin July 1.

Continued Eligibility – If a General Foreman worked in June and the General Foreman's Employer makes Dependent Contributions on his behalf for June, the General Foreman's eligible Dependents will have eligibility for the month of August.

No Employer may designate more than 10% of its full-time equivalent workforce covered under a Collective Bargaining Agreement as General Foremen. For purposes of determining the number of General Foremen allowed, the size of an Employer's full-time equivalent workforce shall be determined over a 6 month rolling average using the number of Employee hours worked for that Employer each month by Employees covered under a Collective Bargaining Agreement. Under this formula, 140 Employee hours worked for an Employer in a month equals one full-time equivalent Employee.

For example: If Employer A's Employees covered under a Collective Bargaining Agreement work an average of 1,400 Employee hours per month during the previous 6 months, Employer A is deemed to employ 10 full-time equivalent Employees and may designate one General Foreman.

DEPENDENT CHILD COVERAGE UPON PAYMENT OF THE MONTHLY PREMIUM

A Participant who is not a General Foreman may nevertheless be eligible for Dependent Child Coverage if the Dependent Child(ren) are enrolled during the open enrollment period or during a special enrollment period under HIPAA and the required monthly Premiums are timely submitted on their behalf each month.

Monthly Premiums to Obtain Dependent Child Coverage - If a Participant is not a General Foreman, the Participant must submit monthly Premiums to obtain Dependent Child coverage. Monthly Premiums are due by the 20th of the month prior to the coverage month. If the monthly Premium is not received in the Fund Office by the due date, coverage will be terminated effective the 1st day of the coverage month; however, the Fund allows a "grace period" to the 15th of the coverage month. Thus, if the monthly Premium is received in the Fund Office by the 15th of the coverage month, coverage will be reinstated retroactively to the 1st day of the coverage month. If the monthly Premium is not received by the 15th day of the coverage month, coverage remains terminated and cannot be reinstated until the next open enrollment period unless special enrollment rights apply under HIPAA.

Open Enrollment for Dependent Children - The Fund will hold a yearly open enrollment period for Dependent Children (other than Dependent Children eligible for coverage under the General Foreman provisions). The yearly open enrollment period will be November 1st through December 1st of each year for a January 1 effective date of the following year. Any

Dependent Child who fails to enroll during the open enrollment period will be ineligible to enroll for coverage until the next yearly open enrollment period unless the Dependent Child is eligible for special enrollment rights under HIPAA. See page 17 for special enrollment rights under HIPAA.

WHEN YOUR ELIGIBILITY ENDS

PARTICIPANT ELIGIBILITY ENDS:

A Participant is no longer eligible for benefits under this Plan if one or more of the following events occur:

- Fails to work the required number of hours;
- Fails to make COBRA payments as described in Article 4, COBRA Continuation Coverage; or
- He makes the maximum number of COBRA payments permitted by law, as described in Article 4, COBRA Continuation Coverage.

DEPENDENT SPOUSE AND CHILD ELIGIBILITY FOR GENERAL FOREMEN ENDS:

For the Dependent of a General Foreman, eligibility for benefits under this Plan ends on the first to occur of the following events:

- Such individual no longer meets the definition of Dependent;
- The Participant's eligibility ends;
- The Dependent Contribution is not paid;
- The COBRA payment as described in Article 4, COBRA Continuation Coverage, is not made; or
- The maximum number of COBRA payments permitted by law have been made as described in Article 4, COBRA Continuation Coverage.

DEPENDENT CHILD ELIGIBILITY FOR NON-GENERAL FOREMEN ENDS:

For the Dependent Child(ren) of a Participant who is not a General Foreman, eligibility for benefits under this Plan ends on the first to occur of the following events:

- Such individual no longer meets the definition of a Dependent Child;
- The Participant's eligibility ends;
- The monthly Premium is not paid before the end of the grace period;
- The COBRA payment as described in Article 4, COBRA Continuation Coverage, is not made; or
- The maximum number of COBRA payments permitted by law have been made as described in Article 4, COBRA Continuation Coverage.

When a Participant and/or Dependent(s)' eligibility terminates, all benefits provided by the Fund cease, except to the extent COBRA coverage is available, as set out below. However, if You are confined in a Hospital, eligibility for medical benefits will continue for the remainder of the confinement, or 30 days, whichever is less.

OBTAINING BENEFITS

When a Participant first becomes covered under the Plan, the Participant must fill out an individual enrollment form for the Fund Office, providing information about the Participant and his/her Dependent(s), if they are eligible for coverage.

A Participant must also update his/her enrollment information whenever there is a change in the Participant's status or the status of one of his Dependents (for example, a change of address, new baby, removal or addition of a Spouse). A Participant will be given a medical card for proof of participation in the Plan.

When You need medical benefits, simply make an appointment with a medical care provider. In most instances they will complete and submit any needed claim forms.

You must be sure Your claim is filed within 12 months of the date of service. If You do not file within the 12 month time limit, the Fund will not pay Your claim.

SPECIAL ENROLLMENT RIGHTS

If You decline enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance or group health plan coverage, You may be able to enroll yourself and Your Dependents in this Plan if You or Your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward Your or Your Dependents' other coverage). However, You must request enrollment within 30 days after Your or Your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll Yourself and Your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- You or Your Dependents lose eligibility for Medicaid or state Children's Health Insurance Program ("CHIP") coverage and You request enrollment within 60 days.
- You or Your Dependents become eligible for a state premium assistance subsidy through Medicaid or a CHIP with respect to coverage under this Plan and You request enrollment within 60 days after the determination of eligibility for assistance.

To request special enrollment or obtain more information, contact the William C. Earhart, Company, Inc. at (800) 846-0611.

COBRA

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Under a federal law referred to as COBRA, if You lose Your eligibility as a result of a "qualifying event," You become what is known as a "qualified beneficiary" and You may be able to purchase temporary extension coverage at group rates. This is "COBRA continuation coverage."

BASIC COBRA PROVISIONS

BENEFITS COVERED

With COBRA continuation coverage a qualified beneficiary will generally be eligible to purchase the same medical benefits provided to that qualified beneficiary under the applicable Schedule of Benefits in effect on the day before the qualifying event occurred. If any changes in benefits occur for active Participants/Dependents while the qualified beneficiary is receiving COBRA continuation coverage, those changes will apply to the qualified beneficiary as well to the extent applicable to that qualified beneficiary.

COBRA CONTINUATION COVERAGE BEGINS

You have the right to purchase continuation coverage only if You lose coverage due to a "Qualifying Event." "Qualifying Events" include:

For Participants:

- Termination of the Participant's employment for reasons other than gross misconduct; or
- Reduction in the Participant's hours of employment.

For Eligible Dependent Spouses:

- The Participant's death;
- The Participant's reduction in hours of employment;
- The Participant's employment ending for any reason other than gross misconduct;
- The Participant becoming entitled to Medicare benefits (under Part A, Part B, or both); or
- The divorce of the Participant and the Dependent Spouse.

For Eligible Dependent Children:

- The Participant's death;
- The Participant's reduction in hours of employment;
- The Participant's employment ending for any reason other than gross misconduct;
- The Participant becoming entitled to Medicare benefits (under Part A, Part B, or both); or
- The loss of Dependent Child status under the Plan.

DURATION OF CONTINUATION COVERAGE

MAXIMUM PERIODS

COBRA requires that COBRA continuation coverage extend from the date of the qualifying event for a limited period of time of 18 or 36 months. The length of time for which COBRA continuation coverage must be made available (the "maximum period" of COBRA continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights.

When the qualifying event is the Employee's termination of employment (for reasons other than gross misconduct) or reduction in hours of work, qualified beneficiaries must be provided 18 months of COBRA continuation coverage.

When the qualifying event is the end of employment or reduction of the Employee's hours, and the Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA continuation coverage for the Employee's eligible Dependents can last until 36 months after the date the Employee became entitled to Medicare. For example, if a Participant becomes entitled to Medicare eight (8) months before the date his employment ends (termination of employment is the COBRA qualifying event), COBRA continuation coverage for his eligible Dependents would last 28 months (36 months minus 8 months).

For all other qualifying events, qualified beneficiaries must be provided 36 months of COBRA continuation coverage.

EARLY TERMINATION

COBRA continuation coverage will terminate earlier than the end of the maximum period if any of the following occur:

- The applicable COBRA premium is not paid in full on a timely basis;
- All coverage offered by the Plan terminates;
- A qualified beneficiary begins coverage under another group health plan after electing COBRA continuation coverage;
- A qualified beneficiary becomes entitled to Medicare benefits after electing COBRA continuation coverage; or
- A qualified beneficiary engages in conduct that would justify the Plan in terminating coverage of a similarly situated Participant or Dependent not receiving COBRA continuation coverage (such as fraud).

EXTENSION OF AN 18-MONTH PERIOD OF CONTINUATION COVERAGE

There are two circumstances under which qualified beneficiaries entitled to an 18-month maximum period of COBRA continuation coverage can become entitled to an extension of that maximum. The first is when one of the qualified beneficiaries is disabled; the second is when a second qualifying event occurs.

Disability

If one of the qualified beneficiaries in a family is disabled and meets certain requirements, all of the qualified beneficiaries in that family are entitled to an 11-month extension of the maximum period of COBRA continuation coverage (for a total maximum period of 29 months of COBRA continuation coverage). The Fund can charge the qualified beneficiary an increased premium, up to 150 percent of the cost of coverage, during the 11-month disability extension.

The requirements are, first, that the Social Security Administration (SSA) determines that the disabled qualified beneficiary is disabled before the 60th day of COBRA continuation coverage and, second, that the disability continues during the rest of the initial 18-month period of COBRA continuation coverage. The disabled qualified beneficiary (or another person on his or

her behalf) also must notify the Fund of the SSA determination within the 18-month period following the Qualifying Event, unless a longer period is required by law.

If a qualified beneficiary's disability ends, however, COBRA continuation coverage will no longer be available beyond the later of the end of the initial 18-month period or the date that is 30 days after a final determination that the qualified beneficiary is no longer disabled. You must notify the Fund in writing within 30-days after the date SSA determines that a disability no longer exists.

Second Qualifying Event
An 18-month extension may be available to qualified beneficiaries receiving an 18-month maximum period of COBRA continuation coverage (giving a total maximum period of 36 months of COBRA continuation coverage) if the qualified beneficiaries experience a second qualifying event that is death of the Employee, divorce of the Employee and Spouse, Medicare entitlement (in certain circumstances), or loss of Dependent Child status under the Plan. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event.

If a qualified beneficiary has a second qualifying event, the qualified beneficiary must notify the Fund in writing of the second qualifying event within the 18-month period following the Qualifying Event, unless a longer period is required by law.

ELECTING COBRA CONTINUATION COVERAGE

The Fund Office must be notified of any qualifying event that may entitle a Participant or his eligible Dependents to COBRA continuation coverage. In the event of divorce or loss of Dependent status, the Participant or his eligible Dependent must notify the Fund Office within 60 days in writing. For other qualifying events, a Participant's Employer must notify the Fund Office within 30 days. An Employer fulfills this obligation by reporting the Qualifying Event on its timely filed contribution report to the Fund Office.

If a qualified beneficiary becomes disabled within the first 18 months of COBRA continuation coverage, the qualified beneficiary is obligated to inform the Fund Office within 60 days of the time the qualified beneficiary receive a Social Security disability award. If the Social Security Administration determines that a qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Fund Office within 30 days.

Within 30 days after receiving notice of a qualifying event, the Fund Office will notify the Participant or his eligible Dependent of the right to elect COBRA continuation coverage. The Fund Office will provide notice of how much such coverage will cost and an election form with instructions for electing the coverage.

To elect COBRA continuation coverage, You must complete the election form and submit it to the Fund Office within 60 days after the later of:

- the qualifying event, or
- the date the notice of the right to elect COBRA continuation coverage was sent out by the Fund Office.

If You do not elect COBRA continuation coverage within this time, You will no longer be eligible for such coverage. A Participant and each of his eligible Dependents have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their eligible Dependent Spouses and parents may elect COBRA continuation coverage on behalf of their eligible Dependent Children.

PAYING FOR COBRA CONTINUATION COVERAGE

You must pay the premium for COBRA coverage. The first premium payment must be made to the Fund Office no later than 45 days after the date COBRA continuation coverage is elected. Subsequent premiums are due on the first day of the calendar month. The Board of Trustees will determine the amount of the monthly premium for COBRA continuation coverage annually but it will be no more than 102% of the cost of coverage provided to similarly situated Participants and eligible Dependents unless a higher charge is permitted by law.

WHY COBRA COVERAGE IS IMPORTANT

Failure to elect COBRA continuation coverage when You are eligible may affect Your future rights under federal law.

- First, You may lose the right to avoid having pre-existing conditions exclusions applied by other health plans if You have more than a 63-day gap in coverage. Election of COBRA coverage may help to fill that gap.
- Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition limitations if You do not elect COBRA coverage for the maximum time available.
- Finally, You should take into account the fact that You may have special enrollment rights under federal law. These rights allow You to enroll in another group health plan for which You are eligible (such as a plan sponsored by Your Spouse's employer) within 30 days after Your coverage under this Plan ends for any reason which entitles You to elect COBRA continuation coverage. You will have the same special enrollment rights at the end of Your COBRA continuation coverage if You elect COBRA continuation coverage for the maximum period available to You.

OTHER COVERAGE OPTIONS BESIDES COBRA COVERAGE

Instead of enrolling in COBRA Coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Coverage.

This is just a summary of the COBRA laws and regulations. Contact the Fund Office if You have questions about COBRA continuation coverage. For more information about Your rights under COBRA and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available on the website.

MEDICAL

5

SCHEDULE OF BENEFITS

GENERAL SERVICES	CIGNA IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Calendar Year Deductible	You pay: $250 individual/$750 family	You pay: $1,000 individual/$3,000 family
PPO Out-of-Area Services	Services rendered outside of any PPO geographical area are paid at 80% of UCR Charge, subject to Out-of-Network Calendar Year Deductibles.	
Out-of-Pocket Annual Maximum	$2,000 individual $6,000 per family	$ 5,000 individual $ 15,000 per family
Lifetime Maximum for Non-Essential Benefits	$1,000,000 per individual	
Co-Insurance	Plan pays: 80%	Plan pays: 50%
Physician Visits	You pay: $25 Co-Payment (Not subject to Calendar Year Deductible)	Plan pays: 50% after Calendar Year Deductible
Office Surgery (Not subject to Calendar Year Deductible)	Plan pays: 80%	Plan pays: 50%
Preventive Care	You pay: $25 Co-Payment (Not subject to Calendar Year Deductible)	Plan pays: 50% after Calendar Year Deductible

- Well Baby Care and Immunizations (through age 2)
- Routine Physicals (over age 2) - One exam per Calendar Year
- Basic Gynecological Care
- Annual pelvic exam & Pap smear & mammogram
- Colorectal Cancer Screening & SA
- Lab & X-Ray

GENERAL SERVICES	CIGNA IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Durable Medical Equipment	Plan pays: 80% Calendar Year Deductible	Plan pays: 50% after Calendar Year Deductible
Lab & X-Ray Services Office and Independent Labs (Not subject to Calendar Year Deductible)	Plan pays: 80%	Plan pays: 50%
Outpatient Physical Therapy 25 visits per Calendar Year Max	Plan pays: 80% after Calendar Year Deductible	Plan pays: 50% after Calendar Year Deductible
Speech, Hearing, Occupational Therapy 25 visits per Calendar Year Max	Plan pays: 80% after Calendar Year Deductible	Plan pays: 50% after Calendar Year Deductible
Chiropractic (Manipulation only) 5 visits per Calendar Year Max	Plan pays: 80% after Calendar Year Deductible	Plan pays: 50% after Calendar Year Deductible
Ambulance	Plan pays: 80% after CIGNA In-Network Calendar Year Deductible using UCR Charges, regardless of network status.	
Emergency Room Care	$100 co-payment for emergency department visit (Not subject to Calendar Year Deductible). Plan pays: 80% for Hospital and Doctors' services associated with emergency department visit (i.e. Lab and X-Ray, Physician charges, surgery costs, etc.) regardless of whether services are billed together under emergency department's bill or separately. Plan pays: 80% regardless of provider's network status. Hospital and Doctors' services associated with emergency department visit are subject to the Calendar Year Deductible other than Lab and X-Ray services.	
Inpatient Hospital Services • Including anesthesia • Requires Pre-Certification • Lab & X-Ray based on facility network status	Facility Charges: Plan pays: 80% after You pay: $100 per Confinement Co-Payment Non-Facility Charges: Plan pays: 80% after Calendar Year Deductible	Not covered
Skilled Nursing Facility Care 100 days per Calendar Year Max Requires pre-certification	Facility Charges: Plan pays: 80% after You pay: $100 per confinement Co-Payment	Not covered
Hospice Care	Non-Facility Charges: Plan pays: 80% after Calendar Year Deductible	Not covered

GENERAL SERVICES	CIGNA IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Hospital Visits • Outpatient surgery • Including anesthesia • Requires pre-certification • Ambulatory surgery • Lab & X-Ray paid based on facility network status	Facility Charges: Plan pays: 80% after You pay $100 per visit Co-Payment Non-Facility Charges: Plan pays: 80% after Calendar Year Deductible	Facility Charges: Plan pays: 80% after You pay $100 per visit Co-Payment Non-Facility Charges: Plan pays: 80% after Calendar Year Deductible
Prescription Drug Benefits		
	Co-Payments Retail (Up to 30-day supply)	Co-Payments Mail Order (Up to 90-day supply)
Pharmacy Plan (Includes Contraceptives) There are no Out-of-Network Prescription Drug Benefits	$10: Generic $20: Tier 2 Brand $40: Tier 3 Brand $40: Specialty Drugs	$20: Generic $40: Tier 2 Brand $80: Tier 3 Brand $40: Specialty Drugs

THE CIGNA PREFERRED PROVIDER ORGANIZATION

The Board of Trustees has contracted with CIGNA HealthCare to make Preferred Provider Organization ("PPO") services available to Plan Participants and their eligible Dependents through the CIGNA Health Care OAP Network ("CIGNA OAP Network"). CIGNA OAP Network is a nationwide group of selected Physicians, specialists, Hospitals and other Treatment centers that have agreed to provide their services to Plan Participants and their eligible Dependents at a discount. The CIGNA OAP Network can be used for regular or Emergency medical services. Certain benefits are provided through a CIGNA subsidiary called CareAllies, the nation's leading provider of Participant-friendly, effective care management programs. Please note the following important information:

In Network Benefits: If You live in the CIGNA OAP Network area, You must use Hospitals, Physicians, and other medical providers that participate in the CIGNA OAP Network in order to receive the In-Network benefit levels. Currently the CIGNA OAP Network has over one million locations across the nation. To determine the providers in Your area, or if You are traveling, You can call CIGNA's member services at (800)768-4695, or You can access an up-to-date listing of participating providers and facilities on the internet at www.cignasharedadministration.com. If you see OAP "Open Access Plus" on the front of your medical ID card, you must select Shared Administration OAP Provider Directory on the website to identify participating providers and facilities in this network.

Out-of-Network Benefits: If You live in the CIGNA OAP Network area but use a Physician or Hospital that is not in the CIGNA OAP Network, Your benefits will be covered at the Out-of-Network benefit levels.

Special Services: Certain services are payable at the network level even when not performed by a network provider. These services include:

- Services (other than surgical assistance) of an Out-of-Network provider such as inpatient consultation, neonatology, x-ray and lab tests, radiology, anesthesiology and other

specialists over whom the Covered Person has no control in selecting after admission, when the Covered Person is admitted for inpatient or outpatient care in an In-Network facility, if the admission and the provider's services are approved by Medical Management.

- Services of any Out-of-Network provider who is qualified to assist during surgery if the surgery is performed by a CIGNA In-Network Doctor in a CIGNA In-Network facility. The use of an assistant during surgery must be appropriate for the type of surgery rendered.
- Inpatient care provided in an Out-of-Network Hospital or by an Out-of-Network Doctor immediately following Emergency Room Care if the services are approved by Medical Management.
- Ambulance services.

Supplemental Network: For Covered Persons that live in an area outside the CIGNA covered area, You may call CIGNA member services and they will provide a list of providers that participate in the program. Because these are not CIGNA participating providers, the Covered Person is responsible for obtaining pretreatment authorization for all services and supplies that require pretreatment authorization.

You are free to choose any service provider You wish. You are encouraged to use the CIGNA OAP Network because **You will save money**. With the CIGNA OAP Network, because You pay a percentage of the contracted rate, You will be paying a smaller percentage of a smaller amount.

When a Participant first becomes eligible for benefits under the Plan, he/she will be given a CIGNA OAP I.D. Card that will cover the Participant and his eligible Dependents. You can check to see if Your current Doctor participates by accessing the CIGNA website at www.cignasharedadministration.com. If you see OAP "Open Access Plus" on the front of your medical ID card, you must select Shared Administration OAP Provider Directory on the website to identify participating providers and facilities in this network. The website can also assist You in finding a new Doctor.

When a Covered Person goes to an In-Network Physician or Hospital, he/she should identify himself/herself as a member of the CIGNA OAP Network by presenting the CIGNA OAP I.D. card. The Physician or Hospital will then submit any claims directly to CIGNA.

DEDUCTIBLE

Except where otherwise stated in the Schedule of Benefits, a Covered Person must pay the first $250 of Covered Services for In-Network (or $1,000 if Out-of-Network) each Calendar Year. The family Deductible is $750 (or $3,000 if Out-of-Network). This is called the "Deductible" or "Calendar Year Deductible." The Deductible applies only once in any Calendar Year. A new Deductible applies each Calendar Year for each person/family covered under the Plan.

MEDICAL COVERED AMOUNT

After You pay Your Deductible, the Plan will pay benefits in accordance with the Schedule of Benefits. When You have paid the Out-of-Pocket Annual Maximum (see Schedule of Benefits), the Plan will pay 100% of the Covered Services for additional Covered Services for the rest of the Calendar Year. Please note this only applies to co-insurance. Even when the Out-of-Pocket Maximum has been met, You will still be responsible for any applicable Co-Payments associated with services as set out in the Schedule of Benefits.

The Calendar Year Deductible will not count towards satisfying Your Out-of-Pocket Annual

Maximum. For example, if You are a single Participant seeking In-Network Benefits, You will be required to pay the $250 Calendar Year Deductible and then 20% of the UCR Charge for the next $10,000 in Covered Services until You have satisfied the Out-of-Pocket Annual Maximum of $2,000.

All Calendar Year Deductibles and Out-of-Pocket Annual Maximums are determined on a Calendar Year basis. You will be required to satisfy the Calendar Year Deductible and meet the Out-of-Pocket Annual Maximum again each Calendar Year. The Plan has a Lifetime Maximum benefit for non-essential benefits of $1,000,000 per Covered Person.

COVERED SERVICES – MEDICAL

Covered Services include the medical services described on the following pages. The Plan will pay only the contracted rate or UCR Charges in accordance with the Schedule of Benefits for Medically Necessary services provided on the recommendation and approval of the attending Physician in connection with the Treatment of bodily Injury or Sickness for these medical services. You must pay any expenses that exceed the UCR Charge. UCR Charge is defined on page 11.

Inpatient Hospital Room and Board – There is a $100 Co-Payment each time You are admitted to the Hospital. The Plan will pay the contracted rates or UCR Charges in accordance with the Schedule of Benefits for a semi-private room, or intensive care unit if needed. Hospital admissions must be pre-certified by the CIGNA CareAllies. Prior to any scheduled Hospital admission, whether for medical Treatment, mental illness or substance abuse, **You or Your Physician must call CIGNA for pre-certification at (800) 768-4695**. In an Emergency or life-threatening situation, You or a family member must notify CIGNA within 24 hours of admission. This requirement applies whether or not Your Physician participates in the CIGNA OAP Network. **If You incur Hospital expenses that are not pre-certified by CIGNA, the Plan will pay only 50%** of the amount which would otherwise be paid by the Plan and You are subject to balance billing by the provider. If You do not pre-certify, there is a 50% penalty. Out-of-Network Hospital room and board is not covered.

Treatment in an approved In-Network hospice program, which is approved by CIGNA in lieu of hospitalization, is a Covered Service.

Inpatient Hospital Services and Supplies – After a $100 Co-Payment per confinement and pre-certification as described above, the Plan will pay 80% of the contracted rate for a CIGNA OAP Network facility until the Out-of-Pocket Maximum has been met. Thereafter the Plan pays: 100%. Out-of-Network inpatient hospital services and supplies are not covered.

Skilled Nursing Facility – After a $100 Co-Payment per confinement, the Plan will pay 80% of the contracted rate for a CIGNA OAP Network facility, up to a maximum of 100 days per Calendar Year. Once the Out-of-Pocket Maximum has been met, the Plan will pay at 100% of the contracted rate for an In-Network facility up to the maximum of 100 days per Calendar Year. Out-of-Network skilled nursing facilities are not covered. Care must be such that it requires the skills of technical or professional personnel on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition that is expected to improve significantly in a reasonable period of time and must show functional improvement. To be eligible for the Skilled Nursing Facility benefit, the Covered Person must have been confined in a Hospital immediately prior to confinement in the Skilled Nursing Facility. Pre-certification is required for Skilled Nursing Facility benefits

Covered Services do not include an admission to a Skilled Nursing Facility where the care is provided principally for:

- Senile deterioration;
- Mental deficiency or retardation;
- Mental illness; or
- Routine nursing care, self-help or training, personal hygiene or Custodial Care.

Home Health Care – After Your Calendar Year Deductible has been met, the Plan will pay 80% of the contracted rate for an In-Network provider (50% of the UCR Charge for an Out-of-Network provider) for 1 (one) visit per day up to 100 visits per Calendar Year.

The Plan covers Home Health Care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The patient must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition that is expected to improve significantly in a reasonable period. **Pre-certification is required for Home Health Care benefits.**

Hospice Care – After Your Calendar Year Deductible has been met (or after $100 Co-Payment for inpatient Hospice Care), the Plan will pay 80% of the contracted rate for an In-Network provider until the Out-of-Pocket Maximum has been met. Thereafter Plan pays: 100%. Out-of-Network inpatient Hospice Care is not covered. The Plan covers Hospice Care if prescribed by a Doctor and the Covered Person's life expectancy is six months or less.

Palliative Care means medical services provided by a Hospice Care program that alleviates symptoms or affords temporary relief of pain but are not intended to effect a cure. If a Covered Person elects Palliative Care, then he or she is not eligible for any other benefits for acute treatment of the terminal Illness. The Covered Person's Physician must certify that the Covered Person is terminally ill with a life expectancy of six months or less if the Injury or Sickness runs its normal course. Pre-certification is required for Hospice Care benefits.

Physician Office Visits – After a $25 Co-Payment, the Plan will pay the contracted rate for an In-Network provider for Covered Services provided by a Physician or other provider for non-surgical office services related to the Treatment of an Injury or Sickness. For Out-of-Network providers, the Plan will pay 50% of the UCR Charge after Your Calendar Year Deductible is met and until Your Out-of-Pocket Maximum has been met for these services.

Office Surgery - The Plan will pay 80% of the contracted rate for an In-Network provider and 50% of the UCR Charge for an Out-of-Network provider until Your Out-of-Pocket Maximum has been met. Thereafter, Plan pays: 100%. This benefit is not subject to Your Calendar Year Deductible.

Physician Surgical Services- After Your Calendar Year Deductible is met, the Plan will pay 80% of the contracted rate for an In-Network provider and 50% of the UCR Charge for an Out-of-Network provider until Your Out-of-Pocket Maximum has been met. Thereafter Plan pays: 100%.

This includes Treatment by an oral surgeon for fractures and dislocations of the jaw due to accidental bodily Injury and for cutting procedures in the oral cavity other than for extractions, repair and care of the teeth or gums.

Second Surgical Opinion - If Your Physician has recommended surgery, the Plan will pay for a

visit to another qualified Physician to obtain a second surgical opinion. The purpose of this benefit is to help You ensure that the surgery is Necessary and to help avoid unnecessary surgery.

Obtaining a second surgical opinion is easy to do. Contact CIGNA member services at (800) 768-4695, and ask for a "Board Certified" surgeon in Your area. The member services representative will give You a list of providers to choose from. Make an appointment with the provider and have them contact the Fund Office for benefit information on second surgical opinions.

Inpatient Doctor Visits – If You are in the Hospital and receive a Medically Necessary visit from Your In-Network Doctor, after Your Deductible has been met, the Plan will pay 80% of the Contracted Rate for an In-Network provider until the Out-of-Pocket Maximum is met, for up to one visit per day. Thereafter the Plan pays: 100%. Charges for visits by Your surgeon are not covered because they are included in the fee for the surgery. The Plan does not cover inpatient Doctor visits by an Out-of-Network provider when you are in an Out-of-Network Hospital.

Ambulatory Surgical Expenses –The Plan will pay the contracted rate or UCR Charges in accordance with the Schedule of Benefits for Hospital expenses incurred at the time of, and in connection with, a surgical operation performed in an ambulatory surgical center.

Ambulatory Surgical Center – The Plan will pay the contracted rate or UCR Charges in accordance with the Schedule of Benefits for services and supplies in connection with a surgical procedure performed in a licensed free-standing independently operated ambulatory surgical facility. Pre-certification is not required for ambulatory surgeries.

X-Ray and Laboratory Expenses include:

- X-ray examinations and microscopy and laboratory tests performed for diagnostic purposes (MRI, MRA, CAT Scan, PET scan, etc.); and
- X-ray, radium and radioactive isotope Treatments.

The Plan will pay 80% of the contracted rate for an In-Network provider and 50% of the UCR Charge for an Out-of-Network provider until Your Out-of-Pocket Maximum has been met. Once Your Out-of-Pocket Maximum has been met, the Plan will pay 100% of the contracted rate for In-Network providers or UCR Charge for Out-of-Network providers.

Ambulance – After your Calendar Year Deductible has been met and until Your Out-of-Pocket has been met the Plan will pay 80% of UCR Charges for transportation (including air ambulance) from the city in which You become disabled to the nearest Hospital qualified to provide Treatment for such Injury or Sickness. Once Your Out-of-Pocket Maximum has been met, the Plan will pay 100% of the UCR Charges.

Anesthetics and the administration thereof.

Durable Medical Equipment- After Your Calendar Year Deductible has been met and until the Out-of-Pocket Maximum has been met, The Plan will pay 80% of the contracted rate for an In-Network provider and 50% of the UCR Charge for an Out-of-Network provider. Charges for rental of Durable Medical Equipment will be paid up to the purchase price. Charges for purchase of Durable Medical Equipment will be covered only when the required length of rental would result in rental fees that exceed the purchase price of the equipment. **Pre-certification is required for any Durable Medical Equipment cost over $500**.

Chiropractor – After Your Calendar Year Deductible has been met and until the Out-of-Pocket Maximum has been met, the Plan will pay 80% of the contracted rate for an In-Network provider and 50% of the UCR Charge for an Out-of-Network provider for up to 5 visits per Calendar

Year for visits and manipulations by a Chiropractor.

Outpatient Physical Therapy –The Plan will pay for up to 25 sessions per Calendar Year for physical therapy performed to restore function and prevent disability following acute disease, Injury or loss of body part. **Pre-certification is required for Outpatient Physical Therapy**.

Outpatient Occupational/Speech/Hearing Therapy - The Plan will pay for up to 25 sessions per Calendar Year for outpatient occupational, speech, or hearing therapy performed to restore function and prevent disability following acute disease, Injury or loss of body part. **Pre-certification is required for Outpatient Occupational/Speech/Hearing Therapy**.

Mental Health and Chemical Dependency – Benefits will be provided only for the type of care that is Medically Necessary. You must obtain pre-authorization for all inpatient services. If You do not obtain pre-authorization, the Plan will only reimburse 50% of the UCR Charge for Covered Services that would otherwise be paid by the Plan and You are subject to balance billing by the provider. Out-of-Network inpatient mental health and Chemical Dependency services are not covered.

The Plan provides confidential Treatment for pre-authorized mental health, drug and alcohol dependency Treatment. Benefits include:

- Outpatient counseling;
- Outpatient group therapy;
- Inpatient rehabilitation Treatment at an approved In-Network rehabilitation center;
- Inpatient detoxification at an approved In-Network Hospital or rehabilitation center; and
- After-care, consisting of outpatient counseling and monitoring of the Participant's or eligible Dependent's progress.

SPECIAL RULES RELATED TO PREGNANCY AND CHILDBIRTH

Group health plans (like this Plan) and health insurance issuers, to the extent they provide pregnancy and childbirth benefits, generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans (including this Plan) and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or insurer (or, in the case of this Plan, from CIGNA OAP) for a length of stay not in excess of 48 hours (or 96 hours as applicable).

SPECIAL RULES RELATED TO MASTECTOMY COVERAGE

The Plan covers the following medical services in connection with coverage for a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and Treatment of physical complications in all states of mastectomy including lymphedemas.

Coverage for these medical services related to mastectomy is subject to applicable Deductibles and co-insurance amounts under the Plan.

PREVENTIVE CARE BENEFITS

The Plan provides several additional benefits to encourage You to live healthy, take preventive actions and test for early discovery of conditions that may need Treatment. The Plan pays: an In-Network Benefit of 100% of UCR Charges for these benefits after a $25 Co-Payment per exam and these benefits are not subject to the Deductible. Please Note: Preventive Care Benefits for Out-of-Network charges are paid at the Out-of-Network Benefit levels.

Well baby care - Charges for routine Doctor visits, testing and immunizations for eligible Dependent Children through the age of two.

Routine physical examinations - once every year for Participants and eligible Dependents age two and older.

Routine gynecological care - once a year.

Mammogram - once a year. All mammography services must be certified by the U.S. Food and Drug Administration.

Proctology screening - once a year for males ages 40 or older.

Routine colonoscopy – once every 10 years.

Preventive care x-ray and lab tests – if ordered as part of an office visit. Tests are covered at 100% and are not subject to the Deductible.

OTHER SERVICES

24-Hour Nurse Line - This program provides toll-free telephone access to medical care professionals 24 hours a day and 365 days a year. The telephone number for Nurse Line is (800) 768-4695.

Maternity Management – Participants and eligible Dependent Spouses have access to a voluntary maternity management program that works to achieve a healthy outcome for both mother and baby. As part of this program, Participants and eligible Dependent Spouses receive valuable prenatal guidance and are given access to a toll free 24-hour a day, 365-day a year answer line. Participants and eligible Dependent Spouses should call (800) 768-4695 to access these services.

LifeSource Organ Transplant Program – Should You need an organ transplant, this program requires participation in the LifeSource Organ Transplant Centers of Excellence program. Through this program, care coordination and case management will be provided across the country.

MyCareAllies.com – There are several other unique services available through myCareAllies.com, a component of CIGNA's care management program, which You are encouraged to use. These services will enable You to:

- Visit an electronic Health Library and learn about a specific disease, Your current medical condition(s), how to treat Your condition(s), questions to ask Your Doctor(s) about Your condition(s), etc.
- Take a Health Risk Assessment to help You determine what medical conditions You have a risk of getting over time due to Your personal habits and family history, and what to do to reduce the chances of getting these conditions.
- Review medications and their potential interactions and alternatives.
- Review preventive care tips.
- Gain access to tools to quit smoking, lose weight, and live a healthier life.

You may access the myCareAllies.com website. Your Plan specific passcode is "rdc" (case sensitive).

CASE MANAGEMENT

The CIGNA OAP Network includes Case Management, which provides assistance and care coordination to chronically or critically ill patients (e.g. cancer, diabetes, heart disease, etc). Case Management is a voluntary program. You may call CareAllies at (800) 768-4695 to speak with a case manager.

Referral Screening - A referral specialist evaluates and assigns the case based on current medical services, the available benefits, and anticipated potential outcomes. Case management most often focuses on costly, complex and/or long term care needs. Referral to case management may result from diagnosis specific triggers such as: traumatic injuries, intensive oncology, stroke, brain Injury, complicated newborn, transplants, amputations and chronic Illnesses with readmission and compliance issues.

Individual Case Manager - Each case manager is a Nurse with expertise in clinical, social, and behavioral health issues who will work with You throughout the life of the case. If You are in the Case Management program, You will have direct access to the assigned case manager via an 800 number and direct extension.

MEDICAL BENEFIT EXCLUSIONS

Medical Benefits are not provided for the following:
All charges for services not specifically listed as Covered Services;

- All charges in excess of UCR Charges;
- Surgical services which alter the refractive character of the eye, including but not limited to, radiokeratotomy and other surgical procedures of the refractive heratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism. Charges for eye refractions or the purchase or fitting of glasses;
- Charges for hearing aids;
- Charges for the care and Treatment of the teeth, gums or alveolar process, and charges for dentures, appliances or supplies used in such care or Treatment, unless such expenses are incurred as a result of, and within 12 months of, an Accident;
- Charges for or in connection with Cosmetic Surgery or Treatment that is not done to repair congenital defects, injuries sustained in an Accident, or organ or tissue damaged by cancer;
- Charges for medical services, supplies or medications specifically for diet control;
- Charges for services or supplies not related to Treatment for Illness or Injury, such as routine immunizations, except as expressly allowed;
- Charges for Custodial Care when condition is stabilized and when current condition is not expected to significantly or objectively improve or progress over a specified period of time;
- Charges for Treatment rendered by the surgeon on the day of any surgical operation or the days of convalescence;
- Any confinement or medical care not recommended and approved by a legally qualified Physician;
- Confinement or medical care, which is caused by or results from pregnancy, childbirth or miscarriage of a Dependent other than an eligible Dependent Spouse;
- Any other general limitations listed in Section 9 of this booklet;

- Any expense or charge resulting from the Covered Person's commission or attempted commission of a felony;
- Any expense or charge for Treatment of Jaw Joint Disorders;
- Any expense or charge for sexual transformations or any Treatment related to sexual dysfunction;
- Any expense or charge for chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- Any expense or charge for services or supplies which:
    - Are considered Experimental, Investigational or Unproven drugs, devices, Treatments, medical procedures, services or supplies; or
    - Result from or relate to the application of such Experimental, Investigational or Unproven drugs, devices, Treatments, medical procedures, services or supplies.
- Any expense or charge which is primarily for the Covered Person's education, training, or development of skills needed to cope with an Injury, Sickness, mental illness or substance abuse disorder;
- Any expense or charge associated with family counseling, marriage counseling or support groups;
- Any expense or charge resulting from court ordered educational or counseling programs or diversion programs;
- Any expense or charge associated with any self-help programs, such as smoking cessation or weight loss programs;
- Any expense or charge related to tobacco cessation;
- Treatment solely for detoxification or primarily for maintenance care (including providing of an environment without access to drugs or alcohol);
- Any expense or charge which is primarily for the Covered Person's convenience or comfort or that of the Covered Person's family, caretaker, Physician or other provider;
- Any expense or charge for telephone calls to or from a Physician, Hospital or other provider and any expense or charge for an internet Physician visit;
- Any expense or charge, which results from services from developmental disability;
- Any expense or charge which results from or is caused by war (whether declared or not), service in the armed forces of any country, invasion, civil or international war or hostilities, insurrections or riot;
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control or education such as air conditioners, humidifiers, air filters, whirlpools, heat lamps and tanning lamps;
- Elective Abortions and any family planning procedure that requires surgical or drug assisted reproductive technology, such as, but not limited to, infertility Treatment, tubal ligations, vasectomies and reversal of such;
- Any expense or charge related to lactation/nursing, including but not limited to supplies, equipment and counseling;
- Services covered under any other group plan or employer, union, or association sponsored plan;
- Any expense or charge for Injury or Sickness which arises out of or in the course of any employment for pay or profit; and
- Non-prescription/over-the-counter drugs or medicines

PRESCRIPTIONS

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SCHEDULE OF BENEFITS

Co-Payment (per prescription)	Retail Network (30-day supply)	Mail Order (90-day supply)
Generic	$10	$20
Preferred Brand	$20	$40
Non-Preferred Brand	$40	$80
Self-Administered Injectable	$40	$80
Supply Limit	Up to 30 days	Up to 90 days

CIGNA PHARMACY

Your CIGNA medical card is also Your pharmacy benefit card. Many pharmacies participate in the CIGNA Network and will accept the card. You may contact the Fund Office or CIGNA Pharmacy at (800) 244-6224, for a list of participating pharmacies. You can also check the CIGNA website at www.CIGNA.com. No Out-of-Network benefit is available for prescription drugs. After the pharmacy has filled Your prescription, present the card, plus a Co-Payment for each prescription. The Plan will pay the balance, provided the prescription was filled with a generic drug, if available.

If You have questions regarding the number of doses or the type of drugs covered under the Plan, please call (800) 244-6224, and a CIGNA representative will assist You. Your CIGNA medical card cannot be used for drugs or other items You can buy without a Doctor's prescription.

PLAN BENEFITS

The Plan recognizes three types of prescription drugs:

Brand name drugs - are medications that are produced and sold under the original manufacturer's name. These drugs are typically the most expensive.

Generic drugs - After a brand name drug has been on the market for a number of years federal law allows other companies to copy and sell a medically equivalent drug. A drug that is produced and sold under its chemical name, rather than a brand name, is a generic drug. Generic drugs are similar to, but generally less costly than, brand name or formulary drugs.

Formulary drugs - are those medications that appear on a comprehensive list of preferred generic and branded drugs that are safe and cost effective for patients. Drugs on this list are chosen by a committee of Physicians and pharmacists. Formularies have been used in Hospitals for many years to help ensure quality drug use. CIGNA has negotiated discount agreements with the pharmaceutical manufacturers of the drugs that are included in the formulary program. Drugs on this list are subject to change. You can get a list of Preferred brand/Non-preferred brand formulary drugs by calling CIGNA Pharmacy at (800) 244-6224.

If there is a generic drug that can be safely substituted for a brand-name drug, the Plan will only pay for the cost of the generic drug. If there is no generic equivalent drug available and You obtain a brand name drug, You will be charged the applicable brand name Co-Payment identified above. If a generic equivalent is available, but You choose to use a brand name, You will be charged the generic drug Co-Payment plus the difference between the cost of the generic equivalent and the cost of the brand name drug.

MAIL ORDER PROGRAM FOR MAINTENANCE DRUGS

A mail order program is available that provides up to a 90-day supply for only one mail order program Co-Payment. Maintenance drugs include medication for regular use over a long period of time. Such drugs are usually prescribed for heart disease, high blood pressure, asthma, diabetes, ulcers, anemia and other ailments. If You are currently taking these types of medications, ask Your Doctor to provide needed medications for a 90-day supply plus refills.

You can save money if You use mail order for maintenance medications. For example, three 30-day fills of a generic maintenance medication at a retail pharmacy can cost You $30 ($10 x 3), whereas the 90-day supply through the mail will only cost You $20. This saves $10 every 90 days.

The rules regarding generic substitution apply to the mail order program. If You choose a brand-name drug where a generic can be substituted, You must pay the generic Co-Payment plus the difference in cost between the brand name and generic drugs.

COVERED MEDICATIONS

The Plan covers the following medications:

- Charges for drugs and medicines Necessary for the care and Treatment of a non-occupational accidental bodily Injury or Sickness that are prescribed by a legally qualified Physician;
- Charges for drugs and medicines that can only be obtained by prescription and bear the legend, "Caution, Federal Law Prohibits Dispensing without a Prescription," subject to the limitations and exclusions described below; and
- When received as an outpatient and while eligible for these benefits.

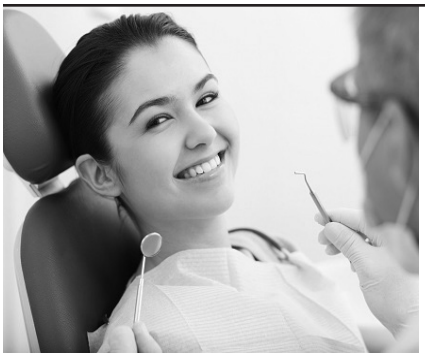
LIMITATIONS AND EXCLUSIONS

The maximum amount, or quantity of prescription drugs that will be considered as eligible charges may not exceed a 30-day supply when taken in accordance with the direction of the prescriber, except:

- Maintenance drugs may be dispensed in amounts of not more than a 90-unit supply (tablets, capsules, etc.), even though, when taken in accordance with the prescriber's directions, such amount would exceed a 30-day supply.

Prescription Drug Benefits are not provided for the following:

- Charges that are not listed as covered charges;
- Charges for a non-legend, patent, or proprietary medicine or medication not requiring a prescription;
- Charges for appliances, supports and prosthetic devices such as, but not limited to, canes, crutches, wheelchairs, or any means of conveyance or locomotion; braces, splints, dressings, bandages, sick room equipment or supplies; heat lamps or similar items; hypodermic syringes and/or needles; or oxygen;
- Charges for immunizing agents, biological sera, blood or blood plasma, injectables, or any prescription directing parental administration or use, except insulin;
- Charges for vitamins, vitamin prescriptions, cosmetics, dietary supplements, or health or beauty aids;
- Charges for medication that is to be taken or administered, in whole or in part, to the individual while a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution;
- Charges for drugs or medicines delivered or administered to the eligible individual by the prescriber;
- Charges for any drug labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the individual;
- Charges for drugs procured without a Physician's prescription;
- Depo-Provera and Norplant;
- Charges for drugs prescribed for Injury or Sickness resulting from war or any act of war;
- Drugs obtained after the termination of eligibility for benefits under this Plan;
- Injectable Drugs (however, Imitrex, Epipen, and diabetic injectables such as insulin are covered);
- Diabetic supplies including test strips, lancets, monitors;
- Retin-A, Renova, and Differen for persons over age 25;
- Drugs used to treat baldness;
- Growth hormones; and
- Any other applicable general exclusion listed in Articles 5 or 9 of this booklet.



DENTAL CARE

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SCHEDULE OF BENEFITS

Calendar Year Maximum Benefit	**Participant = $750** **Dependents = $500 total***
Preventative Services	Plan pays 80%; You pay 20%
Restorative Services	Plan pays 80%; You pay 20%

**$500 Calendar Year Maximum does not apply to essential dental benefits for Dependent Children under 19 years of age.*

CIGNA DENTAL PROVIDER NETWORK

Dental benefits are available to all eligible Participants and their eligible Dependents. The Plan has contracted with CIGNA Dental Provider Network to provide basic dental benefits to eligible Participants and their eligible Dependents. No Out-of-Network benefit is available for dental benefits; therefore, it is necessary for eligible Participants and their eligible Dependents to have services performed by a CIGNA participating In-Network dentist. Benefits will not be paid for any service provided by an Out-of-Network dentist. A nationwide list of participating In-Network dentists can be obtained by contacting CIGNA Dental at (800) 797-3381, or by visiting the website at www.cignadentalnetworksolutions.com.

BENEFITS WITHIN THE CIGNA NETWORK

GENERAL BASIC BENEFITS

The Plan provides the following basic services provided they are performed by a participating In-Network dentist:

Routine oral examination, limited to 2 visits per Covered Person per year (once every 6 months), plus Emergency examinations;

X-rays - including single films, full-mouth series and bite wing x-rays. Full-mouth series are limited to one set per Covered Person every 36 months. Bitewing x-rays are limited to one set per Covered Person every 6 months. Panoramic x-rays may be substituted for full-mouth x-rays if a set of bitewings are taken at the same time for the initial diagnosis.

Prophylaxis - including cleaning, cleaning with fluoride paste, and scaling, but no more frequently than once every six months;

Restorative dentistry as follows:

Fillings - All silver and composite fillings, unlimited in size and quantity, with local anesthesia;

Gum Treatment - Scaling of teeth over and above the routine scaling of a thorough prophylaxis; gum Treatment and/or scaling Treatments are limited to a maximum of 2 Treatments per Covered Person per year;

Simple Extraction (non-Surgical) – Unlimited in quantity, with local anesthesia;

Medications - covered under prescription drugs in Article 6 of this Plan.

This is only a summary of dental benefits provided by the Fund. You may call the Fund Office for a complete benefit listing.

EXCLUSIONS

The following are not covered under the Dental Benefit provisions of the Plan:
Major dental services, i.e., crowns, bridges, etc.

- Expenses incurred after termination of eligibility, except temporary fillings will be replaced with permanent fillings for a period of 30 days following termination;
- Any procedure begun while an individual was not eligible under this Plan;
- Hospital administered anesthesia or general anesthesia for restorative dentistry procedures or fillings;
- Separate fluoride Treatments;
- Panoramic x-rays, except as substituted for a full-mouth x-ray;
- Implants or Temporomandibular Joint Treatment or diagnosis, including such procedures as bite planes;
- Bedside calls, either home or Hospital;
- Treatment of any Covered Person whose medical condition would, in the estimation of the director of dental services, make conduct of dental services in the office unsafe or hazardous to that Covered Person's health;
- Any cosmetic, beautifying or elective procedure;
- Re-cementing of inlays or overlays;
- Services of a dentist or other practitioner of the healing arts not approved by the Plan;
- Experimental procedures, implantation or pharmacological regimens;
- Proprietary drugs, available with or without prescription;
- Convenience and personal items;
- Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability Law;

- Oral surgery;
- Treatment of malignancies, cysts, neoplasms or congenital malformations;
- Dentures, crowns or bridgework;
- Services which, in the opinion of the attending dentist, are not Necessary for the patient's dental health;
- Services provided by or paid for by any governmental agency (whether state, federal or otherwise) or under any governmental plan or law, except as to charges which the Covered Person is legally obligated to pay, unless otherwise required by applicable law, which exclusion extends to any benefits provided under the United States Social Security Act and its amendments;
- Services covered under any other group plan or employer, union, or association sponsored plan;
- The placement of bone grafts or extra-oral substances in the Treatment of periodontal disorders;
- Treatment of any disease contracted, or Injuries sustained as a result of war, declared or undeclared and any Illness or Injury occurring after the effective date of this Plan and caused by atomic explosion, whether or not the result of war;
- Prophylaxis more frequently than once every six months; and
- Any other applicable general exclusion listed in Articles 5 or 9 of this booklet.

VISION CARE

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SCHEDULE OF BENEFITS

	In-Network Provider Plan pays	**Out-of-Network Provider Plan pays**
Annual Examination	100% after You pay: $10 Co-Pay	Up to $50 after You pay: $10 Co-Pay
Eyeglass Lenses (Annually)		
Single Vision	100% after You pay: $25 Co-Pay	Up to $50 after You pay: $25 Co-Pay+
Bifocal	100% after You pay: $25 Co-Pay	Up to $50 after You pay: $25 Co-Pay+
Trifocal	100% after You pay: $25 Co-Pay	Up to $50 after You pay: $25 Co-Pay+
Lenticular	100% after You pay: $25 Co-Pay	Up to $50 after You pay: $25 Co-Pay+
Eyeglass Frames*	Up to $130 allowance	Up to $70 after You pay: $25 Co-Pay+
Contact Lenses**	Up to $130 allowance	Up to $105 after You pay: $25 Co-Pay
Safety Glasses***	100%	$0

* *Every other year*
** *In lieu of examination, lenses and frames, every other year*
*** *Available to Participants only*
\+ *$25 Co-Pay for lenses and frames is a combined Co-Pay; thus, a complete set of eyeglasses including lenses and frames will be subject to no greater than a $25 Co-Pay*

VISION SERVICE PLAN (VSP)

VSP is available to Participants and eligible Dependents receiving medical benefits under the Plan. The Plan provides Vision Care Benefits through a Policy with Vision Service Plan ("VSP"). VSP is a Preferred Provider Organization specializing in vision care at negotiated rates. The Plan will provide a listing of VSP vision specialists, upon request. With VSP, an eligible Participant and his/her eligible Dependents are able to choose from In-Network private practice providers and retail chain providers.

To find an In-Network provider, visit VSP's Website – www.vsp.com – and provider locator or call VSP's Provider Locator Service at (800) 877-7195, and follow the voice prompts. You will need the unique identification number of the primary insured and the zip code for the area You wish to check.

Prior to using benefits at an In-Network provider, please call the provider and make an appointment. Please inform the provider that You are a VSP Participant. This will assist the provider in obtaining a claim authorization number prior to Your visit.

BENEFITS WITHIN THE VSP NETWORK

The following benefits are available through a VSP vision specialist:

Eye Examination - A comprehensive vision examination is covered in full after a $10 Co-Pay, once every year, when provided by an In-Network optometrist or ophthalmologist.

Materials - Standard lenses are covered once every year and frames from VSP's selection are covered once every other year, or an eligible Participant or eligible Dependent may select contact lenses in lieu of lenses and frames once every other year.

Pair of Lenses - If prescribed, a pair of standard single vision or standard multi-focal lenses is covered–in-full after Co-Pay. Standard scratch resistant coating is covered in full. If lens options not covered by the program are chosen, such as, but not limited to, progressive lenses, polycarbonate lenses, high index tints, UV, and anti-reflective coating, these options may be available for purchase at a discount.

Frames – A pair of fashionable frames from VSP's covered in full selection will be covered. If frames outside of VSP's covered in full selection are chosen, a $130 retail ($46 wholesale) frame allowance will be provided at private practice providers.

Contact Lenses - In lieu of lenses and frames, contact lenses may be selected. VSP's covered contact lens benefit includes the fitting/examination fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from an In-Network provider. It is important to note that VSP's covered contact lenses may vary by provider. Should contact lenses outside of the covered selection be chosen, a $130 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every other year. Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of VSP's covered contacts. Necessary contacts are covered in full after applicable Co-Payment.

Refractive Eye Surgery - VSP eligible Participants and eligible Dependents receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in Your area, visit the VSP website at www.vsp.com.

Eligible Participants and eligible Dependents will be responsible for the added cost of:

- Special options such as photosensitive, cosmetic tinted, or over-sized lenses
- Special type of frames (e.g., a designer frame) which exceed the maximum allowable benefit
- A second pair of glasses

BENEFITS OUTSIDE THE VSP NETWORK

If an Out-of-Network provider is chosen for services, reimbursement will be limited to the amounts shown in the Vision Care Schedule of Benefits above.

When Out-of-Network providers are used, itemized receipts with the Participant's unique identification number and the patient's name and date of birth must be submitted **within 60 days after the date of service** to: VSP, Attention: Claims, P.O. Box 997105, Sacramento, CA 95899-7105, or faxed to (916) 851-5152, in order to receive reimbursement.

Please note: Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement.

EXCLUSIONS

The following services and materials are excluded from coverage under the Vision Care Benefits of the Plan:

- Post cataract lenses;
- Non-prescription items;
- Medical or surgical Treatment for eye disease that requires the services of a Physician;
- Services or materials covered under a Workers Compensation law;
- Services or materials that the patient, without cost, obtains from any governmental organization or program;
- Services or materials that are not specifically covered by the Plan;
- Sunglasses, plain or prescription;
- Replacement or repair of lenses and/or frames that have been lost or broken;
- Cosmetic extras, except as stated in the Policy's Table of Benefits;
- Examinations, lenses, frames, or contacts obtained more frequently than provided by the Plan;
- Safety glasses or goggles or the fitting thereof, except as otherwise provided for in the Schedule of Benefits;
- Visual training, orthoptic, aniseilconia, or reading rate and comprehension studies;
- Expenses incurred prior to the date of eligibility or after termination of eligibility;
- Expenses for which benefits are not payable under the Plan;
- Radial Keratotomy; and
- Any other applicable general exclusion listed in Articles 5 or 9.

GENERAL LIMITATIONS

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TYPES OF SERVICE PROVIDERS

The Fund will, within the limits set forth in this Plan, pay for services provided by the following health professionals:

- Doctor of Medicine (MD),
- Doctor of Chiropractic (DC),
- Doctor of Dental Surgery (DDS),
- Doctor of Dental Medicine (DMD),
- Doctor of Osteopathy (DO),
- Doctor of Podiatry Medicine (DPM),
- Doctor of Psychology (DPs/PsyD),
- Doctor of Optometry (OD),
- Licensed Practical Nurse (LPN),
- Registered Nurse (RN),
- Licensed Clinical Social Worker (LCSW), or a
- Licensed Physical Therapist (LPT).

The Plan will also cover other such providers who are providing care under specific referrals from one of the above-mentioned providers, or who are affiliated with an organization that is under the direct supervision of one of the above-mentioned providers. These other service providers must be licensed under the laws of the state in which Treatment is performed. The services they render must be within the scope of their specific license.

SERVICES NOT COVERED

The Plan does not pay claims for the following:

- All charges for services not specifically listed as Covered Services;
- Expenses for care which are not Medically Necessary, except as previously specified;
- Expenses in excess of the UCR Charge for Out-of-Network benefits;
- Work-related Injuries or Illnesses (see Workers' Compensation provisions in Section C below);
- Charges for losses resulting from war or an act of war;
- Charges for an Injury or Sickness contracted while in the Armed Forces;
- Charges for cosmetic, elective or reconstructive surgery, except as previously specified;
- Charges incurred in connection with pregnancy, childbirth or miscarriage other than such charges incurred by the Participant or the Participant's eligible Dependent Spouse;
- Expenses for Custodial Care, except as directed by the Director of CIGNA OAP;
- Charges for services provided by a licensed social worker, or other certified specialist for the Treatment of mental and nervous disorders, unless such services are provided under the direction of a psychiatrist or psychologist;
- Expenses You are not required to pay;
- Charges for, or in connection with, services and supplies which are Experimental, Investigational or Unproven, including any Treatment, drug, or supply which is not recognized as acceptable medical practice, or any items requiring governmental approval which was not granted at the time the services were rendered;
- Charges for education, training, and/or Room and Board while confined in an institution which is primarily a school or institution for training, a place of rest, a place for the aged or a nursing home;
- Charges for which payment is provided under a governmental program;
- Charges for procedures which are not prescribed by a Physician and/or are not Medically Necessary;
- Charges for the Treatment of obesity;
- Charges for the care of corns, bunions (except capsular or bone surgery therefore), calluses, nails of the feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except where major surgery is performed;
- Charges for the purchase or rental of air conditioners, humidifiers, exercise equipment, whirlpools or similar devices;
- Charges for services for which a claim is filed later than one year from the date the service was rendered;
- Expenses for educational training; and
- Any Injury/Illness sustained by the Covered Person for which a Third Party may be liable.

In addition to the foregoing, when two or more surgical procedures are performed at the same time and in the same operative field, payment will be made for only that operation for which the largest cost is scheduled.

WORKERS' COMPENSATION

In general, no benefit payments will be made for workers' compensation claims submitted on behalf of a Participant or his Dependents. This Plan has been designed to provide coverage for Participants and their eligible Dependents for Illnesses or Injuries that are not job-related. In today's world of rising medical costs, You must be extremely careful not to submit work-related claims for payment by the Plan. You also have to be careful not to use Your prescription drug card to obtain medications for a work-related Injury or Illness.

By law, Your employer is required to provide You with medical coverage for all work-related Illnesses or Injuries.

The Board of Trustees recognizes, however, that if a Participant's employer's insurance carrier denies his initial Workers' Compensation claim, the appeal process may take a long time. Consequently, the Board has adopted provisions with respect to work-related injuries and illnesses so that Participants can, in appropriate cases, get some interim financial relief from the Plan while the Workers' Compensation appeal process is pending. This exception applies to Participants only. In order for Participants to receive benefits for a work-related Injury/Illness, the Participant must comply with all of the Fund's subrogation and reimbursement provisions set out in Article 11, and the Participant and the Participant's attorney must sign the Fund's subrogation agreement. Failure to comply with any of the Fund's subrogation and reimbursement provisions or refusal of the Participant or the Participant's attorney to sign the Fund's subrogation agreement will result in no benefits being paid in relation to the Participant's work-related Injury/Illness.

PLAN ADMINISTRATION

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As a Participant in the Regional District Welfare Fund, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

CLAIM DETERMINATIONS

If Your claim for benefits from the Plan is denied, in whole or in part, You will be notified within a reasonable period of time, but not later than the following:

TYPE OF CLAIM	TIME LIMIT FOR CLAIM DETERMINATION	EXTENSION PERMITTED
Medical, Prescription Drug, Dental, Vision, Member Assistance Program, Mental Health, Drug and Alcohol Dependency, Disease Case Management		
Urgent Claims (as medically determined)	72 hours	None
Pre-Service Claims	15 days	15 days
Post-Service Claims	30 days	15 days
Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None

If the Fund Office needs more information to make a determination on Your claim, You will be notified within a reasonable period of time, that will not exceed the time period required by law. Extensions are permitted in certain cases if the Fund Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, You will be provided with written notice of the extension prior to the end of the time period for responding.

The Fund Office's notification of a claim denial will set forth the following:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for You to perfect the

claim and an explanation of why such material or information is necessary;

- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action under Section 502(a) of ERISA after You have exhausted the appeals process;
- With respect to a claim for medical, prescription drug, dental, vision, member assistance program, mental health, or drug and alcohol dependency, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge to You upon request; and
- With respect to a claim for medical, prescription drug, dental, vision, mental health, or drug and alcohol dependency, if the denial is based on a Medical Necessity or Experimental, Investigational or Unproven Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- With respect to an urgent care claim, a description of the expedited review process applicable to such claims.

In the case of a failure by a claimant to follow the Plan's procedures for filing a pre-service claim, the claimant or his/her duly authorized representative shall be notified by the Plan of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days (24 hours for urgent care claims) following the failure.

CLAIM APPEAL

If Your claim is denied, You or Your duly authorized representative may appeal the denial of the claim by giving notice in writing to the Board of Trustees within 180 days from the date of the claim denial. Your appeal may include written comments, documents, records, and other information relating to the claim for benefits. An appeal must be submitted in writing to the Fund Office by the claimant or a duly authorized representative. An appeal must include the following information:

- the benefit determination being appealed;
- the reason(s) for the appeal;
- any additional information that the claimant feels is pertinent.

Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or the parent or legal guardian, where appropriate) which identifies the representative and authorizes him/her to seek the benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim within 180 days of the claim denial will serve as a bar to any claim for benefits or for other relief from the Plan. In the case of a claim involving urgent care, a claimant or his/her authorized representative may submit an expedited appeal orally or in writing and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available expedited method.

Appeal Procedures – The Procedures specified below will be the exclusive procedures available to a claimant who is dissatisfied with an eligibility determination, benefit award or is otherwise adversely affected by an action of the Plan. These procedures must be exhausted before a

Type of Claim	Time Limit for Claim Determination	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Member Assistance Program, Mental Health, Drug and Alcohol Dependency, Disease Case Management	Next quarterly meeting (if claim received 30 days prior)	If received within 30 days before next quarterly meeting postponed until next next quarterly meeting.
Urgent Claims	72 hours	None
Pre-Service Claims	30 days	None
Post-Service Claims	Board meeting (if claim received 30 days prior)	Next quarterly meeting
Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None

claimant may file a suit under Section 502(a) of ERISA. Any claims brought against the Fund, its employees or any of the Trustees, must be brought in the United States District Court for the Eastern District of Missouri and must be brought within two (2) years of the date of the action giving rise to the claim.

In addition, upon request and free of charge, You may have reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination. If a denial is based upon medical determination, an explanation of that determination and its application to the individual's medical circumstances is also available upon request.

Hearings by the Appeal Committee - Except for urgent care claims and pre-service health claims, an appeal will be presented to the Plan's Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following the appeal. The Board will determine Your appeal within a reasonable period of time, but not later than the following:

If Your claim is determined at a Board meeting, You will be notified of the determination upon review as soon as possible but no later than 5 days after the determination is made.

If the denial of a claim for medical, dental, vision, mental health, disease case management, or drug and alcohol dependency benefits was based in whole or in part on a medical judgment, on review, the Board will consult with a health care professional who was not consulted in connection with the denial that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical judgment. In making the determination on appeal, the Board will not afford deference to the initial claim denial.

The Board will notify You in writing of the benefit determination on review. In the case of a claim denial, the notification will set forth the following:

- The specific reason or reasons for the denial;

- Specific references to pertinent Plan provisions on which the denial is based;
- A statement that You are 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 for benefits;
- A statement of other voluntary appeal procedures and Your right to obtain information about such procedures that may be available, and a statement of Your right to bring a civil action under Section 502(a) of ERISA;
- With respect to a claim for medical, prescription drug, dental, vision, mental health, drug and alcohol dependency, or disease case management, an internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request;
- With respect to a claim for medical, prescription drug, dental, vision, mental health, drug and alcohol dependency, or disease case management, if the adverse benefit determination is based on a Medical Necessity or Experimental, Investigational or Unproven Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- The following statement, "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

You may not bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. Any challenge will be limited to the facts, evidence, and issues presented to the Board of Trustees during the claims review procedure. Issues not raised with the Board of Trustees during the appeal process will be deemed waived.

COORDINATION OF BENEFITS

Under the terms of this Plan, You are not entitled to be paid more than 100% of Your Covered Expenses from this Plan and any other plan combined. Payments You receive from other sources can affect payments from this Plan. The Fund Office will work with Your other health plan to ensure You receive all the benefits to which You are entitled.

When two plans provide the same coverage, one is primary, the other is secondary. The primary plan will pay benefits first and without consideration of the other plan(s). The secondary plan(s) then makes up the difference up to the total allowable expenses. The order in which benefits will be determined is as follows:

When another plan does not have a COB provision, that plan must pay its benefits first.

When another plan does have a COB provision, the first of the following rules which applies govern:

1. A plan covering a person as an employee, participant, member, subscriber or non-dependent will be the primary plan.
2. If the claimant is a dependent child covered by more than one plan, the order of benefits is determined as follows unless there is a court order stating otherwise:

(a) For a dependent child whose parents are married and living together, or whose

parents are living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan:

i. If both parents have the same birthday, the plan covering the parent for the longer period of time will be the primary plan.

ii. If one plan uses the gender rule (i.e. the father's coverage is primary over the mother's coverage) and the other plan coordinates using the rule based on the parent's birthdays, the plan using the gender rule shall be the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

iii. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, then the plan covering the parent responsible for the dependent child's health care expenses or health care coverage is the primary plan;

iv. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan covering the parent who has primary custody of the child is the primary plan;

v. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage and the court decree states that the parents have joint custody, the provisions of subparagraph 2(a) above shall determine the order of benefits;

vi. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph 2(a) above shall determine the order of benefits;

vii. If there is no court decree and the child primarily resides with one parent, the order of benefits for the child are as follows:

- The plan covering the parent with whom the child primarily resides

- The plan covering the spouse of the parent with whom the child primarily resides

- The plan covering the parent with whom the child does not primary reside; and then

- The plan covering the spouse of the parent with whom the child does not primarily reside

viii. If there is no court decree and the child resides equally with both parents, the provisions of subparagraph 2(a) above shall determine the order of benefits.

ix. If there is no court decree that governs and the child does not reside with either parent, the provisions of Subparagraph 2(a) above shall determine the order of benefits.

3. When the rules of paragraphs 1 and 2 do not establish an order of priority, the plan which has covered the person for the longer time will be considered primary.

4. If none of the preceding rules determine the order of benefits, the Allowable Expense(s) shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been primary.

5. A governmental plan is always primary, unless required by statute.

You have the responsibility to fully inform the Plan of any and all health insurance coverage available to You. You must disclose this information on the Individual Enrollment Card that You complete at the time You attain eligibility. You are also obligated to inform the Plan at any time the information regarding other health insurance coverage changes.

COORDINATION OF BENEFITS WITH MEDICARE

ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

Under federal law, if a Participant or the eligible Dependent of a Participant is eligible for health care benefits under this Plan and also eligible for Medicare regardless of age, this Plan is the primary plan and Medicare pays secondary to this Plan. That is, this Plan will pay its normal benefits first and Medicare may pay some or all of the charges not paid by this Plan.

Even though this Plan is primary for Participants and eligible Dependents, Participants and eligible Dependents are encouraged to enroll in Medicare when eligible. There is no premium for Part A of Medicare covering hospital expenses, but Part B covering other medical expenses does require a monthly premium.

END STAGE RENAL DISEASE (ESRD)

Medicare has special rules for individuals who are eligible for Medicare due to end stage renal disease (kidney failure). In most cases, this Plan will be primary for the first 30 months the person is eligible for Medicare due to ESRD. After 30 months, or when benefits are exhausted, whichever comes first, Medicare will be primary and this Plan will pay secondary. The only exception is if the person is already retired and covered by Medicare when he meets the eligibility requirements for Medicare due to ESRD. In that case, Medicare will continue to be primary and this Plan will continue to pay secondary to Medicare.

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the Covered Person and at the discretion of the Fund and will not constitute an assignment of benefits under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a court order giving a child who otherwise might not be eligible for medical coverage under the Plan a right to such coverage. Normally, such an order is issued by the court in connection with a divorce or separation. Before the Fund Office will comply with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. A Participant will be notified if a court order relating to the Participant is received by the Fund Office and the procedure used to determine whether the order is a QMCSO. You may get a copy of the Plan's QMCSO procedures from the Fund Office at no charge.

OVERPAYMENT AND MISTAKEN PAYMENT POLICY

If the Plan makes an overpayment or mistaken payment for a Participant, Dependent or other person for which he/she is not entitled, or if the Plan pays: benefits to or on behalf of an individual who fails to observe the Plan's Reimbursement and Subrogation provisions, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including the Participant and/or the provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan which has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the Participant and/or any of his/her Dependents. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes.

Upon a demand for repayment, the Participant shall promptly reimburse the Plan. If no response is received within 10 days, or if the Participant cannot or will not reimburse the Plan directly, any future claims submitted by the Participant and his/her Dependent(s) will be offset against the amount overpaid until it is recovered in full.

If an overpayment or mistaken payment is made to a service provider, such overpayment shall be held in constructive trust by the service provider. The Plan shall seek recoupment from the service provider. If the service provider fails to repay this money, a demand for repayment will be made directly to the Participant. If the Plan is still unsuccessful in recovering the overpayment, or if the Participant cannot or will not reimburse the Plan directly, future claims submitted by the Participant and his/her Dependent(s) will be offset against the amount overpaid until it is recovered in full.

The Trustees reserve all legal rights, including the right to sue for the full amount of the overpayment.

REIMBURSEMENT & SUBROGATION

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The Fund is not obligated to pay out benefits in connection with an Illness or Injury for which a Third Party may be responsible.

If this Fund pays out any benefits in connection with an Illness or Injury for which a Third Party may be responsible, the Fund has rights to reimbursement and subrogation, and such benefits are paid on the express condition that the Covered Person (and his/her spouse, parent(s) and/or child(ren), to the extent the spouse, parent(s) and/or child(ren) recover damages, including but not limited to damages for loss of consortium, in connection with the Covered Person's Illness or Injury) must comply with the terms and conditions set forth herein and in any written agreement executed by and between the Fund and the Covered Person.

In order to receive benefits from this Fund in connection with an Illness or Injury for which a Third Party may be responsible to compensate the Covered Person (and, if applicable, his/her spouse, parent(s) and/or child(ren)), that Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Fund when the Covered Person suffers an Illness or Injury for which a Third Party may be required to compensate the Covered Person (or his/her spouse, parent(s) and/or child(ren)).

DEFINITIONS

For purposes of this Reimbursement and Subrogation section, the following definitions shall apply:

Covered Person means any individual to or on whose behalf this Fund pays out benefits, including such individual's guardian(s), estate, heir(s), or other representative(s).

Third Party means any individual(s) or entity(ies) who caused the Covered Person's Illness or Injury and any other individual(s) or entity(ies) that has an obligation to pay compensation of any sort to the Covered Person (or his/her spouse, parent(s), and/or child(ren)) as a result of that Illness or Injury. For example, both the insurer of the responsible Third Party and the insurer of the Covered Person are included in the meaning of "Third Party" to the extent that such insurers are obliged to compensate the Covered Person (or his/her spouse, parent(s) and/or child(ren)) as a result of the Illness or Injury.

REIMBURSEMENT

A Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Fund when he/she suffers an Illness or Injury for which a Third Party may be required to compensate the Covered Person (or his/her spouse, parent(s) and/or child(ren)). If the Fund pays out any benefits to or on behalf of a Covered Person in connection with an Illness or Injury for which a Third Party may be responsible, such benefits are paid on the express condition that the Covered Person (and his/her spouse, parent(s) and/or child(ren), to the extent the spouse, parent(s) and/or child(ren) recover any damages, including but not limited to damages for loss of consortium, in connection with the Covered Person's Illness or Injury) must reimburse the Fund for the benefits it paid out if the Covered Person (or his/her spouse, parent(s) and/or child(ren)) recover any amounts from any Third Party(ies).

If the Fund pays benefits related to such Injury or Illness, the Fund has first priority in payment over the Covered Person (or his/her spouse, parent(s) and/or child(ren)) or any other party to receive reimbursement from any amounts recovered to the extent of the benefits paid by the Fund on their behalf. This applies to any recovery from any Third Party by settlement, arbitration award, judgment, insurance proceeds or otherwise, including, but not limited to, amounts recovered from uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers= compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. The Covered Person (and his/her spouse, parent(s) and/or child(ren)) agrees to assign to the Fund an interest (equal to the amount of benefits paid in connection with the Illness or Injury) in any suit, claim, demand, action or right of action brought by the Covered Person (or his/her spouse, parent(s) and/or child(ren)).

If the Fund pays benefits on behalf of the Covered Person and he/she makes a recovery (or if his/her spouse, parent(s) and/or child(ren) make a recovery), he/she must promptly reimburse the Fund the lesser of: (1) the full amount recovered, or (2) the full value of the benefits paid by the Fund on his/her behalf, whether or not he/she has been fully compensated or "made whole" for his/her losses, regardless of how the recovery is characterized and regardless of whether the recovery is called something other than a payment for medical expenses, unless due to extenuating circumstances, the Fund agrees to a lesser amount in writing. The Fund specifically rejects the "make whole" doctrine. The Fund may recover the full amount of benefits paid by the Fund, without regard to any claim of fault on the Covered Person's part or the part of his/her spouse, parent(s), child(ren) or beneficiary(ies), whether under comparative negligence or otherwise.

As a condition of the Fund's payment of benefits, the Covered Person (and his/her spouse, parent(s), child(ren) and attorney(s)) must (1) acknowledge that the Fund has first priority against the proceeds of any such settlement, arbitration award, judgment, or any other amounts; and (2) assign to the Fund any benefits he/she may have under any insurance policy or other coverage, to the extent of the Fund's claim for reimbursement. By accepting any benefits advanced by the Fund under this section, the Covered Person (and his/her spouse, parent(s), child(ren) and attorney(s)) acknowledges that any proceeds of settlement or judgment, including a claim to proceeds held by another person, are being held for the benefit of the Fund under these provisions, and the Covered Person (and his/her spouse, parent(s), child(ren) and attorney(s)) consent to the right of the Fund to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Fund's rights.

The Fund agrees that its reimbursement may be reduced by its proportionate share of attorney's fees and costs incurred by the Participant and/or the Covered Person in connection with the recovery in such amount as the Fund in its sole discretion decides, but in no event by more than one-third of the recovery amount for fees and costs. No court costs or attorneys' fees may be deducted from the Fund's recovery without the express written consent of the Fund. Any so-

called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” does not defeat this right.

In cases of occupational Illness or Injury, the Fund’s recovery rights will apply to all amounts recovered, regardless of whether the Illness or Injury is compensable under any workers= compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, will be deemed to include the Fund’s interest and the Fund must be reimbursed in first priority from any such award or settlement.

SUBROGATION

A Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Fund when he/she suffers an Illness or Injury for which a Third Party may be required to compensate the Covered Person (or his/her spouse, parent(s) and/or child(ren)). If the Fund pays out any benefits to or on behalf of a Covered Person in connection with an Illness or Injury for which a Third Party may be responsible, such benefits are paid on the express condition that the Fund will be subrogated to all claims, demands, actions and/or rights of action of the Covered Person (and his/her spouse, parent(s) and/or child(ren)) against the Third Party (including any insurance carrier) to the extent of the value of the benefits paid by the Fund. This right includes, but is not limited to, rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers’ compensation coverage or other insurance. This means that to the extent the Covered Person (and his/her spouse, parent(s) and/or child(ren)) has a claim against any Third Party as a result of an Illness or Injury for which the Fund pays out benefits, the Fund has a right to pursue the Covered Person’s (and his/her spouse, parent(s) and/or child(ren)’s) claim. In effect, the Fund “stands in the place” of the Covered Person (and his/her spouse, parent and/or child(ren)) with respect to such claim(s). The amount of the Fund’s subrogation interest is equal to the amount it paid out in connection with the Illness or Injury, plus the attorneys’ fees and costs it incurs in pursuing the claim against the Third Party(ies).

The Fund may assert its claim against any Third Party regardless of whether the Covered Person (or his/her spouse and/or child(ren)) asserts a claim. In addition, the Fund may join in any claim, demand, action and/or rights of action the Covered Person (and his/her spouse and/or child(ren)) brings against the Third Party. While the Fund may assert its claim individually or join in any claim, demand, action and/or rights of action, the Fund is not obligated to do so. The Fund does not waive any of its rights to reimbursement by not independently asserting its claim against any Third Party or by not joining in any claim, demand, action and/or rights of action brought by the Covered Person (and his/her spouse, parent(s) and/or child(ren)) against any Third Party.

The Fund’s subrogation right is a first priority right and must be satisfied in full before the Covered Person’s (and his/her spouse, parent(s) and/or child(ren)’s) claims or any claims of his/her representative(s), whether or not he/she is fully compensated for all losses.

OBLIGATIONS OF COVERED PERSON (AND HIS/HER SPOUSE AND/OR DEPENDENTS)

The Covered Person (and his/her spouse, parent(s) and/or child(ren)) must cooperate with the Fund and its agents and do whatever is necessary in order to protect the Fund’s reimbursement and subrogation rights. Cooperation means providing the Fund with any relevant information requested by it, including but not limited to information related to the Covered Person’s Illness or Injury; signing and delivering such documents as the Fund reasonably requests to set forth the Fund’s rights and the Covered Person’s (and his/her spouse, parent(s) and/or child(ren)’s)

obligations and effect any assignment of benefits, protect the Fund's right of reimbursement, or to secure the Fund's subrogation claim, including the Fund's Subrogation Agreement, and taking such other actions as the Fund reasonably requests to assist the Fund in making a full recovery. The Covered Person (and his/her spouse, parent(s) and/or child(ren)) must not take any action that prejudices the Fund's rights of reimbursement or subrogation and the Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify their attorney (if any) of: (1) the Fund=s rights to subrogation and reimbursement, and (2) that any monies received by or on behalf of the Covered Person (and his/her spouse, parent(s) and/or child(ren)) are the property of the Fund and are to be held in constructive trust for the Fund. The Covered Person (and his/her spouse, parent(s) and/or child(ren)), must have their attorney complete the attorney portion of the Fund's subrogation agreement. The Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Fund when a claim(s) has been asserted against a Third Party(ies) and must keep the Fund informed as to the status of such claim or claims. Furthermore, the Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Third Party(ies) of the Fund's subrogation and reimbursement rights, and that any monies payable to the Covered Person (and his/her spouse, parent(s) and/or child(ren)) are the property of the Fund and are to be held in constructive trust for the Fund. The Covered Person (and his/her spouse, parent(s) and/or child(ren)) must obtain the written consent of the Fund or its designee prior to settling any claim to which this Fund is subrogated or entitled to reimbursement; notify the Fund of any compensation the Covered Person (or his/her spouse, parent(s) and/or child(ren)) receives from any Third Party in connection with the Illness or Injury; immediately reimburse the Fund upon the receipt of such compensation, and hold any amounts recovered in trust for the benefit of the Fund up to the amount paid by the Fund in connection with the Illness or Injury.

Until the Fund has been fully reimbursed for the benefits it paid out in connection with the Injury or Illness for which a Third Party is liable, any monies received by or on behalf of the Covered Person (and his/her spouse, parent(s) and/or child(ren)) from any Third Party are the property of the Fund and are held in constructive trust by the Covered Person (and his/her spouse, parent(s) and/or child(ren)), as well as their agents, including their attorney(s).

FUND'S ENFORCEMENT OF THESE PROVISIONS

In the event the Covered Person (or his/her spouse, parent(s) and/or child(ren)) fails to fulfill his/her obligations under these reimbursement and subrogation provisions, the Fund may take any action the Trustees deem necessary to enforce the Fund's rights under these provisions. The Fund may refuse to pay benefits in connection with the Illness or Injury if the Covered Person (or his/her spouse, parent(s) and/or child(ren)) fails to fulfill his/her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Fund does pay benefits and the Covered Person (or his/her spouse, parent(s) and/or child(ren)) later fails to fulfill his/her duties under this section, the Fund may recoup the amounts it paid out by withholding future benefits from the Covered Person, the Participant (if different from the Covered Person), and the Participant's covered Dependents, by seeking refunds from the providers of care or by bringing a legal action against the Covered Person (and/or his/her spouse, parent(s) and/or child(ren)). Should the Trustees bring legal action to enforce their rights under these reimbursement and subrogation provisions, and succeed, in whole or in part, in such action, the Covered Person (or his/her spouse, parent(s) and/or child(ren)) shall pay the legal fees and costs the Trustees incur in that action.

OBLIGATIONS OF COVERED PERSON'S (AND HIS/HER SPOUSE, PARENT(S) AND/OR CHILDREN'S) ATTORNEY

Should the Covered Person (or his/her spouse, parent(s) and/or child(ren)) decide to employ an attorney to represent him/her in connection with the Illness or Injury, the Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify the Fund immediately upon retaining said attorney. In addition, the Covered Person (and his/her spouse, parent(s) and/or child(ren)) must notify his/her attorney of the Fund's right to subrogation and reimbursement and have his/her attorney complete the attorney portion of the Fund's subrogation agreement. The Covered Person's (and his/her spouse, parent(s) and/or child(ren)'s) attorney must be willing to enter into an agreement with the Fund stating that he/she acknowledges the Fund's right to subrogation and reimbursement and that he/she acknowledges that if a settlement is made, or any amount is otherwise recovered with respect to the Illness or Injury, or any expenses or damages are recovered in connection therewith, that all said amounts (up to the amount paid by the Fund in connection with the Illness or Injury) are assets of the Fund and that the attorney will hold the Fund assets in constructive trust for the benefit of the Fund. When any Funds are received, the attorney acknowledges that he/she is a fiduciary of the Fund with regard to those assets. The attorney must further agree to, upon receipt of the proceeds of any settlement or judgment, immediately notify the Fund and refund to the Fund all amounts due the Fund. The Fund agrees that its reimbursement may be reduced by its proportionate share of attorney's fees and costs incurred by the Participant and/or the Covered Person in connection with the recovery in such amount as the Fund in its sole discretion decides, but in no event by more than one-third for fees and costs. No court costs or attorneys' fees may be deducted from the Fund's recovery without the express written consent of the Fund. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" does not defeat this right.

FUTURE CLAIMS RELATING TO THE SAME ILLNESS OR INJURY

Once the Covered Person's (or his/her spouse, parent(s) and/or child(ren)'s) claims against the Third Party(ies) are resolved, the Fund will not pay out any additional benefits in connection with the Injury or Illness caused by the Third Party(ies) until the total claims that would otherwise be covered under the Fund exceed the total amount of compensation paid to or on behalf of the Covered Person (and his/her spouse, parent(s) and/or child(ren)) by the Third Party(ies). In such a situation, only the excess portion of the otherwise covered claims will be treated as covered.

NOTICE OF PRIVACY PRACTICES

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- We may say "no" to your request in limited circumstances, but we'll tell you why in writing.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Get an electronic copy of your electronic health information

- If your health information is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or another individual or entity you choose. We will give you your electronic health information as required by law and will make every effort to provide you with your electronic health information in the form or format you request. If we cannot provide you with your electronic health information in the form you request, it will be provided in either our standard electronic format or if you do not want it in that format, in a readable hard copy form.
- We may charge you a reasonable, cost-based fee for the labor associated with transmitting your electronic health information.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer for the Fund.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

HELP MANAGE THE HEALTH CARE TREATMENT YOU RECEIVE

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

RUN OUR ORGANIZATION

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

PAY FOR YOUR HEALTH SERVICES

We can use and disclose your health information to coordinate payment for your health services. This may include certain activities that we undertake before we approve or pay for your health care services, such determining whether you are eligible for coverage and determining whether the services provided to you were medically necessary.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

ADMINISTER YOUR PLAN

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS AND WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

INFORM YOU ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH RELATED BENEFITS

We may use your health information to identify whether you may benefit from communications from us regarding available provider networks or available products or services under the Plan; your treatment; case management or care coordination for you, or to recommend alternative treatments, therapies, health care providers, or settings of care for you.

FUNDRAISING ACTIVITIES

We do not anticipate using or disclosing your PHI for fundraising activities; however, we may use and disclose your health information as necessary in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer listed below.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if a web site is available), and we will mail a copy to you.

EFFECTIVE DATE OF THIS NOTICE

This revised Notice of Privacy Practices is effective September 23, 2013.

PRIVACY OFFICER INFORMATION

Pamela Howard, HIPAA Privacy Officer, Regional District Council Welfare Trust
c/o The William C. Earhart Company, Inc.
3140 NE Broadway
Portland, Oregon 97232
Telephone (503) 331-8200
E-mail: pam.h@wcearhart.com

ADDITIONAL INFORMATION

In certain cases, we are required to comply with applicable state laws and regulations, even if they conflict with HIPAA and its regulations, for example, when the state laws and regulations are more stringent than HIPAA and its regulations. We will comply with any applicable state laws and regulations when they are more stringent than HIPAA and its regulations. For example, we will not disclose the identity of an individual upon whom a genetic test has been performed or the identity of a blood relative of the individual, or disclose genetic information about the individual or a blood relative of the individual in a manner that permits identification of the individual, except as otherwise permitted or required in accordance with ORS Section

192.539. In addition, we will not obtain or retain genetic information about an individual except as permitted or required in accordance with ORS Sections 192.535 and 192.537.

Our use and disclosure of your health information is regulated by federal and state law, including the Health Insurance Portability and Accountability Act ("HIPAA"). This Notice attempts to summarize HIPAA and its relevant regulations. HIPAA and its relevant regulations will supersede any discrepancy between the information contained in this Notice and the regulations, except where the information contained in this Notice pertains to a state law or regulation that is not preempted by HIPAA because it is more stringent.

ERISA INFORMATION

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As a Participant in the Regional District Welfare Fund, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

STATEMENT OF RIGHTS UNDER ERISA

ERISA provides that all Plan Participants shall be entitled to:

1. Examine without charge, at the Fund Office and at other specified locations, such as work-sites and union halls, all documents governing the Fund, including insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
2. Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Fund, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may charge a reasonable amount for the copies.
3. Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.
4. Continue health coverage for yourself or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your eligible Dependents may have to pay for such coverage. Review this Plan and the documents governing the Fund on the rules governing Your COBRA continuation rights.

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

If Your claim for benefits is denied or ignored in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time limits.
Under ERISA there are steps You can take to enforce the above rights. For instance, if You request a copy of the Plan document or the latest annual report from the Fund and do not receive same within 30 days, You may file suit in a federal court. In such case, the court may require the

Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

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

INFORMATION REQUIRED BY ERISA

The following, together with information contained in other portions of this booklet, forms the Summary Plan Description under the Employee Retirement Income Security Act of 1974.

NAME AND TYPE OF PLAN

This Plan is the "Regional District Council Welfare Trust." The Plan is an "employee welfare benefit plan" under ERISA. The Plan provides hospitalization, surgical and medical, mental health, drug and alcohol dependency, dental, and prescription drugs to eligible Participants and their eligible Dependents on a self insured basis. The Plan's vision benefits are provided on an insured basis through a contract with Vision Service Plan.

PLAN IDENTIFICATION NUMBERS

Employer Identification Number: 56-2546659
IRS Plan Number: 001

PLAN ADMINISTRATOR

The Plan Administrator is the Board of Trustees of the Regional District Council Welfare Trust. The Board of Trustees consists of an equal number of Employer and Union representatives selected by the Union and by the Employers who have entered into Collective Bargaining Agreements which relate to this Fund.
Board of Trustees
c/o The William C. Earhart, Company, Inc.
P.O. Box 4148
Portland, Oregon 97208
(800) 846-0611

As of March 21, 2017, the Trustees are:

UNION TRUSTEES

Daniel S. Parker
Regional District Council
208 East New York Avenue
Deland, FL 32724

Bernard Evers
International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers
1750 New York Avenue N.W.
Washington, D.C. 20006

Joseph Simpson
Regional District Council Training Trust
208 East New York Avenue
Deland, FL 32724

Jose J. Mendoza
Regional Local Union No. 846
6220 Woodside Executive Court
Aiken, SC 29803

David Gornewicz
International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers
1750 New York Avenue N.W.
Washington, D.C. 20006

MANAGEMENT TRUSTEES

Jeffry Green
Harris Davis Rebar, Inc.
210 Washington St.
Bellevue, NE 68005

Cary Newton
JD Steel Co., Inc.
2101 West Jackson Street
Phoenix, AZ 85009

Keith Smith
Harris Davis Rebar, Inc.
210 Washington St.
Bellevue, NE 68005

Jeffrey Casadont
Gerdau Reinforcing Steel
7326 Mission Gorge Rd.
San Diego, CA 92120

James Whaley
Whaley Steel Corporation
114 Morenci Ave.
Mio, MI 48647

AGENT FOR SERVICE OF LEGAL PROCESS

Any one of the Trustees is a qualified agent of the Board of Trustees for service of process. Service may also be made upon Legal Counsel or the Administrative Manager noted above.

TYPE OF ADMINISTRATION

The Plan is administered by the Board of Trustees. However, the Trustees have engaged The William C. Earhart Company, Inc. on a contract basis to serve as Administrative Manager to oversee the operation and administration of the Fund on a day-to-day basis. Benefits are provided under the Plan as follows:

- Hospital, surgical and medical benefits in accordance with the Trust Agreement on a self-insured basis; but administered in accordance with a preferred provider contract between the Board of Trustees and CIGNA Healthcare.
- Prescription drug benefits on a self-insured basis, but administered in accordance with a pharmacy benefit manager contract between the Board of Trustees and CIGNA Pharmacy.
- Vision benefits in accordance with a vision care contract between the Board of Trustees and VSP.
- Dental benefits on a self-insured basis, but administered in accordance with a dental services contract between the Board of Trustees and CIGNA Dental.

LABOR ORGANIZATIONS REPRESENTING PARTICIPANTS IN THE PLAN

This Plan is maintained by Collective Bargaining Agreements executed by Iron Workers Local 846, Iron Workers Local 847 and the Regional District Council, affiliated with the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers. A copy of any such agreements may be obtained by a Participant or beneficiary upon written request to the Plan Administrator. Also, Collective Bargaining Agreements are available for examination by a Participant or beneficiary at the Fund Office.

NAME AND ADDRESS OF EMPLOYERS CONTRIBUTING TO THE FUND

Participants or beneficiaries may obtain a complete list of the Employers who contribute to the Fund upon written request to the Plan Administrator. Also, this list is available for examination at the Fund Office by Participants or beneficiaries. A Participant or beneficiary may also receive from the Plan Administrator, upon request to the Fund Office, information as to whether a particular employer or union is a Contributing Employer or a collective bargaining representative of an Employer who participates in the Plan and, if so, the address of such Employer or union.

SOURCE OF CONTRIBUTIONS TO THE FUND

Contributions to the Fund are made by individual Employers under the provisions of Collective Bargaining Agreements. Under certain conditions stipulated in the Plan, Participants and Dependents may qualify to contribute on their own behalf in order to continue their eligibility status for a limited period of time.

FISCAL YEAR OF HEALTH TRUST FUND

The annual fiscal year of the Fund begins on July 1 and ends on the following June 30.

MODIFICATION OF BENEFIT SCHEDULES, BENEFITS TERMINATION, OR PLAN TERMINATION

The Fund's ability to provide health and welfare benefits is dependent upon a number of factors that may vary from year to year or even month to month. Accordingly, the Trustees specifically reserve the right to change, eliminate, add to or delete from the Plan, including the Schedule of Benefits provided to Participants, and to eligible Dependents of such Participants. The Trustees also reserve the right to adopt new rules and regulations or to modify the existing rules and regulations. Nothing in this book or elsewhere should be construed to mean that the Plan's benefits are guaranteed. The Trustees will notify Participants when they make significant changes in the rules, regulations or Schedule of Benefits.

DISCRETIONARY AUTHORITY OF THE TRUSTEES

The Trustees reserve discretionary authority to construe and interpret the terms of the Trust Agreement, the Plan, and the rules and regulations that they may make from time to time. The Trustees also reserve the right to make factual findings, fix omissions and resolve ambiguities in the Plan and the rules or regulations. Benefits under the Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

TRUST FUND

All assets are held in trust by the Board of Trustees. Self-insured benefits and administrative expenses are paid from the Trust Fund.

ELIGIBILITY

The Fund's requirements with respect to eligibility, as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits, are fully described in this booklet.

CONTACT INFORMATION

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If You need eligibility or benefits information, contact the Fund Office at: (800) 846-0611.

The Fund Office can provide:

- Your eligibility information
- enrollment forms
- ID cards
- claim forms
- information about a claim or an appeal
- any other benefit information not listed above

When You call or visit the Fund Office, please have Your Social Security Number or Member Identification Number available. The **Fund Office hours are 9:00 AM to 7:00 PM, Monday through Friday EST**. You may also access Participant information and forms via the Participant Website at **www.wcearhart.com**.

If You need to obtain pre-certification for any medical claim or have an Urgent Claim or concurrent medical claim, contact CIGNA at: (800) 768-4695. A "concurrent medical claim" is a claim to continue a current, ongoing course of Treatment.

If You need information about prescription drugs, contact CIGNA Pharmacy at: (800) 244-6224. They can provide You with the following:

- a list of the CIGNA participating national drug store chains
- verification that a drug store is participating in the CIGNA Pharmacy program
- requirements for using the mail order program

Your Member Identification number is located on Your Medical ID card. Your Group number is **3334886**, and it is also printed on Your Medical ID card.

If You need to locate a CIGNA Participating Dentist, contact CIGNA at: (800) 797-3381 or at **www.cignadentalsolutions.com**

If You need to locate a participating CIGNA mental health provider, contact CIGNA at: (800) 768-4695 or at **www.sharedadministration.com**. If you see OAP "Open Access Plus" on the front of your medical ID card, you must select Shared Administration OAP Provider Directory on the website to identify participating providers and facilities in this network.

If You need information about eyeglasses, contact VSP at: (800) 877-7195 or at **www.VSP.com**

TRUST ADMINISTRATIVE OFFICE

The William C. Earhart Company, Inc.
P.O. Box 4148
3140 N.E. Broadway
Portland, OR 97208
800-846-0611
www.wcearhart.com