CONTRACTORS, LABORERS,
TEAMSTERS & ENGINEERS

Health & Welfare Plan

Summary Plan Description

BENEFITS AND ELIGIBILITY RULES

In Effect as of JUNE 1, 2007

TABLE OF CONTENTS

"Este resumen de descripción del plan contiene un resumen en ingles sobre sus derechos bajo el plan y los beneficios bajo el plan de grupo de seguro medico y bienestar de Contractors, Laborers, Teamsters and Engineers. Si tiene alguna dificultad en comprender cualquier parte del resumen de descripción del plan, llame al administrador del plan al 402-491-3751. El horario de su oficina es de lunes a viernes desde las 8:00 AM hasta las 4:30 PM."

ADMINISTRATIVE INFORMATION

The Contractors, Laborers and Teamsters Health and Welfare Fund was established effective January 1, 1963, as the result of Collective Bargaining Agreements between the Heavy Contractors Association, Inc., a Nebraska Corporation, and the Construction Laborers Local No. 1140, Omaha, Nebraska, General Drivers and Helpers Union, Local No. 554, affiliated with the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Omaha, Nebraska, and the International Union of Operating Engineers, Local No. 571. The latter became effective January 1, 1968, and the Fund name changed to Contractors, Laborers, Teamsters and Engineers Health and Welfare Fund. Your employer is paying the cost of the benefits through negotiated contributions made to the Health and Welfare Fund, pursuant to the Provisions of Collective Bargaining Agreements with the following Local Unions: Construction Laborers Local No. 1140, General Drivers and Helpers Union Local No. 554, affiliated with the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, and the International Union of Operating Engineers Local No. 571, which provide for payments to the Health and Welfare Fund.

Management of the Fund is conducted by a Board of Trustees, consisting of representatives from Labor and Management. The duties, responsibilities, and authority of the Trustees are clearly set forth in a Trust Agreement executed between the parties who negotiated the Collective Bargaining Agreement.

Financial records are maintained in an office which has been established by the Trustees to assist you.

The Trustees request that you read this descriptive booklet very carefully so that you fully understand your Health and Welfare Plan. The Fund Administrator will be pleased to answer any questions you might have.

NOTICE

This Summary Plan Description is the Plan Document.

THE PLAN

The Plan of Benefits shall include this Summary Plan Description, the Trust Agreement, Trustees' Minutes, and letters of notifications of benefit or eligibility changes. To make sure of your coverage on a current basis, please verify your eligibility, coverages, and benefits with the Trust. This Document is intended to be as current as possible, but the Plan may change. Please verify all current rules on eligibility for participation and benefits on your claim. The Plan may be amended, modified, changed, or terminated by the Trustees.

BOARD OF TRUSTEES

UNION TRUSTEES

Kim Quick, Chairman of the Board
Teamsters Local #554
4349 S. 90th Street
Omaha, NE 68127

Rod Marshall
Operating Engineers Local #571
4660 South 60th Avenue
Omaha, NE 68117

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Laborer's Local #1140
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Negus-Sons, Inc.
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Secretary of the Board
Anchor Construction
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Gretna, NE 68028

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Fucinaro Excavating
4901 G St
Omaha. NE 68117

ADMINISTRATION OFFICE

Larry Murray, Fund Administrator
Welfare Plan Administration Office
10334 Ellison Circle
Omaha, Nebraska 68134

CONSULTANT TO THE TRUSTEES

SilverStone Group, Incorporated
Harold W. Logan

ATTORNEYS TO THE TRUSTEES

Duncan A. Young
Maynard H. Weinberg

Trustees Powers

The Trustees shall have final and binding authority to determine eligibility for participation and eligibility for benefits. The Trustees shall have final and binding authority to interpret the terms and conditions of the Plan.

Final Review

The Trustees shall have the authority to determine on a final and binding basis the appropriateness of the utilization of medical, Hospital, drug, or dental coverages, or, any other utilization of any benefit hereunder. The Trustees shall have the authority to determine the appropriateness of all charges by all providers who are seeking reimbursement under the Plan as being proper and to exclude excess charges relative to the services performed.

Miscellaneous Plan Information

This Plan is provided through the Trustees of The Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan, 10334 Ellison Circle, Omaha, Nebraska 68134.

Agent for Service of Legal Process:
Larry Murray
10334 Ellison Circle
Omaha, Nebraska 68134

The Fund Administrator is:
Larry Murray
10334 Ellison Circle
Omaha, Nebraska 68134

The Plan Administrator is:
The Board of Trustees
10334 Ellison Circle
Omaha, Nebraska 68134

Plan Year

The Plan Year for this Plan commences on January 1 of each year and each 12-month period consists of an entire Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

Plan Identification Number

E.I.N.	P.N.
47-0469477	501

PLEASE READ CAREFULLY

Claims incurred will be paid under the Benefit Plan described in this booklet.

Any change in the amount of benefits payable under this Plan, due to an increase or decrease in such benefits, shall apply only to a loss which occurs or a period of disability, or a Hospital confinement which commences after the effective date of such change in benefits. The benefits in force prior to the effective date of the change shall continue in force for a particular disability or Hospital confinement, unless, in the case of an Eligible Participant, he or she returns to work for one full day, or unless, in the case of an Eligible Dependent, he or she is released from the Hospital after the effective date of the change in benefits.

OVERVIEW

The Board of Trustees for the Contractors, Laborers, Teamsters and Engineers (CLT&E) Health and Welfare Plan knows that the benefit plan they offer is an important part of your total wage package. The benefits you receive from the Plan go a long way toward protecting you and your family from the strain of unwanted and unexpected medical bills.

The CLT&E Health and Welfare Plan is designed to provide financial protection from expenses which may otherwise cause severe financial hardship.

Following is a list of those benefits available under the Plan:

- Medical benefits
- Dental benefits
- Vision benefits
- Life and Accidental Death and Dismemberment benefits
- Short-Term Disability benefits

The following pages provide important details regarding these benefits. Be sure to review carefully.

ELIGIBILITY AND PARTICIPATION

Coverage for You

I. ELIGIBILITY

A participant shall become eligible on the first day of the calendar month following the month in which the member had a minimum of 500 hours of employment credited to his/her account by a contributing employer or employers within a continuous 5 month period.

II. CONTINUATION OF ELIGIBILITY

(a) Once having become eligible, to remain eligible a participant must be credited with contributions in the amount of 300 hours in the first three months of the five months immediately preceding the month in which his claim arises or 1,200 hours in the first 12 months of the last 14 months immediately preceding the month in which his claim arises.

(b) Section (a) of this rule shall not apply if the employee has been ineligible for 12 consecutive months or longer. In that event, the employee shall be required to reinstate his eligibility in accordance with Rule IV.

III. MAINTENANCE OF ELIGIBILITY OF EMPLOYEES RECEIVING DISABILITY BENEFITS

A participant of a participating employer who is eligible and is receiving disabilty benefits under this Plan, or who is eligible and entitled to benefits under any Worker's Compensation or Occupational Disease Law, shall, beginning with the eighth day of his disability, receive 21 hours of contribution credit for each week he is entitled to or is receiving such benefits. This contribution credit accumulation shall cease when said benefits cease or when such contribution credits total 250 hours, whichever occurs first.

IV. REINSTATEMENT OF ELIGIBILITY

In the event a participant remains ineligible for twelve (12) consecutive months, he/she shall be required, in order to reestablish eligibility, to comply with the requirements of the Eligibility Provisions stated above.

V. EMPLOYMENT OUTSIDE OF JURISDICTION

A Contributing Employer may continue to contribute for his eligible employees even though doing work outside the territorial jurisdiction of the applicable Collective Bargaining Agreement, provided the contributing employer continues to be recognized as such by the Trustees, and contributes on each man hour worked.

VI. TERMINATION OF INDIVIDUAL COVERAGE

The coverage of any Eligible Participant shall terminate on whichever of the following dates occurs first:

(a) The date the Plan terminates;

(b) The date on which the Eligible Participant enters full-time military, naval or air service, or

(c) The date the Eligible Participant ceases to be eligible for coverage under the Plan.

An Eligible Participant must notify the Fund upon entering military service. The eligibility for benefits of the Eligible Participant and/or his or her Eligible Dependent ceases on the last day of the calendar month in which the Eligible Participant is inducted, enrolled or enlists. If an Eligible Participant notifies the Fund within 180 days from the date of discharge, any accumulated eligibility to the credit of such person shall be reinstated and shall be credited. If the Eligible Participant does not notify the Fund upon entering military service, the Eligible Participant's credited hours will be used to provide continuing benefits until eligibility terminates.

Coverage for You (continued)

VII. CHANGE OF ELIGIBILITY RULES/BENEFITS

The Trustees, at their discretion, are empowered to change or amend the foregoing Eligibility Rules or benefits at any time.

VIII. CONTRIBUTIONS BY SELF-EMPLOYED

No contributions will be accepted or benefits afforded to individuals who are self-employed, except participating owner-operators and such contributions shall not be less than 175 hours per month (such owner-operators are required to sign a corresponding Participation Agreement).

IX. NON-BARGAINING UNIT PARTICIPATION

Notwithstanding any other Provision of the Plan, if the employer elects, in writing on a form provided by the Plan, then all non-bargaining employees must participate in the CLT&E Health & Welfare Plan subject to the following terms and conditions:

(a) The effective date of this amendment shall be April 1, 1997. Any current employer must elect coverage under this amendment by October 1, 1997. Any new employer must elect coverage under this amendment on the date of signing a Collective Bargaining Agreement with a participating Union. During the month of April in the years following 1997, each employer with a current Collective Bargaining Agreement can elect coverage under this amendment.

(b) Except for those Participation Agreements executed on or before October 1, 1997, the term of the Participation Agreement shall be for a period of one year, commencing on April 1 (hereinafter "coverage date") and ending on March 31 annually. Each Participation Agreement shall be deemed renewed automatically for an additional year (12 months) beginning on April 1 (coverage date) unless the employer elects in writing to stop participation and such writing is delivered to and receipted for by the Trust sixty (60) days or more before the coverage date (April 1). Those Participation Agreements executed on or before October 1, 1997 shall be effective on the date of signing and shall continue in effect through and until March 31, 1998 and annually thereafter as set forth above.

(c) All of the employer's Non-Bargaining Unit employees, including owners, must participate provided that the Non-Bargaining Unit employees, excluding the owner, are not considered members of a recognized construction trade or craft.

(d) Only employees regularly employed for more than thirty (30) hours a week shall be allowed to participate. They shall participate from the date of hire and the employer premium payment shall commence from the date of hire and continue until the employee ceases employment in the Non-Bargaining Unit capacity.

(e) The employer must pay the entire premium per month for each participating employee, with or without Eligible Dependents, and the sum paid per month shall be the current COBRA rate chargeable by the fund. The monthly cost is subject to change by action of the Board of Trustees. All premiums must be paid in advance.

(f) All employers must agree to contribute for all eligible Non-Bargaining Unit employees for a minimum period of twelve (12) consecutive full calendar months from the date the employer elects, in writing, to become a signatory to the Plan for his Non-Bargaining Unit employees and thereafter in twelve (12) consecutive month periods if the employer does not elect in writing out of participation in the CLT&E Health and Welfare Plan.

(g) The right to contribute for Non-Bargaining Unit employees shall cease if the employer has no Collective Bargaining Agreement with any Participating Union in the CLT&E Health and Welfare Plan.

Coverage for You (continued)

IX. NON-BARGAINING UNIT PARTICIPATION (continued)

Coverage shall cease immediately if employer has no current Collective Bargaining Agreement with any Participating Union in the CLT&E Health and Welfare Plan. **PROVIDED HOWEVER,** the right and obligation to continue to make contributions and to obtain coverage for Non-Bargaining Unit employees shall continue so long as there is a legally enforceable obligation to pay for any Bargaining Unit employee whose Bargaining Representative is any other Participating Union.

(h) The coverage of Non-Bargaining Unit employees shall cease when they are no longer employed by a contributing employer in a job which makes them eligible for participation in the CLT&E Health and Welfare Plan. COBRA rights shall be provided as required by law.

(i) The employer can contribute to the CLT&E Health and Welfare Plan but may not contribute to the CLT&E Pension Plan for the Non-Bargaining Unit employees.

(j) Any Non-Bargaining Unit employee who is currently shown to be eligible under the terms of the Plan shall continue to be eligible from the effective date, provided the employer has elected to have the Non-Bargaining Unit employees participate and provided the participant satisfies the Plan eligibility rules in the future.

(k) The employer must, by written designation on forms furnished by the Fund Office, disclose all employees and their Eligible Dependents who may be eligible under the above rules, provide their current job description, their hours worked per week, and allow an audit by the Fund to verify eligibility. The information must be provided monthly with premium remittance.

(l) On the termination of employment of any Eligible Participant, the employer must inform the Plan, in writing, no later than seven (7) working days following termination.

(m) The covered owners' employers must provide a CERTIFICATE OF INSURANCE evidencing that he or she is covered by workers compensation insurance.

(n) To be eligible for this coverage, the employer must include all employees from all organizations which are considered related under Internal Revenue Code 414.

(o) When an employer makes an election for Non-Bargaining Unit coverage, the premium of two (2) months is due in advance immediately at the time of election to participate. Thereafter, the contributions are due in advance with their monthly contribution reports on the first of each month thereafter.

X. RETIRED PARTICIPANTS

All participants approved for retirement benefits under the Contractors, Laborers, Teamsters & Engineer Pension Plan, and who are currently eligible at the time of their retirement, are eligible to participate in the Retiree Health and Welfare Plan provided they so elect and they continue to make the required payment.

Benefits under the Retiree Plan differ from those afforded the active participants in several key areas, including the deductible, co-insurance, out-of-pocket limit and the prescription drug plan. ALSO, the Retiree Plan does not provide the following benefits:

Dental	Healthy Well Baby Care
Vision	Maternity Benefits
Loss of Time	Death Benefits

See page 47 for further details regarding the Retiree Benefit Plan.

Coverage for You (continued)

X. RETIRED PARTICIPANTS (continued)

NOTE: Retiree coverage, if eligible, is available in lieu of COBRA coverage. Conversely, if coverage under COBRA is elected, Retirement coverage shall be automatically waived.

A Retiree coverage election form must be completed and witnessed at the Fund Office.

All accumulated hour banks are terminated on the effective date of retirement.

The Retiree Premium is set by the Trustees and is subject to change with advance notice.

Eligible Participants electing to make payment to continue Medical Coverage under the Retiree coverage provision of the Plan must submit application and the first month payment prior to the retirement effective date. Subsequent payments are due to the Fund office no later than the last business day of the month preceding for the month following.

Eligible Dependents of Eligible Participants who lose eligibility have two options for continuation of coverage:

1. COBRA rights as described on page 13;
OR
2. Continued Retiree Plan coverage provided that application with the first month payment is made prior to the effective date of coverage. Subsequent payments are due to the Fund Office no later than the last business day of the month preceding for the month following.

A seven (7) day grace period shall be allowed. Payment must be received by the Fund office no later than the close of business on the last day of the seven (7) day grace period. Failure to make timely payments will result in the loss of your RETIREE COVERAGE.

All coverage terminates for participants or dependents entitled to Medicare.

Retiree coverage is effective on the date of retirement.

Note: COBRA rights may apply. Please reference Continuation of Coverage / COBRA on pages 13-14 and/or contact the Fund Office for details.

ELIGIBILITY AND PARTICIPATION

Coverage for Your Dependents

ELIGIBILITY

Eligible Dependents include the spouse of the Eligible Participant and the Eligible Participant's unmarried children, excluding in any case:

(a) A child more than 18 years of age, except that unmarried children who are more than 18 but less than 23 years of age are eligible if they are wholly dependent upon the Eligible Participant for support and maintenance and their time is devoted principally to attending school or college.

(b) The spouse of the Eligible Participant, if legally separated from the Eligible Participant.

(c) A Dependent Child as herein defined who would otherwise be excluded from dependent status due to being more than 18 years of age shall continue to be considered an Eligible Dependent if such child is totally disabled due to mental retardation which was incurred prior to attainment of age 19, is entirely dependent upon the Eligible Participant for support and maintenance, and is not capable of self-sustaining employment.

(d) A child under the age of 19, who, as a result of a ruling by a court of competent jurisdiction, has been placed in the care and custody of the Department of Social Services, or an Association, or an individual or entity other than the natural parent and by Court Order has made that person or entity the Guardian of the child and having the responsibility of the care of the child.

(e) A child born out of wedlock except where the Eligible Participant provides both Proof of Paternity and that said child is dependent on the participant for support and maintenance.

An Eligible Participant's children shall include any stepchildren and legally adopted children, provided such children are financially dependent upon the Eligible Participant for support and maintenance. Foster Children of the Eligible Participant are eligible for benefits, provided the Eligible Participant has legal guardianship or legal custody and the Foster Child is entirely dependent upon the Eligible Participant for support and maintenance.

DOCUMENTATION

Note: The Fund requires documentation to verify dependent eligibility and identification prior to enrollment. Contact the Fund office for documentation requirements. Upon request of the Fund Office, participants must provide the following documentation:

1. a certified copy, with embossed seal, of the marriage license
2. a certified copy, with the embossed seal, of the birth certificate of each dependent child
3. the signed Social Security card of any dependent(s)
4. a copy of the court order or decree establishing paternity, marriage dissolution, or child support obligation
5. the Federal tax return for the last two years
6. a completed, dated, and signed dependent listing
7. the following may be required if applicable:

(a) a copy of the court order, decree, or certificate of adoption
(b) a copy of the court order establishing guardianship
(c) a copy of the court order for Foster Care placement
(d) a certified statement from a School Registrar's office

Dependent claims will not be processed until all requested information and documentation has been received by the Fund Office. The Fund Office may accept other documentation or verification in lieu of the above.

Coverage for Your Dependents (continued)

DOCUMENTATION (continued)

The Fund Office may require other documentation or evidence necessary to establish the relationship between the Eligible Participant and the claimed dependent.

If the parents are separated or divorced, the Primary Plan is that of the parent who has custody. However, if there is a COURT DECREE designating one parent as responsible for health care expenses, the expenses are paid accordingly. (Except where such parent in violation of such COURT DECREE, fails to meet such Court Ordered responsibility, the Plan, upon proper application to the Plan Administrator, and, under such requirements as may be determined and imposed by the Plan Administrator, may extend benefits.)

EFFECTIVE DATE OF DEPENDENT'S BENEFITS

Coverage for Eligible Dependents shall become effective on the date the Eligible Participant's coverage becomes effective, or the date the participant assumes guardianship or legal custody of the dependent, which ever is later.

TERMINATION OF DEPENDENT'S BENEFITS

The benefits of any dependent shall terminate on whichever of the following dates occurs first:

(a) The date such dependent ceases to be an Eligible Dependent;
(b) The date the Eligible Participant's coverage hereunder terminates;
(c) The date the dependent enters the Uniformed Services on active duty; OR
(d) When an Eligible Participant dies, the coverage for his/her Eligible Dependents will terminate at the end of the period for which the Eligible Participant would have been eligible with contributed hours, but, not to exceed six (6) months.

Note: COBRA rights may apply. Please reference Continuation of Coverage / COBRA on page 13 and/or contact the Fund office for details.

CONTINUING COVERAGE via COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) mandates that certain plan sponsors provide an opportuntity for the continuation of health care coverage under certain circumstances. If eligible, you must elect and pay for this coverage. Please review the COBRA detail below.

1. FOR YOU AND YOUR DEPENDENTS

You and/or any covered dependent may elect to continue health coverage for up to 18 months from the day your coverage ends because of these qualifying events:

(a) Your employment terminates (other than due to gross misconduct);
OR
(b) You no longer satisfy the requirements for hours worked for eligibility for continuing coverage under this Plan.

If a Covered Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Fund Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to part 3 of this Provision.

During the period you continue coverage:

(a) Any new Eligible Dependents you acquire may be added in accord with the Dependents Eligibility Provisions; and

(b) Any Eligible Dependents you declined to cover before your continued health coverage began may be added during any open enrollment period provided by the plan provided any additional premium is paid. However, such dependents, other than a Qualified Beneficiary, who are added after the qualifying event will not be entitled to continue coverage as Qualified Beneficiaries after an event occurs as shown in part 2.

Qualified Beneficiary means, with respect to a Eligible Participant under a Group Health Plan, any other individual who, on the day before the qualifying event for that participant, is a beneficiary under the Plan:

(a) as the spouse of the Eligible Participant;
OR
(b) as the dependent child of the Eligible Participant.

Qualified Beneficiary also includes a child who is born or is placed for adoption with the Eligible Participant during the period of continued coverage.

2. FOR YOUR DEPENDENTS ONLY

Your covered spouse and/or each of your covered dependent children may elect to continue health coverage for up to 36 months from the day coverage ends because of these qualifying events:

(a) You die;
(b) You become entitled to Medicare benefits;
(c) You and your spouse are legally separated;

2. FOR YOUR DEPENDENTS ONLY (continued)

(d) Your marriage is ended by divorce; or
OR
(e) A child is no longer an Eligible Dependent as defined by the Plan.

If your dependent is already continuing coverage under part 1 when an event shown in part 2 occurs, that second event will not entitle your dependent to continue coverage beyond 36 months under parts 1 and 2 combined.

If your dependent becomes entitled to continue health coverage under both parts 1 and 2 on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

3. NOTICE REQUIREMENTS

Your employer is required by law to notify the Fund Administrator within 30 days after your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Fund Administrator within 60 days after the day you are legally separated or divorced, or your child ceases to be an Eligible Dependent.

If a Covered Person who is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, then that person must:

(a) notify the Fund Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and

(b) notify the Fund Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the month that begins no more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Fund Administrator will send you or your dependent written notice of the Continuation Right. The Fund Administrator must receive the Covered Person's written request to continue health coverage within 60 days after the day:

(a) health coverage ends;
OR
(b) the Covered Person is sent notice of the Continuation Right;
whichever is later.

To continue coverage, the Covered Person must pay the required premium, including any retroactive premium. The initial premium must be paid to the Fund Administrator within 45 days after the day continued coverage is elected. The Fund Administrator will inform you or your dependent of procedures to pay subsequent monthly premiums.

4. END OF CONTINUATION

A Covered Person's continued health coverage will end at midnight on the earliest of:

(a) the day your employer ceases to provide any group health plan to any employee;

(b) the day premium is due and unpaid;

4. END OF CONTINUATION (continued)

(c) the day a Covered Person is covered under group coverage as a Participant or otherwise. However, this does not apply when the Covered Person is covered under another group plan which contains any preexisting conditions limitation which apply to that person. Then, he or she may continue coverage under this Plan until the earlier of:

(1) the day the preexisting conditions limitation under the new group plan no longer applies; or

(2) the day continued coverage would otherwise end.

(d) the day a Covered Person again becomes covered under the plan;

(e) the day a Covered Person is entitled to benefits under Medicare;

(f) the day health coverage has been continued for the period of time provided in part 1, part 2 or the first item (b) of part 3 above (or any longer period provided in the Plan);

(g) the day the Plan terminates.

There shall be no extended benefits upon disability and/or retirement. Once a participant is retired or disabled, the participant's eligibility ceases.

5. OTHER CONTINUATION PROVISIONS

In the event health coverage is continued under any other continuation provision of the plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or part by your employer, then the premium you are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.

CERTIFICATE OF CREDITABLE COVERAGE

When your participation in the Plan ends, the Plan shall provide a "Certificate of Creditable Coverage" as follows:

(1) at the time an individual ceases to be covered under the Plan, or, otherwise becomes covered under a COBRA continuation Provision;
(2) at the time an individual ceases to be covered under a COBRA continuation Provision;
(3) at the request of an individual made not later than 24 months after the cessation of coverage in (1) or (2) above, whichever is later.

The Certificate of Creditable Coverage is a written certification of:
(a) the period of creditable coverage of the individual under the Plan, and, the coverage under the COBRA continuation Provision, and,
(b) the waiting period imposed with respect to the individual and coverage under the Plan.

A period of Creditable Coverage shall not be counted with respect to eligibility of an individual under the Plan, if, after such period, and, before the eligibility date, there was a 63-day period, during all of which the individual was not covered under ANY creditable coverage. HOWEVER, any period an individual is in a waiting period for coverage under the Plan shall not be counted in the 63-day period.

CONTINUING COVERAGE via COBRA (continued)

CERTIFICATE OF CREDITABLE COVERAGE (continued)

"Creditable Coverage" means coverage of an individual under ANY of the following:

(1) A group health plan,
(2) Health insurance coverage,
(3) Part A or B of Title XVIII of the Social Security Act,
(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928,
(5) Chapter 55 of Title 10, United States code,
(6) A medical care program of the Indian Health Service or of a tribal organization,
(7) A state health insurance risk pool,
(8) A health plan under Chapter 89 of Title 5 of the United States code,
(9) A public health plan as defined in the regulations,
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

IF YOU JOIN THE MILITARY

If you are absent from your employment by reason of your service in the Uniformed Services, you may elect to continue your coverage for yourself and/or your dependents for the lesser of:

(a) 18 consecutive months after coverage ended; or

(b) the end of the period during which you are eligible to apply for re-employment in accordance with the Uniformed Services Employment and Re-Employment Rights Act of 1994.

If you are in the Uniformed Services for less than 31 days, you do not have to pay for such coverage.

If you are in the Uniformed Services for more than 31 days, you must pay 102% of the full Plan monthly premium in a timely manner.

If your coverage is terminated by reason of service in the Uniformed Services, no exclusion or waiting period may be imposed in connection with your reinstatement of coverage, if such exclusion or waiting period would not have been imposed had your coverage not been terminated as the result of your service.

COVERING YOUR CHILDREN — Under a Qualified Medical Child Support Order (QMCSO)

If your eligible child is not covered because you did not enroll your child for dependent coverage, such child may be enrolled after The Fund:

(a) receives final Qualified Medical Child Support Order which requires enrollment; AND

(b) determines that the order is qualified.

DETERMINING IF YOUR ORDER IS QUALIFIED

When the Fund receives a proposed or final Qualified Medical Child Support Order, the Fund will notify you and each child named in the order, at the address shown in the order, that it has been received. The Fund will then review the order to decide if it meets the definition of a "Qualified Medical Child Support Order." Within 30 days after the Order (or within a reasonable time thereafter), the Fund will give a Written Notice of its decision to you and each child named in the order. The Fund will also send Notices to each Attorney or other Representative who may be named in the Order or in other correspondence filed with the Fund. If the Fund decides that the order is not qualified, the Notice will provide the specific reasons for the decision and the opportunity to correct the Order or Appeal the decision by contacting the Fund within 30 days. If the Fund decides that the Order is qualified, the Notice will provide instructions for enrolling each child named in the Order; and the Plan Provisions that apply for other Eligible Dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the Order. The Fund must receive a Certified Copy for the entire "Qualified Medical Child Support Order" before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from your pay, the Planholder must receive proper authorization in the Order or otherwise.

As part of the Fund's authority to interpret the Plan, the Fund has the discretion and final authority to decide if an Order meets or does not meet the definition of a "Qualified Medical Child Support Order" so as to require the enrollment of your child as an Eligible Dependent; and its reasonable decision will be binding and conclusive on all persons. If, as a result of an Order, benefits are paid to reimburse medical expenses paid by a child or the child's Custodial Parent or Legal Guardian, these benefits will be paid to the child or the child's Custodial Parent or Legal Guardian.

The Planholder will treat each child who is enrolled because of a "Qualified Medical Child Support Order" as a participant for purposes of the reporting and disclosure requirements of a Federal Law known as ERISA.

QMCSO DEFINED

A "Qualified Medical Child Support Order" is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order means any Judgment, Decree or Order (including approval of a Settlement Agreement) issued by a Court of Competent Jurisdiction, which:

(a) either:
  (1) relates to medical benefits under the Plan and provides for your child's support or health benefit coverage pursuant to a State Domestic Relations Law (including a Community Property Law);
  OR
  (2) enforces a Law relating to Medical Child Support described in Section 1908 of the Social Security Act;

(b) creates or recognizes the existence of your child's Right to be enrolled and receive medical benefits under the Plan;

Under a Qualified Medical Child Support Order (QMCSO) (continued)

QMCSO DEFINED (continued)

(c) states the name and last known mailing address (if any) of you and each child covered by the Order;

(d) reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;

(e) states the period to which the Order applies;

(f) states each Plan to which the Order applies; and

(g) does not require the Plan to provide any type of form of benefit or any option not otherwise provided by the Plan, except, to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for Medical Child Support Orders.

MEDICAL PLAN Benefits

Our Medical Plan gives you two choices when you need medical care:

- see a network doctor or use a network facility and save time and money
- choose any doctor or facility outside the network and pay a higher portion of the cost of your care.

Using network providers (referred to as the Preferred Provider Organization or PPO) saves you money because you receive negotiated discounts off their normal rates. In addition, network providers will file claims for you and file for any prior approvals that may be necessary before receiving certain types of care. However, you are always free to use whichever doctor or facility that you choose.

	HEATH AND WELFARE PLAN OF BENEFITS	
	If you use network doctors and facilities, you pay…	If you do not use network doctors and facilities, you pay…
Annual deductible • for one person • for your family	 $200 $400	 $500 $1,000
Out-of-pocket maximum • for one person • for your family	 $1,000 $2,000	 $4,000 $8,000
Doctor's office visits • Primary Care • Surgery in doctor's office • Preventive Care	 10%* No charge No charge up to $500	 40%* No charge* No charge up to $500*
Chiropractic services	10%* Up to $50 benefit per visit, up to 30 visits per year, no more than one visit per day	40%*
Hospital care (inpatient and outpatient) • Pre-admission Testing • Second Surgical Opinions	10%* No charge No charge	40%* No charge* No charge*
Emergency Room (if true emergency)	10%*	40%*
Mental Health • Inpatient • Outpatient	10%* (limited to one course of treatment per calendar year, two per lifetime, up to 45 days per course of treatment) 10%* (up to 45 visits per year, up to 90 visits per lifetime)	40%* 40%*
Substance Abuse • Inpatient • Outpatient	10%* (limited to one course of treatment per calendar year, two per lifetime, up to 45 days per course of treatment) 10%* (up to 45 visits per year, up to 90 visits per lifetime)	40%* 40%*
Prescription drugs At a pharmacy (90-day supply) • generic • name brand Mail order (90-day supply) • generic • name brand	 Greater of… $5 or 10% $25 or 10% Greater of… $5 or 10% $25 or 10%	 Not covered Not covered
Lifetime benefit available	$2,000,000	
*deductible and/or reasonable & customary limits may apply		

HOW DOES THE DEDUCTIBLE WORK?

The deductible amount is $200.00 per calendar year when you use the network, or $500 per calendar year when you do not use the network. The deductible amount applies to eligible charges for each calendar year, including maternity charges, but it applies only once for you, and only once for each dependent, in any calendar year, regardless of the number of illnesses. However, when two members of one family have satisfied their deductible amounts for the same calendar year, no other members of that family will be required to satisfy their deductible amounts for the same calendar year. Hospital, Surgical and other Covered Charges may be combined to satisfy the deductible.

PREFERRED PROVIDER

A preferred provider means a provider of Covered Services, who:

(a) is participating in the selected PPO network; and
(b) is shown on the current list of members in the selected network provider directory.

CLT&E does not supervise, control or guarantee the health care services of any Preferred Provider or non-Preferred Provider.

LIFETIME MAXIMUM BENEFIT AND BENEFIT RESTORATION

Effective June 1, 2007 there is a maximum lifetime benefit payment of $2,000,000.00 for all covered accidents or sickness, or, any combination thereof, for each Covered Person. However, on the first of each calendar year, the amount added to the remaining unused portion of the maximum lifetime benefit, or $2,000,000.00, shall be equal to the lesser of:

(a) $5,000.00, or;
(b) a sum equal to the amount charged against the lifetime maximum benefit which has not been restored.

In no event may the maximum lifetime benefit as adjusted above exceed $2,000,000.00 at any time.

BENEFITS: WHAT IF YOUR BILL HAS AN ERROR?

Participants who detect errors in their Hospital bills that result in a savings to the Fund, will be paid 50% of such savings, in an amount ranging from $20.00 to $10,000.00.

Errors do occur in many Hospital bills. With some diligence, patients can identify these errors and save themelves and the Fund money. Following are some things to do to “BLOC” overcharges:

- When you or a family member are a patient, keep a log of the more significant tests and services.
- Before checking out of the Hospital, examine the bill and question all items you don’t recall or understand. Some Hospitals have staff assigned to help with this.
- Always request an itemized bill. Your Hospital has been notified by the Plan that one is required as a condition of payment.
- Note the stated diagnosis for admission. Were the stated tests and treatment received?

- Pay particular attention to repeated posting for the same service, especially on the same day. The computer may have billed you more than once for the same service.
- Be sure you are charged room and board for only the number of days Hospitalized. Hospitals generally charge for the day of admission, but not for the day of discharge.
- Make particular note of the type of x-ray tests received. Sometimes patients are billed for routine admission tests they didn't receive.
- Pharmacy charges aren't as easy to audit, because medications are administered intravenously, by injection and orally. Be alert for medication charges that you know were discontinued. Unusually high charges for common medicines should be challenged. You also should receive credit for medications returned to the Pharmacy.
- As a general rule, charges for medical or surgical supplies over $50 should be verified.
- Operating room, recovery room and anesthesia charges relate to surgery, and, should be challenged if you weren't a surgical patient.
- Be sure that charges for therapy correspond by type and date to what actually occurred.

Generally, treat your medical bills as you would any major business Document. Verify its accuracy, and, request corrections as necessary.

MEDICAL: WHAT IS COVERED

Following is more detailed information on benefits that are covered by the Plan.

COVERED HOSPITAL CHARGES

Charges incurred for the following Hospital services, which are recommended by the attending Physician:

(a) Hospital Charges for room and board,

(b) Hospital charges for drugs, medicines and other Hospital service and supplies, if used while confined in the Hospital as a resident patient;

(c) Hospital charges for Outpatient Services in connection with emergency treatment for accidental bodily injuries or sickness.

COVERED SURGICAL CHARGES

Charges incurred for the following services:

(a) Charges made by a Physician or Surgeon for the performance of an operation or the repair of dislocation or fracture; or

(b) Charges for the services of a Professional Anesthetist, provided such Anesthetist is not employed by a Hospital which submits a charge for his services.

OTHER COVERED CHARGES

Medically Necessary health care services or supplies that Providers provide to Eligible Participants and/or their Eligible Dependents, which are recommended by the attending Physician, and, for which the Fund is obligated to pay, pursuant to the Summary Plan Description.

(a) Other Hospital charges incurred as an outpatient;

(b) Charges made by a Physician for medical services, including his active services as an Assistant Surgeon;

(c) Charges made by a qualified Physio-therapist or a Registered Graduate Nurse (R.N.), for private duty nursing service rendered solely for the Eligible Participant or Eligible Dependent, except for services provided by a person who ordinarily resides in the Eligible Participant's household, or, is a member of his/her family;

(d) Charges for local professional ambulance service and, if the injuries or sickness requires special and unique Hospital treatment, transportation within the United States or Canada, to the nearest Hospital equipped to furnish treatment not available in a local Hospital, by professional ambulance, railroad or commercial airline, on a regularly scheduled flight;

OTHER COVERED CHARGES (continued)

(e) Charges for the following additional services and supplies: Drugs and medicines requiring a Physician's written prescription; diagnostic x-ray and laboratory service; oxygen and the rental (up to the purchase price) of equipment for its administration; blood or blood plasma and its administration; radium; radioactive isotopes and x-ray therapy; casts, splints, braces, trusses, and crutches; rental (up to the purchase price) of Hospital type bed, wheelchair or iron lung; artificial limbs and eyes to replace natural limbs and eyes lost while covered under this Provision; dental services rendered by a Physician or Dentist for treatment within six (6) months of an injury to the jaw or natural teeth, including the initial replacement of these teeth and any necessary dental x-rays, provided such injury is the result of an accident occurring while covered; or

(f) Charges for durable medical equipment as described below, which is Medically Necessary, will be considered upon receipt of a Prescription from the attending Doctor:

(1) can withstand repeated use;
(2) is mainly and customarily used for a medical purpose;
(3) is not generally useful to a person in the absence of any injury or sickness; or
(4) is suited for use in the home.

(g) Charges for prescription drugs as prescribed by a Physician.

PRE-ADMISSION HOSPITAL TESTS

Prior to surgical procedure that would require Hospital confinement., tests requested by the attending Physician and performed by a qualified laboratory or by a Hospital on an outpatient basis prior to entering the Hospital as a patient for surgery, will be paid at 100% of the Reasonable and Customary charges for such tests with no deductible. However, any such tests that are repeated while Hospital confined **WILL NOT** be considered "payable charges" under the Plan, unless an acceptable written explanation is furnished by the attending Physician. They will then be paid at 80% of the reasonable and customary charges.

SECOND SURGICAL OPINION

Charges for Second Opinion will be paid at 100% with no deductible.

OUTPATIENT SURGERY

Surgery performed in a Doctor's office is paid at 100% of the Reasonable and Customary charges for such Surgical Procedure, without application of any deductible. Certain outpatient procedures may require pre-certification.

MATERNITY BENEFITS (FOR ELIGIBLE PARTICIPANTS AND LEGALLY MARRIED SPOUSES)

Payable in the same manner and subject to the same deductible and Plan Provisions as any other accident or sickness. Routine, Normal Newborn "Well" Baby Care and ancillary charges are covered under the Plan as noted below under Healthy Well Baby Care.

Routine maternity stays will be pre-certified for two (2) days (48 hours) and cesarean section delivery for four (4) days (96 hours).

HEALTHY WELL BABY CARE

Healthy "Well Baby Care" will be extended for the first 180 days of the newborn's life and will include immunizations, routine examinations, etc. subject to the same deductible, Reasonable and Customary deductions, coinsurance and Preferred Provider provisions as major medical coverage.

ABORTIONS

Abortions are **NOT** covered under the Plan, unless the life of the woman would be endangered if the fetus were carried to term, or, where medical complications arise from an abortion. If complications do arise, only those costs attributable to the complications of the abortion are covered.

WELLNESS SERVICES

Benefits are provided for wellness services for Eligible Participants and their Eligible Dependents beyond the age of 180 days. Benefits are payable for an Annual Physical Examination, up to **$500.00** per Plan Year, and includes pap smear, mammography and other lab charges, immunizations and routine examinations. Benefits are subject to the same Reasonable and Customary deductions if services are provided out-of-network. **The deductible does not apply to Wellness Services.**

MASTECTOMY

The Plan will cover necessary procedures to effect reconstruction of the breast on which the mastectomy was performed, as well as the cost of prostheses (implants, special bras, etc.) and physical complications of all stages of mastectomy, including lymph edemas, as recommended by the attending Physician of any patient receiving Plan benefits in connection with the mastectomy in consultation with the patient.

For any participant or beneficiary of the Plan who currently is receiving Plan benefits for a mastectomy, the Plan will provide coverage for any necessary surgery and reconstruction of the breast on which a mastectomy was not performed, in order to product a symmetrical appearance.

This coverage is subject to the same deductibles and copayments that apply to other major medical procedures under the Plan's current terms.

CHIROPRACTIC TREATMENT

After the applicable deductible and co-insurance, benefits are payable for professional services for nonsurgical treatment, including office visits and spinal manipulation (x-rays are applied to the medical plan), which involves manual manipulation (with or without the application of treatment modalities such as, but not limited to; diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue, to restore proper articulation of joints, alignment of bones, or, nerve functions, but not in excess of:

(1) $50.00 for each visit

(2) One visit on any one day; and

(3) A maximum of 30 visits during any one calendar year

ORGAN TRANSPLANT BENEFITS

Maximum Lifetime Benefit payable for Organ Transplants shall be payable in the amount of $250,000.00 per Eligible Participant and/or per Eligible Dependent. This Maximum Lifetime Limitation of $250,000.00 shall include Donor Expenses and Work-up fees, not to exceed $100,000.00. The Organ Transplants that are to be considered as covered under the Fund are listed as follows:

- Kidney
- Cornea
- Liver
- Pancreas
- Bone Marrow
- Heart and Heart/Lung

Organ Transplant Coverage is to be considered a part of the Maximum Lifetime Benefit payable, to the extent that the Organ Transplant Expenses would cause you to exceed the Maximum Lifetime Benefit set out herein, the Maximum allowable Organ Transplant Benefit would be reduced so as not to exceed the Maximum Lifetime Benefit.

SUBSTANCE ABUSE TREATMENT

Treatment must be provided by an Alcoholism and/or Drug/Chemical Treatment Center that has been accredited by the appropriate State governing agency covering such treatment. Inpatient and outpatient treatment is subject to the calendar year deductible and the Plan will pay the applicable coinsurance amount (see page 19) of the Reasonable and Customary charges for such treatment.

INPATIENT TREATMENT

Hospital benefits for Alcoholism and/or Drug/Chemical Addiction incurred as an inpatient in any approved medical facility are limited to one course of treatment, up to a maximum of 30 days per course of treatment, per plan year, for PPO and NON-PPO providers combined. Benefits are limited to two courses of treatment per lifetime.

Benefits for visits by a physician during the period of hospital confinement are covered up to a maximum of 50 visits per course of treatment for PPO and NON-PPO providers combined.

OUTPATIENT TREATMENT

Alcoholism and/or Drug/Chemical Addiction charges incurred as an outpatient are covered up to a maximum of 30 visits per plan year for PPO and NON-PPO providers combined, up to 60 visits per lifetime.

MENTAL HEALTH TREATMENT

Treatment must be provided by a Mental and Nervous Treatment Center that has been accredited by the appropriate State governing agency covering such treatment. Inpatient and outpatient treatment is subject to the calendar year deductible and the Plan will pay the applicable coinsurance amount (see page 19) of the Reasonable and Customary charges for such treatment.

INPATIENT TREATMENT

Hospital benefits for Mental and Nervous Disorders incurred as an inpatient in any approved medical facility are limited to one course of treatment, up to a maximum of 45 days per course of treatment per plan year, for PPO and NON-PPO providers combined. Benefits are limited to two courses of treatment per lifetime.

Benefits for visits by a physician during the period of hospital confinement are covered up to a maximum of 50 visits per course of treatment for PPO and NON-PPO providers combined.

OUTPATIENT TREATMENT

Mental and Nervous Disorder charges incurred as an outpatient are covered up to a maximum of 45 visits per plan year for PPO and NON-PPO providers combined, up to 90 visits per lifetime.

EXCEPTIONS

Benefits for Mental and Nervous Disorders will not be paid for:

(a) the following conditions, diagnoses or therapies:
- (1) conduct disturbances unless related to a coexisting condition or diagnosis for which benefits are payable
- (2) educational, vocational and/or recreational services
- (3) biofeedback for treatment of diagnosed medical conditions
- (4) treatment for learning disabilities;
- (5) pervasive developmental disorders (other than diagnostic evaluation), including but not limited to:
  - i. autistic disorders
  - ii. Rett's Disorder
  - iii. Asperger's Disorder

(b) treatment which the Fund determines to be for the Covered Person's personal growth or enrichment; or

(c) court ordered placements when such placements are not determined to be Medically Necessary.

Following is more information on certain medical expenses that are not covered by the Plan.

Benefits are not provided for:

(a) Any injury or sickness which arises out of, or in the course of, any employment with any employer, or, for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or receives any settlement from a Worker's Compensation Carrier. In addition, where a claim is made for injuries apparently sustained or arising out of, or, in the course of the employment, or for any sickness or occupational disease covered by Worker's Compensation Law or similar legislation, the Plan will require the Covered Person to diligently seek the appropriate remedy under the Worker's Compensation Law or similar legislation, by filing a claim, and, getting a ruling under the Worker's Compensation Court System. The participant will not be required to initiate an Appeal of an Adverse Decision by the Worker's Compensation Court or subsequent Appeals Court. **(Failure on behalf of the Covered Person to file for Worker's Compensation benefits where the injury appears to have arisen out of the course of employment, shall constitute a forfeiture of any Rights under this Plan for said injuries.);**

Limitation (a) shall not apply to Accidental Death and Dismemberment Benefits.

(b) Any loss caused by war or act of war, or loss incurred while engaged in military, naval or air service;

(c) Jaw joint disorders including TMJ Treatment Limitation — No charges will be paid for Temporomandibular Joint Dysfunction (TMJ) treatment, except:

(1) a benefit of up to $1,000 subject to deductible and coinsurance, will be paid for TMJ surgery; and
(2) benefits will be paid under the major medical provisions, if jaw joint disorders, including TMJ, arise out of an accident and treatment is rendered within 90 days of such accident,

(d) Any expense or charge in connection with dental work, dental surgery or oral surgery (except as provided under "Other Covered Charges") including:

(1) treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
(2) surgery or splinting to adjust dental occlusion;

(e) The fitting or cost of hearing aids;

(f) any loss, expense or charge, which relates to, or, results from cosmetic, elective or reconstructive surgery, except:

(1) for injuries received while covered under the Plan;
(2) for repair of defects which result from surgery;
(3) for the reconstructive (not cosmetic) repair of a congenital defect, which materially corrects a bodily malfunction;

(g) any loss, expense or charge which relates to, or, results from breast augmentation or reduction which is not Medically Necessary;

(h) Nursing expense, except as provided under "Other Covered Charges" (see pages 21-22);

(i) Charges which the Covered Person is not required to pay;

(j) Injury or sickness resulting from any attempt at suicide, or, from any intentionally self-inflicted injury, whether the Covered Person is sane or insane;

(k) Routine maternity or pregnancy-related expense for dependent children;

(l) Weekend Hospital admissions;

The Plan **will not pay** any of the charges incurred in connection with Hospital confinement which begins on Friday, Saturday, or Sunday. Except that this will not apply if:

(1) Surgery is performed within 24 hours immediately following the Eligible Participant and/or Eligible Dependent's admission to the Hospital;
OR
(2) The Eligible Participant and/or Eligible Dependent is admitted for acute illness not requiring Surgery; but requires immediate medical attention and Hospitalization;

(m) The reversing of Vasectomies or Tubal Ligations;

(n) Charges for Chiropractic Treatment which are in excess of the visit and calendar year maximums. (refer to page 23);

(o) Personal Leave while Hospital confined;

(p) Birth Control, except Vasectomy and Tubal Ligation (refer to exception for oral contraceptives under mail order prescriptions);

(q) Dental Implants;

(r) Experimental or Investigational Drug, Device, and/or Treatment or Procedure

(s) Abortions, unless the life of the woman would be endangered if the fetus were carried to term, or, where medical complications arise from an abortion. If complications do arise, only those costs attributable to the complications of the abortion are covered.

(t) Mental and Nervous Disorders treatment that involves:

- the following conditions, diagnoses or therapies:
  - (1) conduct disturbances unless related to a coexisting condition or diagnosis for which benefits are payable;
  - (2) educational, vocational and/or recreational services;
  - (3) biofeedback for treatment of diagnosed medical conditions;
  - (4) treatment for learning disabilities;
  - (5) pervasive developmental disorders (other than diagnostic evaluation), including but not limited to;
    - i. Autistic Disorders;
    - ii. Rett's Disorder; and
    - iii. Asperger's Disorder;
- treatment which the Fund determines to be for the Covered Person's personal growth or enrichment; or
- court ordered placements when such placements are not determined to be Medically Necessary.

MEDICAL: TREATMENT REVIEW PROCEDURES

Before receiving certain types of treatment or procedures, it is necessary to have your doctor's treatment plan reviewed and approved. Following is information on those procedures. Certification does not automatically mean that benefits are payable. These Provisions will not apply when Medicare has primary responsibility for the Covered Person's claims.

HOSPITAL CONFINEMENT REVIEW

Review of any Hospital confinements, due to any sickness or injury (with the exception of Alcohol and/or Drug/Chemical abuse and Mental and Nervous Disorders), is required, if a Covered Person is confined for:

(a) a non-emergency admission; or
(b) childbirth, or a Medical Emergency.

It is your responsibility to initiate this Hospital review requirement. The lack of such review will result in a reduction of your benefits as described below.

EFFECT ON BENEFITS

1. Expenses incurred for Hospital confinements which are certified by the Care Review Unit (or by the Covered Person's Primary Plan, if any, as determined in accordance with the COB Provision) as Medically Necessary, will be considered in accord with Plan Provisions.

2. For expenses incurred for Hospital confinements for which review does not first occur (subject to the **Emergency Admission** Provision below), benefits will be reduced by $100 (for all unreviewed days combined and while in the same Hospital); however, no benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.

3. For expenses incurred for Hospital confinements for which review does occur, but for which inpatient care is not certified as Medically Necessary:

(a) benefits for Hospital room and board will not be payable; and
(b) expenses for other covered Hospital services will be considered in accord with Plan Provisions.

When benefits are reduced in accord with part 2 or 3 above:

(a) the $100 reduction for unreviewed confinements; or
(b) the Hospital expenses for services, including but not limited to room and board, which are not Medically Necessary;

will not be used to satisfy any deductible or stop loss limit shown in the Plan.

In accord with Plan Provisions, benefits will not be payable for Hospital, Surgical, Medical or other services, which: (a) are not Medically Necessary; or, (b) are not covered by the Plan. Certification does not automatically mean benefits are payable.

RULES FOR HOSPITAL REVIEW

1. For a Non-Emergency Admission: If a Covered Person is advised by a Physician to enter a Hospital as a resident patient for a reason other than:

(a) childbirth; or
(b) a Medical Emergency;

then you or the Physician must notify the Care Review Unit by phone at least seven (7) days prior to the scheduled Hospital admission.

Within one business day after the Care Review Unit: (a) receives the required notice; and (b) obtains the admission information from the attending Physician by phone; you, the Physician and the Hospital will be sent written notice of any period of confinement which is certified as Medically Necessary.

2. For an Emergency Admission: If a Covered Person enters a Hospital as a resident patient for childbirth or because of a Medical Emergency, then you or the attending Physician must notify the Care Review Unit by phone by the second business day following admission.

Within one business day after the Care Review Unit: (a) receives the required notice; and (b) obtains the Admission Information from the attending Physician by phone; you, the Physician and the Hospital will be sent written notice to confirm any additional days of confinement which are certified as Medically Necessary.

3. For Continued Confinement: Before the approved period of confinement ends, the Care Review Unit will phone the attending Physician to determine whether the Covered Person requires further Hospital confinement. Within one business day, you, the Physician, and the Hospital will be sent written notice to confirm any additional days of confinement which are certified as Medically Necessary.

MEDICAL: TREATMENT REVIEW PROCEDURES (continued)

OUTPATIENT PROCEDURE REVIEW PROGRAM

The Outpatient Procedure Review Program applies to surgical and other procedures listed below which are performed:

(a) in an ambulatory surgery facility;
(b) in a Physician's office or clinic; or
(c) on an outpatient basis in a Hospital.

Pre-certification is required before outpatient surgical treatment of the following conditions:

- Carpal Tunnel Release – surgery to relieve a pinched nerve in the hand.
- Cochlear Implants – insertion of small computer device to transmit to the auditory nerve.
- Endometrial Ablations – complete removal of the lining of the uterus.
- Hysterectomy – surgical removal of the uterus.
- Pelvic Laparoscopy – examination of female organs by a scope.
- Septoplasty – surgical procedure to straighten the nasal septum.
- Tonsillectomy with/without Adenoidectomy – surgical removal of the tonsils and/or adenoids.
- UPP (uvulopalatopharyngoplasty) or Laparoscope Aided UPP – removal of a portion of the uvula or soft palate.

FOR A NON-EMERGENCY MEDICAL PROCEDURE

If a Covered Person is advised by a Physician to undergo a Medical Procedure listed above, then you and/or the Physician must notify the Care Review Unit by phone at least seven (7) days before the scheduled Medical Procedure.

Within one business day after the Care Review Unit:

(a) receives the required notice; and
(b) obtains the Medical Information from you and/or the attending Physician;

you, the Physician, and, if applicable, the facility, will be sent written notice of any medical procedure which is certified as Medically Necessary.

FOR AN EMERGENCY MEDICAL PROCEDURE

If a Covered Person undergoes a Medical Procedure listed above because of a Medical Emergency, then you and/or the attending Physician must notify the Care Review Unit by phone by the second business day following the day the Medical Procedure is performed.

Within one business day after the Care Review Unit:

(a) receives the required notice; and
(b) obtains the Medical Information from you and/or the attending Physician by phone; you, the Physician and, if applicable, the facility will be sent written notice to confirm any Medical Procedure which is certified as Medically Necessary.

EFFECT ON BENEFITS

1. Expense incurred for a Medical Procedure which is certified by the Care Review Unit (or by the Covered Person's Primary Plan, if any, as determined in accordance with the COB Provision) as Medically Necessary will be considered in accord with Plan Provisions.

2. For expense incurred for a Medical Procedure for which review does not first occur, benefits will be reduced by $100 for each unreviewed procedure (including related covered expense); however, no benefits will be payable, unless the services are Medically Necessary, and all other Plan requirements are satisfied.

3. For expense incurred for a Medical Procedure for which review does occur, but which is not certified as Medically Necessary, benefits for all Hospital, Surgical, Medical, and other covered services received as a result of the procedure will not be payable.

When benefits are reduced in accord with part 2 or 3 above:

(a) the $100 reduction for each unreviewed Medical Procedure; or
(b) expense for a procedure which is not Medically Necessary;

will not be used to satisfy any deductible or stop loss limit shown in the Plan.

In accord with Plan Provisions, benefits will not be payable when the Medical Procedure, or any services related to the procedure (including, but not limited to X-ray, laboratory services, or follow-up Physicians visits):

(a) are not Medically Necessary; and
(b) are not covered by the Plan.

MEDICAL: TREATMENT REVIEW PROCEDURES (continued)

EFFECT ON BENEFITS (continued)

It is your responsibility to initiate this Medical Procedure Review requirement. The lack of precertification for Medical Necessity will result in a reduction of your benefits or benefits may not be paid as described in the EFFECT ON BENEFITS section.

CASE MANAGEMENT PROGRAM

A Case Management program is a written alternate treatment plan endorsed by your Physician and accepted by us to provide Medically Necessary and appropriate care in a cost-effective setting. It is the Covered Person's final decision to participate in the program. There is no penalty for not participating in the program or for leaving during its course. In either case, any further benefits will be paid in accordance with the other Provisions, limits and exceptions of the Plan.

ELIGIBILITY FOR THE CASE MANAGEMENT PROGRAM

You may be eligible for the case management program if you have been diagnosed with one of the following conditions:

- Acquired Immune Deficiency Syndrome
- Amputations
- Burns
- Chemotherapy
- Chronic cardiac disease and conditions
- Chronic infections
- Chronic liver disease
- Chronic pulmonary diseases and conditions
- Coagulation defects
- Coma
- Conditions related to diabetes mellitus
- Demyelinating diseases of the central nervous system
- Diseases related to intracranial hemorrhage or occlusion
- Disorders of the immune system
- Inflammatory disease of the central nervous system
- Intestinal disorders
- Multiple fractures, with or without other system involvement
- Myoneural disorders
- Organ transplants
- Paralytic disorders
- Radical surgeries
- Renal diseases
- Spinal cord injuries
- Tumors, malignant or unspecified

EFFECT ON BENEFITS

If, while covered under this Provision, a Covered Person incurs expenses as a result of an injury or sickness listed above, or as a result of any sickness or injury of comparable severity for which an alternate, more cost-effective treatment plan may be developed by us, these expenses are eligible for consideration under our Case Management Program. This program is provided automatically as part of your coverage plan; and may include as Covered Services some services or supplies otherwise limited, excluded, or not specifically shown under the Benefits description of the Plan, but shown in the alternate treatment plan. Benefits payable for services covered under the Case Management Program will be at least equal to benefits otherwise payable by the Plan for the same services; and are subject to the Maximum shown in the Schedule.

DENTAL BENEFIT

The Dental Plan will pay up to $600 per person, per year for dental care. There is no deductible and no coinsurance, and you can see any dentist that you choose.

The CLT&E Board of Trustees encourages its members to seek routine dental care. This way, you can detect an issue before it becomes a significant problem. With the $600 benefit, you decide how you want to spend it. You select the dentist of your choice.

Eligible expenses include the routine oral exam, x-rays, fillings, crowns or even orthodontia services (braces).

To file a claim under this benefit you can either pay for the claim yourself and submit the bill and receipt to the Fund Office, or ask your Dentist office to submit the bill to the Fund Office directly.

VISION BENEFIT

The Vision Benefit will pay up to $200 per person, per each two year period for vision care, including exams, glasses, other corrective treatment, and contacts. There is no deductible and no coinsurance, and you can see any eye doctor or lens lab that you choose.

Coverage is provided for examination, treatments and corrective lenses only. No payments will be made for non-corrective lenses.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS

PARTICIPANT DEATH BENEFIT
Amount of Insurance $20,000.00*
*(Some limitations apply for those over the age of 64.)

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
Principal Sum. $20,000.00*
*(Some limitations apply for those over the age of 64.)

SPOUSE DEATH BENEFIT
Amount of Insurance $3,000.00

CHILD(REN) DEATH BENEFIT
Child age 14 days to 6 months
Amount of Insurance $100.00

Child age 6 months to 19/23 if full-time student
Amount of Insurance $1,000.00

MEMBERS, be sure to designate a beneficiary and record such with the CLT&E Fund Office.

Conversion privileges do exist in some cases. For complete details on the death benefit provisions, refer to the Mutual of Omaha certificate of coverage.

MEMBER DISABILITY: Accident and Sickness Income Replacement

When you are totally disabled due to accident or sickness, and, under the care of a legally qualified Physician, the Weekly Benefit will be paid to you beginning on the day shown in the Plan, and, up to the Maximum Number of Weeks Payable during any disability, as specified in the Plan.

During partial weeks of disability, you will be paid at the daily rate of one-seventh of the Weekly Benefit. Two or more periods of disability are considered as one (1) unless between periods of disability, you have returned to active full-time work for at least two (2) weeks, or, unless the disability(s) is/are due to causes entirely unrelated and begin after you have returned to full-time active work.

ACCIDENT AND SICKNESS WEEKLY BENEFITS

Occupational Accident Only
Weekly Benefit. . . . . NONE*

Non-Occupational Accident or
Sickness Weekly Benefit. $250.00*

Benefits begin on the first day of a disability caused by an accident and on the eighth day of a disability caused by sickness.
Maximum Number of Weeks Payable . . . 12 weeks*

NOTE: If an Eligible Participant is totally disabled because of an occupational accident, but returns to work before qualifying for the first week's benefits under the State Workmen's Compensation Law, benefits at the rate of $250.00 will be paid for the first week or any part thereof for such disability.

FILING CLAIMS

All indemnities provided by the Plan will be payable immediately after receipt of due proof.

Indemnity for Loss of Life of the Eligible Participant, resulting from accidental bodily injuries, shall be paid to the Beneficiary designated by the Eligible Participant, or, if there is no Beneficiary designated, or surviving, to the estate of the Eligible Participant.

All other indemnities shall be payable to the Eligible Participant.

Consent of the Eligible Participant's Beneficiary, if one be named, shall not be requisite to any change of Beneficiary, or to any changes in the Plan.

If any benefits of the Plan shall be payable to the estate of the Eligible Participant or to an Eligible Participant who is a minor, or otherwise not competent to give valid release, the Trustees may pay to the Hospital, Physician or Surgeon, on whose charge or fee claim is based, any sums due for Hospital Benefits, Surgical Benefits or Medical Benefits, toward satisfaction of any amounts still owed such Hospital, Physician or Surgeon, and, any balance of such sums may be paid, up to an amount not exceeding $1,000.00, to any relative by blood, or connection by marriage of the Eligible Participant, who is deemed by the Trustees to be equitably entitled thereto. Any payment made by the Trustees in good faith, pursuant to this Provision shall fully discharge the Trustees to the extent of such payment.

MEDICAL EXAMINATION

The Trustees shall have the Right, through a Medical Examiner, to examine the Covered Person, so often as it may reasonably require, during the pendency of a claim hereunder, and, the Right and the opportunity to make an Autopsy in case of death where it is not forbidden by Law.

SPECIFIC INFORMATION ON MEDICAL CLAIMS

The Fund's Administration Office wishes to provide the fastest possible claim service. By following the steps shown below when filing a claim, prompt service will be assured.

FOR IN-NETWORK PPO PROVIDERS

In most cases you do not need to file a claim form when you use the services of a Preferred Provider. However, in certain instances, additional claim forms may be required. Just present your ID card to the Preferred Provider when receiving services and the Preferred Provider will file all claims on your behalf.

FOR OUT-OF-NETWORK PROVIDERS

1. Secure a claim form from your Fund Administrator.

2. Complete your portion of the form by filling in all information requested and signing your name on the line specified.

3. Have your doctor complete their portion of the form.

4. Notice of claim must be filed within 90 days of the occurrence of the illness or accident, or as soon as reasonably possible, but not later than one year after 90 days of the occurrence, unless the claimant is not legally capable.

5. In order to obtain benefits, it is necessary that all claimants comply with the applicable claim rules established by the Trustees. The Trustees shall exercise every right provided under the terms of the Plan and their rules to prevent any claimant from receiving benefits, who is, in their opinion, attempting to subvert the purposes of the Fund, or who does not present a bona fide claim.

6. Forward your completed form, with all itemized bills attached, to:
   ADMINISTRATION OFFICE
   Welfare Plan Administration Office
   10334 Ellison Circle
   Omaha, Nebraska 68134
   Telephone: (402) 491-3751

IF YOUR CLAIM IS DENIED

Effective January 1, 2003, except for Loss of Time benefits which will be effective January 1, 2002, the Fund Administrator shall approve or deny the claim within the time periods set forth below, depending on the type claim:

Urgent Care Claim (Claims for care which is considered necessary, by either the attending Physician or the Plan, to preserve the life, health or ability of the patient, giving him or her maximum function or for which a delay of treatment would have caused the patient severe pain.) **72 Hours**

Pre-Service Claim (Approval of benefit prior to obtaining medical care)
. . . . . **15 Days (With one 15 day extension available)**

If a claimant fails to follow the procedure for filing a Pre-Service claim, the claimant shall be notified no later than 5 days following the failure and the proper procedures to follow in filing a claim. Notification may be oral, unless the claimant requests written notification.

Post Service Claim . . . . . 30 Days (With one 15 day extension available)

Disability Claim . . . . . 45 Days (With one 45 day extension available)

If additional information is requested, the time period for making a benefit decision shall be suspended from the date on which the notice is sent to the claimant until the date the claimant responds to the request.

If a claim is denied in full, or in part, by the Fund Administrator, the Fund Administrator shall provide each claimant written Notice stating the following:

(a) The specific reasons(s) for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

IF YOUR CLAIM IS DENIED (continued)

(c) A description of any additional information necessary for the claim to be granted and an explanation of why such information is necessary;

(d) A description of the Plan's claim review procedures, the time limits under the procedures and a statement regarding the claimant's right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal (see pages 33-34);

(e) If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant upon request; and

(f) If the adverse determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of scientific or clinical judgement for the determination or a statement that such explanation will be provided free of charge to the claimant upon request.

In addition, access to all documents, records and other information relevant to the benefit determination must be provided free of charge.

REVIEWING A DENIED CLAIM

If a claim is denied in full, or in part, by the Fund Administrator, the claimant may appeal the denial of the claim to the Board of Trustees, within 180 days of such denial, which will cause the Board to conduct a full and fair review, and reach resolution of such appeal in accordance with the following schedule:

Urgent Care Claim . . . . . 72 Hours
Pre-Service Claim . . . . . 30 Days
Post-Service Claim . . . . . 60 Days
Disability Claim . . . . . 45 Days

The claimant or his/her duly authorized representative, may request a Review upon written application to the Plan or Administrator, review and copy all pertinent documents prior to the Hearing.

The claimant may submit written comments, documents, records and other information related to the benefit claim on appeal.

The claimant shall be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim.

The review on appeal shall consider all comments, documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination.

The review on appeal shall not defer to the initial adverse benefit determination and may not be conducted by the individual who made the initial adverse determination nor the subordinate of such individual.

In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgement, the Plan fiduciary conducting the appeal review shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgement (Health Care Professional includes a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services under state law).

The Health Care Professional engaged with respect to the review of the claim on appeal may not be an individual who was consulted in connection with the initial adverse benefit decision nor the subordinate of such individual.

Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim (even if the advice was not relied upon in the benefit determination) shall be notified.

REVIEWING A DENIED CLAIM (continued)

If the claimant requests a review in writing, by the Board of Trustees, the Board shall (within the time frames enumerated herein), cause the Fund Administrator to notify the Applicant of the date, time and place for a full hearing on the claimant's Application, by regular mail, addressed to the claimant's address, as shown on the Notice of Appeal.

The time and place for the Appeal shall be convenient and accessible for the claimant, who may, but need not, be represented by an Attorney of his/her choice. At any time prior to said hearing, the Fund Administrator, will grant access to all documents, records and other information relevant to the benefit determination, free of charge.

Further, if the denial or partial denial of a claim involves reduction of benefits to a participant who is receiving ongoing treatment, such claimant must be given reasonable notice of such reduction.

THE HEARING

The following procedures are established for review by the Board of Trustees:

1. The proceedings of the Hearing shall be preserved by means of tape recording, stenographic or Court Reporter's records. The Trustees shall determine the method of recording.

2. In conducting the Hearing, the Board shall not be bound by the usual Common Law or Statutory Rules or Evidence.

3. The claimant or his/her attorney shall have the right to review the records and make a copy thereof.

4. The Applicant shall be afforded the opportunity of presenting any evidence in his/her behalf. If the Applicant offers new evidence, the Hearing may be adjourned for a period of not more than thirty (30) days, so the Board may, if it wishes, investigate it, and determine whether additional evidence, or the accuracy of the Applicant's new evidence, should be considered.

5. There shall be copies made of all Documents and records introduced at the Hearing, attached to the record of the Hearing, and, made a part thereof at the Fund's cost.

6. All information upon which the Board bases it decision shall be disclosed to the Applicant at the Hearing. In the event that additional evidence is introduced by the Fund Administrator, which was not made available to the Applicant prior to the Hearing, the Applicant shall be granted a Continuance of so much time as he desires, not to exceed (30) days.

(For purposes of this section, evidence discovered, upon examination of the Applicant's own witnesses, shall not be considered "new evidence.")

7. Immediately upon the conclusion of the Hearing (or within the prescribed limits for determination noted herein), the claimant shall be mailed written findings of fact, and the determination of the Board, stating the specific reasons for the adverse determination with reference to the specific Plan provisions on which the determination is based.

8. (a) The claimant shall be provided, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim;

   (b) The review on appeal shall consider all comments, documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination;

   (c) The review on appeal shall not defer to the initial adverse benefit determination and may not be conducted by the individual who made the initial adverse determination nor the subordinate of such individual;

   (d) In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgement, the Plan fiduciary conducting the appeal review shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved

THE HEARING (continued)

8. (e) in the medical judgement (Health Care Professional includes a Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services under state law);

   (f) The Health Care Professional engaged with respect to the review of the claim on appeal may not be an individual who was consulted in connection with the initial adverse benefit decision nor the subordinate of such individual; and

   (g) Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim (even if the advice was not relied upon in the benefit determination) shall be identified.

The claimant shall be provided written findings of fact and the determination of the Board stating the specific reason(s) for the adverse determination with reference to the specific Plan provisions on which the determination is based.

The claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records, and other information relevant to the benefit claim appeal.

GENERAL DEFINITIONS

Wherever used in this booklet, the following terms shall be deemed to have the meanings described below.

ADMISSION INFORMATION Means the following information which the attending Physician must provide the Care Review Unit before a period of confinement is approved:

(a) the diagnosis or reason for the confinement;
(b) any proposed treatment or surgical procedure; and
(c) the expected days of confinement

CALENDAR YEAR Begins on January 1 of each year and ends on December 31 of that same year.

CARE REVIEW UNIT Means our Care Review medical staff, or a qualified party or entity named by us. For the Care Review Unit's toll-free phone number, contact your Plan Administrator.

CONTRIBUTING EMPLOYER Any employer who is participating in the Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan, pursuant to the Health and Welfare Trust.

COVERED PERSON An Eligible Participant or Eligible Dependent.

ELIGIBLE PARTICIPANT Any employee who is covered under the Plan pursuant to the terms of the Eligible Participant Plan Provisions.

ELIGIBLE DEPENDENT Any current legal dependent of an Eligible Participant who is covered under the Plan pursuant to the terms of the Eligible Participant Plan Provisions.

EXPENSE INCURRED Only those charges made for services and supplies which a prudent person would consider to be reasonably priced and reasonably necessary in the light of the injury or sickness being treated.

EXPERIMENTAL OR INVESTIGATIONAL DRUG, DEVICE AND TREATMENT OR PROCEDURE MEANS

(a) a drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished;
OR
(b) a drug, device, treatment or procedure which was reviewed and approved (or which is required by Federal Law to get reviewed and approved) by the treating facility's Institutional Review Board or other Body serving a similar function, or a drug, device, treatment or procedure, which is used with a patient informed consent document, which was reviewed and approved (or which is required by Federal Law to be reviewed and approved) by the treatment facility's Institutional Review Board or other Body serving a similar function;
OR
(c) a drug, device, treatment or procedure, which reliable evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, as compared with a standard means of treatment or diagnosis;
OR
(d) a drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, as compared with a standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility, or, by another facility studying substantially the same drug, device, treatment or procedure.

HOSPITAL

A legally constituted Hospital shall mean any institution which meets all of these requirements:

(a) Maintains permanent and full-time facilities for bed care of five (5) or more resident patients;
(b) Has a doctor in regular attendance;
(c) Continuously provides 24-hour-a-day nursing service by registered nurses;
(d) Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons, on a basis other than as a rest home, nursing home, convalescent home, or a place for the aged.

MEDICAL INFORMATION

Means the following information which you and/or the attending Physician must provide to the Care Review Unit before a Medical Procedure is approved:
(a) the diagnosis or reason for the Medical Procedure;
(b) the proposed Medical Procedure;
(c) the expected follow-up care required by the patient; and
(d) any related information regarding the patient's history, condition, and the proposed Medical Procedure.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Means covered services which are determined through Utilization Management and by the Plan to be:

(a) Appropriate, necessary and consistent with the symptoms and findings or diagnosis and treatment of an Eligible Participant and/or Eligible Dependent's injury or sickness;
(b) Provided for the diagnosis or direct care and treatment of an injury or sickness of an Eligible Participant and/or an Eligible Dependent;
(c) Provided in accordance with generally accepted medical practice on a national basis;
(d) Not primarily for the convenience of the Eligible Participant and/or their Eligible Dependent's Physician or other provider; and
(e) The most appropriate supply or level of service of supplies which can be provided on a cost-effective basis.

GENERAL DEFINITIONS (continued)

OTHER PLAN

Any Plan providing benefits or services for Hospital, medical or dental care or treatment, which benefits or services are provided by:

(a) Group, blanket or franchise insurance coverage;
(b) Group Blue Cross, Blue Shield and other pre-payment coverage provided on a group basis.
(c) Any coverage under Labor-Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans or any other arrangement of benefits for individuals of a group.

PHYSICIAN (LEGALLY QUALIFIED) OR PHYSICIAN OR SURGEON

A person who is duly licensed to prescribe and administer all drugs, to perform all surgery, and, shall include Chiropractors, Chiropodists, Podiatrists, Optometrists, Dentists, Psychologists, and Osteopaths operating within the scope of their license.

PLAN

The Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan.

PREFERRED PROVIDER ORGANIZATION

A select group of physicians and facilities (Hospitals, physicians, etc.) who have agreed to work with the selected network to provide health services to Eligible Participants and/or Eligible Dependents of the Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan.

REASONABLE AND CUSTOMARY

The designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross-section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any complications or unusual circumstances which require additional time, skill or expertise.

UNIFORMED SERVICES

United States Army, Navy, Air Force, Marine Corps, Coast Guard, and Public Health Services to include activated Reservists and Federalized Army/Air Guard personnel.

UTILIZATION REVIEW

The review of any Hospital confinement due to any sickness and/or injury; also the review of specified outpatient procedures. The reviews are completed by Mutual of Omaha under contract number G0007R42.

QUESTIONS AND ANSWERS (For Eligible Participant and Dependents)

1. **Q. How can I make sure that my name is included in the Welfare Fund?**
   A. It is your responsibility to check with your employer to see that your name is included on the list forwarded by your employer to the Plan, and, that the monthly contribution is paid to the Fund by your employer.

2. **Q. Will I be required to pass a physical examination in order to qualify for the Plan?**
   A. No. Benefits are provided for active employees, regardless of age or condition of health.

3. **Q. Will the Death Benefit be payable if my death results either directly or indirectly from my occupation or employment?**
   A. Yes.

4. **Q. To whom will the benefits be paid in the event of my death?**
   A. To the Beneficiary or Beneficiaries designated by you on your Beneficiary Card at the Fund Administration office.

5. **Q. Is the Accidental Death and Dismemberment Benefit payable, in addition to the Death Benefit?**
A. Yes, if you are killed accidentally.

6. **Q. Are any Accident Sickness Weekly Benefits payable if an accident is covered by Workmen's Compensation?**
A. Yes, see Sec.III in this booklet on page 7.

7. **Q. May I choose my own Hospital?**
A. Yes, but it must be a Legally Constituted Hospital. We strongly encourage the selection of a Preferred Provider Hospital.

8. **Q. May I choose my own Physician and Surgeon?**
A. Yes, but he/she must be a legally qualified Physician. You must remember that the Plan now has Preferred Providers and Non-Preferred Providers from which to choose. Please refer to your PPO Provider Directory when obtaining the services of a PPO Provider.

9. **Q. When do benefits for Hospital confinement begin?**
A. Immediately.

10. **Q. Do the Plan Benefits include medicines, drugs, and dressings, and other miscellaneous charges made by the Hospital?**
A. Yes. As shown under the Plan, after the deductible has been satisfied, the Plan pays the designated coinsurance amount (90% for PPO Providers, and 60% for Non-PPO Providers) of the reasonable and customary charges for Eligible Participants and/or Eligible Dependents.

11. **Q. What is meant by "satisfying the deductible?"**
A. Before benefits are paid, each Eligible Participant, or Eligible Dependent, must have out-of-pocket expense during the calendar year for covered health care expense (similar to a deductible on automobile insurance). After the deductible ($200 for PPO Providers, and $500 for Non-PPO Providers) has been satisfied, the Plan pays the designated coinsurance amount for all covered expenses, up to $10,000.00, and then 100% for the remainder of the calendar year, up to the $2,000,000.00 Maximum Lifetime Benefit for Eligible Participants and/or Eligible Dependents.

12. **Q. Does the Deductible always have to be satisfied before benefits are paid?**
A. No. The deductible does not have to be satisfied for the following:

(1) Pre-admission Testing done prior to Hospital confinement or surgery;
(2) Surgery performed in a doctor's office;
(3) Dental Benefit,
(4) Vision Benefit,
(5) Wellness Services, and
(6) Second Surgical Opinion.

This booklet gives a complete explanation of each of the above.

13. **Q. How does the Coordination of Benefits work?**
A. Assume that your spouse, as an Eligible Dependent under this Plan, is also an Eligible Employee under another Group Health Plan. This Plan is then the Secondary Plan, and will pay this Plan's Benefits on what is not paid by the other Plan, up to, but, not exceeding 100% of the claim. The remaining balance of the amount that this Plan would have paid if no other Plan had been involved is established as a "Medical Benefit Credit." This Medical Benefit Credit may be used to provide coverage toward covered medical expenses, during the same period, by the same eligible family member. A claim period is the calendar year, which is January 1 through December 31.

14. **Q. If I or one of my dependents go to the Hospital as an outpatient for sickness or illness, how are benefits paid?**
A. The deductible must be satisfied, or previously have been satisfied, and then, the Plan pays 90%, or 60% of the reasonable and customary charges, depending upon the provider utilized. (Refer to page 19.) PRE-CERTIFICATION PROVISIONS APPLY, which are defined on page 28.

15. **Q. What is meant by $2,000,000 lifetime maximum for benefits?**
A. You and each of your Eligible Dependents have a lifetime maximum benefit of $2,000,000.00. However, each year, if you use a part of your $2,000,000.00, there will be restored (up to $5,000.00) an amount to bring your total back to $2,000,000.00. **EXAMPLE:** During 2006 you have $4,500.00 of Plan paid medical expenses. For 2007 there would be $4,500.00 restored to bring your maximum Lifetime Benefit payable back up to $2,000,000.00.

16. **Q. Must I be confined in a Hospital in order to be eligible to receive reimbursement for surgical operations?**
A. No. Reimbursement will be made for surgical operations, regardless of whether they are performed in or out of the Hospital.

17. **Q. Will I receive payments directly or will the Plan pay the Hospital or doctor?**
A. Benefits are automatically assigned to the provider , provided such will not waive any deductible or coinsurance amount under the Plan, or, any amount which is not covered or paid for by the Plan. No claim will be paid to any provider of benefits, if the provider forgives any amount owed on the claim; including, but not limited to, deductibles, coinsurance amounts, or amounts not covered by or paid for by the Plan.

18. **Q. Are any Maternity or Obstetrical benefits payable?**
A. Yes. Maternity for Eligible Participants or their spouses is treated as any other sickness or illness (see Maternity Benefits in this booklet).

19. **Q. Are abortions covered?**
A. Abortions are covered only where the life of the woman would be endangered if the fetus were carried to term or where medical complications arise from an abortion. If complications do arise, only those additional costs attributable to complications of the abortion are covered.

20. **Q. When will I know if I am in danger of losing my eligibility?**
A. If you are unemployed, you are in danger of losing your eligibility. Phone or contact the Fund Administrator at once. Phone (402) 491-3751 and you will be advised of your present status.

21. **Q. If I, as a wife of an Eligible Participant, am pregnant at the time that my husband becomes eligible, am I covered for pregnancy benefits?**
A. Yes. Pregnancy is handled as any other sickness. However, your benefits terminate (same as any other sickness) if your husband loses his eligibility.

22. **Q. Where do I obtain the proper claim forms for presenting a claim?**
A. Claim forms and other forms relating to your coverage/benefits may be obtained from your Administration Office, 10334 Ellison Circle, Omaha, Nebraska 68134, (402) 491-3751.

23. **Q. How soon must I make a claim for benefits after a period for which the claim is incurred?**
A. As soon as possible; but no later than 1 year from the date of service.

24. **Q. When will claims be paid?**
A. As soon as possible, after the claim form, together with fully itemized Hospital and/or doctor's bills, and, answers to any questions, are turned in to the Fund Administration Office.

25. **Q. Is it necessary for me to furnish to the Fund a Social Security Number for my dependent spouse and/or dependent child(ren)?**
A. Yes. A claim for benefits cannot and will not be paid if the Fund does not have the spouse and/or dependent's validated Social Security Number. (Refer to Dependent Eligibility on pages 11-12 as well as any other documentation requested by the Fund office.)

YOUR ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 requires that certain information be furnished to each participant (or Eligible Participant) in an employee benefit plan. This is your Summary Plan Description. Contributions to this Plan are made by Participating Employers and in certain circumstances by the Participant. Contributions are based on the amount of funds necessary to provide the coverage required by the Plan.

ERISA provides that all Plan participants shall be entitled to:

(a) Examine, without charge, at the Plan Administrator's office, and, at other specified locations, such as worksites and Union Halls, all Plan Documents, including Insurance Contracts, Collective Bargaining Agreements, a list of Participating Employers and Employee Organizations sponsoring the Plan, and, copies of all Documents filed by the Plan with the U.S. Department of Labor, such as detailed Annual Reports and Plan Descriptions. Upon written request, you may receive information as to whether a particular Employer or Employee Organization is a Sponsor of the Plan, and, if so, the Sponsor's address.

(b) Obtain copies of all Plan Documents, and, other Plan information, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's Annual Financial Report. The Plan Administrator is required by Law to furnish each participant with a copy of this Summary Annual Report.

If you wish to examine such Documents or receive any of this information, the Trustees have adopted certain procedures to assure your request is handled promptly:

(1) Your request should be in writing;
(2) It should specify what materials you wish to look at; and
(3) It should be received at the Fund office at least three (3) days before your want to review the materials at the Fund office.

In addition to creating Rights for the Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently, and in the interest of you and other Plan Participants and Beneficiaries.

No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit or exercising your Rights under ERISA.

Under ERISA, there are steps you can take to enforce the above Rights. For instance, if you request materials from the Plan, and do not receive them within thirty (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 your claim for a benefit is denied in whole or in part, the participant must receive a written explanation for the reason for the denial. The participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the participant may take to enforce the above rights. 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. If it should happen that the Plan Fiduciaries misuse the Plan's money, or, if you are discriminated against for asserting your Rights, you may seek assistance from the U.S. Department of Labor, or, you may file Suit in a Federal Court. The Court will decide who should pay Court costs and Legal fees. If successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement, or, about your Rights under ERISA, 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 & Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

This Amendment is intended to bring the Contractors, Laborers, Teamsters, and Engineers Health and Welfare Plan (hereinafter "H&WP" or "Plan") into compliance with the requirements of §164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and §164.504(f) is referred to as "the 504 provisions") by establishing the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information. Accordingly, the Plan is hereby amended as follows:

I. H&WP's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the HIPAA Security Officer to take all actions required to be taken by the H&WP in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan sponsor).

II. Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

A. Plan (also referred to as "H&WP") means the Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan.

B. Plan Documents mean the H&WP's governing documents and instruments (i.e., the documents under which the H&WP was established and is maintained), including but not limited to the Health and Welfare Plan Document.

C. Plan Sponsor means "plan sponsor" as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is Contractors, Laborers, Teamsters and Engineers.

D. HIPAA Security Rule means the Security Standards published on February 20, 2003 at 68 Fed. Reg. 8334 et seq. (45 C.F.R. Parts 160, 162 and 164) as hereafter amended.

E. EPHI means electronic protected health information as defined in the HIPAA Security Rule that is created, received, maintained or transmitted by or on behalf of Plan.

III. The H&WP's Disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

A. Except as provided below with respect to the H&WP's disclosure of summary health information, the H&WP will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the H&WP, **only if** the H&WP has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the "504" provisions;

2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this Amendment; and

3. the Plan sponsor agrees to comply with the Plan provisions as modified by this Amendment.

IV. Permitted Disclosure of Individuals' Protected Health Information to the Plan Sponsor

A. The H&WP (and any business associate acting on behalf of the H&WP), or any health insurance issuer or HMO servicing the H&WP will disclose individual's Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Amendment.

B. All disclosures of the Protected Health Information of the H&WP's individuals by the H&WP's business associate, health insurance issuer, or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this Amendment and in the "504" provisions.

C. The H&WP (and any business associate acting on behalf of the H&WP), may not, and may not permit a health insurance issuer or HMO, to disclose individuals' Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

D. The Plan sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

E. The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the H&WP (or from the H&WP's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

F. The Plan sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

G. The Plan sponsor will report to the H&WP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan sponsor becomes aware.

V. Disclosure of Individuals' Protected Health Information – Disclosure by the Plan Sponsor

A. The Plan sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

B. The Plan sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

C. The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that is must account for in accordance with 45 C.F.R. § 164.528.

D. The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the H&WP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the H&WP with the HIPAA Privacy Rule.

E. The Plan sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the H&WP (or a health insurance issuer or HMO with respect to the H&WP) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. The Plan sponsor will ensure that the required adequate separation, described in paragraph VII below, is established and maintained.

VI. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

A. The H&WP, or a health insurance issuer or HMO with respect to the H&WP, may disclose summary health information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the H&WP;
OR
2. Modifying, amending, or terminating the H&WP.

B. The H&WP, or a health insurance issuer or HMO with respect to the H&WP, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

(continued)

VII. Required Separation Between the H&WP and the Plan Sponsor

A. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to individuals' Protected Health Information received from the H&WP or from a health insurance issuer or HMO servicing the H&WP.

- Board of Trustees
- Plan Administrator
- HIPAA Security Officer
- Claims Analyst
- Benefit Analyst
- Administrative Support

B. This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the H&WP. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

C. The Plan sponsor will promptly report any such breach, violation, or noncompliance to the H&WP and will cooperate with the H&WP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

VIII. Safeguards, Agents and Reporting

A. With regard to its use and/or disclosure of EPHI, beginning no later than the compliance date applicable to Plan under the HIPAA Security Rule (April 20, 2005), we shall:

1. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that we create, receive, maintain or transmit on behalf of Plan;

2. ensure that any and all of our subcontractors or agents to whom we provide EPHI agree in writing to implement reasonable and appropriate safeguards to protect such EPHI; and

3. report to Plan any security incident (as defined in 45 CFR Section 164.304) relating to EPHI of which we become aware, in accordance with our standard reporting procedures.

IX. Termination

A. Plan may terminate the Agreement if it determines that we have violated a material term of this Amendment and such breach has not been cured to Plan's reasonable satisfaction within sixty (60) days after our receipt of written notice from Plan identifying the breach, or if such breach is not reasonably curable within sixty (60) day period, then the Agreement may be terminated if the cure for such breach has not been commenced by us within such sixty (60) day period and completed within reasonable diligence.

FAMILY AND MEDICAL LEAVE ACT OF 1993

As of February 5, 1994, a Covered Person may be entitled to Family and/or Medical Leave (hereinafter ""FMLA") provided certain conditions are met. If you qualify under the Federal Law for such leave, then your employer has to provide up to twelve (12) weeks of payment during a 12 month period commencing on the first effective date of leave for your Health and Welfare contributions while you are on leave.

The Contractors, Laborers, Teamsters & Engineers Health and Welfare Plan requires each participant and their employer to comply with the following rules to be eligible for FMLA Coverage under the Plan:

1. It shall be the duty and responsibility of the employer to determine the eligibility for FMLA benefits of its employees under Federal Law at the time application for such benefits is made. CLT&E may, but is not required to, verify the eligibility for FMLA benefits.

2. The Plan must be notified in writing by the employee/participant within 14 days after the application for Family Leave has been made to the employer for such leave.

3. The Plan must be notified by the employer within 14 days after the employee's application for Family Leave has been made to the employer for such leave indicating that such leave has been granted and for what period, or, in the alternative that such leave has been denied.

4. The failure to comply with the requirements of paragraphs two (2) and three (3) above means that the Plan will not provide FMLA Coverage.

5. The Plan then will issue notification to the employee/participant and the employer of the amount of the required contribution per day of leave granted. Currently the leave day rate for contribution is five (5) hours at the current rate per working day, five (5) days per week, but such contribution is subject to change, in accordance with the terms and conditions of the Trust and Plan governing benefits.

6. The failure to pay the sums owed by the employer means that no FMLA benefits will be provided. No FMLA benefits will be provided if the employee is not otherwise eligible for benefits under the Plan.

No FMLA benefits will be provided if the employee does not comply with all the terms and conditions of the Plan.

7. It shall be the sole responsibility of the employer to advise its employees of the requirements, rights, duties and obligations under the FMLA.

THE RIGHT TO RECOVER BENEFITS FROM A THIRD PARTY (SUBROGATION)

Subrogation is the right of the Plan to recover any and all amounts paid by the Plan to, or, on behalf of the Covered Person:

1. Because of an injury or occupational disease to a Covered Person; and
2. Which a Covered Person recovers from a Third Party, a representative of the Third Party, or, the Third Party's insurer including:

Any payments received from the Third Party, its representatives or insurer, as a result of:

(a) a legal judgment;
(b) an arbitration award;
(c) a compromise and settlement; or
(d) any other arrangement, settlement, or, agreement whereby money is received by the Covered Person from the Third Party, its representatives or insurer.

Third party means another person or organization.

SUBROGATION RIGHTS

If a Covered Person is injured because of a Third Party's act, omission, or negligence; relating to, or, arising out of, or, causally connected to the actual injury, accident or sickness for which the party is being treated, or the treatment thereof, then:

1. The Plan will pay benefits for that injury, subject to the conditions that the Covered Person:
   (a) Agrees to our being subrogated to any recovery, or, right of recovery the Covered Person has against that Third Party;
   (b) Will not take any action which would prejudice our Subrogation Rights; AND
   (c) Will cooperate in doing what is reasonably necessary to assist us in any recovery.

2. The Plan will be Subrogated to the extent of benefits paid because of that injury.

3. The Plan will be Subrogated to, as a matter of Agreement, to any claim the Covered Person will, or may have, against any Third Party, for any injuries, accidents, or sickness, coming as a result of, or related to, any medical or dental treatments given to the Covered Person(s) that are covered under the Plan. This includes any and all Malpractice claims.

THE RIGHT TO RECOVER FROM YOU (REIMBURSEMENT)

In addition to the Plan's Subrogation Rights, all Plan participants must agree in writing to reimburse the Plan prior to recovering benefits for all monies paid by the Plan for an Eligible Participant, or his or her Eligible Dependent, under the Plan relating to or arising out of, or causally connected to an injury arising out of a Third Party's act, omission, or negligence from any and all monies paid from a Third Party, a representative of the Third Party or the Third Party's insurer as a result of:

(a) A legal judgment;
(b) An arbitration award;
(c) A compromise or settlement; or
(d) Any other arrangement, settlement, or agreement whereby money is owed or received by the covered party or their dependents from the Third Party, its representatives, or insurer.

Third Party means any other person or organization.

ASSIGNMENT OF BENEFITS

No assignment of benefits shall be effective which will waive any deductible or coinsurance amount under the Plan, or, any amount which is not covered or paid by the Plan. No claim will be paid to any provider of benefits, if the provider forgives any amount owed on the claim, including, but not limited to; deductibles, coinsurance amounts, or amounts not covered by, or paid for by the Plan.

COORDINATION OF BENEFITS

This Provision shall apply only if the total benefits due the Covered Person, would be reduced because of a similar Provision in any other Plan, or Plans, under which the Covered Person may be eligible for benefits.

IF OTHER PLAN HAS SIMILAR PROVISIONS

If the other Plan has coordination of benefits or similar Provisions, benefits shall be paid under this Plan as follows:

(a) When the patient is covered as a Covered Person under this Plan, benefits will be paid under this Plan, without regard to benefit payments under any other Plan. However, if the Covered Person is also a Covered Person under any other Employer-Sponsored or Government-Sponsored Plan, that Health Plan will be considered the Primary Plan and benefits will be paid accordingly.

(b) When the patient is covered as an Eligible Participant or Eligible Dependent, under this Plan, and, as an Eligible Participant or Eligible Dependent under any other Plans, the amount of benefits payable under this Plan, shall be the difference between the total allowable expenses incurred by such Eligible Participant or Eligible Dependent, and the benefits payable under all other Plans; but, not to exceed the benefits that would be payable under this Plan in the absence of this Provision.

(c) When the patient is covered as an Eligible Dependent under this Plan and as an Eligible Dependent under any other Plan:

Birthday Rule: Under the Birthday Rule, the Primary Plan is the one of the parent whose birthday falls earlier in the year — year of birth is not taken into account.

If an Eligible Dependent is covered by another Employer-Sponsored or Government-Sponsored Plan that does not use the Birthday Rule in determining primary coverage, this Plan will pay 50% of the eligible expenses after the calendar year deductible.

If the parents are separated or divorced, the Primary Plan is that of the parent who has custody. However, if there is a COURT DECREE designating one parent as responsible for health care expenses, the expenses are paid accordingly. (Except where such parent in violation of such COURT DECREE, fails to meet such Court Ordered responsibility, the Plan, upon proper application to the Plan Administrator, and, under such requirements as may be determined and imposed by the Plan Administrator, may extend benefits.) Refer to Dependent Eligibility documentation on page 11.

(d) Any Eligible Participant or Eligible Dependent who would have been otherwise eligible as an Eligible Participant under another Employer-Sponsored Group Plan but has been denied coverage because of being eligible for benefits under this Plan, shall be assumed to be covered under the other Plan. Benefits will be coordinated as if other benefits had been received under the other Plan and will be paid as under (b) above.

(e) Under no circumstances shall this Coordination of Benefits apply to benefits or services provided under individual policies.

MEDICARE COORDINATION OF BENEFITS

For employees and their spouses age 65 or over who are covered by an Employer Provided Health Plan, Medicare is now the Secondary Payor for heath services.

RETIREE BENEFIT PLAN

The Retiree Benefit Plan is similar to the plan of benefits described herein, with the exceptions noted below:

The Retiree Plan does not provide the following benefits:

Dental	Healthy Well Baby Care
Vision	Maternity Benefits
Loss of Time	Death Benefits

FURTHER, the Retiree Benefit Plan has different benefit limits as described below:

	IN-NETWORK	OUT-OF-NETWORK
Deductible	$500/$1,000	$1,000/$2,000
Co-Insurance	80%/20%	60%/40%
Out-of-pocket Maximum • for one person • for your family	 $5,000 $10,000	 $10,000 $20,000
ALL Prescription Drugs	Greater of... $50 or 10%	Not covered

CONTRACTORS, LABORERS,
TEAMSTERS & ENGINEERS

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