SCHEDULE B

$25,000 MEDICAL BENEFIT

NOE-ILA, AFL-CIO WELFARE PLAN
FOR NON-MEDICARE ELIGIBLE RETIREES & DEPENDENTS
Effective: October 1, 2010

TABLE OF CONTENTS

$25,000 MEDICAL BENEFIT

SCHEDULE OF BENEFITS
Effective October 1, 2010

MEDICAL BENEFIT:

Designated Network.....MultiPlan PHCS

Designated Utilization Reviewer ..... American Health Holding

Lifetime Maximum Benefit $25,000

Calendar Year Deductible
Network Providers ..... $250 per Participant
Out-of-Network Providers ..... $500 per Participant

Out-of-Pocket Maximum Limit (applies only to
Network Providers and services) ..... $3,000 per Participant per calendar year
$6,000 per family per calendar year

There is no Out-of-Pocket Maximum Limit for Out-of-Network Providers or services.

Preventive and Wellness Benefit .....100% up to a maximum of
$200 per Participant per calendar year

Co-Insurance payable by Plan (after satisfy Calendar Year Deductible) for Eligible Charges incurred during calendar year until satisfy Individual or Family Out-of-Pocket Maximum:

Network Providers..... 90%

Out-of-Network Providers..... 60%

Out-of-Network Providers When Outside Network Area 80%

Outpatient Surgical Procedures

Network Providers 90%

Out-of-Network Providers 60%

Prescription Drugs

Non-Generic Drugs.....80% after satisfying the $250 Calendar Year Deductible

MEDICAL BENEFIT (continued):

Generic Drugs..... 100% after satisfying the $250 Calendar Year Deductible

The designated Network, for purposes of obtaining discounted prices for Prescription Drugs, is CAREMARK. This means that Participants who purchase their Prescription Drugs from a CAREMARK pharmacy will be given certain discounted pricing. For questions relating to CAREMARK pharmacies, you may contact CAREMARK as follows:

- Call a CAREMARK customer service representative, available 24 hours a day, seven days a week, at: 1-866-875-6452 toll-free, or 1-800-231-4403 for TDD Users; or

- Use the interactive voice response system, using the same telephone numbers listed above, to refill an order or check the status of an order, also available 24 hours a day, seven days a week; or

- Visit CAREMARK's website at www.caremark.com to fill prescriptions or to check prescription history, shipping status or drug pricing.

A CAREMARK Mail Service Pharmacy is also available at: P.O. Box 3223, Wilkes-Barre, PA 18773-3223.

Pre-Certification Required For Non-Emergency Hospital Admissions & Non-Emergency Outpatient Surgical Procedures, And Notification Required Within 48 Hours After Emergency Hospital Admissions & Emergency Outpatient Surgical Procedures.

For required pre-certification and required notification for Hospital admissions and outpatient surgical procedures, call American Health Holding at (866) 353-6507 to initiate the process.

Penalty For Failure To Pre-Certify Or Notify Within 48 Hours As Required:

For Hospital admissions..... benefits otherwise payable will be reduced by $250 per day of Hospitalization

$25,000 MEDICAL BENEFIT

SCHEDULE OF BENEFITS
Effective October 1, 2010

MEDICAL BENEFIT (continued):

For outpatient surgical procedures ..... benefits otherwise payable for the outpatient surgical procedure will be reduced by $250

Hospital Room & Board ..... applicable Co-Insurance of average semi-private rate in admitting Hospital ICU and CCU

Hospital Co-payments (Out-of-Network only)

Inpatient ..... $300 per confinement
Outpatient ..... $100 per treatment
Emergency Room Visit (waived if confined) ..... $50 per visit

Home Health Care Benefit ..... Applicable Co-Insurance for up to 75 visits per Participant per calendar year

Skilled Nursing Facility Benefit

Maximum Number of Days ..... 60 Days Per Participant Per Calendar Year
Room and Board Limit ..... 50% of Semi-Private Room Rate in Hospital Where Patient Was Confined

Hospice Care Benefit (for terminally ill patient) ..... Combined maximum benefit of $5,000 for both inpatient and outpatient coverage

Inpatient coverage ..... 90% of Allowable Charge
Outpatient coverage ..... 100% of Allowable Charge

Counseling for immediate family within 6 months of Participant's death ..... 100% (Maximum of 20 visits limited to $40 per visit)

Chiropractic Services Benefit ..... 20 visits per Participant per calendar year, limited to $30 per visit

$25,000 MEDICAL BENEFIT

SCHEDULE OF BENEFITS
Effective October 1, 2010

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT:

Coverage provided *Only* for Network Providers. No benefits are payable for Out-Of-Network Providers.

Designated Network, Network Manager & Patient Care Coordinator ..... Magellan Health Services

Contact Information for Network, Network Manager & Patient Care Coordinator:

Magellan Health Services
14100 Magellan Plaza
Maryland Heights, MO 63043
Telephone Number: 1-800-584-7459

Pre-Certification Required As Condition Of Coverage:

The Patient Care Coordinator *Must* Be Contacted Before Receiving Treatment for Referral to a Network Provider. **Effective January 1, 2013, pre-certification is not required as a condition of coverage for outpatient procedures but is still required as a condition of coverage for inpatient procedures.**

Penalty For Failure To Pre-Certify When Required: ..... No Coverage

Lifetime Maximum Benefit for Mental Health Combined with Lifetime Maximum Benefit for Medical Benefit $25,000

Lifetime Maximum Benefit for Substance Abuse only (Inpatient and Outpatient Combined) per Participant (in addition to Lifetime Maximum Benefit for Mental Health combined with Medical Benefit) $25,000

Calendar Year Maximum for Substance Abuse only (Inpatient and Outpatient Combined) per Participant $20,000

Outpatient Calendar Year Deductible per Participant $250

Hospital Deductible per Participant ..... $250 plus $50 per day for 1st 5 days of hospitalization (maximum $500 deductible)

$25,000 MEDICAL BENEFIT

SCHEDULE OF BENEFITS
Effective October 1, 2010

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT (continued):

Co-Insurance (after deductible) payable by Plan for Eligible Charges incurred during calendar year until satisfaction of Family Out-of-Pocket Maximum..... 80%

Co-Insurance (after deductible) payable by Plan for Eligible Charges incurred during calendar year after satisfaction of Family Out-of-Pocket Maximum, up to Calendar Year and Lifetime Maximum Benefits..... 100%

Family Out-of-Pocket Maximum Per Calendar Year $1,500

ARTICLE I
ELIGIBILITY AND COVERAGE

Section 1.1 – Eligibility Requirements for $25,000 Medical Benefit

Only those Retired Employees and their Dependents who are eligible to participate in the Welfare Plan and, as of January 1, 1997, were receiving the same level of medical benefits as those described in this Schedule of Benefits through an arrangement with the Management International Longshoremen's Association (MILA) Health Care Trust Fund, are covered for the $25,000 Medical Benefit described in this Schedule B.

Section 1.2 – Extension of Coverage Due to Total Disability

In addition to the rules that otherwise apply under the Welfare Plan with regard to eligibility and termination of coverage, if a Retired Employee or Dependent is covered for the $25,000 Medical Benefit and is totally disabled on the date coverage would otherwise end by reason other than exhaustion of the Lifetime Maximum Benefit or termination of the $25,000 Medical Benefit or of Dependent coverage in general, his or her coverage for the $25,000 Medical Benefit will be extended as described in this Section, solely with respect to Eligible Charges incurred for such total disability.

This special extension of coverage for charges related to the total disability, which begins after coverage of the disabled Retired Employee or Dependent would otherwise end, will end on the earlier of the following dates: (a) December 31 of the calendar year immediately following the calendar year in which the coverage would have ended but for this extension; or (b) the date such disabled person becomes eligible for medical benefits under another group health plan.

ARTICLE II
$25,000 MEDICAL BENEFIT

Section 2.1 – Overview of $25,000 Medical Benefit

The $25,000 Medical Benefit covers Eligible Charges incurred by Participants while covered for the $25,000 Medical Benefit, for medical care, services, supplies and prescription drugs that are Medically Necessary for the treatment of non-work related illness or injury to the extent described in this Schedule B. This benefit is self-insured by the Fund. An expense is incurred on the date the service or supply for which it is charged is furnished.

Section 2.2 – What Is Covered and What Is Excluded By the $25,000 Medical Benefit

(a) Coverage in General:

The $25,000 Medical Benefit pays the applicable Co-Insurance percentage of the Eligible Charges incurred by a Participant depending upon the category of medical services, subject to the Lifetime Maximum Benefit, Calendar Year Deductible and other exclusions and limitations that apply, all as described in the Schedule of Benefits and this Schedule B.

(b) Calendar Year Deductible:

The Calendar Year Deductible is the amount of Eligible Charges incurred during a calendar year, as shown in the Schedule of Benefits, that each Participant must pay before benefits will begin to payable for Eligible Charges incurred by the Participant for the remainder of the calendar year. The Calendar Year Deductible applies to both medical and prescription drug claims.

(c) Carryover Deductible:

If a Participant does not satisfy his or her Calendar Year Deductible for a calendar year, any Eligible Charges incurred by the Participant during October, November, or December that were applied to the Calendar Year Deductible for such calendar year, will be carried over to the following calendar year and credited toward satisfaction of the Participant's Calendar Year Deductible for that year.

(d) Common Accident Deductible:

If two or more covered members of a family are injured in the same accident, only one of their Calendar Year Deductibles must be satisfied before benefits are payable for treatment of the injuries sustained by such family members in the accident during that calendar year.

(e) Reasonable and Customary Charges:

All major medical benefits payable hereunder are based on Eligible Charges and Reasonable and Customary Charges.

(f) Network Providers and Out-of-Network Providers:

The Trustees have arranged for participation in a Network. The name of the Network and all contact information are set forth in the Schedule of Benefits. The Trustees may change the Network from time to time. Participants will be notified of any such changes.

The level of benefits payable for a Network Provider will be higher than the level of benefits payable for an Out-of-Network Provider as set forth in the Schedule of Benefits. A directory of Network Providers will be provided to Participants, free of charge, upon their initial enrollment and at any time thereafter upon written request to the Fund Office or a Field Office.

As reflected in the Schedule of Benefits, there is a difference in the Co-Insurance payable under the $25,000 Medical Benefit depending upon whether the Prescription Drug is a Generic Drug or non-Generic Drug, regardless of whether the Participant uses a Network Provider or an Out-of-Network Provider. However, the Trustees have provided for an arrangement which allows Participants to take advantage of discounted pricing for Prescription Drugs obtained through certain Network pharmacies, as described in the Schedule of Benefits.

For example, assume you are a Participant and you have satisfied your Calendar Year Deductible but not your Out-of-Pocket Maximum for the year. You have a non-generic Prescription Drug filled, so the Co-Insurance level will be 80% regardless of whether it is filled by a Network pharmacy or an Out-of-Network pharmacy. This means that 80% of the cost is payable under the $25,000 Medical Benefit and 20% of the cost is payable by you. If you have it filled at a Network pharmacy and qualify for discounted pricing (depending upon the Prescription Drug), you will pay less out-of-pocket since your 20% share will be based on a lower cost.

(g) Co-Insurance and Out-of-Pocket Maximum:

The following terms, when used in this Schedule B, have the meaning set forth below:

(i) "Co-Insurance" means the percentage of Eligible Charges payable under the $25,000 Medical Benefit, after the Participant satisfies the Calendar Year Deductible, as listed in the Schedule of Benefits for certain categories of services. If the Co-Insurance percentage is less than 100%, the remaining charges are payable by the Participant;

(ii) "Out-of-Pocket Maximum" means the maximum amount of Eligible Charges that a Participant or family is responsible for paying during a calendar year, before the Co-Insurance percentage payable under the $25,000 Medical

Benefit for the Participant or family (as applicable) increases to 100% for Eligible Charges incurred during the remainder of the calendar year. The Calendar Year Deductible counts toward satisfaction of the Out-of-Pocket Maximum. Benefits for any Participant are payable only up to that Participant's Lifetime Maximum Benefit.

Any change to the Co-Insurance or Out-of-Pocket Maximum will be reflected in an amended Schedule of Benefits adopted by the Trustees, and Participants will be notified of the change.

(h) Lifetime Maximum Benefit:

The Lifetime Maximum Benefit is the maximum amount payable under the $25,000 Medical Benefit for each Participant during his or her lifetime, as shown in the Schedule of Benefits. Once a Participant reaches the Lifetime Maximum Benefit, no further benefits are payable under the $25,000 Medical Benefit for that Participant.

(i) Weekend Hospital Admissions:

Except for medical emergencies, if a Participant is admitted to a Hospital on Saturday or Sunday, the Eligible Charges incurred will not be covered under the $25,000 Medical Benefit.

(j) Outpatient Surgery Benefit:

Eligible Charges incurred for outpatient surgery performed at an outpatient surgical facility are covered by the $25,000 Medical Benefit at the applicable Co-Insurance level (subject to the Calendar Year Deductible), as reflected in the Schedule of Benefits, but only if the following requirements are satisfied:

(1) The outpatient surgical facility must be approved by the appropriate State regulatory authority and may be free-standing or part of a Hospital facility; and

(2) The outpatient surgical facility must be capable of handling surgical cases on a "same day" basis; have a staff of Physicians and continuous Physician and registered nursing (R.N.) care when patients are present; and be used primarily for performing outpatient surgery.

If an outpatient surgery is covered in accordance with the above requirements, Eligible Charges related to the outpatient surgery and incurred for medical supplies, drugs, medications, laboratory services and Physicians' services will also be covered provided they would have been covered had the surgery been performed on an inpatient basis in a Hospital.

(k) Pre-Admission Testing for Hospital Admission:

Eligible Charges incurred for medical tests and studies performed on an outpatient basis prior to the Participant's scheduled Hospital admission for surgery, when required for

admission and rendered or accepted by the Hospital, are covered at the applicable Co-Insurance level without application of the Calendar Year Deductible, provided the services would have been available to patients admitted to the Hospital. Pre-admission testing does not include medical tests and studies performed to establish a medical diagnosis.

This benefit will still be provided if the Hospital or Physician cancels or postpones the Participant's admission to the Hospital on an inpatient basis; however, this benefit will not be provided if the Participant cancels or postpones admission to the Hospital on an inpatient basis.

(l) Prescription Drug Benefit:

Eligible Charges incurred for Prescription Drugs ordered by the Participant's Physician and dispensed by a licensed pharmacist are covered at the applicable Co-Insurance level listed in the Schedule of Benefits, depending on whether the Prescription Drug is a Generic Drug or a non-Generic Drug, subject to the Calendar Year Deductible and Lifetime Maximum Benefit.

(m) Home Health Care Benefit:

Eligible Charges incurred for Home Health Care, as defined in this subsection, are covered at the applicable Co-Insurance level, subject to the Calendar Year Deductible and visit limit per calendar year, as set forth in the Schedule of Benefits. For coverage purposes, "Home Health Care" means medical care that is arranged through a Home Health Agency or Hospital and furnished to a Participant at home.

"Home Health Agency" means an agency that is licensed to provide Home Health Care under Medicare.

"Home Health Aide" means a person who provides services for patient care and is appropriately trained for Home Health Care under the supervision of a registered nurse employed by the Home Health Agency.

In order for charges for Home Health Care to be covered, the following requirements must be satisfied:

(1) A Home Health Care treatment plan, prescribing the plan for continued treatment and including an estimate of duration, must be submitted in writing by the attending Physician within 14 days following the end of a Hospital or Skilled Nursing Facility confinement. The Physician must recertify the need for continued care upon request by the Network; and

(2) The Home Health Care services must begin after the Participant is released from the Hospital or Skilled Nursing Facility for the illness or injury; and

(3) The Participant's confinement in the Hospital or Skilled Nursing Facility for the illness or injury must be for at least 1 day; and

(4) The Home Health Care must be needed by the Participant in place of being an inpatient in a Hospital or Skilled Nursing Facility; and

(5) The treatment must be a curing aid and necessary for treatment of an illness or injury.

The following Home Health Care services are covered under the Home Health Care Benefit:

(1) Services on a part-time or intermittent basis by a registered nurse, licensed practical nurse or Home Health Aide;

(2) Services performed by a licensed physical, occupational, speech and/or respiratory therapist; and

(3) Medical support services and supplies, such as drugs and medicines, when prescribed by the Physician, as well as laboratory services and other supplies that would have been covered if the Participant had remained in the Hospital or a Skilled Nursing Facility.

Up to 4 hours of Home Health Care will count as 1 visit.

Charges incurred for any of the following are excluded from coverage:

(1) Services provided during any period in which the patient is not under the care of a Physician;

(2) Services or supplies not included in the Home Health Care treatment plan;

(3) Food, housing, homemaker services and home-delivered meals; and

(4) Services provided by a person who ordinarily resides in the patient's home, or is a member of the patient's family.

(n) <u>Hospice Care Benefit</u>:

Eligible Charges incurred for Hospice Care, as defined in this subsection, are covered at the applicable Co-Insurance level and subject to the limitations set forth in the Schedule of Benefits. "Hospice Care", for coverage purposes, is defined as care for a Participant who is terminally ill, which means the Participant's life expectancy is six months or less as certified by the Participant's Physician. Hospice Care is a coordinated program of home and inpatient care, for a terminally ill patient and the patient's immediate family,

provided by a hospice care agency. "Immediate family", for purposes of the Hospice Care Benefit, means the Retired Employee and any eligible Dependent.

The Hospice Care Benefit covers the following Hospice Care services and types of medical charges, subject to the conditions and limits described above and in the Schedule of Benefits:

(1) Room and board charged by the Hospice Care agency;

(2) Special charges and supplies;

(3) Part-time nursing care by or supervised by a registered nurse (RN);

(4) Home Health Care services as described under the Home Health Care Benefit, except that the number of visits is not limited and prior Hospital confinement is not required;

(5) Counseling for the patient and the patient's immediate family by a licensed social worker or licensed pastoral counselor; and

(6) Bereavement counseling for the patient's immediate family by a licensed social worker or licensed pastoral counselor within six months after the patient's death.

(o) Skilled Nursing Facility Benefit:

For purposes of this benefit, a "Skilled Nursing Facility" is a facility that is mainly engaged in providing skilled nursing care and other therapeutic services. The Skilled Nursing Facility must be licensed by the State in which it is located and must be an eligible provider of Medicare and Medicaid nursing care services.

The Skilled Nursing Facility Benefit covers Eligible Charges incurred by a Participant for the first 60 days of confinement in a Skilled Nursing Facility each calendar year, payable at the Co-Insurance level described in the Schedule of Benefits, provided the following requirements are satisfied:

(1) The Participant's Physician prescribes a written treatment plan for the Participant, while confined in the Skilled Nursing Facility, and supervises such care and treatment; and

(2) The Skilled Nursing Facility maintains the written treatment plan, in addition to medical records, for the Participant and each other patient while confined to the facility; and

(3) The Participant is confined for at least three days in the Hospital prior to confinement in the Skilled Nursing Facility; and

(4) The skilled nursing care and other therapeutic services rendered in the Skilled Nursing Facility begin within 14 days after the Participant's release from the Hospital and are for the same illness or injury that caused the Hospital confinement; and

(5) In the absence of such skilled nursing care, the Participant would be required to be an inpatient at a Hospital.

Coverage for the room and board charges by a Skilled Nursing Facility is limited to the percentage of the daily room and board charge for the Hospital where the Participant was or would otherwise be confined, as described in the Schedule of Benefits.

(p) Utilization Management:

To help hold down health care costs, the $25,000 Medical Benefit has a utilization management program that requires Hospital precertification and participation in case management services as a condition of coverage. There is a "Utilization Reviewer" ("UR") appointed by the Trustees to manage the utilization management program for the $25,000 Medical Benefit. The name of the UR and contact information are set forth in the Schedule of Benefits. Participants will be notified of any changes in the utilization management program or UR.

(q) Required Hospital Pre-Certification and Notification With Penalty For Failure to Comply:

Hospital Pre-Certification is the process used to pre-certify, for coverage purposes, the Medical Necessity and, as applicable, the approved length of Hospital confinement, for a Participant's non-emergency outpatient surgical procedures. Hospital Pre-Certification is required for all non-emergency Hospital admissions, whether on an inpatient basis or for an outpatient surgical procedure.

Once a Participant is admitted to a Hospital, the Utilization Reviewer (UR) will continue to monitor the length of stay to help assure that the admission continues to be Medically Necessary, and will provide discharge planning, if and as needed, for Home Health Care and for medical equipment that may be needed during recovery.

Participants are responsible for satisfying the Hospital Pre-Certification requirements, in order to qualify for full benefits, by contacting the UR as described in the Schedule of Benefits, prior to a non-emergency Hospital admission or surgical procedure, to initiate the process. If it is an emergency Hospital admission or surgical procedure, the Participant must contact the UR within 48 hours following the admission or procedure. Participants will be notified of any changes in the UR or contact information. The Physician or a family member may also initiate the required Hospital Pre-Certification, or satisfy the required notification following an emergency Hospital admission or surgical procedure, on behalf of the Participant by contacting the UR.

There is a penalty for failure to comply with these requirements as described in the Schedule of Benefits.

(r) Case Management:

Case Management applies when a serious medical condition indicates that a Participant may need long term care. Under the Utilization Management program, the UR will designate a case manager and/or Physician to assist the Participant's own Physician in identifying, if and as appropriate, other treatment settings and other levels of care, and to coordinate the long term care needs of the Participant by working with the Participant, the family members, and members of the medical team.

(s) Other Medical Charges Covered under the $25,000 Medical Benefit:

In addition to the specific benefits described above, Eligible Charges incurred by a Participant for any of the following services and supplies, which are Medically Necessary and prescribed by the attending Physician for injury, illness or maternity care, are covered subject to the limits set forth in the Schedule of Benefits:

(1) Hospital charges for room and board, with the daily allowance not to exceed the average semi-private room rate charged by the Hospital; however, the full charge for an intensive care unit will be considered eligible;

(2) Other Hospital charges incurred by a Participant, on an inpatient basis or outpatient basis, for use of an emergency room, operating room, delivery room, treatment room, recovery room, outpatient department or free-standing surgical center, as well as for any of the following: anesthesia materials and administration of anesthesia by licensed personnel; laboratory examinations; oxygen and its administration; medical and surgical supplies; Prescription Drugs and medicines approved by the Food and Drug Administration or its successor and provided to a Participant while confined in the Hospital or outpatient surgical facility; blood, blood plasma, blood derivatives, and blood processing; transfusion fees and equipment; electrocardiograms; x-ray, nuclear medicine, sonography, computerized tomography, and magnetic resonance imagery; physical therapy; intravenous injections and solutions; electroencephalograms; traction; use of an intensive care unit, cardiac unit or burn unit when such units are approved by the UR; heart laboratory, cardiovascular laboratory, or vascular laboratory; chemotherapy and radioisotope therapy including use of materials such as nitrogen mustard, radioactive gold or radioactive iodine; radiation therapy and high intensity x-ray therapy including electrically produced therapy, and radioactive materials such as cobalt, radium and radium implant; and hemodialysis expenses related to laboratory tests and consumable and expendable supplies, such as dialysis membrane, dialysis solution, tubing and drugs required during dialysis;

(3) Physician's services for surgery; home, office and Hospital visits; examination, diagnosis, consultation and evaluation; and other medical care and treatment;

(4) Medical services of a Physician or Dentist for dental care and treatment, dental surgery, dental appliances and replacement of natural healthy teeth, but only in the following cases: the surgical removal of impacted wisdom teeth; and services directly related to an injury resulting from an accident occurring while the Participant is covered under the $25,000 Medical Benefit and rendered within 24 months immediately following such injury;

(5) Chiropractic services subject to the limits described in the Schedule of Benefits, and x-rays, casts, splints and braces if they are consistent with the diagnosis;

(6) Physical, occupational, speech, visual and audio therapy prescribed by a Physician or registered therapist who is not a member of the Participant's immediate family (for purposes of coverage for these services, defined as the Retired Employee's spouse and the children, brothers, sisters and parents of the Retired Employee or of the Retired Employee's spouse);

(7) Private duty nursing when prescribed by a Physician and provided by a registered nurse or licensed practical nurse who is not a member of the Participant's immediate family (for purposes of coverage for these services, defined as the Retired Employee's spouse and the children, brothers, sisters and parents of the Retired Employee or of the Retired Employee's spouse);

(8) Casts, splints, crutches, surgical dressings and artificial limbs and eyes;

(9) Rental of basic wheelchairs, Hospital beds and durable medical and surgical equipment for the treatment of an injury or illness, which (a) can withstand repeated use; and (b) is primarily and customarily used to serve a medical purpose; and (c) is not generally useful to a person except in the treatment of an injury or illness;

(10) Artificial prosthetic devices that replace a natural part of the body except for an artificial heart. Loss of the natural body part must occur while the Participant is covered under the $25,000 Medical Benefit, and replacements are limited to two per year;

(11) Transportation by professional ambulance to or from a local Hospital, or if special treatment is required which is not available in a local Hospital, transportation by professional ambulance, railroad, or a regularly scheduled commercial passenger flight to or from the nearest Hospital equipped to furnish such special treatment;

(12) Outpatient diagnostic x-rays and microscopic or laboratory tests;

(13) Prescription Drugs prescribed by a Physician for use outside of the Hospital, provided that coverage is limited to those drugs approved by the Food and Drug

Administration or its successor. Over-the-counter drugs or drugs available without a prescription are not covered even if a Physician has prescribed them in writing;

(14) Medical care and services for or related to pregnancy including childbirth, miscarriage, abortion and any complications resulting from pregnancy, provided that such coverage is provided only for or related to the pregnancy of a Retired Employee or Dependent spouse, and not of a Dependent child; and

(14) Removal of mammary implant(s) that were surgically implanted, but only if a preoperative report from a Physician specializing in the field indicates that removal of the implant(s) is Medically Necessary. If removal is not specifically recommended as Medically Necessary, coverage (although denied on the basis of the pre-operative report) will again be considered after surgery when Hospital records, an operative report and a pathology report are available and provided to the UR.

(t) <u>Exclusions and Limitations under the $25,000 Medical Benefit</u>:

Notwithstanding any other provision in this Schedule B to the contrary, charges incurred for any of the following are excluded from coverage and will not be payable under the $25,000 Medical Benefit:

(1) Dental work (except when Hospital confined), dental diagnosis and treatment, eye examinations, eye glasses and contact lenses (except for special eye glasses and/or contact lenses required as a result of a cataract operation), hearing aids and or cosmetic surgery, except to the extent specifically covered in connection with services directly related to an accidental bodily injury sustained while covered under the $25,000 Medical Benefit and rendered during the 24-month period immediately following such injury, provided the treatment giving rise to such charges begins within 90 days after such injury;

(2) Charges for mental and emotional illness or substance abuse, except to the extent covered under the Mental Health and Substance Abuse Benefit described in Article III;

(3) Sickness, disease, or bodily injury resulting from war or any act incident to war, whether the war is declared or undeclared;

(4) Injury which arises out of or in the course of employment, or sickness for which benefits are payable under a Workers' Compensation Act or similar legislation;

(5) Health or check-up examinations other than those necessary for the treatment of a sickness, disease, or bodily injury;

(6) Any bodily injury or sickness caused by, or as a result of, the commission of a felony or attempt to commit a felony, by a Participant. In the event the Participant is arrested, charged with, or indicted for a felony or an attempted felony, any and

all payments that may be due under the $25,000 Medical Benefit will not be payable until a final judicial determination has been made;

(7) Charges which are in excess of Reasonable and Customary Charges;

(8) Charges which a Participant is not legally required to pay;

(9) Charges for experimental or investigational treatment or procedures, or for research purposes, or when not a generally recognized accepted medical practice;

(10) Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an injury or illness by any of the following: (a) the American Medical Association; or (b) the U.S. Surgeon General; or (c) the U.S. Department of Public Health; or (d) the National Institute of Health;

(11) Charges for actual or attempted impregnation or fertilization which involves either a Participant or a surrogate as a donor or recipient;

(12) Charges for services or supplies, including tests and check-up exams, that are not "needed" for the medical care of a diagnosed sickness or injury. To be considered "needed", a service or supply must meet all of the following tests:

(i) It is ordered by a Physician;

(ii) It is commonly and customarily recognized throughout the Physician's profession as appropriate in the treatment and diagnosis of the sickness or injury;

(iii) It is not educational or experimental in nature, and for coverage purposes, investigational procedures are considered experimental; and

(iv) It is not furnished mainly for the purpose of medical or other research.

Expenses incurred for treatments, procedures, devices, and drugs which the person or entity appointed by the Trustees or their designee, in the exercise of their discretion, determine are experimental, investigational or done primarily for research, are excluded under this provision unless all of the following requirements are satisfied:

(i) Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

(ii) "Reliable evidence" shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy or

efficacy as compared with the standard means of treatment or diagnosis; and

(iii) "Reliable evidence" shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, if efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence", for purposes of this exclusion, includes anything determined to be such by the Trustees or their designee, in the exercise of their discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

Also in the case of a Hospital confinement, the length of the confinement and Hospital services and supplies will be considered "needed" only to the extent they are determined to be related to treatment of the sickness or injury and not allocable to the scholastic education or vocational training of the patient.

ARTICLE III
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT

Section 3.1 – Definitions

Whenever the following terms are used in this Article III as capitalized terms, they will have the meaning set forth below (notwithstanding the "Definitions" Section of the Welfare Plan), unless otherwise plainly indicated by the context.

(a) **"Chronic Mental Condition"** means a Mental Health/Substance Abuse Condition for which a Participant has been hospitalized at least four times in his or her lifetime, with at least two occurring within the three year period immediately before the date on which the Participant obtains or seeks to obtain Mental Health/Substance Abuse Treatment Services.

(b) **"Covered Services"** means Mental Health/Substance Abuse Treatment Services that are Medically Necessary and covered under the Mental Health and Substance Abuse Benefit as described in this Article III.

(c) **"Emergency Treatment"** means Medically Necessary services to treat a Participant's sudden, unexpected acute symptoms of mental illness or substance abuse which are so severe that, without immediate treatment, could reasonably cause serious injury to life or limb and/or immediate jeopardy to the Participant's health.

(d) **"Family Unit"** means a Retired Employee and his or her Dependents who are covered by the Welfare Plan.

(e) **"Medically Necessary"** means, for purposes of the Mental Health and Substance Abuse Benefit, a determination by the Network Manager that a particular Mental Health/Substance Abuse Treatment Service meets all of the following criteria:

(1) It is appropriate for the symptoms, diagnosis and treatment of a particular disease or condition that is defined under the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) of the American Psychiatric Association, (DSM-IV) or its replacement;

(2) It is provided in accordance with generally accepted standards of Mental Health and Substance Abuse professional practice;

(3) It is provided for the diagnosis or direct care and treatment of a disease or condition that is defined under DSM-IV or its replacement;

(4) It is not rendered mainly for the convenience of the Participant, the Participant's family or the provider; and

(5) The type, level and length of treatment services are needed to provide safe and adequate care and are reasonably likely to improve a Participant's condition and not merely to maintain the current level of functioning. For inpatient stays, this means that because of the symptoms or condition, the Participant cannot receive safe and adequate care as an outpatient or in another less intensive setting.

(f) **"Mental Health/Substance Abuse Condition"** means a nervous, mental, or substance abuse condition that satisfies all of the following requirements:

(1) It is a clinically significant behavioral or psychological syndrome or pattern;

(2) It is associated with present distress or substantial or material impairment of the patient's ability to function in one or more major life activities (e.g., employment);

(3) It is not merely an expectable response to a particular event (e.g., the death of a loved one); and

(4) It is listed as an Axis I disorder (other than a V Code of the DSM-IV or its replacement).

(g) **"Mental Health/Substance Abuse Treatment Services"** means psychiatric and/or other mental health services for a Mental Health/Substance Abuse Condition.

(h) **"Network Provider"** means, for purposes of the Mental Health and Substance Abuse Benefit under this Article III, a Provider or facility that is licensed under applicable state law and contracts with or is employed by the Network Manager to deliver Mental Health/Substance Abuse Treatment Services to Participants.

(i) **"Provider"** means a licensed psychiatrist, licensed psychologist, licensed chemical dependency therapist, licensed psychiatric nurse, social worker (licensed or accredited by the Academy of Clinical Social Workers), or other health care provider or facility as described in this Article III, that is licensed or certified under the laws of the State in which the services are delivered.

(j) **"Structured Outpatient Services"** means a structured treatment program consisting of multiple sessions of Mental Health/Substance Abuse Treatment Services in each 7 day period, with each session no shorter than 2 hours and no longer than 12 hours in any 24-hour consecutive period. It may also be referred to as intensive outpatient treatment, partial hospitalization, or day hospitalization, and for coverage purposes includes Residential Treatment Programs.

Section 3.2 – Scope of Coverage and Required Use of Network Providers

The Mental Health and Substance Abuse Benefit covers only the services described in this Article III, when coordinated through the Network Manager and received from Network Providers, and subject to the limits described in the Schedule of Benefits.

Section 3.3 – Limitations and Exclusions

Notwithstanding any provision to the contrary, the following services, treatments and supplies are **not** Covered Services and are **not** covered under the Mental Health and Substance Abuse Benefit, so any related expenses incurred will **not** be covered:

(a) Services, treatment and supplies provided by an Out-of-Network Provider, except for Emergency Treatment;

(b) Services, treatment and supplies provided without the required Pre-Certification, except for Emergency Treatment; effective January 1, 2013, Pre-Certification is not required for outpatient procedures as a condition of coverage but is still required for inpatient procedures as a condition of coverage;

(c) Services, treatment and supplies which are not Medically Necessary;

(d) Services, treatment and supplies which are primarily for rest, custodial, domiciliary or convalescent care;

(e) Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification;

(f) Services, treatment and supplies which are determined to be experimental;

(g) Private hospital rooms and private duty nursing, unless determined to be Medically Necessary and authorized by the Network Provider;

(h) Expenses incurred for broken appointments except in cases where the Network Provider is notified at least 24 hours before the appointment time, otherwise a charge of no more than $25.00 will be billed directly to the Participant as a broken appointment charge;

(i) All Prescription Drugs and non-Prescription Drugs, unless prescribed by a Network Provider in the course of inpatient treatment;

(j) Marriage counseling except for treatment of a Mental Health/Substance Abuse Condition;

(k) Treatment of congenital and/or organic disorders, including but not limited to organic brain disorder and Alzheimer's disorder;

(l) Treatment of mental retardation other than the initial diagnosis;

(m) Diagnosis and treatment of developmental disorders, including but not limited to developmental reading disorders, developmental arithmetic disorders and developmental articulation disorders;

(n) Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training and education therapy for learning disabilities and other education services;

(o) Services, treatment and supplies provided as a result of any Worker's Compensation or similar law, or obtained through or required by any governmental agency or program, whether federal, state or any subdivision thereof, or caused by the conduct or omission of a third-party for which you have a claim for damages or relief, unless you provide the Network with a lien against such claim for damages or relief in a form and manner satisfactory to the Network Manager;

(p) Any court-ordered diagnosis or treatment, including any diagnosis or treatment ordered as a condition of parole, probation or custody or a visitation evaluation, unless and except to the extent it is Medically Necessary;

(q) Psychological examination, testing and treatment for purposes of satisfying a current or prospective employer, or any requirements for obtaining employment, licensing or insurance, or for the purpose of judicial or administrative proceedings (including but not limited to parole or probation proceedings);

(r) Other psychological testing except when conducted for the purpose of diagnosis of a Mental Health/Substance Abuse Condition;

(s) Services, treatment and supplies for military services and other disability;

(t) Treatment of detoxification in newborns;

(u) Treatment of obesity, weight reduction, and smoking cessation (including supplies);

(v) Stress management therapy and aversion therapy;

(w) Treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins but not including tension headaches;

(x) Sex therapy, treatment for sexual deviance, and diagnosis and treatment in conjunction with sexual reassignment procedures;

(y) Damage or other harm to a Network Provider caused by you (Participants will be solely responsible for all such damage or harm);

(z) Treatment for a Chronic Mental Condition, except for (i) stabilization of an acute episode of such disorder, or (ii) management of medication;

(aa) Any mental illness or substance abuse illness for which the individual has received treatment in the first six months immediately prior to commencement of coverage under the Plan;

(bb) Frontal Lobe Syndrome;

(cc) Post Concussion Syndrome; and

(dd) Gilles de Touret's Syndrome.

Section 3.4 – Grievance Procedure for Disputes and Complaints

The Network Manager maintains a voluntary internal grievance procedure for resolving Participants' disputes or complaints with the Network Manager or with any Network Provider. You may call the Network Manager at the telephone number listed in the Schedule of Benefits, to discuss any inquiries or complaints about the Network Manager, any Network Provider or any other related matter. If the Network Manager does not satisfy your concern by telephone, you may file a complaint by completing a complaint form and sending it to the Network Manager at the address listed in the Schedule of Benefits.

Copies of complaint forms and grievance procedure for Network matters are available at Network Provider offices and upon request to the Network Manager. Assistance will be provided by a Network representative to any Participant who files a grievance. Neither the Network Manager nor any Network Provider will discriminate against a Participant for filing a complaint.

Within twenty (20) days of receiving a Participant's complaint, the Network Manager will contact the Participant to acknowledge receipt, solicit details as needed and conduct an investigation. The Participant will then be notified of the disposition of the complaint. If it is not resolved to the Participant's satisfaction, the Participant will have 30 days to request that his or her complaint be reviewed by the Network's Grievance Committee. The Grievance Committee will review the complaint further and notify the Participant of its decision within thirty (30) days of receiving a request for review. The Grievance Committee will also investigate any alleged retaliation and take appropriate action.

In addition to this Grievance Procedure, there is also a Claims Procedure and Claims Review Procedure maintained in accordance with the requirements under the federal law known as ERISA. Those procedures are described in greater detail in the general provisions for the Welfare Plan. Participants should review those procedures to learn more about their rights and obligations with regard to filing claims for benefits and requesting a review when a claim is denied in whole or part.