

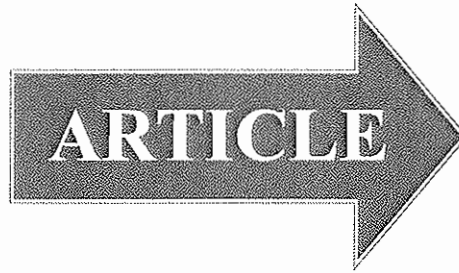
THIS IS PLAN 501-C

RESTATED RULES AND REGULATIONS

The United Food and Commercial Workers and Employers Arizona Health and Welfare Trust agrees to provide Plan 501-C Employees and their eligible Dependents (other groups of Employees are covered by a separate plan pursuant to their Collective Bargaining Agreements) the benefits hereafter described during the continuance of the Plan.

This Plan is subject to all the terms, provisions and conditions contained in the following pages.

The United Food and Commercial Workers and Employers Arizona Health and Welfare Trust has caused this Restated Plan to take effect as of 12:01 a.m., Mountain Standard Time, on January 1, 2008. As printed, the document includes any subsequent amendments.



ELIGIBILITY

PART A – INITIAL AND CONTINUING ELIGIBILITY

Persons whose Employers have entered into a Collective Bargaining Agreement with the Union, U.F.C.W. Local 99, and who are bound to the United Food and Commercial Workers and Employers Arizona Health and Welfare Trust by such agreement, become covered as Covered Employees or Covered Dependents subject to the following:

Section 1A.01 Eligibility. All Employees covered under the applicable provisions of a Collective Bargaining Agreement will be eligible for benefits coverage for themselves and their Covered Dependents in the month immediately following the completion of that period of employment with the same Contributing Employer specified in the applicable Collective Bargaining Agreement, provided they have worked the amount of hours (if any) required by the Collective Bargaining Agreement in the last month of such period specified in the applicable Collective Bargaining Agreement.

Section 1A.02 Continuing Eligibility. An Employee will remain covered for each succeeding month, following establishment of eligibility as provided in Section 1A.01, provided the Employee has worked (or, under some Agreements, has been scheduled to work) the amount of hours required by the Collective Bargaining Agreement in the succeeding work month.

Section 1A.03 Dependents' Coverage. Dependents are covered simultaneously with Employees. Newborn children are covered from the date of birth.

Section 1A.04 [This section intentionally left blank]

Section 1A.05 Coordination of Benefits. If both the Employee and the spouse are eligible for coverage under this Fund by virtue of employment, either as an Employee or a Retiree, benefits not to exceed the Allowable Expense of the claim will be extended under traditional NAIC Coordination Rules.

Section 1A.06 Medicare Election. An eligible Employee or Dependent who is entitled to receive Medicare coverage (Parts A and B) may elect in writing to reject coverage under this Plan and to rely exclusively on Medicare for coverage.

PART B - TERMINATION OF ELIGIBILITY

Section 1B.01 Termination. Employees and Dependents who have been eligible for the benefits of this Plan will cease to be eligible for the benefits on the earliest of:

Employee:

- (a) The date of termination of the Plan or, if any benefit of the Plan is terminated, on the date of termination of such benefit;
- (b) At the end of the month for which eligibility is generated under Section 1B.01 or, if earlier:
 - (1) At the end of the month the Fund Office receives notice from the Contributing Employer that the Employee's employment has terminated; or
 - (2) At the end of the day the Fund Office receives notice that an appropriate governmental agency has certified that the Employee's bargaining unit is no longer represented by the Union.

Dependent:

- (a) The date of termination of the Plan, or if any Dependent's benefit of the Plan is terminated, the date of termination of such Dependent's benefit;
- (b) The date the Employee ceases to be eligible for coverage under the Plan;
- (c) The date the person ceases to be a Dependent as defined in the Plan.
- (d) The date the person enters the military service of any country.

PART C – SELF-PAYMENT EXTENSION OF ELIGIBILITY

Section 1C.01 Employee Self-Payments.

- (a) **Eligibility.** If a Covered Employee loses eligibility for the benefits of this Fund because of a termination of employment or a reduction in hours (including leave of absence in the Uniformed Service of the United States) he/she and/or his/her Dependents may continue eligibility for certain Fund benefits by making self-payments directly to the Fund Office.
- (b) **Notice.** The Fund Office will determine if a Covered Employee has lost eligibility for the reasons specified in Section 1C.01(a) from the Employer Contribution Report submitted to that Office by contributing Employers. The Fund Office will notify a Covered Employee who has lost eligibility of that loss. The affected Covered Employee will have until the later of 60 days from the date of such notice, or 60 days from the date coverage is lost, to notify the Fund Office of his/her election to continue eligibility by making self-payments.
- (c) **Benefits Available.** A Covered Employee electing to continue coverage for himself/herself and/or his/her Dependents will be able to continue medical benefits only, or medical, dental and vision benefits.
- (d) **Self-Payment Amount.** The amount of the monthly self-payment for former Covered Employees and/or their Dependents will be established by the Board of Trustees of the Fund and will differ depending upon the benefits elected. In no event will a former Covered Employee who takes leave of absence for service in the Uniformed Services of the United States be responsible for any self-payment for the first month of such continuation of coverage.
- (e) **Maximum Number of Self-Payments.** The rights of a former Covered Employee and/or his/her Dependents to coverage under this Section will be continued until the end of the month in which the earliest of the following events occurs:
 - (1) The Trust Fund ceases providing any benefits to any Covered Employee.
 - (2) Coverage ceases by reason of the failure of the Employee and/or his/her Dependents to timely make the self-payments required by the Trustees.
 - (3) The former Covered Employee and/or his/her Dependents become covered under any other group health plan.

NOTE: If the other plan contains lawful limitations or exclusions for any pre-existing conditions covered by the benefits under this Section, any individual so limited or excluded by the other plan may continue coverage under the Trust Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Subsection (e). Benefits of this Plan and the other plan will be coordinated in accordance with the provisions of Article 9.

- (4) The former Covered Employee and/or his/her Dependents become entitled to Medicare.
- (5) Eighteen months have passed since the end of coverage by virtue of active employment (twenty-four months in the case of an individual taking leave for service in the Uniformed Services of the United States).

In the event that a Covered Employee becomes entitled to Medicare while eligible as an active Employee, no Dependent of such Employee will be denied the right to continue self-payments to the Fund under this provision until 36 months have passed from the date the Covered Employee became entitled to Medicare.

In the case of a Covered Person who was totally and permanently disabled for Social Security award purposes on the date of the employment termination of an active Employee or within 60 days after that, up to eleven additional months of self-payments may be allowed to bridge the gap between these provisions and Medicare entitlement. In order to enjoy this additional extension of self-pay rights, the totally disabled individual is required to notify the Fund Office within 60 days of the date of Social Security's determination of the disability at the time of the termination of employment and before the end of the eighteen-month period described above. Such individual is also required to notify the Fund Office within 30 days of any final Social Security determination that the individual is no longer disabled. The additional disability extension of self-payment rights under this Subsection (e) will terminate at the end of the month following the month in which a final Social Security determination is made that the individual is no longer disabled.

- (f) **Termination of Self-Payments.** Once a Covered Employee fails to make the required self-payment within the specified time or has made the maximum number of self-payments specified in Subsection (e) of this Section, the Covered Employee will no longer be permitted to make the self-payments described and must requalify for coverage under this Plan in accordance with Article 1, Part A.

Section 1C.02 Disability Waiver of Self-Payment. If a Covered Employee who intends to make self-payments hereunder is totally and continuously disabled due to Injury, Illness or Mental/Substance Abuse Condition, whether occupational or non-occupational, for a period of seven (7) or more consecutive days and is prevented from engaging in the essential duties of the Employee's occupation and is not performing work of any kind for compensation or profit at the time self-pay coverage is initiated, the Fund may waive or subsidize the self-payment for up to 3 months of the maximum periods specified in Section 1C.01(e) of this Part, provided the individual makes proper application for waiver of self-payments.

Section 1C.03 Dependent Self-Payments.

- (a) **Eligibility.** If any Covered Employee's Dependent or Dependents lose coverage for the benefits of this Fund because of:
 - (1) The death of a Covered Employee;
 - (2) The divorce of a Covered Employee;
 - (3) The attainment of Medicare entitlement by a self-pay Employee; or

- (4) In the case of a dependent child, the failure of such Dependent to meet the definition of a Dependent under Section 11.08 of this Plan;

they may continue eligibility by making self-payments directly to the Fund Office.

- (b) **Notice.** Dependents whose eligibility under the Plan is affected by divorce or the failure to meet the definition of a Dependent under the Plan are responsible for notifying the Fund Office of those facts within 60 days of the affecting event or within 60 days of the date coverage under the Plan would be lost as a result of the event, whichever is later. The Fund Office will then notify the Dependent(s) of their rights under these provisions within 14 days. The Dependent(s) will have until the later of 60 days from the date of the notice from the Fund Office, or 60 days from the date eligibility is lost, to notify the Fund Office of their election to continue eligibility by making self-payments.
- (c) **Benefits Available.** Dependents electing coverage under this Section will be able to continue medical benefits only, or medical, dental and vision benefits.
- (d) **Self-Payment Amounts.** The amount of the monthly self-payment for Dependents electing coverage under this Section will be established by the Board of Trustees of the Fund. The amount will vary depending on the benefits continued.
- (e) **Maximum Number of Self-Payments.** The right of Dependent(s) to make self-payments under this Section will be continued until the end of the month in which the earliest of the following events occurs:
 - (1) The Trust Fund ceases providing any benefit to any Covered Employee;
 - (2) Coverage ceases by reason of the failure of the Dependent(s) to timely make the self-payments required by the Trustees;
 - (3) The Dependent(s) become covered under any other group health plan;

NOTE: If the other plan contains lawful limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage under the Trust Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Subsection (e). Benefits of this Plan and the other plan will be coordinated in accordance with the provisions of Article 9.

- (4) The Dependents become entitled to Medicare;
- (5) Thirty-six months have passed since the end of coverage by virtue of a Covered Employee's employment.

Section 1C.04 Notice Procedures. The following notices must be made, in writing, and within the specified timeframes, to the Fund Office:

- (a) Notice of divorce, Medicare eligibility or failure to meet Dependent definition under Section 1C.03(b);
- (b) Notice of a Social Security disability award or the revocation of that award under Section 1C.01(e); or
- (c) Notice of any other event giving rise to self-payment rights under Part C.

Such notices must include either the information which will allow the Fund Office to determine the self-payment rights of those individuals involved or the contact information for the person from whom such information may be obtained.

Section 1C.05 Due Date of Self-Payment Premiums for Employees and Dependents. Initial self-payment(s) (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Fund Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the 20th day of the month proceeding the month for which coverage is intended. Self-payments received at the Fund Office later than 40 days after the due date will not be accepted, and rights to self-payments will terminate. **There will be no waivers granted.**

Section 1C.06 Trustee Rights Concerning Self-Pay Eligibles. The Board of Trustees reserves the right to request and receive from self-pay Employees and Dependents any pertinent information bearing on the eligibility of such Persons for the benefits provided under the self-payment provisions of this Trust Fund. The failure of any such Person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described herein being suspended or terminated, in the discretion of the Trustees.

Section 1C.07 Self-Pay Eligible Affected by Multiple Events. Notwithstanding anything to the contrary herein, no person may enjoy any one continuous self-pay coverage extension under the Trust Fund beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that Person occurred.

Section 1C.08 Transfers. Notwithstanding anything to the contrary in these Rules and Regulations, if an Employer ceases to be a Contributing Employer to this Fund, any self-payment beneficiary whose last employment-related coverage was secured by virtue of employment for that Employer may be required by the Board of Trustees to obtain self-payment rights from the new coverage of that Employer.

PART D – RIGHTS UPON TERMINATION OF ELIGIBILITY

Section 1D.01 Individual Conversion Policy. In accordance with any arrangement the Trust has with an insurance carrier which so provides, an individual who has exhausted employment related and/or self-payment eligibility may secure, upon timely application, an individual health insurance policy.

Section 1D.02 Creditable Coverage Certificate. In accordance with the Health Insurance Portability and Accountability Act of 1996, all Employees and their Dependents who terminate eligibility will receive a Certificate of Health Coverage.

A Certificate will also be provided upon receipt of a written request for such Certificate that is received by the Fund Office within two years after the date coverage ended under this Plan. The written request must be mailed, faxed or e-mailed to the Fund Office and should include the names of individuals for whom a certificate is requested (including spouse and dependent children) and the address where the Certificate should be mailed. A copy of the Certificate will be mailed by the Trust to the address indicated.



ARTICLE

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GENERAL PROVISIONS

Section 2.01 Non-Assignment. The benefits payable hereunder are not subject to any manner of assignment, anticipation, alienation, sale or transfer. Notwithstanding the foregoing, the Plan will honor any qualified medical child support order, as defined by ERISA Section 609, received with respect to the Plan, and will make any payment required by ERISA Section 609 to a State which has acquired rights under that Section. The Fund Office will provide to Covered Persons, on request, a copy of the Plan's procedures governing medical child support orders.

Section 2.02 Facility of Payment. In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, to the spouse or relative by blood of the Covered Person or to any other person or institution determined by the Plan to be equitably entitled thereto; or, in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: lawful spouse, child or children, parents, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment made in accordance with this provision will discharge the obligation of the Plan hereunder to the extent of such payment.

Section 2.03 Claim Disputes. No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereof will be resolved by the Board of Trustees under and pursuant to this Plan and the Trust Agreement, and its decision of the dispute will be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees. No such action may be brought unless brought within one year after the date of such decision unless the claimant was unable to file the claim on a timely basis.

Section 2.04 Effect on Worker's Compensation. The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

Section 2.05 Trust Agreement Controls. The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement will prevail. All legal relationships created by the Plan are governed by the laws of the United States of America and, where not preempted by federal law, the laws of the State of Arizona.

Section 2.06 Benefits Limited to Fund Reserves. The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the Contributing Employer to make Contributions as stipulated in the Collective Bargaining Agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan will be construed as obligating any Contributing Employer to make benefit payments or Contributions (other than the Contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder. Likewise, there will be no liability upon the Board of Trustees, individually or collectively, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

Section 2.07 Independent Examination. The Fund, at its own expense, has the right and opportunity to have a Physician of its choice examine the Covered Person when and so often as it may reasonably require during the pendency of any claim and also the right and opportunity to have an autopsy performed, in the case of death, if not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Trustees.

Section 2.08 Large Case Management. Payments for expenses normally not covered under this Plan that are recommended by a large claim management service that has been arranged for by the Board of Trustees will be reimbursable with the approval of the Board of Trustees.

It is not the intent of this Section to expand the coverage provided by the Plan except as approved by the Board of Trustees.

Section 2.09 Trustee Termination and Amendment Powers. To carry out its obligation, to maintain, within the limits of the funds available to it, a sound economic program dedicated to providing the maximum possible benefits for Covered Employees and Covered Dependents, the Board of Trustees expressly reserves the right, in its sole discretion and without notice to eligible individuals, Employers or the Union, but on a nondiscriminatory basis:

- (a) To terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects claims in process and/or expenses already incurred; and
- (b) To alter or postpone the method of payment of any benefit; and
- (c) To amend any provisions of these Rules and Regulations.

Section 2.10 Acts of Third Parties. This provision applies when a Covered Person has an Injury or Illness caused by the act or omission of another person or party. In such a case, to the extent of any benefit payments provided by the Trust, the Covered Person must reimburse the Trust from any and all recoveries made by the Covered Person. It is the intent of this provision to establish a constructive trust/equitable lien on the recoveries made by the Covered Person at the time the recoveries come into the hands of the Covered Person or that person's representative.

The term "recoveries made by the Covered Person" includes any amount received by way of judgment, arbitration award, settlement or any other arrangement from any third party or third party

insurer, or from the Covered Person's uninsured or underinsured motorist coverage. It includes all monies received regardless of how held, and includes monies directly received by the Covered Person as well as any monies held in any account or trust on their behalf. The Trust's share of any recovery will not be reduced because the Covered Person has not received the full damages claimed from the third party, unless the Trust agrees in writing to a reduction.

The Plan may require the Covered Person to complete, in a form acceptable to the Trustees and prior to the payment of any benefits in relation to the Injury or Illness, a Reimbursement Agreement and other appropriate documentation. In the event that a Covered Person fails or refuses to execute such an Agreement/Document, the Trust shall, notwithstanding any other provision to the contrary, be relieved of any obligation to provide benefits to the Covered Person.

The Covered Person shall take such action as may be necessary or appropriate to recover payments made by the Trust from any responsible third party or insurer in connection with the Injury or Illness. Further, the Covered Person shall not do anything to release, discharge or prejudice the rights of the Trust as set forth in this provision, and the Covered Person and/or that person's representative shall assist and cooperate with the Trust hereunder, doing everything necessary and appropriate to enable the Trust to enforce its rights as described herein. In this regard, the Covered Person shall promptly respond to inquiry from the Trust concerning the status of any such action and shall direct any legal representative retained to comply with and facilitate the reimbursement contemplated by this provision.

Section 2.11 Benefit Overpayment/Offset. In the event any payment is made by the Plan to or on behalf of an individual who is not entitled to such payment, the recipient shall hold any such amount in trust and the Trustees shall have an equitable lien thereon in addition to any other remedy provided by the Plan, by law, or otherwise. In addition, the Plan has the right to reduce future payments due to such individual by the amount of any such erroneous payment. Such a right of offset will not, however, limit the rights of the Plan to recover such overpayments in any other manner.

Section 2.12 Utilization Review – Disease Management. The Fund may provide utilization review services through a Fund Nurse who will provide patient health care information services to help Covered Persons decide on their best treatment plan.

- (a) **Non-Emergency Hospital Pre-Admission Review Services.** If a Covered Person's physician recommends hospitalization for a Covered Person for non-emergency medical treatment or surgery, upon notification to the Fund Office before admission, the Fund Nurse may confirm whether hospitalization will provide the best possible treatment plan or whether an alternative, outpatient procedure may be more appropriate. The Fund Nurse or an advisory Physician will discuss the procedure with the Covered Person's doctor to help make this determination. If the Covered Person's doctor agrees with an alternative outpatient care recommendation, the Fund Nurse will assist the Covered Person in locating a suitable outpatient facility near the Covered Person's home. If the Covered Person's doctor does not agree with the review recommendations, the original plan may be followed.
- (b) **Second Surgical Opinion Services.** If surgery is recommended, the Covered Person may contact the Fund Nurse who will assist in determining if a second opinion is needed, or if outpatient surgery can provide a better treatment plan.

The Fund will pay 100% of the charges for a second (or third, if necessary) surgical opinion, including diagnostic testing.

Compliance with the second surgical opinion services is not required for emergency surgery that must be performed in order to protect the Covered Person's health or life. The Fund Nurse may waive a second opinion, if appropriate.

- (c) Hospital Continued Stay Review Services. When a Covered Person requires inpatient hospital care, and the Fund Office is notified, the Hospital Continued Stay Review Service can help assure that the Covered Person is discharged as early as possible without sacrificing quality care by monitoring the Covered Person's progress. When a Covered Person no longer needs acute care in a hospital, the Fund Nurse may recommend alternative care, such as outpatient care, home health care or the use of a skilled nursing facility.
- (d) Discharge Planning Service. During the course of Continued Stay Review, if it is determined that an alternative to an acute hospital stay would better meet the Covered Person's needs, the Fund Nurse may coordinate with the attending physician and appropriate facilities or services to encourage the best possible care for the Covered Person, with the most economical use of Plan benefits.

The Fund may also provide disease management services to help Covered Persons manage chronic illness.

Section 2.13 HIPAA/Dependent Status Change Notice. Covered Employees are required to notify the Fund Office in writing when a Covered Dependent ceases to meet the Plan's definition of Dependent. This Notice is required when:

- (a) The Covered Employee's marriage is dissolved.
- (b) A Dependent Child marries.
- (c) A Dependent Child, not a fulltime student, attains the age of 19.
- (d) A Dependent Child age 19 to 23 ceases to be a fulltime student.
- (e) A Dependent Child who is a fulltime student attains the age of 23.
- (f) A Stepchild or Foster Child ceases to reside with and depend upon the Covered Employee or Covered Person.
- (g) A disabled Child over the age of 23 ceases to be disabled or ceases to be dependent on the Covered Employee or Covered Person.

The Notice must contain the name and the Social Security Number of the Covered Employee and the name and the address (if different from the Covered Employee) of the Dependent whose status has changed. At the discretion of the Board of Trustees, a Covered Employee who fails to comply with this Section may be required to repay to the Fund any benefits provided to persons not eligible, where their status would have been apparent from the Notice required by this Section.

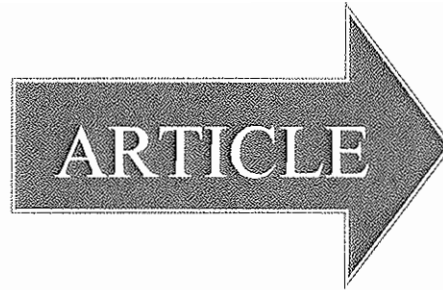
Section 2.14 Privacy. The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's

Board of Trustees (the “Trustees”) for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

- (a) Disclosure of PHI to the Trustees.
 - (1) Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
 - (2) Disclosures by Business Associates. The Plan’s Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
 - (3) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:
 - (i) the Plan’s Payment activities,
 - (ii) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and
 - (iii) all of the Plan’s Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.
- (b) Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations.
- (c) Privacy Safeguards. The Trustees agree to:
 - (1) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
 - (2) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

- (3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
 - (4) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;
 - (5) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;
 - (6) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedure;
 - (7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
 - (8) Make available the information required to provide and accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
 - (9) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
 - (10) If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and
 - (11) Ensure that adequate separation between the Plan and the Trustees is established, as described below.
- (d) Adequate Separation. The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses

PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.



DEATH/ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

The Plan's Death Benefit and Accidental Death and Dismemberment Benefits are provided under an insurance arrangement. The terms of the group policy govern the provision of these benefits with respect to Covered Employees and Covered Dependents. A certificate reflecting the benefits and options available under the group policy will be provided to Covered Employees by the Fund.

PART A - DEATH BENEFIT

Section 3A.01 Schedule of Death Benefits.

Employees	\$5,000
Dependents (when eligible)	1,000

Section 3A.02 Proof of Death. Upon receipt of due proof (certified death certificate) that a Covered Employee or Covered Dependent has died while covered for this benefit, the Plan will provide the benefits set forth in the group policy.

Section 3A.03 Beneficiary. The proceeds of a Covered Dependent's Death Benefit coverage are payable to the Covered Employee. The proceeds of an Employee's Death Benefit coverage are payable to the beneficiary last designated by the Employee on a form for that purpose before that person's death. If more than one person is so designated and if the Employee has failed to specify their respective interests, they will share alike. Any part of an Employee's benefits for which there is no beneficiary designated or surviving at the Employee's death will be payable in the order set forth in the group policy.

Section 3A.04 Accelerated Benefit Amount. If a determination is made that a Covered Employee or Covered Dependent has a life expectancy of twelve months or less as the result of a medical condition caused by Injury or Illness, a lump-sum accelerated benefit may be payable to the Covered Employee or party designated by the Covered Employee. The balance of the Death Benefit amount shall be payable to the designated beneficiary upon the death of the Covered Person.

Section 3A.05 Conversion Privilege. If eligibility for a Death Benefit ceases because of termination of employment, death, or a Covered Dependent ceasing to meet the definition of Covered Dependent, a Covered Person may be entitled to convert to an individual policy of life insurance, provided written application and the first premium payment are timely made to the insuring company.

Section 3A.06 Total Disability (Employee Only). If, while eligible for Death Benefits and prior to attainment of age 60, an Employee becomes and remains totally disabled, the Employee's eligibility for life insurance may continue through age 65, subject to all of the group policy terms and conditions, provided written proof of such disability satisfactory to the insurance company is timely furnished.

PART B - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Section 3B.01 Schedule of Accidental Death and Dismemberment Benefits. Subject to the limitations in the group policy, if a Covered Employee, while eligible for this benefit, sustains,

through external and violent means, an accidental bodily Injury, and as a direct result thereof and independently of all other causes suffers one of the following losses, the Plan will provide the following benefit:

LOSS	AMOUNT
Accidental Death	\$5,000
Both Hands or Both Feet or Sight of Both Eyes	5,000
One Hand and One Foot	5,000
One Hand and Sight of One Eye	5,000
One Foot and Sight of One Eye	5,000
One Hand or One Foot	2,500
Sight of One Eye	2,500

No more than said applicable maximum amount will be paid for all losses sustained in any one accident. The meaning of "loss" is set forth in the group policy.

Section 3B.02 Payment of Benefits. Accidental Death Benefits for loss of life will be paid in accordance with the beneficiary provisions of the group policy. Dismemberment Benefits will be paid to the Employee, except that any such benefits which have accrued but remain unpaid at the Employee's death will be paid in accordance with the group policy's beneficiary provisions.

Benefits



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MEDICAL BENEFITS

(OTHER THAN MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS)

PART A -- MEDICAL BENEFITS

Section 4.A01 Schedule of Medical Benefits.

Deductible (Applied in conjunction with Mental Health/Substance Abuse Deductible)	\$150 per person per Calendar Year \$450 per family per Calendar Year
Maximum Lifetime Benefit (Applied in conjunction with Mental Health/Substance Abuse lifetime maximum) (Annual Automatic Restoration)	\$500,000 \$ 2,000

Unless otherwise noted, percentages shown in the Schedule of Benefits are based on Allowable Expense as defined in Section 11.01. Except where otherwise noted, Allowable Expense that exceeds \$10,000 per calendar year will be paid at 100%. Calendar year maximums are applied as if all Trust Fund plans were one plan.

Benefits Not Subject to Deductible:

Outpatient Diagnostic X-ray and Laboratory	100% of the first \$200 per Calendar Year
Accident benefit (Treatment must commence within 24 hours following an accident)	100% of the first \$500 per accident
Physical examination	100% up to \$250 per Calendar Year
Smoking cessation	100% up to \$250 per lifetime

	NETWORK	NON-NETWORK
Prescription Drugs - Generic	100% less \$10 co-pay per prescription	60%
	NETWORK	NON-NETWORK

Brand Name (when no generic exists)	100% less \$15 co-pay per prescription	60%
Brand Name (when generic exists)	100% less \$25 co-pay per prescription	60%
Maintenance Medication for 90-day supply	100% less 2 times the applicable co-pay noted above	Not Available

Benefits Subject to Deductible:

The Fund is party to discounted preferred provider organization (PPO) network arrangements, which offer substantial discounts on the prices of medical care to Covered Persons. To encourage use of these network providers, the Fund offers more generous benefit payments with respect to services secured from these network providers, as follows:

- 1) **Blue Cross Blue Shield of AZ PPO:** This PPO network is available for services in Arizona.
- 2) **Out-of-State Network:** This network is provided by the Fund for services outside of Arizona but in the continental United States.

Additionally, from time to time, the Fund may be party to Mexico PPO arrangements under which medical, dental and vision services and supplies may be obtained in Mexico for discounted rates. The Fund Office will make a list of such providers, and the schedule of benefits for services obtained from such providers, available to Covered Persons.

The benefits outlined in this section are generally available through the PPO networks at the benefit levels specified.

	PPO	NON-PPO
Diagnostic X-ray, laboratory	80%	60%
Hospital room and board, including Intensive Care Unit	80%	60%
Other hospital charges (per calendar year)	80%	60%
Outpatient surgical facility	80%	60%
Other covered outpatient expenses	80%	60%
	PPO	NON-PPO

Convalescent care facility Not to exceed 50% of average semi-private rate of hospital from which transferred. Not for custodial or long-term care. Maximum of 60 days per 12 consecutive months following hospital confinement of at least 5 consecutive days for surgery or illness. Must be certified by surgeon or attending Physician as being medically required.	Not Applicable	60%
Hospice care	80%	60%
Home health care	80%	60%
Physician office visits		
a) Charges for office visits	100% less \$15 co-pay per visit (No deductible)	60%
b) Charges for other services provided at physician's office	80%	60%
Surgeon	80%	60%
Assistant Surgeon 20% of Surgeon's benefit	80%	60%
Anesthesia	80%	60%
Surface ambulance	80% of \$600	60% of \$600
Air ambulance	80% per trip	60% per trip
Chiropractic care Maximum of 15 visits per Calendar Year, unless additional visits are medically Required and pre-approved	50% of up to \$40	50% of up to \$40
	PPO	NON-PPO

Temporo-mandibular Joint Dysfunction “TMJ” \$3,000 lifetime maximum benefit (hospital in-patient facility charges not subject to the TMJ lifetime maximum)	80%	60%
Hearing Benefit Allowable charges: \$100 per Calendar Year for examination; \$850 for hearing appliances every 3 years; \$75 for repair per Calendar Year (excluding batteries)	80%	60%
Vision Surgery Benefit Allowable charges: \$750 per eye per lifetime	80%	60%
Infertility Treatment Lifetime maximum of \$10,000	80%	60%
Mammography Screening Baseline (Women 30-39); Thereafter, Yearly or as Physician-Recommended No Deductible	80%	60%

Section 4A.02 Preventative Care Benefits. If a Covered Employee or a Covered Dependent incurs medical expenses described in this Section, the Plan will pay the designated benefit for Allowable Expenses as shown in the Schedule of Medical Benefits, which are incurred during a Calendar Year and which exceed the amount of the deductible (except as noted), but not to exceed the maximums specified in the Schedule for:

- (a) Physical Examinations. Charges for physical examinations (including well woman exams and contraceptive management). The deductible does not apply to this benefit.
- (b) Smoking Cessation. Charges for smoking cessation programs, including prescribed medication, subject to a lifetime maximum of \$250. The deductible does not apply to this benefit.
- (c) Sterilization. Charges for reproductive system sterilization performed by a Physician.

- (d) Birth Control. Charges for prescription birth control drugs. The deductible does not apply to this benefit.
- (e) Mammography Screening. Charges for (i) a single baseline screening for women between the ages of 30 and 39 and (ii) an additional mammogram every year for women age 40 and over (or more frequently for such women based on the recommendations of a Physician). This benefit is subject to a calendar year maximum of \$300. The deductible does not apply to this benefit.

Section 4A.03 Benefits for Treatment of Illness or Injury. If, as a result of non-occupational accidental Injury or Illness, a Covered Employee or a Covered Dependent incurs medical expenses described in this Section, the Plan will pay the designated benefit for Allowable Expenses as shown in the Schedule of Medical Benefits which are incurred during a Calendar Year and which exceed the amount of the deductible (except as noted), but not to exceed the maximums specified in the Schedule for:

- (a) **Outpatient Diagnostic X-Ray and Laboratory Benefit.** Outpatient charges for diagnostic x-rays and laboratory fees are payable if a Covered Employee or a Covered Dependent are injured or become ill and undergo a laboratory or x-ray examination, on an Outpatient basis, solely for diagnostic purposes. The Plan will pay the benefit outlined in the Schedule of Medical Benefits.

Benefits are not payable under the diagnostic x-ray and laboratory provision for:

- (1) Diagnostic x-ray and laboratory examinations while confined as an Inpatient; or
- (2) Diagnostic x-ray and laboratory examinations which are payable under the supplemental accident benefit provision.

The deductible does not apply to this benefit.

- (b) **Accident Benefit.** Charges for treatment and service directly resulting from and commencing within 24 hours following an Injury effected through external, violent and accidental means, up to the amount shown in the Schedule of Medical Benefits, are payable in full. Accidental Injury covered charges not payable under this Benefit will be subject to regular Plan provisions (deductible, co-insurance, etc.) the same as non-accident charges. Covered charges are:

- (1) Charges made by the Hospital for required services; and
- (2) Physician and Registered Nurse fees; and
- (3) Charges for diagnostic x-ray and laboratory examinations.

The maximum benefit will be restored for each new accident. The deductible does not apply to this benefit.

- (c) **Outpatient Surgical Facility.** Charges for use of an Outpatient Surgical Facility are payable for medically necessary services performed by a Physician, provided the service performed would have been covered if performed as a Hospital Inpatient service.
- (d) **Physician Office Visits.** Charges for Physician office visits.
- (e) **Hospital Charges.** Charges made by a Hospital.
- (f) **X-ray and Laboratory.** Charges for x-ray and laboratory services performed while hospital confined and charges for services which exceed the Outpatient diagnostic x-ray and laboratory benefits, prescribed by a legally qualified Physician.
- (g) **Blood.** Charges for whole blood or blood plasma and the cost of its administration.
- (h) **Allergy Testing.** Charges for allergy testing and the cost of the resultant serum preparation and its administration.
- (i) **Nursing.** Charges made by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.), for nursing services medically required and prescribed by a legally-qualified Physician.
- (j) **Physical and Occupational Therapy.** Charges for physical and occupational therapies are covered only when rendered by a Registered Physical Therapist, a Registered Occupational Therapist, an M.D. or D.O.

A maximum of sixteen (16) physical/occupational therapy treatments are covered per calendar year. An additional 16 visits may be covered if pre-authorized and approved based on medical information provided by the treating physician. The initial visit/evaluation is allowed separately and not included in the sixteen-treatment limitation. The therapy must be prescribed by a physician, with duration and interval of therapy noted on the prescription. The Plan will not pay for therapy elected by the patient. Services rendered in health clubs, even when rendered by a Registered Physical Therapist, and services rendered by a masseur/masseuse are not covered.

- (k) **Speech Therapy.** Charges for a maximum of 32 speech therapy treatments are covered per calendar year, under the following conditions:
 - Prescribed by a legally qualified Physician.
 - For Participants and Dependents of All Ages: Speech therapy benefits only apply to individuals who have experienced a stroke (brain attack), or who have had an injury or surgery affecting speech. In these cases, speech therapy must be rendered by a Licensed Speech Pathologist, and must be prescribed within 90 days of the event.

- For Dependent Children Age 16 Years and Younger: Speech therapy is covered for the following diagnoses: Developmental Speech Delay, Stuttering, Autism, Apraxia and Dysarthria. In these cases, speech therapy coverage will be determined by the documentation submitted by the treating licensed Speech Pathologist.
- (l) **Medical Supplies.** Charges for casts, splints, trusses, braces, crutches, surgical dressings and artificial limbs and eyes or their replacement or other prescribed medical supplies due to Illness or Injury.
- (m) **Oxygen.** Charges made for oxygen, its administration and the rental of oxygen equipment, but not to exceed the purchase price of such equipment.
- (n) **Durable Medical Equipment.** Charges for the rental of a wheelchair, special Hospital bed, iron lung, crutches, and other reasonable mechanical, therapeutic and durable medical equipment, but not to exceed the purchase price of such equipment.
- (o) **Convalescent Care.** Charges made by a Convalescent Care Facility for care and treatment except custodial care and long term care, resulting from Injury or Illness, not to exceed the Allowable Expense of the daily room and board maximum specified in the Schedule of Medical Benefits.
- (p) **Chiropractic Care.** Charges for correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the removal of nerve interference where such interference is the result or related to distortion, misalignment, or subluxation of or in the vertebral column, not to exceed the amount per visit and the number of visits per Calendar Year as stated in the Schedule of Medical Benefits.
- (q) **Dental Injury.** Charges for restorative and surgical treatment for accidental Injuries of the alveolar processes, or restoration of teeth for an accidental Injury requiring Oral Surgery.
- (r) **Ambulance.** Charges made for services rendered by a:
 - (1) Licensed professional surface or air ambulance service, to and from the nearest Hospital; or
 - (2) Licensed professional surface or air ambulance to the nearest Hospital with the necessary equipment and facilities if treatment cannot be performed at the initial Hospital.
- (s) **Physician's Hospital Visits.** Charges for Physician's Hospital visits.
- (t) **Surgical Expense.** Charges necessary for surgical expense incurred for the services of:

- (1) The principal surgeon, up to the amount specified in the Schedule of Medical Benefits;
- (2) One assistant surgeon, but not to exceed the amount indicated in the Schedule of Medical Benefits; and
- (3) An anesthetist or anesthesiologist, up to the amount specified in the Schedule of Medical Benefits.

The Fund Office will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of reasonable charges will be allowed as the Plan's benefit:

- (1) Allowances for multiple surgeries through the same incision or operational field shall be paid up to the amounts in the Schedule of Benefits for the primary procedure and up to one-half of the amounts in the Schedule of Benefits for all other procedures;
 - (2) Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session shall be paid up to the amounts in the Schedule of Benefits for the first site primary procedure and up to one-half of the amounts in the Schedule of Benefits for the first site secondary and additional procedures and up to one-half of the amounts in the Schedule of Benefits for the second site primary and additional procedures.
- (u) **Orthopedic Equipment.** Charges for prescribed orthopedic shoes and other supportive appliances, including replacement, once in each twelve-month period or, if under 19 years of age, once in each six-month period, provided that such equipment prescribed pursuant to chiropractic care shall be additionally limited to a maximum of \$300 per Calendar Year.
- (v) **Acupuncture.** Charges for acupuncture administered by a Physician.
- (w) **Abortion.** Charges for a legal abortion performed by a Physician on Covered Employees and their Dependent spouses only.
- (x) **Audiology and Hearing.** Charges made by a licensed audiologist not to exceed the amount shown in the Schedule of Medical Benefits. Charges made for hearing appliances not to exceed the amount shown in the Schedule of Benefits. Charges made for hearing appliance repairs, excluding batteries, not to exceed the amount shown in the Schedule of Medical Benefits.
- (y) **Home Health Care Agency.** Charges made by a licensed Home Health Care Agency for Home Health Services performed, except custodial care, which a

Physician has prescribed in lieu of Hospital services, provided the Hospital services would have been covered, not to exceed 60 visits per Calendar Year.

- (z) **Hospice.** Treatment for terminal Illnesses through a Hospice care program which is accredited by the National Hospice Organization. Treatment for individuals whose life expectancy is six months or less may be provided at the Hospice or in the home. Benefits for the following services will be paid if they are directed by the Hospice care program up to the maximums shown in the Schedule of Benefits:
 - (1) Charges by a Home Health Care Agency for part-time or intermittent nursing care that is supervised by a Registered Nurse;
 - (2) Part-time or intermittent Home Health Services for you or your Dependents. Patients must be under a Physician's care;
 - (3) Counseling services by a licensed social worker for the patient and immediate family members;
 - (4) Charges for bereavement counseling for immediate family members.
- (aa) **Infertility.** Charges made for treatment of infertility, not exceed the amount shown in the Schedule of Medical Benefits.
- (bb) **Prescription Drugs.** Charges actually incurred for drugs and medicines that are:
 - (1) Prescribed by a legally qualified Physician; and
 - (2) Available only by prescription; and
 - (3) Approved by the U.S. Food and Drug Administration; and
 - (4) Identified by a prescription number; and
 - (5) Dispensed by a licensed Pharmacist or Physician.

Optional Prescription Drug Plan Network:

Charges incurred for medically necessary drugs and medicines which are dispensed by a participating Pharmacy of the Prescription Drug Network which meet the requirements set forth in items (1) through (5) above will be paid directly to the participating Pharmacy for covered charges for generic prescription drugs and charges

in excess of the co-payments specified in the Schedule of Benefits for each 34 day or, under “Mail at Retail”, for each 90-day supply.

The deductible does not apply to this benefit.

The Trustees may implement in the Prescription Drug Network a “Step-Therapy” program under which certain drugs will be covered by the Plan only after less costly alternatives have been explored. In furtherance of such a program, the Plan may provide coverage of non-prescription medications that would otherwise not be covered by the Plan.

(cc) **Vision Surgery.** Charges for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy, (RK) and automated keratoplasty (ALK), or laser assisted in situ keratomileusis (LASIK), not to exceed the amount shown in the Schedule of Medical Benefits.

Section 4A.04 Maternity Benefits. A pregnant Covered Employee or Covered spouse of a Covered Employee only is covered for maternity benefits. (Dependent children are not covered for maternity benefits.) Such covered individuals may participate in the healthy maternity program offered by the Trust. Under such a program, screening for pregnancy risks may be available, and the Trust may provide an incentive for participation in the program.

PART B – MEDICAL DEDUCTIBLE

Section 4B.01 Calendar Year Deductible. The deductible amount applies once during each Calendar Year and is satisfied when covered expenses incurred by a Covered Person exceeds the \$150 deductible amount specified in the Schedule of Medical Benefits. The deductible is applied in conjunction with the Mental Health/Substance Abuse deductible. All Trust Fund Plans are considered to be one plan for this purpose

Section 4B.02 Family Deductible. When the deductible amount as specified in the Schedule of Medical Benefits per family has been satisfied in a Calendar Year, no further deductible needs to be satisfied in that Calendar Year. This applies only to covered expenses that are actually incurred during the Calendar Year.

Section 4B.03 Deductible Carryover. In order that a cash deductible will not be applied late in one Calendar Year and soon again in the following year, any covered expense incurred during the last three months of a Calendar Year which are applied toward the deductible amount (whether or not it is fully satisfied) will apply in the immediately subsequent Calendar Year.

Section 4B.04 Coordination of Deductible. The deductible amount applies separately to the Employee and to each Dependent except with respect to a family as provided in Section 4B.02. With respect to any person covered under this Plan, both as an Employee and as a Dependent during the same Calendar Year, only one deductible amount will apply to all covered expenses incurred by or on behalf of such person during the Calendar Year, provided that the coverage on such person was in effect continuously from the date on which the deductible amount was satisfied.

Section 4B.05 Family Accident Deductible. If two or more covered family members sustain bodily Injuries in the same accident, and if the deductible amount of one such family member incurring covered expenses in such accident is satisfied, all other such family members will be reimbursed as if their deductible amounts had already been applied. This provision will not affect administration of benefit payments with respect to covered expenses not incurred as a result of such accident.

PART C – MEDICAL LIFETIME MAXIMUM BENEFIT

Section 4C.01 Lifetime Maximum. The lifetime maximum payable for all expenses incurred by a Covered Person due to all Injuries and Illnesses is specified in the Schedule of Medical Benefits. The lifetime maximum is applied in conjunction with the Mental Health/Substance Abuse maximum.

Section 4C.02 Automatic Annual Restoration of Benefits. If benefits have been paid hereunder with respect to a Covered Person who has been covered for at least 12 months, an amount equal to either the benefits paid with respect to said Person, or \$2,000.00, whichever is less, will be restored automatically at the beginning of each subsequent Calendar Year while the coverage of such Covered Person continues in force, until the amount of the lifetime maximum specified in the Schedule of Medical Benefits for such Covered Person has been restored.

PART D – MEDICAL BENEFIT LIMITATIONS AND EXCLUSIONS

Section 4D.01 Limitations and Exclusions. The benefits described herein do not cover:

- (a) **Acts of War.** Injury or Illness resulting from insurrection, riot, war or any act of war, whether declared or undeclared.
- (b) **Services Provided at No Cost to the Participant.** Medical care, treatment, services or supplies in a Hospital owned or operated by the United States Government, any agency thereof, or a state or political subdivision, or paid for by the United States Government, or any agency thereof, or any care or treatment, services or supplies for which the individual is not required to pay and/or has no legal obligation to pay, unless required by law.
- (c) **Cosmetic or Plastic Surgery.** Cosmetic or plastic surgery primarily intended to improve appearance, including sex transformation surgery, except expenses incurred for:
 - (1) Treatment of a congenital abnormality; and
 - (2) Procedures that are necessary for post traumatic or post oncology treatment.
- (d) **Dental Services Limitation.** Dental x-rays or dental services performed on or to the teeth, nerves within the teeth, gingivae or alveolar processes except as provided in Section 4A.03(b) and Article 7.
- (e) **Physician's Treatment Required.** Injury or Illness for which the Person on whose behalf a claim is presented is not under the regular care of a Physician.
- (f) **Illegal Activities.** Injury or Illness resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or felonious act.
- (g) **Occupational Illness or Injury.** Charges for any condition or disability which would entitle the Covered Person to any benefit under a Worker's Compensation Insurance laws or similar legislation or which is due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit.
- (h) **Services Provided by Relatives.** Professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person as a spouse, parent, child, brother, or sister whether such relationship is by blood or exists in law.
- (i) **Rest and Relaxation.** An institution or part thereof which is primarily a place for rest, custodial care, the aged, a hotel or similar institution.

- (j) **Services Outside of North America.** Charges for services received or supplies purchased outside the United States, Canada or Mexico unless the charges are incurred while traveling on business or for pleasure.

- (k) **Weight Control.** Charges for services, supplies or treatment in connection with or related to obesity (except for morbid obesity) including vitamins, dietary and/or nutritional supplements whether or not prescribed by a physician, surgery or excess fat in any part of the body or resection of excess skin or fat following weight loss or pregnancy. Surgical treatment of morbid obesity will be covered up to a lifetime maximum of \$25,000 when, as confirmed by a legally qualified physician:
 - (1) The covered employee or dependent has a body mass index (BMI) exceeding 40; or
 - (2) The covered employee or dependent has BMI greater than 35 in connection with the co-morbidities of heart disease, type 2 diabetes mellitus, clinically significant sleep apnea, or high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic and:
 - (a) The patient has completed growth (18 years of age or documentation of completion of bone growth); and
 - (b) The patient has participated in a physician-supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:
 - (i) Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists; and
 - (ii) Nutrition and exercise program must be six months or longer in duration; and
 - (iii) Nutrition and exercise program must occur within the two years prior to surgery; and
 - (iv) Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. *Note:* A physician's summary letter is not sufficient documentation.

- (l) **Sterilization Reversal.** Charges as a result of reproductive system sterilization reversal.

- (m) **Experimental Procedures.** Charges for procedures that are considered experimental or investigative in nature.

- (1) Experimental and investigational procedures are defined as any medical procedure, equipment, treatment or course of treatment, or drug or medicine that has been approved by neither the Food and Drug Administration when FDA approval is required for lawful distribution nor the Health Care Financing Administration as noted in the Medicare Coverage Issue Manual.
- (2) Notwithstanding (1) above, such procedures will be covered when outside, independent review confirms that all of the following conditions are met:
 - (i) conventional therapy will not adequately treat the patient's condition;
 - (ii) conventional therapy will not prevent progressive disability or premature death;
 - (iii) the procedure is the lowest cost item or service that meets the patient's medical needs and is less costly than all other conventional alternatives;
 - (iv) the procedure is not being performed as part of a research study or clinical trial.
- (n) **Dietary Supplements.** Charges for dietary or nutritional supplements and medications available without a prescription, except as authorized under any "Step-Therapy" program implemented by the Trustees within the Prescription Drug Network.
- (o) **Other Charges.** Charges for procedures, services or equipment not otherwise covered by the Plan.
- (p) **Taxes.** Charges for state taxes or surcharges added to medical bills, unless authorized by the Trustees.

PART E -- MEDICAL PRE-EXISTING CONDITIONS

Section 4E.01 Pre-Existing Conditions. A pre-existing condition is an Illness or Injury, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received by a Covered Person within the six-month period ending (1) on the Covered Employee's date of hire in a classification leading to participation in this Plan under Section 1A.01, or (2) if later, on the date the individual first became a Dependent in the Plan. No payments are made for a pre-existing condition until after the first of the following dates:

- (a) For Covered Employees, the date of expiration of six consecutive months after the Covered Employee's date of hire in a classification leading to participation in the Plan under Section 1A.01. This six-month period includes those periods of employment leading to eligibility during which the Employee is not eligible; i.e., the waiting period.
- (b) For Covered Dependents, the date of expiration of twelve consecutive months after the date specified in (1) or (2), above.

Section 4E.02 Creditable Coverage. The six and twelve-month periods described in Section 4E.01 will be reduced by creditable coverage, as defined below, demonstrated by the Covered Individual pursuant to federal law. For these purposes, the term creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

- (a) A group health plan
- (b) Health insurance coverage
- (c) Part A or Part B of Title XVIII of the Social Security Act
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928
- (e) Chapter 55 of Title X, United States Code
- (f) A medical care program of the Indian Health Service or of a tribal organization
- (g) A state health benefits risk pool
- (h) A health plan offered under Chapter 89 of Title V, United States Code
- (i) A public health plan, as defined by federal regulation
- (j) A health benefit plan under Section 5(e) of the Peace Corps Act

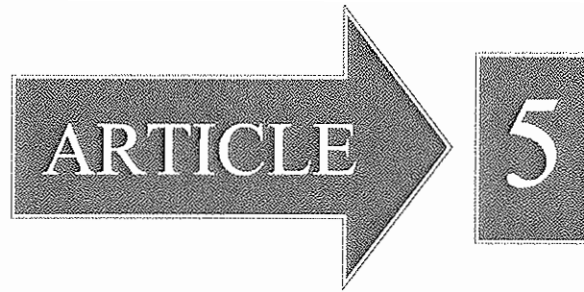
The term creditable coverage will not include coverage consisting solely of "excepted benefits" as defined by federal law. No period of creditable coverage will be counted for purposes of this Section if, after such period and before the "enrollment date" in a plan, as defined by federal law, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

Section 4E.03. Pregnancy is not a condition limited or excluded by this Article.

Section 4E.04. The limitations expressed in this Article do not apply to:

- (a) A Dependent who first became a legally adopted child, as defined by Article 11, Section 11.08, at a time when the Covered Employee was eligible for benefits hereunder.
- (b) A Dependent who, as of the last day of the 30-day period beginning with the date of birth of the child, was covered under creditable coverage which is counted under Section 4E.02.
- (c) A Dependent child adopted or placed for adoption with a Covered Employee before the age of 18 years who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption of the child, was covered under creditable coverage which is counted under Section 4E.02.

Section 4E.05. Covered individuals affected by the provisions of this Article have the right to request a certificate of creditable coverage from a prior plan or prior health insurance issuer, and the Trust Fund's administrative office will assist a covered individual in obtaining such a certificate, if necessary.



BENEFITS FOR MENTAL HEALTH/SUBSTANCE ABUSE CONDITIONS

If a Covered Person incurs medically necessary expenses for Mental Health or Substance Abuse Conditions, the Plan will provide the designated benefit for eligible expenses as shown in the Schedule of Mental Health/Substance Abuse Benefits, but not to exceed the maximums and limitations specified.

Section 5.01 Schedule of Mental Health/Substance Abuse Benefits. Benefits for conditions relating to Mental Health and Substance Abuse issues are provided through Health Management Center, Inc. under its Employee Member Assistance Program (EMAP) approved by the Board of Trustees. The Trust Fund will make HMC-EMAP materials available to Covered Persons. The EMAP benefits, together with reduced benefits for care sought outside the EMAP network, are as follows:

	IN EMAP NETWORK	OUT OF EMAP NETWORK
Lifetime Maximum (Applied in conjunction with Medical lifetime maximum)	\$500,000	\$500,000
Deductible	\$150 per person \$450 per family per Calendar Year; applied in conjunction with per Calendar Year Medical Benefits Deductible. Waived for first alcohol/drug inpatient or alternative care treatment. No deductible for first 8 outpatient visits. After 8 visits, co-payments apply.	\$150 per person \$450 per family per Calendar Year; applied in conjunction with per Calendar Year Medical Benefits Deductible to any treatment.

	IN EMAP NETWORK	OUT OF EMAP NETWORK
Inpatient Hospital Treatment, Partial Hospital Day/Evening, and Intensive Outpatient Treatment		
Psychiatric		
Limitations	45 days per calendar year, 120 days per lifetime	
Hospital	100% of EMAP-approved treatment	65% of EMAP-negotiated rates.
Professional Fees	100% of EMAP-approved treatment	65% of EMAP-negotiated rates.
Alcohol/Drug		
Limitations	Treatment: 2 per lifetime, 28 days per admission. Detox: 2 per lifetime, 7 days per admission.	
	<i>NOTE: For purposes of Partial Hospital, Day/Evening and Intensive Outpatient Care, 2 days of treatment will be the equivalent of 1 day of inpatient care. Must complete treatment for benefits to be paid.</i>	
Hospital	100% of EMAP-approved treatment for first treatment 95% of EMAP-approved treatment for second treatment.	65% of EMAP-negotiated rates.
Professional Fees	100% of EMAP-approved treatment for first treatment. 95% of EMAP-approved treatment for second treatment.	65% of EMAP-negotiated rates.
Outpatient Treatment		
Limitations	50 visits per Calendar Year including MD's, Ph.D's and licensed social workers	
Deductible	None	Deductible applies
First 8 visits	100% of EMAP-approved treatment	65% of EMAP-negotiated rates
After 8 visits; co-pay	\$5 co-payment for Masters' level and Psychologists \$10 co-payment for MD's (Psychiatrists)	65% of EMAP-negotiated rates

	IN EMAP NETWORK	OUT OF EMAP NETWORK
Out of Network Area (No EMAP-contract provider in the geographical area. Also applies for participants who are out of area and select their own provider.)	EMAP will locate a provider to provide treatment to Covered Persons. EMAP will negotiate with the provider to provide treatment at EMAP's contracted rates. If no provider in the area is willing to provide treatment at EMAP rates, EMAP is authorized to pay the provider their charged rates or final negotiated rates (EMAP will set up an ad-hoc provider contract.)	65% of EMAP-negotiated rates

NOTE: Prescription Drugs medically necessary for treatment of Mental Health/Substance Abuse conditions are provided under the Prescription Drug benefits of Article 4. Benefits for blood tests and other physical diagnostic measures necessary for treatment of Mental Health/ Substance Abuse Conditions are also provided under Article 4.

Section 5.02 Definitions.

- (a) For purposes of this Article, a “mental health/substance abuse condition” is any disorder that involves a clinically significant behavioral or psychological syndrome or pattern; is associated with serious symptoms; impairs a patient’s ability in one or more major life functions or activities; and is not solely a character disorder, problem of living or for personal exploration, desire for self-fulfillment or forensic evaluation as listed or defined in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association). Within the EMAP program network, but not outside of that network, limited outpatient assessment and treatment benefits are available for problems of living such as marital, family or job related issues, that do not constitute a “mental health/substance abuse condition” as defined herein.
- (b) A service, treatment or supply is “medically necessary” for purposes of this Article only if it meets all of the following conditions:
 - (1) It is rendered for the purpose of the diagnosis or treatment of a mental health/substance abuse condition;

- (2) It is consistent with the symptoms and diagnosis of the involved mental health/substance abuse condition;
 - (3) It is the type, level, and length of service or supply and setting that is needed to provide safe and adequate care and treatment and is in keeping with the generally accepted standards for good medical practice within the organized medical/clinical community;
 - (4) It is not primarily for the convenience of a Covered Person or the Covered Person's health care facility or provider.
 - (5) It is the most appropriate level of service for the treatment of the involved mental health/substance abuse condition. (For hospital admissions, this means that acute-care treatment is medically or clinically necessary for the Covered Person's condition and that safe and adequate care cannot be provided in an alternate, less restrictive setting or an outpatient basis;
 - (6) The service, treatment or supply is not experimental or investigational;
 - (7) Professionals that render service, treatment or a supply to a Covered Person must be properly licensed or certified pursuant to applicable state and federal law and such service, treatment or supply must fall within the involved professional's permissible scope of practice under the controlling law(s) as well as the rules of any supervising professional organization.
- (c) Care that is primarily "custodial" is not medically necessary and is not covered by this Article. "Custodial" care is defined as any institutional care or service rendered to a Covered Person when:
- (1) The condition is one for which no known or effective treatment exists;
 - (2) The care or service is rendered to a Covered Person who requires a protected, monitored or controlled environment whether in an institution or in a home;
 - (3) The rendered care or services are primarily related to assisting the Covered Person in performing any of the essential elements of daily living;

- (4) The Covered Person refuses the recommended and appropriate treatment for the involved condition such as psychiatric medications;
- (5) The Covered Person is not under active and specific psychiatric treatment that will reduce the disability to the extent necessary to enable the Covered Person to function outside the protected, monitored or controlled environment; and
- (6) The Covered Person is maintained in the hospital, facility or institution primarily for protective services (e.g., an adolescent who cannot be returned home where an abusive parent or step-parent is currently residing).

Section 5.03 Excluded Diagnoses. The following diagnoses are not considered amendable to psychotherapeutic or psychiatric intervention, and treatment for these diagnoses is not covered by this Article:

- (a) Developmental and learning disorders other than the initial diagnosis;
- (b) Speech disorders;
- (c) Congenital and/or organic mental disorders, including, but not limited to, organic brain disease and Alzheimer's disease;
- (d) Uncomplicated withdrawal from the following substances:
 - amphetamines or similarly acting drugs
 - cannabis (marijuana)
 - cocaine
 - nicotine
- (e) Organic mental disorders associated with physical disorders or conditions, with the exception of the psychiatric component of treatment in a general medical treatment setting;
- (f) Psychoactive substance abuse, without dependence; and
- (g) Sleep disorders, unless related to another specific mental disorder (non-organic).

Section 5.04 Excluded Services. The following services are excluded from coverage under this Article:

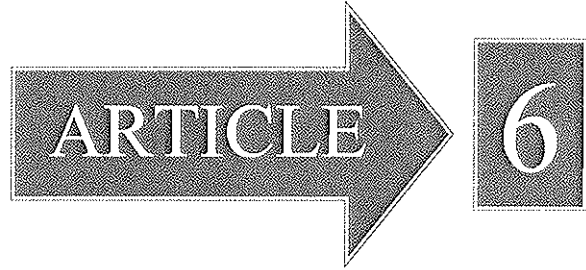
- (a) Case management and administrative supervision, when billed separately. This is considered an essential part of the billing for daily hospital care by the attending physician, and should not be paid as a separate billing.

- (b) Other administrative services such as expert testimony, medical records review and maintenance, preparation of reports regarding civil or legal matters (child custody issues), ability to stand trial, consultation with attorneys or other representatives of social control systems.
- (c) Consultation with a professional for adjudication of marital, child support, and custody cases.
- (d) Treatment for any condition not covered in the standard nomenclature of the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association) such as co-dependency, etc.
- (e) Private duty nursing is considered the responsibility of the treatment facility in order to provide the level and intensity of nursing care clinically required by the patient.
- (f) Eating disorder, sexual addiction, and gambling programs based solely on the twelve-step model.
- (g) Educational evaluation and therapy, including vocational testing and counseling, behavioral training, employment counseling or training or education for learning disabilities or other educational services.
- (h) Other therapies existing or developed in the future that do not have general acceptance within the scientific field, and whose safety and efficacy are not supported by a body of independently confirmed research results.
- (i) Care, treatment, services or supplies which are primarily for rest, custodial, domiciliary or convalescent care.
- (j) Court-ordered testing, care, treatment, services (including protective services) or supplies if not medically necessary and/or clinically appropriate.
- (k) Damage to the facility of a participating provider or participating facility caused by a Covered Person. The actual cost of the damage may be billed directly to the Covered Person.
- (l) Care, treatment, services or supplies received by a Covered Person in cases in which the Covered Person was not eligible for coverage under the EMAP at the time that the care, treatment, services or supplies were rendered or received.
- (m) Treatment of detoxification in newborns (any medically necessary and clinically appropriate treatment is covered under Article 4 of this Plan).
- (n) Care, treatment, services or supplies directly related to the inpatient and/or outpatient care and treatment of a Covered Person's physical Injuries or Illness

resulting from any attempt at suicide or from an intentionally self-inflicted Injury or drug overdose. (Care, treatment, services or supplies related to such Injuries or Illnesses are covered under Article 4 of this Plan. Medically necessary and clinically appropriate mental health/substance abuse care, treatment, services or supplies received by a Covered Person at such time as the Covered Person no longer requires hospitalization for the treatment of their physical Injuries or Illnesses resulting from an attempt at suicide or from an intentionally self-inflicted Injury or drug overdose shall be considered to be services covered by this Article.)

Section 5.05 Limitations. In addition to the limitations noted above, the mental health/substance abuse benefits described in this Article do not cover:

- (a) Medical care, treatment, services or supplies in a Hospital owned or operated by the United States government, any agency thereof, or a state or subdivision, or paid for by the United States government, any agency thereof, or any care or treatment, services or supplies for which the individual is not required to pay and/or has no legal obligation to pay, unless required by law.
- (b) Charges for any condition or disability which would entitle the Covered Person to any benefit under a Workmen's Compensation Act or similar legislation or which is due to a condition arising out of or in the course of any occupation or employment for wages or profit.
- (c) Professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person as a spouse, parent, child, brother or sister whether such relationship is by blood or exists in law.
- (d) Charges for services received or supplies purchased outside of the United States, Canada or Mexico unless the charges are incurred while traveling on business or for pleasure.
- (e) Charges for state taxes or surcharges added to bills, unless authorized by the Trustees.



DISABILITY INCOME BENEFIT

Section 6.01 Schedule of Disability Income Benefits

Benefits payable for Accidents from	8 th day
Benefits payable for Illnesses from	8 th day
Maximum benefit period	13 weeks
Benefit percentage	70%
Gross weekly maximum benefit	\$125.00
Less FICA tax	<u>9.56</u>
Net weekly maximum benefit	\$115.44
(Federal and State Income Tax Not Withheld)	

Section 6.02 Qualifying for Disability Benefits. If a Covered Employee becomes totally and continuously disabled as a result of a non-occupational accidental Injury or Illness or Mental Health/Substance Abuse condition, the Plan will pay the Weekly Disability Income Benefit for which the Employee is eligible subject to the applicable Waiting Period stated in Section 6.04.

Section 6.03 Total Disability Definition. The Covered Employee will be considered totally disabled when that individual is prevented by a non-occupational Illness or Injury or Mental Health/Substance Abuse Condition from performing the essential duties of the Employee's occupation, and is not performing any other occupation for wage or profit. No Waiting Period nor benefit payments will begin until or unless the Covered Employee is under the regular care and attendance of a Physician (as defined in Section 11.27, Subsections a-m) or other authorized provider, who certifies as to the Employee's Total Disability.

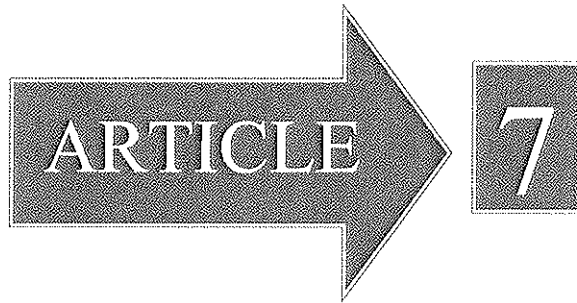
Section 6.04 Disability Waiting Period. Weekly Disability Income Benefits commence with the eighth day of disability due to accidental Injury or the eighth day of disability due to Illness or Mental Health/Substance Abuse Condition, and are payable for up to 13 weeks of continuous disability.

Section 6.05 Return to Work. If the Employee returns to regularly scheduled active work for a continuous period of at least two (2) weeks, any subsequent disability will be deemed a new disability irrespective of its cause or causes.

Section 6.06 Weekly Disability Income Benefit. 70% of the base weekly earnings, not to exceed the amount shown in the Schedule of Benefits. The Weekly Disability Income benefits will not be paid for accidental Injury or Illness or Mental Health/Substance Abuse Condition resulting from

participation in a felonious act, intentionally self-inflicted injury, riot, insurrection, war or any act of war, whether declared or undeclared.

Section 6.07 Disability Income Duration. In no event will such Weekly Disability Income Benefit be paid for longer than the applicable maximum period for any one continuous period or for all successive periods of disability due to the same or related cause or causes which are separated by less than two (2) weeks of continuous, full-time active work.



DENTAL AND ORTHODONTIC BENEFITS

PART A – DENTAL BENEFITS

If, as a result of non-occupational accidental Injury or Illness, a Covered Person incurs necessary dental Allowable Expenses described in this Article which exceed any applicable Dental Deductible, the Plan will pay, subject to the terms and conditions hereafter stated, the designated benefit for Allowable Expenses actually incurred during a Calendar Year, but not to exceed the maximums specified in the Schedule of Dental Benefits.

Section 7A.01 Schedule of Dental Benefits.

Dental Deductible	\$50
Maximum Plan Benefit, per person	\$1,500 per Calendar Year
Preventative Care (Diagnostics, oral examination (2 per Calendar Year), x-rays, cleaning, etc.)	80% of Allowable Expense
Restorative Care (Fillings, tooth extractions, etc.)	50% of Allowable Expense
Specified Oral Surgery (Excision of bony impacted teeth, root canals with apicoectomy, osseous surgery with graft or gingivectomy.)	50% of Allowable Expense
Prosthetic Care (Crowns, bridges, dentures, etc.)	50% of Allowable Expense

Section 7A.02 Incurred Dental Expenses. Dental expenses are deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

Section 7A.03 Covered Dental Expense. Covered dental expense means only an expense incurred for necessary treatment received by a Covered Person from a dentist, which is, in the geographical area where treatment is rendered, the usual and customary procedure for the condition being treated. However, the amount considered as covered dental expense will not exceed the amounts shown in the Schedule of Dental Benefits for the following:

- (a) **Diagnostic and Preventative.** Treatment for routine oral examinations, including diagnosis, x-rays and prophylaxis (cleaning, scaling and polishing),

but not including more than two examinations for the same Covered Person in any Calendar Year.

- (b) **Restorative.** Restorations for treatment of carious lesions, tooth extractions and non-Specified Oral Surgery, anesthesia (100% for general anesthesia), periodontal services and endodontics.
- (c) **Specified Oral Surgery.** For removal of tumors, cysts, impacted teeth partially or totally covered by bone, root canal treatment, apicoectomy, osseous surgery with graft, or gingivectomy.
- (d) **Prosthetic.** (Crowns, bridges & dentures)
 - (1) Treatment for initial installation of, or addition to, full or partial dentures or fixed bridgework. Such installation or addition is covered if required due to the extraction of one or more natural teeth, injured or diseased. Such denture or bridgework includes replacement of the extracted teeth.
 - (2) Treatment for replacement or alteration due to one of the following events will be covered:
 - a. Oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue; or
 - b. Replacement of a full denture, if required as a result of structural change within the month and if made more than five years after the installation of the denture; or
 - c. Repair of dentures or bridgework.

Section 7A.04 Dental Limitations. This Plan does not pay for:

- (a) Expense incurred for more than two oral examinations during any Calendar Year;
- (b) Expense incurred for any dental procedure performed for cosmetic reasons;
- (c) Expense incurred for replacement of an existing denture that, in the opinion of the attending dentist, is or can be made satisfactory;
- (d) Expense incurred for a temporary full denture;
- (e) Expense incurred for replacement of a denture for which benefits were paid under the Plan, if such replacement occurs within five years from the date expense was incurred for the denture unless:
 - (1) Such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or
 - (2) The denture is a stayplate or a similar temporary partial denture, and is being replaced by a permanent denture; or
 - (3) The denture, while in the oral cavity has been damaged beyond repair as a result of Injury which occurred while covered;

- (f) Expense incurred for tooth implants, athletic mouthguards, or educational programs;
- (g) Expense incurred for any procedure that commenced before the date the person became covered under the Dental Benefit, or any supplies furnished in connection with such procedure, except that for purposes of this benefit limitation, x-rays and prophylaxis treatment shall not be deemed to commence a dental procedure;
- (h) Expense incurred for replacement of a lost or stolen appliance;
- (i) Any treatment for a condition which a Covered Person has a right to compensation under any Worker's Compensation Insurance law, or occupational disease law, or for a condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain;
- (j) Any supplies or services:
 - (1) For which no charge is made;
 - (2) For which a Covered Person is not required to pay, or
 - (3) Furnished by or payable under any plan or law of any government, federal or state, dominion or provincial, or any political subdivision thereof, unless required by law.
- (k) Charges for procedures, services or equipment not otherwise covered by the Plan.

PART B – ORTHODONTIC BENEFITS

Section 7B.01 Schedule of Orthodontic Benefits

Deductible	None
Coinsurance	50% of Allowable Expense
Maximum payment	\$750 per Calendar Year

Section 7B.02 Orthodontic Expenses. The Plan will pay benefits for necessary orthodontic expenses incurred by Employees and Dependents which are incurred while covered under this Part. The benefits and payment will be limited to the amount shown in the Schedule of Orthodontic Benefits.

Section 7B.03 Incurred Orthodontic Expenses. Orthodontic expenses are deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

Section 7B.04 Covered Orthodontic Expenses. Covered orthodontic expense means only expense incurred for necessary treatment received by Covered Persons from a licensed orthodontist or dentist who has a degree in orthodontics or a dentist whose practice is principally orthodontic care, in a geographical area where treatment is rendered, and is the usual and customary procedure for the condition being treated. However, the amount considered as Allowable Expense will not exceed the fees and prices regularly and customarily charged for the approved non-cosmetic orthodontia.

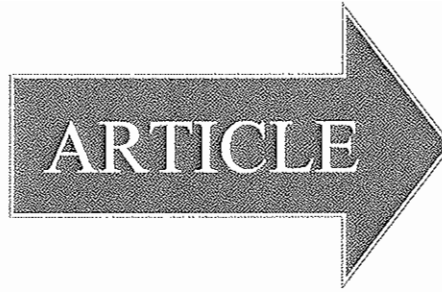
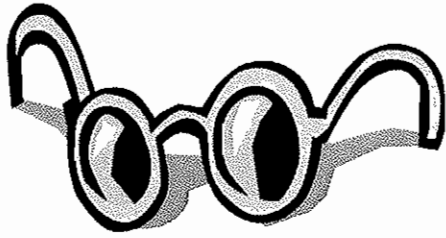
Section 7B.05 Orthodontic Limitations. This Plan does not pay expenses for orthodontic treatment:

- (a) For cases in which the desired results are unlikely to be obtained such as those with severe periodontal problems, poor bone structure, or extremely short roots or other severe medical disabilities; or
- (b) Primarily for cosmetic purposes; or
- (c) Other courses of treatment, which in the opinion of the Trustees, are unlikely to produce professionally accepted corrections of existing malocclusion; or
- (d) Charges for procedures, services or equipment not otherwise covered by the Plan.

PART C – OPTIONAL DENTAL/ORTHODONTIC BENEFITS

Section 7C.01 CIGNA Dental Health Plan of Arizona, Inc. The Fund provides an optional prepaid dental benefit through CIGNA Dental Health Plan of Arizona, Inc. Under this benefit, which is in lieu of benefits under Parts A and B of this Article, a Covered Person must enroll in the CIGNA plan. The Administrative Office of the Fund will make CIGNA brochures and enrollment materials available to Covered Persons.

Section 7C.02 Mexico Dental Benefits. Covered Persons may secure dental care in Mexico under any Mexico PPO network made available by the Fund. The Administrative Office of the Fund will make brochures and enrollment materials to any such program available to Covered Persons.



VISION CARE BENEFIT

The Trust has an agreement with Vision Service Plan to provide certain Vision benefits. Please refer to the VSP brochure for further information.

Section 8.01 Schedule of Vision Care Benefits

Deductible	None
Vision Examination Allowance	\$ 35
Lens Allowance (pair)	
Single Vision	\$ 42
Bi-Focal	\$ 65
Tri-Focal	\$ 82
Lenticular	\$ 82
Contacts - Medically required	\$190
- Cosmetic (In lieu of glasses)	\$ 82
Frame Allowance	\$ 40

Section 8.02 Coverage. If a Covered Employee or a Covered Dependent shall incur optical expenses for:

- (a) Eye examinations made by a person licensed to practice as an ophthalmologist or an optometrist; or
- (b) Lenses and frames which are prescribed by an ophthalmologist or an optometrist,

the Plan will pay a benefit equal to such charges or equal to the amount set forth in the "Schedule of Vision Care Benefits", whichever is the lesser amount.

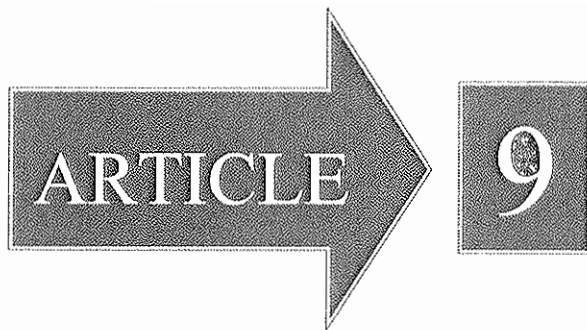
Section 8.03 Vision Care Limitations. The Plan does not pay expenses for:

- (a) Sunglasses, tints, safety glasses or goggles; or
- (b) Services and materials not specifically provided herein; or
- (c) Accidental Injury arising out of or in the course of any occupation or employment for remuneration or profit, or accidental injury or sickness for which the Covered Employee or Covered Dependent is entitled to benefits under any Worker's Compensation Insurance law, or similar law.

Section 8.04 Payment Period. A Covered Person who is eligible at the time of the vision examination and becomes ineligible for coverage at the time the expense is incurred for frames and lenses shall be entitled to benefits, provided the expense for frames and lenses is incurred within ninety (90) days following the end of the month in which the vision examination was made.

Section 8.05 Vision Examination, Frames and Lenses or Contacts Limitation. A vision examination, frames and lenses or contacts shall be payable not more than once within a two consecutive Calendar Year period.

Section 8.06 Additionally, from time to time, the Fund may be party to Mexico PPO arrangements under which medical, dental and vision services and supplies may be obtained in Mexico for discounted rates. The Fund Office will make a list of such providers, and the schedule of benefits for services obtained from such providers, available to Covered Persons.



COORDINATION OF BENEFITS

Section 9.01 Benefits Subject to this Article. Any medical, prescription, behavioral health, indemnity dental and vision benefits provided under these Rules and Regulations are coordinated with other plans according to the following provisions:

Section 9.02 Primary Plan. If two or more plans provide benefits to a Covered Person, the primary plan will be determined under these rules:

- (a) The plan which covers you as other than a dependent will pay before the plan which covers you as a dependent;
- (b) The plan which covers you other than as a retiree or laid-off employee pays before the plan which covers you as a retiree or laid-off employee;
- (c) The plan which covers your child as a dependent of the parent whose birthday (excluding year of birth) occurs earlier in the Calendar Year pays first. If both parents have the same birthday (month and day), the plan which has covered the dependent for whom claim is being made for the longer period of time pays first. However, if the parents are divorced or separated, the plan covering the parent who has custody will pay first. If the parent with custody remarries, the order of payment is as follows:
 - (1) Natural parent with whom the child resides;
 - (2) Stepparent with whom the child resides;
 - (3) Natural parent not having custody of the child.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the medical, dental, vision or other health care expenses of the child.

- (d) A plan which covers a dependent as other than a dependent of a retiree or laid-off employee pays before a plan which covers such dependent as a dependent of a retiree or laid-off employee;
- (e) When the above-mentioned rules do not apply, the benefits of the plan which covered the eligible individual for the longest period of time will pay before any other plan. If

an eligible individual's other plan has no duplication of benefits provision, it will pay first.

For purposes of this section, a "plan" means any plan of medical, dental or vision care benefits or services provided by any group, blanket or franchise insurance coverage; any service plan contracts, group practice, individual practice and other pre-payment coverage; any labor-management trusteed plan, union welfare plan, employer organization plan, or employee organization plan; or any coverage under governmental programs, and any coverage required or provided by any statute.

Section 9.03 Effect on Benefits.

- (a) **Medical Benefits (other than prescriptions) under Article 4.** If this Plan is primary, it will provide the medical benefit of Article 4 according to the terms and conditions of that Article. If this Plan is secondary, it will provide benefits such that the total combined benefits of any primary plans and this Plan will not exceed the benefits of that Article. In this regard, if this Plan is secondary, copies of the original bills and a copy of the primary plan's Explanation of Benefits (EOB) should be submitted to the Fund Office. This Plan will determine how much it would have paid had there been no other coverage. It will then subtract what was paid by the primary plan from the amount this Plan would have paid had there been no other coverage.
- (b) **Other Indemnity Benefits.** If this Plan is primary, it will provide its available indemnity benefits other than medical benefits (which will include prescriptions and behavioral health benefits and may include dental and/or vision benefits) according to the terms of this Plan. If this Plan is secondary, the indemnity benefits other than medical benefits payable under this Plan in the absence of this provision will be reduced so that the total benefits payable for all Allowable Expense under this Plan and all other plans will not exceed the total Allowable Expense.

Section 9.04 Right to Receive and Release Necessary Information. This Plan may, with the consent of the Covered Employee, release to or obtain from any insurance company or other organization or person any information, with respect to the Covered Person, which this Plan deems to be necessary for the purpose of implementing this Article. Any eligible individual claiming benefits under this Plan must furnish to the Fund such information as may be necessary to implement this Article.

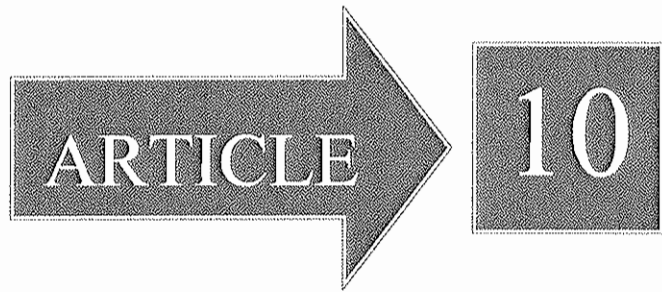
Section 9.05 Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan, this Plan has the right in its sole discretion to pay to any organization making such payments any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Fund will be fully discharged from liability under this Plan.

Section 9.06 Right of Recovery. Whenever payments have been made by this Plan with respect to expenses incurred in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, this Plan has the right to recover such payments, to the extent of such excess, from among one or more of the following, as this Plan determines:

- (a) The eligible individual;
- (b) Any Person to, or for or with respect to which, such payments were made;
- (b) Insurance companies, service plans or other organizations.

Section 9.07 Other Coordination Rules. If: (a) the spouse of a Covered Employee works, and does not opt into available health benefit coverage offered by his or her employer; or (b) the spouse of a Covered Employee works and opts into available health benefit coverage offered by his or her employer, but such health benefit coverage is “token” coverage; the benefits payable from this Plan will be provided at 40% of Allowable Expense. For this purpose, “token” coverage is coverage that is reduced or restricted because of the availability of this Plan’s benefits.

This Plan will not consider as an allowable expense any charge that would have been covered by an HMO had a covered person for whom the HMO is primary payor used the services of a participating HMO provider. Nor will this Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.



APPEALS PROCEDURE

Section 10.01 Timely Claim Filing. Benefits will be paid by the Plan only if notice of claim is made within 90 days from the date on which the covered charges were incurred. The claimant must submit properly completed forms and itemized statements as authorized by the Board of Trustees. Exceptions to the submission of the claims later than 90 days are subject to approval; but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred unless it was not feasible to file the claim on a timelier basis.

Section 10.2 Right of Review. Each individual whose claim for benefits under the Plan has been denied shall be provided adequate notice in writing setting forth the specific reasons for such denial, written in a manner calculated to be understood by the claimant. A claimant aggrieved by such decision may request review. The Trustees shall establish and publish to Covered Persons the Trust Fund rules and procedures for review of denied claims. Such rules and procedures shall comply with federal law.

Section 10.03 Trustee Authority. The Trustees have full and exclusive authority to determine all questions of coverage and eligibility, the methods of providing or arranging for benefits and any other related matters. The Trustees are authorized to construe the Trust Agreement and the Rules and Regulations of the Plan. The Trustees may delegate all or a portion of their authority hereunder to a Claims Review Committee, or to such other appropriate named fiduciary as the Trustees may determine, in order to provide individuals with a full and fair review of claims.

Section 10.04 Determination on Review. A determination on a request for review shall be final and binding upon all parties concerned, except that a claimant may pursue such remedies as are provided under federal law.



ARTICLE 11

DEFINITIONS

Section 11.01 Allowable Expense. An expense or charge will be an Allowable Expense only if the Trustees in their sole discretion determine that it is:

- (a) Necessary for the care and treatment of a non-occupational accidental bodily Injury or Illness of a person who is an eligible individual at the time the expense is incurred;
- (b) Recommended and approved by a Physician and is for a valid course of medical treatment, which is not experimental and which is recognized as valid by an established medical society in the United States, provided that the Plan may obtain and rely upon independent medical advice to determine whether services or supplies are medically necessary, are consistent with professionally recognized standards of care with regard to quality, frequency and duration and are provided in the most economical and medically appropriate site for treatment;
- (c) Determined to be a medical benefit as described in Article 4 Part A;
- (d) A Usual, Customary and Reasonable Charge as defined in Article 11, Section 11.34;
- (e) Not otherwise excluded or limited by provisions under Article 4-D.

Charges resulting from services or supplies provided by preferred participating providers as defined in Section 11.02 are allowable at the least of the following:

- (a) A predetermined allowance (prevailing fee) determined by Blue Cross and Blue Shield of Arizona;
- (b) A Fair Allowance Reimbursement Effort (FARE) based on Diagnosis Related Groups (DRG's) established by Blue Cross and Blue Shield of Arizona for the reimbursement of Hospital expenses or billed charges, if less.

Section 11.02 BCBSAZ PPO means the network of medical providers with discounted servicing fee arrangements to which Covered Persons have access under the Trust's agreement with Blue Cross Blue Shield of Arizona. The term participating provider means those providers with prevailing fee arrangements with Blue Cross/Blue Shield of Arizona.

Section 11.03 Calendar Year means a period of 12 consecutive months beginning with January 1st.

Section 11.04 Collective Bargaining Agreement means a labor agreement with the Union calling for contributions to the Trust Fund.

Section 11.05 Contributions mean those payments due the Trust under the terms of a Collective Bargaining Agreement or Subscription Agreement for participation in the Trust.

Section 11.06 Convalescent Care Facility means an institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Illness, and;

- (a) Is approved by and is participating extended care facility of Medicare;
- (b) Has organized facilities for medical treatment and provides twenty-four hour nursing service under the full-time supervision of a Physician or Registered Nurse;
- (c) Maintains daily clinical records on each patient and has available the services of a Physician under the established agreement;
- (d) Provides appropriate methods for dispensing and administering drugs and medicines;
- (e) Has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operations policies developed with the advice of, and reviewed by, a professional group including at least one Physician; and
- (f) Is not an institution or part thereof which is primarily a place for rest, a place for custodial or long term care, a place for the aged, a hotel or similar institution.

Section 11.07 Covered Employee means an Employee who has satisfied the conditions for benefit eligibility under the Plan. **Covered Dependent** means a Dependent who has satisfied the conditions for benefit eligibility under the Plan. **Covered Person** means a Covered Employee or a Covered Dependent. Individuals eligible by virtue of self-payments are Covered Persons only for the benefits for which self-payments have been made.

Section 11.08 Dependent means, with respect to an Employee, that Employee's:

- (a) Lawful spouse;
- (b) Unmarried natural child or legally adopted child;
- (c) Unmarried stepchild or foster child who lives with the Covered Employee in a regular parent-child relationship.

Legally adopted children shall include children placed for adoption and as to which the Employee assumes and retains a legal obligation for total or partial support in anticipation of the adoption of the children.

A foster child is one who primarily depends upon the Covered Employee for support and maintenance and who is properly reported as a dependent on the Covered Employee's tax return under the Internal Revenue Code.

Said children will be Dependents and are eligible for all benefits provided for Covered Dependents from birth through the age of 18 years. The term Dependent may also include such children from age 19 years through 22 years provided they are attending an accredited and state-licensed high school, technical school or institution of higher education on a full-time basis (at least 12 credit hours), remain unmarried and are dependent upon the Covered Person for support and maintenance. (Spring full-time student certification grants coverage through August 31.)

Such term also includes a dependent child after the child's nineteenth birthday for all benefits provided herein, provided the child both has been, from the nineteenth birthday on, and remains:

- (a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- (b) Primarily dependent upon the Covered Person for support and maintenance.

The Plan will require appropriate documentation of such a child's disability and dependency.

Section 11.09 EMAP Network means the network of mental health/substance abuse providers to which Covered Persons have access under the Trust's agreement with Health Management Centers, Inc.

Section 11.10 Employee means an employee of a Contributing Employer covered by a Collective Bargaining Agreement.

Section 11.11 Employer or Contributing Employer means an employer bound by a Collective Bargaining Agreement with the Union to make Contributions to the Trust on behalf of its Employees covered by that Agreement.

Section 11.12 Employer Contribution Report means the reports of the employment activity of Employees under the Collective Bargaining Agreements that are submitted to the Trust Fund together with Contributions for purposes of verifying eligibility.

Section 11.13 Fund Nurse means that individual responsible for utilization review and cost containment measures under Section 2.12 of these Rules and Regulations.

Section 11.14 Fund Office means the person or firm employed by the Trustees which is responsible for the processing of claims, payment of benefits, accounting, reporting, and other administrative services for the Trust or Plan.

Section 11.15 Home Health Care Agency means a licensed public agency of private nonprofit organization which:

- (a) Is primarily engaged in providing skilled nursing services and other therapeutic services; and

- (b) Has policies, established by a group of professional personnel associated with the agency or organization (including one or more Physicians and one or more Registered Nurses), to govern the services which it provides [referred to in Subsection (a)]; and provides for the supervision of such services by a Physician or Registered Nurse; and
- (c) Maintains clinical records on all patients.

Section 11.16 Home Health Services means the items and services enumerated in this paragraph that are furnished to a Covered Person who is under the care of a Physician. Such items and services may be furnished by a licensed Home Health Care Agency or by others under arrangements made by such an agency, under a plan established and periodically reviewed by such Physician. Such items and services, except as provided in Subsection (c), will be furnished on a visiting basis in a place of residence used as such Covered Person's home and will consist of:

- (a) Each visit by a representative of a Home Health Care Agency of four hours or less will be considered as one home health care unit.
- (b) Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse and either physical or speech therapy, or part-time or intermittent services of a home health aide who is licensed to perform such items and services that may further consist of any or all of the following:
 - (1) Medical social services under the direct supervision of a Physician; and
 - (2) Medical supplies, other than drugs, and the use of medical appliances while under such plan; and
 - (3) In the case of a Home Health Care Agency which is affiliated or under common control with a Hospital, medical services provided by an intern or resident-in-training of such Hospital.
- (c) Any of the items and services listed in Subsection (b) which are provided on an Outpatient basis, under arrangements made by the Home Health Care Agency at a Hospital or Convalescent Care Facility or at a rehabilitation center under one of the following conditions:
 - (1) The furnishing of such items and services involves the use of equipment of such a nature that the items and services cannot readily be made available to such Person in such place of residence; and
 - (2) Such items and services are furnished at such facility while the Covered Person is there to receive any such items or service described in item (1) of this Subsection but not including

transportation of such Covered Person in connection with any such item or service.

Section 11.17 Hospice means a facility constituted and operated pursuant to law, engaged primarily in providing supportive and related care for the Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is six months or less; and

- (a) Provides Hospice care on a 24-hour basis including control of symptoms associated with terminal illness; and
- (b) Has an interdisciplinary medical team consisting of at least one Medical Doctor or Doctor of Osteopathy, at least one Registered Nurse, at least one social workers, at least one volunteer and a volunteer program; and
- (c) Maintains central clinical records on all patients; and
- (d) Provides appropriate methods for dispensing and administering drugs and medicine; and
- (e) Is not an institution or part thereof which is primarily a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel or similar institution.

Section 11.18 Hospital means an institution constituted and operated pursuant to law, engaged in providing on an Inpatient basis at the patient's expense diagnostic and therapeutic facilities for the surgical and medical Diagnosis, treatment and care of injured and ill individuals by or under the supervision of a licensed Physician and continuously provides 24 hour-a-day services by Registered Nurses. The term "Hospital" will not include an institution or part thereof that is other than incidentally a place for rest, a place for the aged or a nursing home or Convalescent Care Facility. However, an institution specializing in the care and treatment of mentally ill patients as a Hospital, except solely for the fact that it lacks organized facilities on its premises for major surgery, will be deemed a Hospital under the Plan.

Section 11.19 Illness means a bodily sickness or disease diagnosed or treated by a Physician. Illness includes pregnancy of Covered Dependent spouses, but not of Covered Dependent children.

Section 11.20 Injury means physical harm or damage to a person that results independently of illness and all other causes, and is as a result of an externally violent force.

Section 11.21 Inpatient means a Covered Person whose treatment requires Hospital confinement, including room and board charges.

Section 11.22 Intensive Care Unit means a section, ward or wing within the Hospital which is separated from other Hospital facilities; and

- (a) Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; and
- (b) Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use; and
- (c) Provides room and board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Section 11.23 Medicare means Title XVIII (health insurance for the aged) of the United States Social Security Act as amended.

Section 11.24 Mental Health/Substance Abuse Condition means a condition as defined in Section 5.02(a) of these Rules and Regulations.

Section 11.25 Outpatient means a Covered Person's treatment that does not require Hospital confinement.

Section 11.26 Outpatient Surgical Facility means an institution, other than private offices or clinics of Physicians or surgeons, which meets the official Free Standing Surgical Facility requirements of the State Department of Health and the State of Arizona or which, in the absence of such requirements, has:

- (a) Been established, equipped, and operated for purposes of performing surgical procedures by a Physician or surgeon; and
- (b) A permanent plant, equipment, and supplies not usually available in the Physician's or surgeon's office for surgical procedures not requiring Inpatient confinement; and
- (c) At least two operating rooms and at least one post-anesthesia recovery room, is equipped to perform diagnostic x-ray and laboratory examinations required in connection with any surgery performed, and has a blood bank or other blood supply; and
- (c) The full-time service of Registered Nurses for patient care in the operating and post-anesthesia recovery room; and
- (e) A written agreement with one or more Hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- (f) An organized medical staff supervising its operation in accordance with established policy, and maintains adequate medical records for each patient.

Section 11.27 Physician means only a person acting within the scope of a license and holding the degree of:

- (a) M.D. – Doctor of Medicine

- (b) D.O. – Doctor of Osteopathy
- (c) D.M.D. – Doctor of Medical Dentistry
- (d) D.D.S. – Doctor of Dental Surgery
- (e) D.P.M. – Doctor of Podiatry
- (f) D.C. – Doctor of Chiropractic
- (g) C.N.M. –of Optometry
- (h) Doctor of Homeopathy/Naturopathy
- (i) Family Nurse Practitioner
- (j) CRNA – Certified Nurse Midwife (in Arizona only)
- (k) O.D. – Doctor Certified Registered Nurse/Anesthesiologist
- (l) CORT & CFA - Certified Operating Room Technician, Certified First Assistant and such other surgical assistant designations as the Trustees, in their discretion, may find to have appropriate credentials.
- (m) PA – Physicians Assistant

Physician does not include the Covered Person or a Covered Dependent or any person who is the spouse, parent, child, brother, or sister of such Covered Person or Dependents.

Benefits for the services of a D.P.M. acting within the scope of a license are payable only to the extent that benefits under this Plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition.

Services rendered by a D.C. are covered for the diagnosis and correction by manual or mechanical means, including x-rays incidental thereto, of structural imbalance, distortion or subluxation in the human body for removal of nerve interference where such interference is the result of or related to distortion.

Services rendered by a C.N.M. must be for obstetrical procedures within the scope of a license.

Services rendered by an O.D. must be for vision examinations and the dispensing of lenses, frames or contact lenses within the scope of a license.

NOTE: *Mental Health/Substance Abuse condition providers under the EMAP program specified in Article 5 may include Psychiatrists (M.D.'s and D.O.'s), Certified Independent Social Workers (CISW), Certified Professional Counselors (CPC), Certified Marriage and Family Therapists (CMFT), and Mental Health Nurse Practitioners (MHNP), and Psychiatric Nurse Practitioners (Psy. MHNP).*

Section 11.28 Plan means this program of health and related benefits. Plan may also refer to these Rules and Regulations, as amended from time to time by the Trustees.

Section 11.29 Prescription Drug Network means the network of prescription drug providers to which Covered Persons have access under the Trust's pharmacy agreements.

Section 11.30 Trust Agreement means the Agreement and Declaration of Trust of the United Food and Commercial Workers and Employers Arizona Health and Welfare Trust and any Amendments thereto.

Section 11.31 Trust, Fund, or Trust Fund means the United Food and Commercial Workers and Employers Arizona Health and Welfare Trust.

Section 11.32 Trustees or Board of Trustees means those individuals serving as trustees of the Trust Fund under the Trust Agreement.

Section 11.33 Union means United Food and Commercial Workers, Local No. 99, the collective bargaining representative of the Employees.

Section 11.34 Usual, Reasonable and Customary Charge means a charge that is within the range of the usual charges made by providers of medical services, with similar training and experience, for the same service within the same specific and limited geographical area and is reasonable in the opinion of responsible medical authorities.

Section 11.35 Visit means an in person interview between the Physician and the Covered Person.

Section 11.36 Workers Compensation Insurance means any program of occupational Injury or Illness coverage, no matter how formed or styled.

IN WITNESS WHEREOF, the Trustees have caused this Plan to be adopted as of January 1, 2008.

BOARD OF TRUSTEES
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST

By 
Its Chairperson

7/17/08
Date

By 
Its Secretary

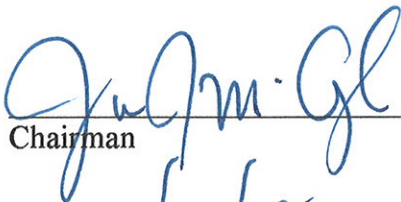
7-17-08
Date

**AMENDMENT NO. 1
TO THE
JANUARY 1, 2008 RULES AND REGULATIONS
OF PLAN 501-C
OF THE
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST**

Effective May 1, 2008, Article 3, Section 3B.01 is amended and restated to read as follows:

Section 3B.01 Schedule of Accidental Death and Dismemberment Benefits. Subject to the provisions of the group policy, the Plan provides a Covered Employee, while eligible for this benefit, an Accidental Death and Dismemberment Benefit in a face amount of \$5,000. A certificate reflecting benefits and options available under the group policy will be provided to Covered Employees.

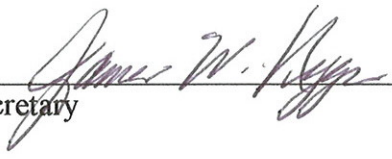
The undersigned Chairman and Secretary of the UFCW and Employers Arizona Health and Welfare Trust do hereby certify that the foregoing Amendment to the Plan 501-C Rules and Regulations was duly adopted by the Board of Trustees at a meeting duly called and held on October 16, 2008.



Chairman

10/16/08

Date



Secretary

10-16-08

Date

**AMENDMENT NO. 2
TO THE
JANUARY 1, 2008 RULES AND REGULATIONS
OF PLAN 501-C
OF THE
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST**

1. Effective January 1, 2005, the following sentence is added to Article 1, Part C, Section 1C.02:

Benefits continued under this Section may, in the discretion of the Trustees, include all fund benefits.

2. Effective January 1, 2009, the following entry is added to Article 4, Part A, Section 4 A.01:

Trustee-Approved
Mail Orded Diabetic 100%
Supplies Provider

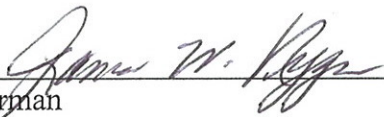
3. Effective January 1, 2009, the following sentence is added to Article 4, Part A, Section 4 A.03(1):

The deductible does not apply to the Trustee-Approved Mail Order Diabetic Supplies

4. Effective January 1, 2009, the following paragraph is added to Article 11, Section 11.08:

No individual will be considered a Dependent under this Plan in the absence of specific documentation to substantiate dependent status, including accurate identification information (e.g., Social Security Number, Medicare health insurance number, etc.)

The undersigned Chairman and Secretary of the UFCW and Employers Arizona Health and Welfare Trust do hereby certify that the foregoing Amendment to the Plan 501-C Rules and Regulations was duly adopted by the Board of Trustees at a meeting duly called and held on March 26, 2009.



Chairman



Secretary

3-26-09

Date

3/26/09

Date

**AMENDMENT NO. 3
TO THE
RULES AND REGULATIONS
OF PLAN 501-C
OF THE
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST**

1. Effective June 1, 2009, the deductible amounts of Sections 4A.01, 4B.01 and 5A.01 are increased to \$250 per person per Calendar Year and \$750 per family per Calendar Year.
2. Effective June 1, 2009, the attachment point for 100% reimbursement of Allowable Expense which is expressed in Section 4A.01 is increased from \$10,000 to \$20,000.
3. Effective June 1, 2009, the physician office visit co-payment expressed in Section 4A.01 is increased from \$15 to \$20.
4. Effective June 1, 2009, the prescription drug provisions of Article 4, section 4A.01 are amended and restated to read as follows:

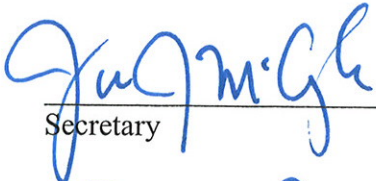
	NETWORK	NON-NETWORK
Prescription Drugs – Generic	100% less \$10 co-pay per prescription	60%
Brand Name (when no generic exists)	100% less \$20 co-pay per prescription	60%
Brand Name (when generic exists)	100% less \$30 co-pay per prescription	60%
Maintenance Medication 90 Day Supply	100% less 2 times the applicable co-pay noted above	Not Available

5. Effective June 1, 2009, the dental deductible amount expressed in Section 7A.01 is increased from \$50 to \$100.

The undersigned Chairman and Secretary of the UFCW and Employers Arizona Health and Welfare Trust do hereby certify that the foregoing Amendment to the Plan 501-C Rules and Regulations was duly adopted by the Board of Trustees at a meeting duly called and held on July 23, 2009.



 Chairman



 Secretary

7-23-09

 Date

7.23.09

 Date

1001

**AMENDMENT NO. 4
TO THE
RULES AND REGULATIONS
OF PLAN 501-C
OF THE
UNITED FOOD AND COMMERCIAL WORKERS AND
EMPLOYERS ARIZONA HEALTH AND WELFARE TRUST**

1. Effective October 1, 2009, Article 2, Section 2.14 is amended to add a new subsection (e) to read as follows:

Section 2.14 Privacy

* * *

- (e) In compliance with HIPAA Security regulations, the Board of Trustees will:
- (1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the health plan;
 - (2) Ensure that the adequate separation discussed in (d) above, specific to electronic PHI, is supported by reasonable and appropriate security measures;
 - (3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
 - (4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

2. Effective January 1, 2010, the language of Article 11, Section 11.34 is deleted and marked “[Reserved]”, and Article 11, Section 11.01 is amended and restated to read as follows:

Section 11.01 Allowable Expense means the expense or charge for medical services and supplies, as described in Article 4, Part A, or for any dental and/orthodontic services and supplies described in Article 7, which is:

- (a) With respect to a covered PPO provider, the fee set forth in the agreement between the preferred provider organization (PPO) network and the Trust;
or
- (b) With respect to a non-PPO provider, the fee identified in the schedule that lists the dollar amounts the Trustees have determined the Plan will allow for covered services or supplies (or, if lower, the provider’s actual billed charge).

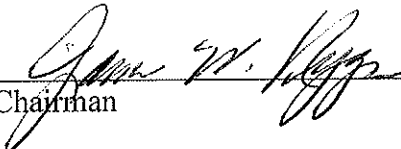
No expense or charge will be an Allowable Expense unless it is necessary for the care and treatment of a non-occupational accidental bodily Injury or Illness of a person who is a Covered Person at the time the expense is incurred. No expense or charge will be an Allowable Expense unless it is recommended and approved by a Physician and is for a valid course of medical treatment, which is not experimental and which is recognized as valid by an established medical society in the United States. No expense or charge will be an Allowable Expense if it is otherwise excluded or limited by Plan provisions under Article 4D or Article 7.

The Trustees may obtain and rely upon independent medical advice to determine whether services or supplies are medically necessary, are consistent with professionally recognized standards of care with regard to quality, frequency and duration and are provided in the most economical and medically appropriate site for treatment.

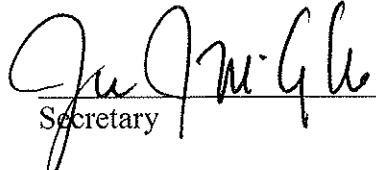
3. Effective January 1, 2010, Article 1, Part B, Section 1B.01 is amended to add the following at its conclusion:

Notwithstanding this provision or any other provision of the plan to the contrary, the eligibility of a Dependent child will be continued at no cost if the child is enrolled in a postsecondary educational institution, enjoys Dependent status under the Plan by virtue of such enrollment, and takes a medically necessary leave of absence from such enrollment and loses such Dependent status because of the absence. Eligibility so continued will terminate the earlier of (a) the date that is one year after the first day of the medically necessary leave of absence, or (b) the date on which such eligibility would otherwise have terminated under the Plan. The Trustees will require written certification by the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. At the conclusion of continued eligibility under this paragraph, a child will be treated as having failed to meet the definition of Dependent for purposes of the Dependent Self-Payments allowed by the Plan.

The undersigned Chairman and Secretary of the UFCW and Employers Arizona Health and Welfare Trust do hereby certify that the foregoing Amendment to the Plan 501-C Rules and Regulations was duly adopted by the Board of Trustees at a meeting duly called and held on January 14, 2010.



Chairman



Secretary

1-14-10

Date

1.14.10

Date