BMWE HEALTH AND WELFARE

PLAN FOR OCCUPATIONALLY

DISABLED MEMBERS

SUMMARY PLAN DESCRIPTION

Effective January 1, 2014
BMWE HEALTH AND WELFARE PLAN
FOR OCCUPATIONALLY DISABLED MEMBERS
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131
Toll-Free: (800) 831-4914
Fax: (615) 859-0324

THE FUND IS ADMINISTERED BY THE BOARD OF TRUSTEES

THE TRUSTEES ARE:

MR. NATHANIEL TRAWICK
Chairman
7720 Breezewood Circle
Pensacola, Florida 32534-4015

MR. GREGORY HARLESS
Secretary
P.O. Box 413a, RR2
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Hendersonville, Tennessee 37075

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BMWED-IBT
P.O. Box 24068
Knoxville, Tennessee 37933-2068

THE SPONSORING BMWE FEDERATIONS ARE:

ALLIED FEDERATION
111 Imperial Boulevard, C-300
Hendersonville, Tennessee 37075

SOUTHERN SYSTEM DIVISION FEDERATION
800 Concord Road
Knoxville, Tennessee 37922

CONSOLIDATED RAIL SYSTEM FEDERATION
(FORMER MEMBERS OF THE NICKEL PLATE-WHEELING &
LAKE ERIE FEDERATION ONLY)
58 Grand Lake Drive, Suite 2
Port Clinton, Ohio 43452-1450

ADMINISTRATIVE SERVICES ARE PROVIDED TO THE TRUSTEES BY:

SOUTHERN BENEFIT ADMINISTRATORS, INCORPORATED
P.O. BOX 1449
GOODLETTSVILLE, TENNESSEE 37070-1449
PHONE: (615) 859-0131
TOLL-FREE: (800) 831-4914   FAX: (615) 859-0324
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PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund participates in the CIGNA HealthCare Preferred Provider Organization (PPO). You may search for participating providers on CIGNA’s website at

www.cigna.com/SA-PPO2

or you may call CIGNA toll-free at:

(800) 768-4695

If you would like a PPO directory, please contact the office of the Plan and one will be provided to you free of charge.

PHARMACY DISCOUNT PROGRAM

Coverage for prescription drugs is provided under your Major Medical Expense Benefit as outlined in the Schedule of Benefits. The Plan has entered into an arrangement with Express Scripts to secure discounts on prescription drugs. When you have a prescription filled at a participating pharmacy, the cost of the prescription is discounted to both you and the Plan. Additionally, Express Scripts offers a mail order drug program under which you can receive maintenance drugs at a discount.

You should have received a Plan I.D. card, which also serves as your drug discount card, to be presented to your pharmacy when you have a prescription filled. If you have not received one, please contact the office of the Plan. For information, or to locate a pharmacy, you may contact Express Scripts as follows:

Toll-Free: (800) 467-2006

Or Online at: www.express-scripts.com
SUMMARY OF MEDICAL BENEFITS

Maximum Lifetime Benefit Per Covered Person
For All Covered Medical Expenses ........................................................ $130,000

Calendar Year Deductible Per Covered Person ................................................. $250

Benefit Percentage Payable by the Fund:
Outpatient Treatment of a Mental or Nervous Disorder ........................................ 65%
Counseling Services in Connection with a Terminal Illness .................................. 65%
For the Purchase of Covered Prescription Drugs -
   Generic Drugs .................................................................................. 90%
   Brand Name Drugs ........................................................................... 70%
For All Other Covered Medical Expenses -
If Incurred with a Participating PPO Provider ................................................... 85%
If Incurred with a Non-PPO Provider ........................................................... 75%

Other Benefit Limitations:
Maximum Hospice Care Benefit Per Occurrence -
   Room and Board, Care and Treatment of the Patient ................................... $ 3,000
   Counseling for the Patient and the Patient’s Family .................................. $ 1,000
Maximum Lifetime Benefit for Sleep Apnea and Other Sleep Disorders ................... $ 2,500
Maximum Lifetime Benefit for Non-Surgical Treatment of Temporomandibular Joint (TMJ) Dysfunction .......................................................... $ 1,000
Maximum Annual Benefit Per Covered Person for Home Health Care .................. $ 2,500
Maximum Annual Benefit Per Covered Person for Pain Management, Exclusive of Cancer-Related Charges ......................................................... $ 2,500
Maximum Annual Benefit Per Covered Person for Chiropractic Care ..................... $1,000
Maximum Period Per Confinement in a Skilled Nursing Facility .......................... 31 days
Maximum Covered Medical Expense For Hospital Room and Board .................. Semi-Private Room Rate
CLAIM PROCEDURES

HOW TO FILE YOUR CLAIMS

When you have a claim, please follow the instructions outlined below.

1. Time Limit for Filing Claims - All claims must be submitted within one year from the date on which they are incurred.

2. Who Files the Claims?

   - If you receive services from a participating PPO doctor, hospital or other health care provider, you must furnish to that provider the information needed to file a claim with the Fund. This information is found on your Fund I.D. card. The provider should then file the necessary bills and related information with the Fund office.

   - If you receive services from a non-PPO provider, the provider may choose to file the claim in your behalf. However, it is your responsibility to either file the claim yourself or verify that your doctor, hospital or other provider will file the claim for you in accordance with the information found on your Fund I.D. card.

   - You must file all drug claims directly with the Fund office. Forms are available from the Fund office for this purpose.

3. If a claim is filed without sufficient information or documentation regarding the claim, you will be notified within 30 days after the Fund office receives the claim. To the extent possible, missing information will be requested from your health care provider. However, on some occasions, it may be necessary to request some information directly from you.

Remember, it is your responsibility to provide your doctor, hospital and any other medical service providers with information about your coverage under the plan and to ensure that all claims are properly filed with the Fund office.

PAYMENT OF CLAIMS BY FUND OFFICE

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly by the Fund office staff and you will be notified regarding any benefit payments. However, in no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.
If the Fund office determines that additional information is required from you or in your behalf, you will be given 45 days in which to provide any missing information necessary to process the claim.

**PRE-APPROVAL OF A CLAIM**

This Fund has no pre-certification or pre-approval requirements for treatment. However, certain treatments and procedures are not covered under the Fund, and you may wish to contact the Fund office at certain times prior to receiving treatment in order to assure that the treatment will be covered. The following rules apply to pre-approval of treatment:

1. **Approval of Medically Necessary Treatment** - As explained in this booklet, a charge must be Medically Necessary to be covered by the plan. If there is any doubt about whether your expected treatment will be considered Medically Necessary under the plan, you may contact the Fund office for an advance decision. As explained later in this booklet, you may appeal any adverse decision made by the Fund office regarding Medical Necessity.

2. **Compliance With Plan Provisions, Exclusions and Limitations** - In an effort to help control the cost of providing benefits under the plan, and in order to limit coverage to benefits for treatment of a medical nature, various plan provisions, exclusions and limitations have been included in the plan. These are very specific and they are described in this booklet. However, questions sometimes arise as to whether a particular provision, exclusion or limitation applies to a specific condition or treatment.

   If there is any question as to whether your anticipated treatment will be covered under the plan, you may contact the Fund office in advance. Once appropriate information is received, the Fund office staff will let you know whether your expected treatment will be covered under the plan. If you receive an adverse decision, you may of course appeal that decision as explained further in this booklet.

**THE PLAN'S RESPONSIBILITIES TO RESPOND TO YOUR REQUESTS FOR PRE-APPROVAL**

As explained in the preceding section, you may want to request pre-approval of treatment to ensure that it will be covered under the plan. The Fund office staff will respond to all such requests in a timely manner, as follows:

1. **Urgent Care Claims** - If proposed treatment is determined to be *urgent* in nature, as defined below, a decision on your request for pre-approval will be made and communicated to you within 72 hours of receipt of your request. If
additional information is necessary in order to make a decision on your claim, you will be notified as soon as possible, but in no instance more than 24 hours after receipt of the request. You will then be given not less than 48 hours to provide the requested information.

An Urgent Care Claim is a claim which, if treated as a claim for non-urgent care:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment.

2. Non-Urgent Care Claims - If proposed treatment is determined to be of a non-urgent nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If additional information is necessary to make a decision on your claim, the plan may require up to an additional 15 days to make a decision on your request. If an extension is required, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it is necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.
DEFINITIONS

In order to properly explain each of the benefits to which you may be entitled it has been necessary to use certain specific terms in this booklet to describe these benefits. The definitions of many of those terms are as follows:

ACCIDENTAL BODILY INJURY

The term “Accidental Bodily Injury” means an injury which:

1. Results from and is caused by a sudden and violent event;

2. Is caused by an external force or object; and

3. Occurs unexpectedly and by chance, or is not due to any fault or misconduct on your part.

AMBULATORY SURGICAL CENTER

The term “Ambulatory Surgical Center” means a permanent public or private facility which:

1. Has a staff of Physicians who are organized into a corporation, a partnership or other formal business entity and is operated under the supervision of a Physician who is employed full-time in such supervision, and which permits a surgical procedure only by a Physician who at the time of the surgery is privileged to perform the procedure in at least one Hospital in the area;

2. Is equipped and operated mainly for the purpose of performing surgery;

3. Has continuous services of Physicians and nurses when a patient is in the facility;

4. Does not provide services or other accommodations for patients to stay overnight;

5. Maintains an adequate medical record for each patient (containing an admitting diagnosis, a medical history, an operative report and a discharge summary, at a minimum);

6. Maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or who require post-operative confinement;
7. Requires, in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure; and

8. Has the capability to handle foreseeable emergencies, and has trained personnel and necessary equipment including, but not limited to, a defibrillator, a tracheotomy set and a blood bank or other blood supply.

BIRTHING CENTER

The term “Birthing Center” means a facility established for providing maternity services which:

1. Is accredited by the Commission for the Accreditation of Birth Centers; and

2. Is licensed to deliver covered services by the state in which it is located.

COVERED MEDICAL EXPENSES

The term “Covered Medical Expenses” means those expenses outlined in this booklet which are actually incurred by you for treatment of an illness, Accidental Bodily Injury or congenital defect, or in connection with the pregnancy you or your spouse, or for vasectomies and sterilization procedures performed on you or your spouse, or for the routine care of a newborn infant during the Hospital confinement immediately following birth, unless otherwise specified, and subject to all the limitations outlined in this booklet. Further, “Covered Medical Expenses” are limited to those expenses which are Medically Necessary and which are Usual, Customary and Reasonable Expenses, as defined in this section.

COVERED PERSON

The term “Covered Person” means an Eligible Member, an Eligible Dependent or an Eligible Surviving Spouse.

CUSTODIAL CARE

The term “Custodial Care” means any services, including room and board or supplies provided to a person:

1. Who is not receiving medical treatment for rehabilitation from an Accidental Bodily Injury or illness; or

2. For the purpose of assisting the person in the activities of daily living; and
3. When such services or supplies do not require the continuous attention of trained medical personnel.

Custodial Care includes, but is not limited to: administration of medicines, dressings or therapies which can be self-administered; routine monitoring of vital signs; help in walking, getting in and out of bed, bathing, dressing and eating.

**DURABLE MEDICAL EQUIPMENT**

The term “Durable Medical Equipment” means equipment which:

1. Can withstand repeated use;

2. Can only be used to serve the medical purposes for which it is prescribed;

3. Generally is not useful to a person in the absence of an illness or Accidental Bodily Injury; and

4. Is appropriate for use in the home.

All of these requirements must be met before an item can be considered to be Durable Medical Equipment. Equipment will not be considered a Covered Medical Expense simply because its use has an incidental health benefit.

**ELIGIBLE DEPENDENT**

The term “Eligible Dependent” means the following:

1. The legal spouse of the Eligible Member.

2. Any unmarried child of the Eligible Member if the child is less than 19 years old, excluding any child who is serving in the Armed Forces of any country. A step-child or a legally adopted child will be a dependent if:

   (a) The child lives in the household of the Eligible Member, and

   (b) The Eligible Member contributes more than 50% toward the maintenance and support of the child.

   The Fund may request a statement to verify a claim that a step-child or legally adopted child is a dependent.

3. Any unmarried child of an Eligible Member who is at least 19 years of age, but less than 25 years of age, provided the child is enrolled in a full-time educational
institution and is dependent for the major portion of his support from the Eligible Member and maintains permanent residence in the Eligible Member’s home.

4. Any child who has passed the limiting age outlined above and who is unmarried if he is totally and permanently disabled and is dependent on the Eligible Member for support and maintenance because of a physical handicap or mental retardation as certified by a Physician. The Fund may request a statement indicating the extent of the maintenance and support. For benefits to be effective, the disability must have occurred before the child reached the limiting age outlined above. This dependent coverage will be in effect until the first of the following:

(a) The child marries;
(b) The child no longer lives with the Eligible Employee;
(c) The disability ceases; or
(d) The Eligible Member’s coverage is terminated.

5. Any child less than 19 years of age who has been placed with an Eligible Member for adoption, but the adoption has not become final. Being placed for adoption means that the Eligible Member has assumed, and retains, a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child’s placement with the Eligible Member terminates upon termination of that legal obligation. Upon an adoption becoming final, the child may continue to meet the definition of Eligible Dependent in accordance with the provisions outlined on the previous page.

A dependent child otherwise described above who is the surviving child of a deceased Eligible Member or the surviving child of a deceased member who died due to an on-the-job injury will also be considered an Eligible Dependent, subject to the provisions further outlined in the Rules of Eligibility. For purposes of determining support and residency status, “Eligible Surviving Spouse” will be substituted for “Eligible Member” where appropriate.

**ELIGIBLE MEMBER**

The term “Eligible Member” means any person who meets the Rules of Eligibility for Occupationally Disabled Members as outlined in this booklet.
ELIGIBLE SURVIVING SPOUSE

The term “Eligible Surviving Spouse” means any person who meets the Rules of Eligibility for Surviving Spouses of Members Who Are Fatally Injured While On Duty as outlined in this booklet.

EXPERIMENTAL OR INVESTIGATIVE

1. The term “Experimental or Investigative” means any treatment, equipment, technology, drug, procedure or supply which:

   (a) Is not accepted as standard medical treatment for the illness, disease or injury being treated by Physicians practicing the suitable medical specialty;

   (b) Is the subject of scientific or medical research or study to determine the item’s effectiveness and safety;

   (c) Has not been granted, at the time services are rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare; or

   (d) Is performed subject to the Covered Person’s informed consent under treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

2. In determining whether a treatment, equipment, technology, drug, procedure or supply is Experimental or Investigative, the view of the state or national medical communities will be considered as well as to whether:

   (a) Scientific evidence permits conclusions concerning the effect of the health outcome;

   (b) The net health outcome for the patient is improved, as much or more than for established alternatives; and

   (c) Improvement in the patient’s condition would be attainable through the use of more conventional or widely-recognized treatment alternatives.

3. Treatment may be considered Experimental or Investigative even if a Physician has previously prescribed, performed, ordered, recommended or approved such
treatment. Charges for an Experimental or Investigative treatment, equipment, technology, drug, procedure, service or supply are excluded from coverage.

HOME HEALTH CARE

The term “Home Health Care” means the services and supplies listed below:

1. The Home Health Care must replace a needed Hospital stay. Also, it must be for the care or treatment of sick or injured persons and must be:
   
   (a) Ordered in writing by the Covered Person's Physician; and
   
   (b) Provided in the Covered Person's home by a Home Health Care Agency team.

2. Home Health Care consists of these services and supplies:
   
   (a) Part-time or intermittent home nursing care from, or supervised by, a registered nurse;
   
   (b) Part-time or intermittent home health aid services;
   
   (c) Physical therapy and speech therapy; and
   
   (d) Medical supplies, drugs and medication prescribed by a Physician, and laboratory services, but only to the extent that they would have been covered in a Hospital.

HOME HEALTH CARE AGENCY

The term “Home Health Care Agency” means a public or private agency that:

1. Specializes in giving nursing or therapeutic services in the home;

2. Is licensed as a home health care agency; and

3. Operates within the scope of its license.

HOSPICE CARE

The term “Hospice Care” means care given to a terminally ill person by either of the following:

1. A hospice care agency which has hospice care available 24 hours a day and meets any licensing or certification standards for the jurisdiction where it is located and which:
(a) Provides:

- Skilled nursing services,
- Medical social services,
- Psychological and dietary counseling, and
- Bereavement counseling for the immediate family;

or, arranges for other services which include:

- Services of a Physician,
- Physical therapy,
- Part-time home health aid services which mainly consist of caring for terminally ill persons, and
- In-patient care in a facility when needed for pain control and acute and chronic symptom management;

(b) Has personnel which include at least:

- One Physician,
- One registered nurse,
- One licensed or certified social worker employed by the agency, and
- One pastoral or other counselor;

(c) Establishes policies governing the provision of hospice care;

(d) Assesses the patient's medical and social needs;

(e) Develops a hospice care program to meet those needs;

(f) Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency;

(g) Permits all area medical personnel to utilize its services for their patients;

(h) Keeps a medical record on each patient;

(i) Utilizes volunteers trained in providing services for non-medical needs; and

(j) Has a full-time administrator.

or

2. A hospice care facility which is licensed or certified to provide in-patient hospice care and which:
(a) Keeps a medical record on each patient;

(b) Makes charges to its patients;

(c) Has a full-time administrator;

(d) Is run by a staff of Physicians of which one is on call at all times;

(e) Provides nursing services under the direction of a registered nurse 24 hours per day; and

(f) Provides an ongoing assurance program with reviews by Physicians other than those who own or direct the facility.

HOSPITAL

The term “Hospital” means:

1. Any institution which is an approved and accredited hospital recognized by the American Hospital Association and which is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; or

2. Any institution which meets all of the following requirements:

   (a) Maintains permanent and full-time facilities for bed care of five or more resident patients;

   (b) Has a doctor in regular attendance;

   (c) Continuously provides 24-hour-a-day nursing service by registered nurses;

   (d) Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; and

   (e) Is operating lawfully in the jurisdiction in which it is located.

MEDICALLY NECESSARY

The term “Medically Necessary” means that a service or supply which the patient receives is required to identify or treat an illness or Accidental Bodily Injury or other
covered condition which a Physician has diagnosed or reasonably suspects. To be Medically Necessary, the service or supply must:

1. Be consistent with the diagnosis and treatment of the patient's condition;
2. Be in accordance with standards of good medical practice;
3. Not be for the convenience of the patient or his Physician; and
4. Be performed in the least costly setting required by the patient's medical condition.

MENTAL OR NERVOUS DISORDER

The term “Mental or Nervous Disorder” means any condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental or Nervous Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin and irrespective of cause, basis or inducement.

PHYSICIAN

The term “Physician” means a physician and/or surgeon (M.D. or D.O.) licensed to practice medicine in the state in which treatment is rendered. To the extent that benefits are provided, and while practicing within the scope of his or her license, “Physician” includes a dentist, podiatrist or chiropractor.

SKILLED NURSING FACILITY

The term “Skilled Nursing Facility” means a facility that fully meets all of these tests:

1. It is licensed to provide persons convalescing from Accidental Bodily Injury or illness with professional nursing services on an inpatient basis. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided;
2. Its services are provided for compensation from its patients and under the fulltime supervision of a Physician or a registered nurse;
3. It provides 24 hour a day nursing services by licensed nurses, under the direction of a full-time registered nurse;

4. It maintains a complete medical record on each patient;

5. It has an effective utilization review plan;

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, Custodial Care, educational care or care of Mental or Nervous Disorders; and

7. It is approved and licensed by Medicare.

**USUAL, CUSTOMARY AND REASONABLE EXPENSE**

“Usual, Customary and Reasonable Expense” means a level of charges that does not exceed the prevailing range of charges generally made by providers in the locality for similar services or supplies. In determining whether charges are Usual, Customary and Reasonable, due consideration will be given to the circumstances that may require additional time, skill or experience. The determination of Usual, Customary and Reasonable Expense is at the sole discretion of the Trustees.
RULES OF ELIGIBILITY FOR OCCUPATIONALLY DISABLED MEMBERS

INITIAL ELIGIBILITY

You will become an Eligible Member and will be eligible for the benefits outlined in this booklet, provided you are a member in good standing of a sponsoring federation, on the date that you satisfy all of the following requirements (no member of the Allied Federation who is a former member of the Missouri Pacific Federation or the Southern Pacific Atlantic Federation is eligible to participate):

1. You must be occupationally disabled as determined by the U.S. Railroad Retirement Board;

2. You must have been credited with a minimum of 12 compensated service months in employment coming under the jurisdiction of the Brotherhood of Maintenance of Way Employes, with those 12 months of service having been earned within the 24 consecutive month period ending on the date you became occupationally disabled;

3. You must have qualified for coverage under the Railroad Employees National Health and Welfare Plan as of the date you became occupationally disabled, if applicable;

4. You must have last performed compensated service as follows:
   (a) If you are a member of the Allied Federation or the Southern System Division Federation, on or after January 1, 2004, or
   (b) If you are a member of the former Nickel Plate-Wheeling & Lake Erie Federation, on or after April 1, 2005;

5. You must have ceased to be eligible for benefits under, or eligible to enroll for benefits under, the Railroad Employees National Health and Welfare Plan or any other plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work; and

6. You must make application and must make any payment for the coverage as may be required by the Trustees;

Except that no member of the former Nickel Plate-Wheeling & Lake Erie Federation could become eligible for benefits prior to April 1, 2008.

Your Eligible Dependents will become covered on the same date as you, except that no individual who is eligible to enroll under Medicare or who is eligible for benefits from, or
is eligible to enroll under, any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work will become eligible for benefits under the Fund.

Generally, when you satisfy the eligibility requirements you must make timely application. However, if you submit a late application which is approved by the Trustees upon appeal, based upon the facts and circumstances surrounding your late application, and subject to standards of review applied uniformly to all applicants, you will be allowed to begin participation under the Fund on a prospective basis only, with coverage to be effective the first day of the month following the month in which your complete application was received.

Except as outlined above, if you fail to enroll for coverage when first eligible to do so, you may enroll only as of any subsequent January 1st, so long as you continue to meet the eligibility requirements and provided you make application prior to your requested effective date. Initial eligibility can commence only as of January 1st of each calendar year.

CONTINUING ELIGIBILITY

Once you become an Eligible Member, you will continue to be eligible for benefits in each calendar month for which you meet all of the following requirements:

1. You must make any monthly payments, if required;

2. You must continue to be occupationally disabled; and

3. You must not be eligible for benefits under, or eligible to enroll under, any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work.

Your Eligible Dependents will remain covered as long as you remain covered, but only so long as your Eligible Dependent is not eligible to enroll under Medicare and is not eligible for benefits under, or eligible to enroll under, any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work.

TERMINATION OF ELIGIBILITY

Coverage under the Fund will terminate when any of the following events occurs (see the following section for information on extended eligibility for your dependents if you should die):

1. The date on which you cease to be occupationally disabled;
2. The date on which you fail to make the required payment for the coverage;

3. The date on which the you become eligible for benefits under, or eligible to enroll for benefits under, the Railroad Employees National Early Retirement Major Medical Benefit Plan (GA-46000) or any successor plan or plan of similar intent, or any other plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work; or

4. The date on which you become eligible to enroll for Medicare benefits.

Except as outlined below, coverage for your Eligible Dependents will cease on the date that your coverage ceases. Additionally, coverage for any Eligible Dependent will cease on the date that that individual becomes eligible to enroll under Medicare or becomes eligible for benefits from, or eligible to enroll under, any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work.

ELIGIBILITY FOR YOUR SURVIVING SPOUSE AND DEPENDENT CHILDREN

If you should die while covered under this plan, your Eligible Dependents, if any, will be entitled to continue coverage, subject to the following rules:

1. Your Eligible Dependents must make monthly payments to the plan, if required; and

2. Coverage will cease on the earliest of the following to occur:
   
   (a) The end of the month in which you would have attained age 65;
   
   (b) The date on which your Eligible Dependent becomes eligible to enroll under Medicare or eligible for benefits from, or eligible to enroll under, any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work; or
   
   (c) With respect to coverage for your entire surviving family unit, the date on which your surviving spouse, if any, remarries.

DEFERRAL OF COVERAGE

If, on the date you meet the Initial Eligibility requirements, your spouse is eligible for and covered under an employer-sponsored group health plan, coverage under this plan may be deferred as follows:

1. This coverage may be deferred for your spouse only, or for you and your spouse, provided you are covered under the other plan;
2. You must make application to this plan when first eligible to do so and must provide all of the information required of other Eligible Members, along with a written request to defer coverage under this plan and information regarding the source and nature of the other coverage;

3. Eligibility for benefits under this plan, along with any requirements for payment for this coverage, will be deferred until the date on which you or your spouse cease to be eligible for, or otherwise terminate, the other coverage;

4. Upon termination of the other coverage, you will be required to furnish evidence of the termination, and your spouse, or you and your spouse, as applicable, must begin participation under this plan immediately upon the termination of the other coverage; and

5. Coverage under this plan may be deferred only once for each Covered Person.

ELIGIBILITY FOR NEWLY ACQUIRED DEPENDENTS

Dependents acquired you after your initial participation can become covered for benefits under the Fund upon your making application to the Fund office, subject to the following requirements:

1. Your dependents must otherwise qualify as Eligible Dependents;

2. Your dependents will be subject to all of the other provisions outlined in this section pertaining to qualification of an Eligible Dependent to obtain and continue coverage for benefits;

3. You must pay any applicable monthly self-contributions; and

4. Your Eligible Dependent(s) must be enrolled –

   (a) Within 30 days following the “life event” (that is, marriage, birth or adoption) causing the dependent to become eligible to be covered, or, if later

   (b) On any subsequent January 1, provided you make advance application.

REENROLLMENT OF TERMINATED DEPENDENTS

If your Eligible Dependent’s coverage is voluntarily terminated for any reason other than those outlined under the “Termination of Eligibility” section, coverage for your dependent may be reinstated only in accordance with the following provisions:
1. If your Eligible Dependent was eligible for benefits under an employer sponsored group health plan as of the date of termination under this plan, your Eligible Dependent may be reenrolled upon termination of that other coverage, provided application is submitted to the Fund office within 30 days following the termination of the other coverage and further provided this coverage is effective as of the first day of the month following the termination of the other coverage. Written proof of the effective date and termination date of the employer-sponsored coverage will be required in order to reinstate coverage under this plan.

or

2. If your Eligible Dependent does not qualify under 1. above, coverage may only be reinstated following a minimum period of 24 consecutive months during which your dependent was not covered under this plan. Coverage will not be reinstated retroactive to any date prior to receipt of a completed application.

**REINSTATEMENT OF TERMINATED MEMBERS**

If your coverage has been terminated for failure to make the required monthly payments (when in effect), or failure to make your payments on a timely basis, whether voluntary or involuntary, you may apply to the Trustees for reinstatement of coverage for yourself and your dependents. The Trustees will review your request and will grant reinstatement subject to the following conditions:

1. You must not have previously had coverage reinstated under this provision;

2. You must make arrangements to have any monthly payments paid by automatic bank draft;

3. Coverage will be reinstated prospectively only, effective as of the January 1\textsuperscript{st} next following the Trustees’ review and approval;

4. Your coverage will be terminated as of the date any payment due is not made timely; and

5. Coverage may be reinstated under this provision one time only.
RULES OF ELIGIBILITY FOR ELIGIBLE SURVIVING SPOUSES OF MEMBERS WHO ARE FATALLY INJURED WHILE ON DUTY

INITIAL ELIGIBILITY

If you are a member in good standing of a sponsoring federation and you suffer a fatal injury while on duty, your surviving spouse and Eligible Dependent children, if any, will become Covered Persons eligible for benefits under the plan on the date that all of the following requirements have been satisfied, except that no surviving spouse or child of a member of the Allied Federation who was a former member of the Missouri Pacific Federation or the Southern Pacific Atlantic Federation will be eligible to participate:

1. You must have been determined to have suffered an on duty fatal injury on or after January 1, 2013, as determined by the Federal Railroad Administration;

2. You must have been credited with a minimum of 12 compensated service months in employment coming under the jurisdiction of the Brotherhood of Maintenance of Way Employes Division of the International Brotherhood of Teamsters with those 12 months of service having been earned within the 24 consecutive month period ending on the date you suffered the fatal injury;

3. You must have last performed compensated service as follows:
   (a) For members of the Allied Federation (except as noted in (3) below) or the Southern Systems Division Federation, on or after January 1, 2004,
   (b) For members of the Consolidated Rail System Federation who were formerly members of the Nickel Plate-Wheeling & Lake Erie Federation, and in whose behalf contributions were remitted to the fund, on or after April 1, 2005, or
   (c) For members of the Allied Federation who were formerly members of the Seaboard System Federation, on or after April 1, 2013; and

4. Your spouse or child must make application for the coverage.

Your Eligible Dependent children will become covered:

1. On the same date as your surviving spouse, or

2. If born posthumously to you, on the date of birth,

except that no individual who:
1. Is eligible to enroll under Medicare;

2. Is eligible for and enrolled in any employer-sponsored group health coverage; or

3. Is eligible, free of charge, for any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work;

will be eligible to enroll.

Each Covered Person who satisfies these eligibility requirements must generally make timely application. However, should a late application be approved by the Trustees upon appeal, based upon the facts and circumstances surrounding the late application and subject to standards of review applied uniformly to all applicants, the applicant will be allowed to participate under the Fund on a prospective basis only, with coverage to be effective the first day of the month following the month in which the completed application was received.

**CONTINUING ELIGIBILITY**

Once your surviving spouse and/or Eligible Dependent child qualifies as a Covered Person, he or she will continue to be eligible for benefits in each calendar month for which the following requirements are satisfied:

1. Your surviving spouse and/or Eligible Dependent child makes any appropriate monthly payments to the Fund as determined by the Trustees from time to time;

2. Your surviving spouse/Eligible Dependent child:
   
   (a) Is not eligible to enroll under Medicare,

   (b) Is not eligible for and enrolled in any employer-sponsored group health coverage, and

   (c) Is not eligible, without charge, for any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad connected work; and

3. With regard to coverage for your surviving spouse only, he or she is not remarried.
TERMINATION OF ELIGIBILITY

Coverage for your surviving spouse and Eligible Dependent children will terminate upon the first of the following to occur:

1. Regarding coverage for your surviving spouse only, the date on which he or she remarries;

2. The date on which the Covered Person fails to make any required payment for the coverage; or

3. The date on which the Covered Person:
   
   (a) Becomes eligible to enroll under Medicare;

   (b) Becomes eligible for and enrolled in any employer-sponsored group health coverage; or

   (c) Becomes eligible, without charge, for any group health plan sponsored by any railroad, railroad association or any union with jurisdiction over any railroad-connected work.

DEFERRAL OF COVERAGE

If, on the date on which your surviving spouse meets the initial eligibility requirements outlined above, he or she is eligible for and covered under an employer-sponsored group health plan, coverage under this Plan may be deferred as follows:

1. This coverage may be deferred for your spouse only or for your spouse and Eligible Dependent children provided your spouse is covered under the other plan;

2. Your surviving spouse must make application to this Plan when first eligible to do so and must provide all of the information required of other surviving spouses, along with a written request to defer coverage under this Plan and information regarding the source and nature of the other coverage;

3. Eligibility for benefits under this Plan, along with any requirements for payment for coverage, will be deferred until the date on which your surviving spouse ceases to be eligible for, or otherwise terminates, the other coverage;

4. Upon termination of the other coverage, your surviving spouse will be required to furnish evidence of termination, and your spouse must begin participation under this Plan immediately upon the termination of the other coverage; and

5. Coverage may be deferred only once for each surviving spouse.
MEDICAL BENEFITS

Medical Benefits become payable if a Covered Person incurs Covered Medical Expenses in excess of the Deductible Amount.

The Deductible Amount, Covered Medical Expenses, the amount payable - called the Benefit Percentage - and the maximum amounts are described on the following pages and shown in the Schedule of Benefits.

The Deductible Amount, Benefit Percentages and the Maximum Benefit are applied separately for each Covered Person. The deductible and charges in excess of the Benefit Percentage paid by the plan are your responsibility.

DEDUCTIBLE AMOUNT

The Deductible Amount is the amount to be paid by you for services or supplies for treatment of a covered condition. The Deductible Amount is shown in the Schedule of Benefits. Only Covered Medical Expenses may be used to meet the deductible.

BENEFIT PERCENTAGE

Once the deductible has been satisfied, the Plan will pay the percentage specified in the Schedule of Benefits of the Covered Medical Expenses incurred during the rest of that calendar year.

USE OF PREFERRED PROVIDER ORGANIZATION

The Fund uses the CIGNA HealthCare Preferred Provider Organization (PPO) to offer health care services to plan participants at discounted prices. The PPO consists of Physicians, Hospitals and other facilities providing health care services.

MAXIMUM LIFETIME BENEFIT

The Maximum Lifetime Benefit is listed in the Schedule of Benefits. This maximum applies individually to each Covered Person.

RESTORATION OF MAXIMUM AMOUNT

On January 1 of each year, if you have used Medical Benefits, you will have your remaining individual overall Maximum Lifetime Benefit increased. The amount of the increase will be:

1. The amount to restore your full maximum, if less than $1,000.00; or
2. $1,000.00, if more than $1,000.00 is required to restore the full maximum.

This Restoration of the Maximum Lifetime Benefit provision cannot increase the maximum above the overall maximum amount set forth in the Schedule of Benefits.

This provision means that if you have exhausted your complete overall Maximum Lifetime Benefit and continue to incur expenses, you will receive up to $1,000.00 in benefits in each calendar year in which you are eligible for benefits.

**COVERED MEDICAL EXPENSES**

Covered charges are limited to Covered Medical Expenses, as defined in this booklet, incurred by a Covered Person for the services and supplies listed below which are required in connection with the Covered Person's treatment. The service or supply must be furnished on the recommendation and approval of the attending Physician.

Covered Medical Expenses are those charges listed below:

1. Charges made by a Hospital for:

   (a) Room and Board up to the semi-private room rate. If a private room is utilized, the maximum Covered Medical Expense for room and board will be the average semi-private room rate for that Hospital or, if the Hospital has only private rooms, a similar average for Hospitals within the same geographical area. Room and Board charges in excess of this daily limit will not be considered a Covered Medical Expense.

   (b) Other Hospital Services and Supplies. This means the actual charges made by a Hospital in its own behalf for services and supplies rendered to you and required for your treatment.

   The term “Other Hospital Services and Supplies” does not include Hospital charges for room and board, or the professional services of a Physician or the services of a private duty nurse or any special nursing service.

2. Charges made by a Physician for his services. A Physician's services may be rendered in or out of a Hospital and will include surgical procedures as well as medical care and treatment.

3. Only the following charges for dental care or treatment:

   (a) Charges incurred for treatment of an Accidental Bodily Injury to sound natural teeth; and
(b) Charges for Hospital expenses incurred while you are Hospital confined for dental care and treatment.

4. Charges for nursing care by a trained nurse when a Physician certifies in writing that the nursing care is Medically Necessary. This nursing service must be rendered by a nurse who is not a relative by blood or marriage and who does not ordinarily live in your home.

5. Charges for emergency transportation service by professional ambulance, other than air ambulance. This is limited to the first trip to and from a Hospital for any one sickness and for all injuries sustained in any one accident.

The transportation must be within the continental limits of the United States or Canada or within the geographical boundaries of Puerto Rico or the State of Hawaii.

Service must be by professional ambulance other than by air ambulance.

In the event your disability requires specialized treatment, transportation for that treatment is covered. The transportation must be by regularly scheduled airline or railroad or by air ambulance. The covered transportation is only from the city or town where the disability occurred to the nearest Hospital qualified to render the special treatment. This Covered Medical Expense will cover only the first trip to and from the Hospital for any one sickness and for all injuries resulting from any one accident. This provision only provides for a trip from the place of disability to the nearest Hospital qualified to give special treatment which may or may not be the Hospital where you desire to be treated.

6. Charges for X-ray examinations and laboratory examinations.

7. Charges for X-ray, radon, radium and radioactive isotope treatments.

8. Charges made for an anesthetic and the administration of the anesthetic.

9. Charges for the following medical supplies:

   (a) Bandages and surgical dressings administered by or under the oversight of a Physician; and

   (b) Medical supplies required during recovery from surgery, including appliances to replace lost physical organs or parts. Only the initial charge for any such appliances will be considered a Covered Medical Expense.
10. Charges for the purchase, or rental up to the purchase price, whichever is more cost effective, of the following Durable Medical Equipment when required in the direct treatment of an illness or Accidental Bodily Injury or to aid in your recuperation from an illness, Accidental Bodily Injury or covered surgical procedure:

(a) Iron lungs or ventilation equipment of similar function and purpose;
(b) Manually operated hospital beds;
(c) Non-motorized wheelchairs;
(d) Crutches and walkers;
(e) Equipment used for the administration of oxygen (to include purchase of oxygen);
(f) Blood glucose monitors (to include purchase of necessary supplies);
(g) Nebulizers; and
(h) Traction equipment.


12. Charges incurred for services and supplies rendered in connection with human tissue and/or whole organ transplant procedures, subject to the following:

(a) Eligible transplants include only those which are approved by the American Medical Association as not being Experimental or Investigative.

(b) The reasonable costs of securing an organ from a donor, cadaver or tissue bank, including the surgeon's charge for removal of the organ and the hospital's charge for storage or transportation of the organ, will be considered a Covered Medical Expense.

(c) Eligible expenses incurred in connection with the transplant will be charged to the lifetime maximum of the recipient.

(d) If the donor is not covered under this Plan, expenses incurred by the donor will be considered only to the extent that such expenses are not payable by the donor's plan.
13. Charges made by a Physician, Hospital or other covered provider of services for routine care of an Eligible Dependent newborn during the Hospital confinement immediately following birth, including circumcision of a newborn male infant, up to a maximum period of 48 hours following a normal delivery or 96 hours following a caesarean section.

14. Charges made for the following services and supplies when rendered in connection with reconstructive breast surgery following a mastectomy:

(a) Reconstruction of the breast on which the mastectomy was performed;

(b) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(c) Coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas;

In a manner determined in consultation with the attending Physician and patient.

15. Charges incurred in connection with the diagnosis or treatment of sleep apnea and all other sleep disorders combined, subject to the limitation outlined in the Schedule of Benefits. Covered charges will include, in addition to the other types of expenses outlined in this section, sleep studies and the purchase, or rental up to the purchase price, of a continuous positive airway pressure (CPAP) machine.

16. Charges incurred for Hospice Care, subject to the limitations outlined in the Schedule of Benefits.

17. Charges made by a Skilled Nursing Facility, subject to the limitation outlined in the Schedule of Benefits. Separate confinements for the same cause(s) will be considered one confinement unless separated by a period of 14 or more days. Covered charges will be limited to the facility’s daily charge for a semi-private room.

18. Charges for Home Health Care, subject to the limitation outlined in the Schedule of Benefits.

19. Charges made by an Ambulatory Surgical Center.

20. Charges made by a Birthing Center.

21. Charges made by a licensed physical therapist, subject to the following:

(a) The therapy must be ordered and monitored by a Physician;
(b) The therapy must be administered in accordance with a written treatment plan approved by a Physician; and

(c) The therapist must submit regular, written progress reports to the Physician.

22. Charges made by a speech-language professional, subject to approval by the Trustees. Therapy must be rendered due to speech loss or impairment caused by:

(a) Removal of vocal cords;

(b) Cerebral thrombosis or other cerebral vascular incident; or

(c) Brain damage due to Accidental Bodily Injury or organic brain lesion.

23. Charges for drugs which may only be purchased with a written prescription of a Physician, to include insulin and related supplies.

EXPENSES NOT COVERED

1. No payment will be made for any charges that have been incurred as the result of a disease, illness or Accidental Bodily Injury for which benefits are payable under any Workers’ Compensation Act or any Occupational Disease Act, or any such similar law.

2. No payment will be made for any charges that are incurred while you are confined in any Hospital that is operated by the United States Government or any agency of the United States Government except as may be required by applicable federal laws or regulations.

3. No payment will be made for any charges which are incurred by an individual which you are not legally required to pay.

4. No payment will be made for any charges incurred for education, training or room and board while you are confined in an institution which is primarily a school or institution of learning or training.

5. No payment will be made for any charges incurred while you are confined in an institution which is primarily a place of rest, a place for the aged or a nursing home.

6. No payment will be made for any charges incurred for any type of Custodial Care.
7. No payment will be made for any charge incurred for any type of physical examination, employment physical examination, or school physical examination. This exclusion also applies to Pap Smears, cancer prevention examinations and Cancer Detection Center examinations, tuberculosis examinations, sickle cell anemia examinations and all such routine examinations and tests which are not rendered to diagnose an actual illness or Accidental Bodily Injury.

8. No payment will be made for charges for any services or treatments which are preventive in nature. This exclusion applies to items such as flu shots and other inoculations and treatments which you may receive as a result of being exposed to a particular disease or to prevent the contraction of any disease.

9. No payment will be made for any charges incurred for any treatment or surgical procedure or service performed that is of an elective nature except as specifically outlined. This exclusion applies to such items as cosmetic surgery and breast implants or reduction procedures. This exclusion does not apply to cosmetic surgery that is the result of an Accidental Bodily Injury. This also does not apply to the correction of congenital defects or to corrective surgical procedures for conditions which prevent an organ of the body from performing and functioning properly or to vasectomies or sterilization procedures performed on Eligible Members or their covered spouses. Reversals of vasectomies or sterilization procedures are not covered, however.

10. No payment will be made for any charges which are incurred for services, treatment or surgical procedures rendered in connection with any overweight condition or condition of obesity.

11. No payment will be made for any charges for any services or supplies which are not recommended and approved by an attending Physician.

12. No payment will be made for any charges for services or supplies received from a Physician or Hospital that does not meet the definition of a Physician or a Hospital as outlined in this booklet.

13. No payment will be made for any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection with, a specific illness or Accidental Bodily Injury or other condition which is specifically covered.

14. No payment will be made for charges incurred as a result of a pregnancy or pregnancy-related condition of any individual other than an Eligible Member or the spouse of an Eligible Member.

15. No payment will be made for charges incurred as a result of treatment or consultation with a psychologist, social worker or marriage counselor.
16. No payment will be made for any charges incurred as part of psychiatric treatment of a Covered Person that involves consultations and sessions with other family members.

17. No payment will be made for any physical therapy or speech therapy if either the prognosis or history of the individual receiving the treatment or therapy does not indicate to the Trustees a reasonable chance of improvement.

18. No payment will be made for any charges for any special education rendered to any individual. This exclusion applies regardless of the type of education, the purpose of the education, the recommendation of the attending Physician or the qualifications of the individuals rendering this special education.

19. No payment will be made for any charge made by a Physician or other provider of medical service for completing claim forms required by the Fund for the processing of claims.

20. No payment will be made for any charges incurred in connection with abortion procedures or pregnancy related conditions resulting in abortion unless such procedures are therapeutic in nature and are Medically Necessary to protect the life of the mother; however, in the event of medical complications arising from elective abortion procedures, charges resulting from treatment of such complications will be payable.

21. No payment will be made for any service or procedure which is Experimental or Investigative.

22. No payment will be made for any charges incurred for, or in connection with, the introduction into, or attachment to, the body of an artificial organ.

23. No payment will be made for any charges incurred for, or in connection with, the removal of an organ or portion of an organ for donor purposes, except as specifically outlined under Covered Medical Expense item 12.

24. No payment will be made for any expenses incurred for surgical sex transformation.

25. No payment will be made for any expenses incurred for in-vitro fertilization, embryo transfer or in-vivo fertilization.

26. No payment will be made for any expenses incurred for acupuncture, whether or not administered by a medical doctor.
27. No payment will be made for any expenses incurred for an external breast prosthesis or bra, except as specifically provided under Covered Medical Expenses item 14.

28. No payment will be made for any expenses incurred for in-patient care and services rendered solely for observation or diagnostic testing or any expenses incurred for care and services, whether in-patient or out-patient, rendered solely as preventive measures.

29. No payment will be made for any expenses incurred for the purchase of prosthetic appliances which are not determined to be necessary for the alleviation or correction of conditions arising out of Accidental Bodily Injury or sickness or birth defects.

30. No payment will be made for any expenses incurred in connection with the treatment of premenstrual syndrome (PMS).

31. No payment will be made for any expenses incurred for services or supplies related to sexual dysfunctions or inadequacies.

32. No payment will be made for any expenses incurred for any care and treatment of the teeth and gums except as expressly set forth under Covered Medical Expenses item 3.

33. No payment will be made for any expenses incurred for eye refraction, eyeglasses, audiological examinations, hearing aids, dental prosthetic appliances, any charges made for the fitting of any such appliances, or any charges incurred for the performance of, or in connection with, a keratotomy. However, if any of these services or items are required as the result of an Accidental Bodily Injury to a physical organ, this exception will not apply.

34. No payment will be made for any expenses incurred on account of any injury or sickness that happened as the result of war, or any act of war, whether or not war is declared. This exclusion also applies to any act of international armed conflict or any conflict involving the armed forces of any international body.

35. No payment will be made for any expenses incurred for any service or treatment that is determined to exceed the Usual, Customary and Reasonable Expense.

36. No payment will be made for any expenses incurred for any services or treatments which are not recommended and approved by your attending Physician.
37. No payment will be made for any expenses incurred in connection with the removal, or the removal and replacement, of a breast implant, regardless of the medical necessity of the original emplacement, except as expressly set forth under Covered Medical Expense item 14.

38. No payment will be made for chelation therapy.

39. No payment will be made for any charges relating to the purchase or implantation of cochlear implants.

40. No payment will be made for any charges made for, or in connection with, the treatment of alcoholism, drug addiction or any form of substance abuse.

41. No payment will be made for any charges incurred for any of the following drugs, devices, supplies or supplements:

   (a) Contraceptives or contraceptive devices unless Medically Necessary for non-contraceptive uses;

   (b) Drugs considered Experimental or Investigative;

   (c) Drugs for infertility treatment or erectile dysfunction;

   (d) Smoking cessation drugs or devices;

   (e) Drugs prescribed for cosmetic purposes;

   (f) Nutritional supplements or vitamins, except for pre-natal vitamins prescribed for an Eligible Member or an Eligible Dependent spouse;

   (g) Injectibles, other than insulin; and

   (h) Dietary supplements.

In determining the satisfaction of any applicable plan deductible and the payment of benefits, a charge for any service or treatment will be considered to have been incurred on the date that the service or treatment was rendered.
APPEAL PROCEDURES

If your claim for benefits is denied under the terms of the plan, you are entitled to certain rights, including the right to receive a full explanation of the denial and an opportunity to appeal the denial. The following procedures have been adopted by the Board of Trustees explaining those rights.

NOTICE OF ADVERSE BENEFIT DETERMINATION (Notice of Denial)

Upon determination that a claim submitted by you or your dependent is not covered under the plan, you will be notified in writing within the time frame outlined in the Claim Procedures section of this booklet regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by you, all of the following information.

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the determination is based;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;
5. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, practice or procedure will be provided free of charge to you upon request;
6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation that you will be provided free of charge upon request an explanation of the scientific or clinical judgment applied to the terms of the plan with respect to the medical circumstances used in making the determination; and
7. If the claim involves urgent care, a description of the expedited review process applicable to such claims. If an adverse benefit determination involves an urgent claim, the contents of this notice may be provided orally to you. However, in such instances this written notification will be furnished to you no later than three days after the oral notification.
YOUR RIGHT TO APPEAL AN ADVERSE BENEFIT DETERMINATION

A claimant whose claim for benefits has been denied under the terms of the plan and to whom a notice of adverse benefit determination has been issued in accordance with the preceding section will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which you may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below. The procedures will:

1. Provide you at least 180 days following receipt of notification of an adverse benefit determination in which to appeal the determination;

2. Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of such individual;

3. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Trustees or their committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

5. Provide that the health care professional engaged for purposes of this appeal is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

6. Provide, in the case of a claim involving urgent care, for an expedited review process under which-

   (a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you; and
(b) All necessary information, including the plan’s benefit determination on review, will be transmitted between the plan and you by telephone, facsimile or other available similarly expeditious method.

NOTICE OF TRUSTEES’ DECISION

The Board of Trustees, or their committee, will review all appeals in accordance with the following and will notify you as indicated:

1. **Urgent Care Claims** - When the appeal of a claim involving urgent care, as that term is defined on page 4 of this booklet, is received as provided by the Plan, a decision on the appeal will be made and will be communicated in writing (and otherwise as appropriate) within 72 hours of receipt of your request for review of an adverse benefit determination. Appeals of adverse benefit determinations involving urgent care will be addressed promptly by the Trustees, or their committee, taking into account the urgent nature of the claim, but in no instance will the decision be made later than 72 hours after receipt of your request.

2. **Non-Urgent Care Claims** - Appeals of adverse benefit determinations which are of a non-urgent care nature will be reviewed by the Trustees, or the committee, in accordance with the following guidelines, and notification of the decision will be communicated in writing to you within the time period prescribed:

   (a) **Pre-Service Claims** - If the appeal involves a request for review of an adverse benefit determination for medical services which have not yet been provided, the Trustees or the committee will make a decision on the appeal and the decision will be communicated in writing not later than 30 days after receipt of your request for review.

   (b) **Post-Service Claims** - If your request for review of an adverse benefit determination involves a claim for medical services which have already been provided, a decision on your appeal will be made by the Trustees or their committee and communicated in writing to you within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee which immediately follows the Plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of the meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the plan’s receipt of the request for review, but in no instance more than 120 days following receipt of the appeal.

3. Regardless of the statements set forth above, notice of every appeals determination will be given within 5 days of the determination.
ACCESS TO PLAN DOCUMENTS

At any time during the course of these appeal proceedings you will be granted access to, and copies of, documents, records and other information relied upon by the Trustees or the committee in making their decision, as requested by you.

NOTIFICATION OF DECISION ON APPEAL

Each claimant whose adverse benefit determination has been appealed to the Trustees will receive notification in writing, within the time period outlined above, of the Trustees’ or the committee’s decision. Such notification will set forth, in a manner calculated to be understood by you:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan provisions on which the benefit determination is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;

4. A statement describing any additional voluntary appeal procedures offered by the plan and your right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of your right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and

5. The following information where applicable -

   (a) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to you upon request;

   (b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination, applying the terms of the plan to the medical circumstances, will be provided free of charge to you upon request; and

   (c) A statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what
may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency. While the plan does not currently offer voluntary alternative dispute resolution options to the procedures set forth above, you may contact the local U.S. Department of Labor Office and your State Insurance Regulatory Agency to determine what options might be available to the plan.

**COMPLIANCE WITH APPEAL PROCEDURES**

1. You may, at your own expense, have legal representation at any stage of these Appeal Procedures.

2. Every effort will be made by the Trustees to interpret plan provisions in a consistent and equitable manner, and you will be given maximum opportunity to present your viewpoints regarding any claim for benefits.

3. Every Covered Person will be required to exhaust each and every step of these Appeal Procedures before he proceeds to litigation, and any attempt to circumvent these Appeal Procedures in any manner will be resisted by the Trustees.
COORDINATION OF BENEFITS

The objective of a Coordination of Benefits provision is to limit the reimbursement from this plan and any other plan providing benefits to 100% of Allowable Expenses.

Benefits are coordinated with other group health, dental or vision plans including the following coverages:

1. Group, blanket or franchise insurance coverage;

2. Blue Cross Blue Shield, group practice, individual practice and other prepayment coverage;

3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; and

4. Any coverage under governmental programs and any coverage required or provided by any statute.

ALLOWABLE EXPENSES

Benefits are paid under this Coordination of Benefits provision only for Allowable Expenses. In addition to expenses covered under this plan, Allowable Expenses include any usual, customary and reasonable expense that is covered under another plan. This does not imply that this Fund would normally pay benefits for those expenses. It means that when expenses are calculated to determine the Coordination of Benefits payment, any charge that is covered under another plan but is not covered under this plan, will, for this purpose only, be considered an Allowable Expense.

CLAIM DETERMINATION PERIOD

The Coordination of Benefits provision is administered on a calendar year basis. This calendar year basis for administration of this provision is sometimes referred to as the Claim Determination Period. Any benefit savings resulting from this Coordination of Benefits provision in any calendar year will be held in a benefit account for that individual for that calendar year. Funds will be released from the benefit credit during that calendar year, if necessary, to give reimbursement of 100% of Allowable Expenses.

ORDER OF BENEFIT DETERMINATION

When two or more plans pay benefits, the rules for determining the order of payment are as follows:
1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

2. A plan that does not contain a coordination of benefits provision is always primary.

3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

4. The first of the following rules that describes which plan pays its benefits before another plan will be used:

   (a) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary.

   (b) Child Covered Under More Than One Plan. The order of benefit payments when a child is covered by more than one plan is:

      (1) The primary plan is the plan of the parent whose birthday is earlier in the year if:

      • The parents are married;
      • The parents are not separated (whether or not they ever have been married); or
      • A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.

      (2) If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

      (3) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefit payments is:

      • The plan of the custodial parent;
      • The plan of the spouse of the custodial parent;
• The plan of the noncustodial parent; and then
• The plan of the spouse of the noncustodial parent.

(c) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under (a) above.

(d) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law (such as COBRA coverage) also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(e) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, subscriber or retiree longer is primary.

(f) If the preceding rules do not determine the primary plan, the Allowable Expenses will be shared equally between the plans meeting the definition of plan under this section. In addition, this plan will not pay more than it would have paid had it been primary.

When this provision operates to reduce the total amount of benefits otherwise payable for a Covered Person, each benefit that would be payable in the absence of this provision will be reduced proportionately and the reduced amount will be charged against any applicable benefit limit of this plan.

HEALTH MAINTENANCE ORGANIZATION

If a Covered Person, while covered under this plan, is also covered under an HMO (Health Maintenance Organization) and receives treatment through an HMO provider, no benefits will be payable for such treatment under this plan.

For treatment received outside of the HMO setting for which the Covered Person is expected to pay, benefits will be paid up to the limitations of this plan.
STATE MEDICAL ASSISTANCE PROGRAM (MEDICAID)

This plan will not limit or exclude the benefits payable due to a person being covered by a State Medical Assistance Program (Medicaid).

Benefits will be paid to the state or state agency and will be paid up to the cost of medical expenses paid by the state through medical assistance. Benefits paid to the state will not be more than the benefits to which the Covered Person is entitled under this plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of implementing the terms of this provision of this plan or any provision of similar purpose of any other plan, this plan may, without the consent of or notice to any other person, release to or obtain from any insurance company or other organization or person, any information, with respect to any person, which the Fund considers necessary for those purposes. Any person claiming benefits under this plan will be required to furnish to the Fund any information as may be necessary to implement this provision.

RIGHT OF RECOVERY

If excess payments have been made by the Fund with respect to Allowable Expenses, the Fund has the right to recover such excess payments, from among one or more of the following, as the Fund may determine: any persons to or for or with respect to whom the payments were made, any insurance companies, any other organization or any further claims made to this Fund by the Covered Person.

GENERAL

Under this Coordination of Benefits Provision it is necessary that claim be made for any benefits the individual may be entitled to from any source. Whether or not claim is made to these other sources, this Coordination of Benefits Provision will be fully operable as if claim were made.
REIMBURSEMENT OF PAID CLAIMS

Situations sometimes arise where benefits are payable from the this Fund for medical or other expenses incurred by a participant or beneficiary (“Covered Person”), due to an injury, sickness or condition caused to the Covered Person, and the Covered Person has a right to receive full or partial payment of his or her damages caused by the injury from some other person or entity. Typical examples of such situations are where the Covered Person is injured in an automobile accident and another driver is responsible, or on the property of someone else and the property owner is liable. In such cases, the other person’s automobile, homeowner’s, or property insurance carrier may be liable and pay for all or part of the Covered Person’s injury, although claims for the medical expenses have been submitted and paid by this Fund. In these and other similar situations, the Covered Person may receive a double payment of medical bills or may have a right to recover the amounts paid by the Fund.

In accordance with the Employee Retirement Income Security Act (ERISA), a federal law which applies to this Fund, the Fund is required to take all steps which are reasonable and necessary to maintain the financial health of the Fund so that the Fund can continue to provide all benefits. Because of the increasing cost of medical care, the Fund has determined that it is in the best interest of the Fund and its participants and beneficiaries to adopt and incorporate provisions to enable the Fund to recover all sums it has paid to or on behalf of a Covered Person and for which another person or entity may pay damages to or for the Covered Person. Under these provisions, the Fund has the right to be reimbursed in full for all sums paid by the Fund to or on behalf of a Covered Person to the extent that the Covered Person has recovered and/or has a right to recover damages from another person or entity.

If a claim is filed with the Fund for benefits in connection with an injury, sickness or condition arising in such a situation, the Fund will still pay all benefits. However, these benefits will be paid only after the Covered Person has signed and returned to the Fund a written agreement, (the “Agreement”), giving the Fund full right of recovery against all persons or entities which may be liable to pay damages to the Covered Person, the right of recovery to be for the full amount of sums paid by the Fund. It is the purpose of these provisions and the Agreement to give the Fund a right of recovery, which includes a loan agreement, a right to reimbursement, a right to subrogation, and a first priority of recovery, all of which are described in the Agreement.

The Plan’s reimbursement provisions will be administered as follows:

If a claim is submitted in connection with an injury, sickness or condition arising in a situation where another person or entity may be required to pay damages to or for the Covered Person, the Covered Person must notify the Fund and provide the Fund with specific details and information regarding the situation. Any corrections as well as
additional information or documentation must be supplied to the Fund by the Covered Person on an ongoing basis.

In order to receive benefits from the Fund, the Eligible Member must complete, sign, and return the written Agreement, and the Agreement will give the Fund a full right of recovery against all persons or entities which may be liable for damages to the Covered Person and will obligate the Covered Person to repay the Fund a loan in the amount of sums paid by the Fund, and will give the Fund a right of reimbursement and subrogation. If a claim is made on behalf of a Covered Person who is married, the spouse must sign the Agreement. If a claim is made on behalf of a Covered Person who is a minor, the minor’s parent(s) and/or legal guardian must sign the Agreement on behalf of the minor.

Covered Persons shall do nothing that will prejudice the Fund’s right of recovery, and common law doctrines such as “make whole” and “common fund” or other similar doctrines will not be applied to reduce the Fund’s right of recovery, and any subrogation or reimbursement or loan payment by the Covered Person to the Fund shall be as to any amounts recoverable by the Covered Person, without regard to contributory or comparative fault of the Covered Person. Further, the Fund’s entitlement shall be applied against any recovery, except for loss of consortium, to which the Covered Person is entitled, including but not limited to damages for physical injury and impairment, future medical costs, past and future pain, suffering and mental anguish, and past and future lost earnings.

Most important: The Fund does not authorize deductions from a recovery for attorney fees unless the Trustees specifically approve a deduction; therefore, if the Covered Person retains an attorney to pursue a claim in connection with the Covered Person’s injuries, it is the Covered Person’s obligation to provide the attorney with a copy of the Agreement and to inform the attorney that fees may be taken only from the amount of money recovered in excess of the amount to which the Fund is entitled. Any agreement between the Covered Person and an attorney that reduces the amount recoverable by the Fund will be a violation of these provisions and of the Agreement unless the Trustees have specifically approved a deduction.

If a recovery is obtained by the Covered Person, the Fund’s entitlement shall be as to any such payment; and, the Fund’s entitlement shall also be applied to any amounts the Covered Person receives or is entitled to receive from any liable person or entity, any liability or other insurance payment on behalf of the liable person or entity, and any other insurance or medical payments from any source.

If a recovery is obtained by the Covered Person, either through settlement, administrative or judicial proceedings, the Fund is to be fully reimbursed, from the first dollars paid to or received by the Covered Person, for all sums paid by the Fund on behalf of the Covered Person as well as for those benefits that are reasonably
foreseeable. Any question about the apportionment of a damages award or settlement shall be resolved by the Trustees, who have complete discretion in establishing the reasonable portion of such award/settlement to which the Fund has a right of recovery, reimbursement, subrogation or loan repayment.

The Covered Person is expected to take whatever steps are reasonable and necessary to obtain a recovery from persons or entities which may be liable for the payment of the Covered Person’s damages. Such steps include the timely filing of a claim with the appropriate person, entities or insurance company. The Covered Person shall keep the Fund informed of any action taken, the progress of settlement negotiations, and of any recovery obtained.

The Covered Person is to take whatever steps they deem reasonable and necessary in their own name to obtain a recovery and is not to assume that the Fund or its representatives will take action on behalf of the Covered Person unless notified by the Fund that such action will be taken. However, the Fund reserves the right either to request the Covered Person to take a specific type of action or take action on behalf of the Covered Person if such action is deemed in the best interest of the Fund. In the event the Fund acts on behalf of a Covered Person, attorney fees and costs incurred by the Fund in obtaining a recovery will be deducted from the proceeds obtained.

While the Fund expects full reimbursement for all sums paid on behalf of a Covered Person, there may be occasional situations in which full reimbursement is not required, for example, where the relevant insurance policy is insufficient to reimburse the Fund for the full amount of its claim, or where other factors make full reimbursement impractical. In such situations, the Fund will expect reimbursement to the extent of the Covered Person’s recovery, except that the Covered Person may deduct, after requesting and receiving approval from the Trustees, any out-of-pocket expenses they may have incurred for medical expenses, actual and reasonably projected lost wages, or other amounts as may be approved by the Trustees. Any recovery shall be subject to the Fund’s reasonable apportionment authority with regard to the Fund’s right of recovery/reimbursement/subrogation, as well as the approval of any reduction by the Trustees. Any deductions for out-of-pocket medical expenses, lost wages or other factors must be fully documented.

The Fund expects full compliance with these reimbursement provisions and with the provisions of the Agreement. Therefore, the Fund reserves the right to withhold future medical benefits from a Covered Person and/or any person signing the Agreement along with the Covered Person where the Covered Person has obtained a recovery but has not reimbursed the Fund as required. Future benefits may be withheld in an amount equal to the amount previously owed the Fund until such time as the Fund’s claim for reimbursement has been completely paid.
The Agreement also requires a Covered Person to consent and agree that any and all litigation between the Covered Person and the Fund relating to the Agreement shall take place in the United States District Court for the Middle District of Tennessee or the Chancery Court of Davidson County, in Tennessee; and, at the option of the Fund, any litigation between the Covered Person and the Fund may be removed from the Chancery Court to the Federal Court.
IMPORTANT INFORMATION

CONSTRUCTION BY TRUSTEES

The Board of Trustees has the exclusive and maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person’s rights, to determine any questions arising in connection with the administration of the plan, including determining all questions of classification, subrogation, reimbursement, restitution, status and rights of Eligible Members and Eligible Dependents, and the amount, manner and time of benefit payments. The Board of Trustees may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as it deems necessary or advisable to carry out the purpose of this plan.

Any decision or action of the Board of Trustees in its administration of this plan as set out above will be conclusive and binding on all Covered Persons.

THE PLAN MAY BE CHANGED

The Trustees have the authority to change the Plan.

Although the Trustees expect to maintain and to improve benefits, this can only be done within the limits of available financial resources. The Trustees have an obligation to make whatever plan changes are necessary to assure the financial stability of the plan.

The Trustees also may change the plan in any way to protect its tax exempt status under Internal Revenue Service rules.

PAYMENT AND ASSIGNMENT OF BENEFITS

Benefits which are payable under this Plan and which have not been assigned to a provider of covered services will be paid to you, whether the claim is made on behalf of yourself or one of your dependents, unless benefits are being provided under a Qualified Medical Child Support Order, as that term is defined in the Omnibus Budget Reconciliation Act of 1993. In such case, benefits otherwise payable to you will generally be paid to the custodial parent or legal guardian of the dependent child on behalf of whom the benefits are provided.

You may assign benefits which are payable to you under this Plan, but only to a medical service provider. If benefits are provided under a Qualified Medical Child Support Order, benefits may also be assigned by the custodial parent or legal guardian of the
dependent child on behalf of whom the benefits are provided. Benefit assignments made in accordance with any state Medicaid law will also be honored by the Plan.

**NO CONVERSION PRIVILEGE**

No benefits provided by the Fund may be converted to individual coverage.

**TERMINATION OF PLAN**

The following information regarding the conditions under which the plan may be terminated, and the disposition of the assets of the plan on termination, are furnished in accordance with federal laws and regulations.

The plan will be terminated upon the termination of the Trust Agreement establishing the plan. The Trust Agreement will terminate upon the occurrence of any of the following events:

1. In the event the Trust Fund becomes inadequate to carry out the intent and purpose of the Trust Agreement or to meet the payments due or to become due under the Plan of Benefits;

2. In the event there are no individuals living who can qualify as Eligible Members or Eligible Dependents;

3. In the event of termination by action of the sponsoring federation; or

4. In the event of termination as otherwise may be provided by law.

Upon termination of the Trust, the Fund will continue to pay the benefits outlined in the plan, along with the other plan expenses, until the assets of the Fund are completely exhausted.

**STATEMENT OF RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

**IMPORTANT NOTICE REGARDING THE WOMEN’S HEALTH AND CANCER RIGHTS ACT**

Under federal law, group health plans and insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. As part of the plan’s Schedule of Benefits, such benefits are subject to the plan’s appropriate cost control provisions such as deductibles and payment percentages.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

The Fund will honor the provisions of a Qualified Medical Child Support Order. The Fund office has established procedures for determining whether such an order meets all of the legal requirements. A copy of these procedures will be furnished to you, without charge, upon written request filed with the Fund office.

**PROTECTED HEALTH INFORMATION**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established rules for handling and disclosing confidential health information (called protected health information or “PHI”). PHI is any information relating to your health, the provision of health care to you, payment of your health claims and your eligibility for health claims.

The BMWE Health and Welfare Plan for Occupationally Disabled Members is bound by HIPAA to protect your PHI, and that of your dependents, by treating all such information as confidential. While this will generally prove beneficial to you, it may sometimes inconvenience you when calling or corresponding with the Fund office to check on or discuss the health claims of other family members. Federal law will not allow us to disclose PHI on other adult family members, such as your husband or wife,
without their written permission. Generally, parents will have access to the PHI of their minor children.

Authorization forms are available in the Fund office that are designed to allow you or your spouse to designate another individual or individuals, such as each other, to have access to your PHI. The information required for this authorization is very specific, and no forms other than the one furnished by the Fund office will be honored.

Remember, the Fund office is bound by federal law to restrict access to your PHI. If you want to allow access by another person, you **must** complete an approved authorization form.
RIGHTS OF PLAN PARTICIPANTS

As a participant in this Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

WAIVER OF PREEXISTING CONDITIONS EXCLUSIONS

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. This Plan currently has no preexisting condition exclusion.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may request the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The courts will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the courts may order you to pay theses costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you should need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
INFORMATION OF INTEREST AS REQUIRED BY THE EMPLOYEE RETIREMENT
INCOME SECURITY ACT (ERISA)

You most likely have heard about ERISA. ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

ERISA requires that plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits, and the procedure to follow when filing a claim for benefits. This information is presented to you in this booklet.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the plan and about their rights under the plan. This information follows:

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR AS DEFINED BY ERISA

This plan is maintained and administered by a Board of Trustees. A list of all the Trustees as of the date this booklet was prepared is contained in the front of this booklet.

This Board has the primary responsibility for decisions regarding eligibility rules, type of benefits, administrative policies, management of plan assets and interpretation of plan provisions.

Any communication with the Board of Trustees should be addressed to the Fund office at:

BMWE HEALTH AND WELFARE PLAN
FOR OCCUPATIONALLY DISABLED MEMBERS
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

TYPE OF ADMINISTRATION

Although the Trustees are legally designated as the Plan Administrator, they have delegated the performance of the day-to-day administrative duties to a professional Administrative Manager, Southern Benefit Administrators, Incorporated.

The Fund office staff maintains the eligibility records, accounts for employer contributions, processes claims, informs participants of plan changes and performs other routine administrative functions in accordance with Trustee decisions.
PLAN SPONSORS

The plan is maintained by certain participating federations of the Brotherhood of Maintenance of Way Employes Division of the International Brotherhood of Teamsters. A list of the sponsoring federations, and their addresses, is found in the front of this booklet.

SOURCE OF FINANCING

The primary source of financing for the benefits provided under the plan is contributions from the sponsoring federations. Additional income comes from monthly contributions by covered Eligible Members and/or their covered spouses.

AGENT FOR SERVICE OF LEGAL PROCESS

Every effort will be made by the Trustees of this plan to resolve any disagreements with participants promptly and equitably. It is recognized, however, that on occasion, some participants may feel that it is necessary for them to take legal action. Be advised that the following has been designated as Agent for service of legal process:

Board of Trustees
BMWE Health and Welfare Plan
For Occupationally Disabled Members
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

Or legal papers may be served on the Trustees individually as well as the Fund office manager.

PLAN IDENTIFICATION NUMBERS

When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to properly identify the Fund including:

Employer Identification Number (EIN)
Assigned by the Internal Revenue Service............................................. 41-2122976
Plan Number......................................................................................................... 501

FISCAL YEAR

The accounting records for this plan are kept on the basis of a fiscal year which ends December 31.