M I L A

NATIONAL

CHOICE

PLAN

MILA NATIONAL CHOICE PLAN

PREAMBLE

THIS INSTRUMENT, made and published by Management — International Longshoremen's Association, AFL-CIO, Managed Health Care Trust Fund (hereinafter called "MILA-MHCTF" or "Plan Sponsor"), creates the MILA—National Choice Plan, a plan which includes medical benefits and prescription drug benefits, and as amended as of June 1, 2000.

Establishment of Plan. The Trustees of the MILA-MHCTF hereby establish the MILA National Choice Plan (the "Plan" or "Health Plan").

Effective Date. The Plan shall be effective in respect to the benefits provided under Article 5, Prescription Drug Benefits, as of October 1, 1999, and for all other plan benefits as of January 1, 2000, or on such later date with respect to all plan benefits as specified in an applicable employer participation agreement with respect to the Employees covered by such agreement.

ARTICLE 1

DEFINITIONS

Section 1.01. Allowable Expenses. The term "Allowable Expense" shall mean an expense or charge that the Trustees, in their sole discretion, determine:

a. is necessary for the care and treatment of a non-occupational accidental bodily injury or sickness of a person who is a covered individual at the time the expense is incurred;

b. is recommended and approved by a Physician and is for a valid course of medical treatment, which is not experimental as determined by Medicare, and which is expected to lead to the cure and/or rehabilitation of the patient, provided that the Plan may obtain and rely upon independent medical advice to determine whether services or supplies are necessary for such medical treatment, are consistent with professionally recognized standards of care with regard to quality, frequency and duration and are provided in the most economical and medically appropriate site for treatment;

c. is a Covered Charge as described in the applicable section below;

d. is a Reasonable Charge; and,

e. is not otherwise excluded or limited by provisions of the applicable section.

Section 1.02. Behavioral Health Manager. The term "Behavioral Health Manager" shall mean the organization retained by the Trustees to operate the member assistance program (MAP), to serve as utilization manager, to process claims and to maintain claim histories on covered individuals solely with respect to mental health and chemical dependency benefits.

Section 1.03. Claims Manager. The term "Claims Manager" shall mean the organization retained by the Trustees, to serve as utilization manager, to process medical claims and maintain claim histories for benefits other than mental health and chemical dependency benefits on covered individuals.

Section 1.04. Contract Year. The term "Contract Year" shall mean the period between October 1 of one calendar year and September 30 of the following calendar year.

Section 1.05. Co-pay or Co-payment. The terms "Co-Pay" or "Co-payment" shall mean the amount which must be paid directly by a covered individual for any medical service or supply.

Section 1.06. Creditable Coverage. The term "Creditable Coverage" means prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

Section 1.07. Dependent. The term "Dependent" means, as follows:

Section 1.07.01. Child. The term Child means all of the following: (1) a natural child; (2) a stepchild by legal marriage; (3) a child who has been legally adopted by the Employee or placed with the Employee for adoption by a court of competent jurisdiction; and (4) a child (including a foster child) for whom legal guardianship has been awarded, provided that to be eligible for coverage, the child must be primarily dependent on the Employee or Pensioner for maintenance or support, or be covered under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). A person will be considered a child of a Pensioner under this Plan (as described above) only if (1) that child was a covered person under this plan or a predecessor plan on the date the pensioner retired or (2) that child is a natural child of the pensioner born after the date the pensioner retired.

Section 1.07.02. Child Limiting Age. A child shall be eligible from birth to age 21. However, if the child is or becomes a full time student, as defined by the accredited college or university or other institution of higher learning in which the child is enrolled and the study is being conducted, then eligibility shall extend during such enrollment to age 23.

Section 1.07.03. Incapacitated Child Coverage. An unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent on the Employee for support and maintenance may continue to be covered under the Plan regardless

of age provided that the disability commenced before the child reached age 21. The child will remain eligible so long as the child remains dependent for federal income tax purposes and the disability persists. Written proof of the child's mental or physical disability may be requested from the Employee by MILA on an annual basis, and the MILA-MHCTF reserves the right to require at its expense an independent medical, psychiatric, or psychological valuation in connection with any annual review of the child's disabled status.

Section 1.07.04. Collateral Dependent(s). An Eligible Employee who had designated his parent or parents as his collateral dependents by December 31, 1999, under an existing local Port Health Plan shall have those persons considered a "Dependent" under this Health Plan after the date that he becomes covered under this Plan and for as long as such coverage would have been provided under the local Port Health Plan. However, such parent shall no longer qualify as a collateral dependent under this Plan:

a. on the date that the Eligible Employee has a Spouse or Child who falls within the definition of the term "Dependent" in this Plan Document; or

b. on the last day of the Calendar Year on which the Eligible Employee first fails to claim his Collateral Dependent(s) as dependent(s) on his Federal Income Tax Return or on which his claim for their dependency is disallowed by the Internal Revenue Service.

Section 1.07.05. Spouse. The term "Spouse" means a person who is wedded to an Eligible Employee or Pensioner pursuant to a marriage that is accepted as legal in the State of the Eligible Employee or Pensioner's domicile. The status of "Spouse" shall cease at the date of any interlocutory or final decree in a proceeding to dissolve or terminate the marriage and any benefit otherwise payable with respect to a spouse shall also thereupon cease.

Section 1.08. Disability. The term "Disability" shall mean such physical or mental condition as to make an Employee unable to perform his regular job function for which he had been receiving coverage under this Health Plan.

Section 1.09. Eligible Employee. The term "Eligible Employee" shall mean an Employee who meets the conditions of eligibility set forth in Article 2, herein, or who is otherwise approved for participation in the Plan by the Trustees.

Section 1.10. Employee. The term "Employee" shall mean an individual who is employed under the Master Contract between multi-employer associations stevedores, terminal operators and ocean carriers and the Union or any other collective bargaining agreement recognized by the Trustees under which an employee may qualify for benefits. The term also shall include Officers and Employees of the Union, Employees of local Port Benefit Plans, administrative employees of the MILA Managed Health Care Trust Fund, and individuals employed by other Employers subject to the following conditions:

a. an individual must be employed for a sufficient number of hours in employment covered under the provisions of a Collective Bargaining Agreement or Participation Agreements with the Union for whom the Employer is obligated to contribute to the MILA-MHCTF;

b. the term "Officers and Employees of the Union" shall mean officers and employees of the Union, as a party to the Agreement and Declaration of Trust, for whom the Union has agreed to make contributions to the MILA-MHCTF in such amounts as are determined by the Trustees;

c. the term "Administrative Employees" shall mean the regular employees of the MILA-MHCTF Office for whom contributions, as determined by the Trustees, are made; and

d. individuals employed by local Port Benefit Plans or Employer Associations which are participating in the Trust Fund may be considered "Employees" if there is a written obligation to contribute to the MILA-MHCTF which is acceptable to the Trustees.

Section 1.11. Employer. The term "Employer" shall mean various Employers of Employees working under the provisions of a Collective Bargaining Agreement with the Union which requires contributions be made to this Plan and Employers who have executed a Participation Agreement with the Union requiring that contributions be made on behalf of Employees, provided that any Participation Agreement must be accepted in writing by the Trustees. The term "Employer" shall

also be deemed to be the MILA Managed Health Care Trust Fund, a local participating Port Benefit Plan, or the Union and any other Employer from which the Trustees mutually agree that contributions may be accepted and which is not covered by a Collective Bargaining Agreement or Participation Agreement.

Section 1.12. ERISA. The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 1.13. Experimental and Investigational. The terms "Experimental and Investigational" mean services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical or dental community or government oversight agencies at the time services were rendered. The Trustees must make an independent evaluation of specific technologies to determine whether they are experimental. The Trustees shall be guided by a reasonable interpretation of plan provisions. Their decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Trustees will be final and binding on the plan. Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use. The Trustees will consider the following as indications that the drug, device or treatment are experimental or Investigational:

a. if the drug or device cannot be lawfully marketed without approval of the US Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or

b. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

d. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Section 1.14. FMLA. The term "FMLA" means the Family and Medical Leave Act of 1993 (29 USCS § 2601 *et seq.*).

Section 1.15. FMLA Leave. The term "FMLA leave" means a leave of absence that an Employer is required to extend to an Employee under the provisions of the FMLA.

Section 1.16. Formulary. The term "formulary" shall mean the listing of preferred prescription drugs, and the guidelines and protocols for the appropriate dispensing and use of medications, approved by the Trustees.

Section 1.17. Fund Office. The term "Fund Office" shall mean the administrative office of the MILA Managed Health Care Trust Fund, located in New York City, New York.

Section 1.18. Hospital. The term "Hospital" shall mean an institution operated pursuant to law 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 Physician in regular attendance;

c. continuously provides twenty-four hour a day nursing service by a Registered Nurse;

d. is an institution that is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or any institution that the Trustees designate as a hospital, in their sole discretion, reasonably exercised on a consistent basis and in a nondiscriminatory manner; and

e. 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 alcoholics or a place for drug addicts.

Section 1.19. In-Network. The term "In-Network" shall mean services rendered by a provider which has a contract or formal arrangement with the Claims Manager and/or another organization selected by the Trustees and which establishes specific charges and procedures for medical services. "Out-of-Network" means services rendered by a provider which either does not have such a contract or arrangement or is operating outside such contract or arrangement in the delivery of the service or supply.

Section 1.20. Maintenance Drugs. The term "maintenance drugs" shall mean outpatient prescription drugs taken on a regular or long-term basis.

Section 1.21. Medically Necessary. The term "Medically Necessary" care and treatment means care and treatment which are recommended or approved by a physician or dentist; are consistent with

the patient's condition or accepted standards of good medical or dental practice; are medically proven to be effective treatment of the condition; are not performed mainly for the convenience of the patient or provider of medical or dental services; are not conducted for research purposes; and are the most appropriate level of services which can be safely provided to the patient. All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary. The Trustees have the discretionary authority to decide whether care or treatment is medically necessary.

Section 1.22. Medicare. The term "Medicare" shall mean the federal insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted or as subsequently amended.

Section 1.23. Non-bargaining Unit Employee. The term "Non-Bargaining Unit Employee" shall mean an Employee who is participating in this Health Plan but is not covered by the Master Contract or another collective bargaining agreement between the Union and Employer.

Section 1.24. Out-of-Area. The term "Out-of-Area" refers to situations where an Eligible Employee, Pensioner, or Widow resides in a geographic location for which the Trustees determine that In-Network services are not reasonably available to the individual. "Out-of-Area" also refers to persons, regardless of location, for whom Medicare is the primary payer for their benefits.

Section 1.25. Participant. The term "Participant" shall mean the Eligible Employee or Pensioner and any of that individual's eligible Dependent who are participants in the MILA National Choice Plan.

Section 1.26. Participating Pharmacy. The term "Participating Pharmacy" shall mean the group of pharmacies which have a contract or formal arrangement with the Pharmacy Benefit Manager providing for discounted charges for prescription drugs covered by this Plan.

Section 1.27. Pensioner. The term "Pensioner" shall mean an individual who retired from a local Port that is participating in the MILA-MHCTF, who qualified for pensioner health benefits in accordance with the Collective Bargaining Agreement under which he was covered on the date he retired, who is receiving a pension from a local Port Pension Fund negotiated by Employers and the Union and who is not eligible for benefits under this Plan as an employee.

Section 1.28. Pharmacy Benefit Manager. The term "Pharmacy Benefit Manager" or "PBM" shall mean the organization or organizations retained by the Trustees to process claims and maintain claim histories and certain other administrative functions solely with respect to prescription drug benefits provided by this Plan.

Section 1.29. Physician. The term "Physician" shall refer to any licensed practitioner of the healing arts while operating within the scope of his profession. The term includes but is not limited to a

Doctor of Medicine (M.D.); Psychiatrist (M.D. or Ph.D.); Osteopath (D.O.); Chiropractor (D.C.); or Dentist (DDS). The definition of a Physician shall not include an Eligible Employee or any person who is the spouse, parent, child, brother or sister of such Eligible Employee.

Section 1.30. Plan Document. The term "Plan Document" or "Health Plan Document," or "Health Plan," herein, shall mean the benefits provided and conditions governing the operation of the MILA National Choice Plan, including medical and the Prescription Drug Benefits, set forth herein, adopted and any modification, amendment, extension or renewal thereof pursuant to a Collective Bargaining Agreement, Trust Agreement or Trustees' action.

Section 1.31. Plan Year. The term "Plan Year" shall mean the period beginning October 1, 1999, and ending December 31, 1999, for the first Plan Year. Thereafter, it shall mean the calendar year.

Section 1.32. Prescription Drug. The term "Prescription Drug" shall mean any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendment thereto, only upon a written or oral prescription of a Physician or other medical provider licensed by law to administer it. Covered drugs under the Prescription Drug Plan shall also include insulin and diabetic supplies including syringes, needles and test material.

Section 1.33. Qualified Medical Child Support Order. The term "Qualified Medical Child Support Order" involves the use of several terms that have special meaning in the law and regulations. Those terms include:

Section 1.33.01. "Alternate Recipient". This means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

Section 1.33.02 "Medical Child Support Order". This term means any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

a. provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

b. enforces a law relating to medical child support described in Social Security Act § 1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Section 1.33.03. "Qualified Medical Child Support Order". (QMCSO) is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such an order to be a QMCSO, it must clearly specify:

a. the name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

b. a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

c. the period of coverage to which the order pertains; and

d. the name of this Plan. However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants and Eligible Beneficiaries without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act § 1908 (as added by Omnibus Budget Reconciliation Act of 1993 § 13822).

Section 1.33.04. "National Medical Support Notice". (NMSN) is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that directs the Trustees to effectuate coverage for an Alternate

Recipient as the dependent child of the non custodial parent who is (or will become) a Participant in this Plan pursuant to a domestic relations order that includes a provision for health care coverage.

Section 1.34. Reasonable and Customary Charge. The term, "Reasonable and Customary Charge" or "Reasonable Charge" shall mean that portion of a charge for necessary services and supplies which does not exceed the lesser of:

a. the charges usually made for such service or supply by the provider who furnishes it; or

b. the usual, customary and reasonable charges for such service or supply in the same geographic area taking into account the complexity involved and the degree of professional skill required; or

c. the actual charge for such service or supply; or

d. the contractual rate negotiated for the service or supply between the Network and the Hospital or Provider or between MILA-MHCTF and the Hospital or Provider; or

e. when Medicare is the primary payer for a service or supply, the charge the Hospital or Provider is permitted to charge to the beneficiary plus any Medicare payment to the Hospital or Provider for the service or supply.

Section 1.35. Skilled Nursing Facility. The term, "Skilled Nursing Facility" shall mean an institution operated pursuant to law which meets all of the following requirements:

a. it is regularly engaged in providing skilled nursing care for sick and injured persons under twenty-four hours a day supervision of a Physician or a Registered Nurse;

b. the services of a Physician who is a staff member of a general hospital is available at all times;

c. it has either a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse on duty twenty-four hours a day and has a Registered Nurse on duty at least eight hours per day;

d. it maintains a daily medial record for each patient;

e. it complies with all licensing and other legal requirements; and

f. is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for alcoholics or drug addicts, a hotel or a similar institution.

Section 1.36. Surgery. The term "Surgery" means a procedure for cutting, suturing, endoscopy, electrocauterization, and it includes obstetrical procedures. It also means the correction of fracture, reduction of dislocation, manipulation of a joint under general anesthesia, tapping (paracentesis), application of plaster casts, treatment of burns, administration of pneumothorax, and injection of sclerosing solution.

Section 1.37. Trustees. The term "Trustees" shall mean the Employer Trustees and Union Trustees, collectively, acting under the terms of the Trust Agreement establishing the MILA Managed Health Care Trust Fund.

Section 1.38. Uniformed Services. The term "Uniformed Services" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Section 1.39. Union. The term "Union" as used herein shall mean the International Longshoremen's Association, AFL/CIO and any subordinate District or Local Union which participates in this Plan.

Section 1.40. Utilization Manager. The term "Utilization Manager" or "U.M." shall mean the organization or organizations retained by the Trustees to provide management of the medical care of covered individuals in such areas as hospital pre-admissions certification, concurrent review for medical necessity of hospital confinement, and other managed care procedures.

Section 1.41. Widow. The term "Widow" shall include "Widower" and shall mean a spouse who was married to an Eligible Employee or Pensioner on his death, who was eligible for coverage under

the Eligible Employee's or Pensioner's Health Plan at his death and remains eligible for coverage under the terms of the collective bargaining agreement or benefit plan under which the Eligible Employee/Pensioner was covered at death and who has not remarried.

ARTICLE 2

ELIGIBILITY

Section 2.01. Eligibility for Coverage under the Plan.

Section 2.01.01. Initial Eligibility. An Employee and his dependents shall be eligible for prescription drug benefits, effective October 1, 1999 if he was eligible for prescription drug benefits in his local Port Health Plan on September 30, 1999.

Section 2.01.02. Basic Eligibility. An Employee and his dependents shall be eligible for benefits, effective January 1, 2000 if he meets the existing rule for eligibility in force in his local Port Health Plan based on his employment, or other credited events, in the Contract Year October 1, 1998 to September 30, 1999.

Section 2.01.03. On-going Eligibility. Effective January 1, 2001, an Employee and his Dependents shall be eligible for benefits for a calendar year if he has had at least one thousand (1,000) hours of service credited under the rules of this Health Plan on his behalf in the Contract Year which ends in the prior calendar year.

Section 2.01.04. Special Eligibility Conversion. In the event a collective bargaining agreement requires employer contributions to the Trust Fund at a rate lower than the existing contribution rate

in the Master Contract, then Employees and their Dependents under that agreement shall be required to have contributions made on their behalf for more than 1,000 hours in a Contract Year, using the following formula:

a. Hourly Rate ($4.00) of Master Contract x 1,000 hours = Minimum Dollar Contribution; and.

b. Minimum Dollar Contribution divided by hourly contribution rate contained in local collective bargaining agreement = minimum hours of contribution required in a Contract Year to obtain eligibility for the following calendar year.

Notwithstanding the above formula, each employee's employer who is making contributions at a rate lower than $4.00 per hour, must contribute to MILA the lower man-hour contributions on every hour for which man-hour contributions are made.

Section 2.01.05. Non-Bargaining Unit Employees. An individual who is employed as a full time salaried Employee of the Union, the MILA Health Care Trust Fund, a participating local Port Benefit Plan or other organization accepted by the Trustees and who is scheduled to work a minimum of 30 hours per week, and his Dependents, shall become eligible for benefits on the first day of the month following completion of his or her employment probation period, if any, provided that the Employer contributes at a rate sufficient to meet the annual cost of anticipated benefits for the Employee and his Dependents.

Section. 2.01.05(a). "Banked Hours" for Non-Bargaining Unit Employees. If any non-bargaining unit employee worked 1,000 or more hours as a bargaining unit employee in the contract year preceding his becoming a non-bargaining unit employee, and such non-bargaining unit employee has contributions made on his behalf by the non-bargaining unit employer for the current year, such individual will be entitled to receive coverage in the calendar year following the last year in which such employee is covered because of payments made on his behalf by the non-bargaining unit employer.

Section 2.01.06. Continued Eligibility for Disabled Employees. If an Employee becomes disabled prior to his termination of eligibility under this Health Plan, and he is receiving weekly benefits under Workers Compensation or an accident and sickness benefit provided by a local Port Health Plan, then credit for establishing eligibility for the following calendar year shall be recognized at the rate of 20 hours per week. In no event, however, will an Employee receive credit for periods of disability in excess of 1,000 hours in any Contract Period. An Employee shall receive credit for no more than thirty-six consecutive months.

An Employee who remains disabled but is no longer receiving weekly benefits from Workers Compensation or a local accident and sickness program because he has reached the limits of such weekly benefits shall nevertheless be credited with 20 hours per week for eligibility purposes, up to the maximum of 1,000 hours in a Contract Period. An Employee shall receive credit for no more than thirty-six consecutive months.

Section 2.02. Termination of Eligibility - Active Employees. The eligibility of an Employee and his Dependents shall terminate on the earliest of the following dates:

a. the end of a calendar year in which the Employee fails to be credited with 1,000 hours of service in the Contract Year which ends in that calendar year;

b. the date he enters military service in the armed forces of the United States or any other country;

c. the date he becomes a Pensioner, unless he meets the requirements of Section 2.03;

d. in the case of non-bargaining unit employees, at the end of the month following the month in which employment terminates; and

e. upon the termination of this Health Plan by the Trustees.

Section 2.03. Pensioners.

Section 2.03.01. Initial Pensioner Coverage. On the date an employee retires, he shall be entitled to benefits as described herein for as long as he qualifies as a Pensioner as defined in this Plan. The initial period of his coverage shall be referred to as his Initial Pensioner Coverage. Thereafter, he shall be entitled to regular pensioner coverage as described in Articles 6 and 7. Benefits payable under this plan during a period of Initial Pensioner Coverage shall be determined on the same basis as for persons eligible for benefit under Section 2.01. However, if the covered person is entitled to

enroll for Medicare benefits, Medicare will be the primary payor of his benefits and those benefits will be calculated as described in Article 8 unless the individual enrolls in a Medicare HMO; in that case, benefits shall be those described in Section 6.02. During the period of his Initial Pensioner Coverage the Trustees shall reimburse the Pensioner for the regular cost of Medicare, Part B, actually incurred for persons so covered.

Section 2.03.02. Duration of Initial Pensioner Coverage. The Pensioner shall be covered for Initial Pensioner Coverage for a period which extends through the last day for which he qualified for active coverage as described in Section 2.01 on the day before he retired. Thereafter, he shall be entitled to regular pensioner coverage as described in Articles 6 and 7 for as long as he qualifies as a Pensioner as defined in this Plan.

Section. 2.03.03. Pensioner Contributions For Health Plan Coverage. A Pensioner who is entitled to benefits described in this plan under the terms described above and from whom a Plan contribution is required for participation under the rules of the local Port Health Plan shall not be covered under this plan unless such contribution is timely made. The amount and frequency of the required contribution will be determined solely by this Plan's Trustees and may be changed from time to time solely at the discretion of the Trustees.

Section 2.04. Widows. The widow of a deceased Eligible Employee or Pensioner shall continue to be eligible for benefits from this Health Plan provided she is eligible for health benefits under the terms of the Health Plan of the local port in which the Eligible Employee worked or from which the Pensioner retired and, if applicable, continues to make any required Plan contribution. Such benefits shall be subject to eligibility and length of coverage rules that were in effect in a participating local Port Health Plan as of September 30, 1996 and shall be limited to the extent of widow benefits in the local Port Health Plan on that date.

Section. 2.05. Termination of Eligibility - Pensions and Widows. The eligibility of a Pensioner or a Widow will terminate on the earliest of the following:

a. the date of his or her death;

b. the date of the termination of this Plan by the Trustees;

c. for the Pensioner or Widow who is required to make Plan contributions in order to be covered, the end of the month in which the last full plan contribution was made;

d. for the Pensioner, the end of the month in which he is no longer eligible to receive a monthly pension or otherwise fails to meet the definition of a pensioner in this Plan; and

e. for the Widow, the end of the month in which she either (1) fails to meet this Plan's definition of a widow (because she remarried, for example) or (2) reaches

the limit of her coverage as provided in the local Port Health Plan in existence on September 30, 1996.

Section 2.06. Termination of Eligibility - Dependents. The eligibility of a Dependent shall terminate on the earliest of the following dates:

a. the date of termination of the Eligible Employee or Pensioner or Widow on whom the individual is dependent;

b. the end of the month in which the individual no longer meets the definition of Dependent in Section 1.07;

c. the date the individual becomes covered under Section 2.01 as an Eligible Employee, or Section 2.05 as a Widow or Widower;

d. the date of his or her death; and

e. upon the termination of this Health Plan by the Trustees.

Section 2.07. Commencement of Pensioner or Widow Coverage Under Special Enrollment. If the Pensioner or Widow from whom a Plan contribution is required for coverage fails to enroll himself or herself or his/her eligible dependents when first eligible, coverage will be available only during a Special Enrollment Period or a Dependent Special Enrollment Period as described below.

Section 2.07.01. Special Enrollment Period. If an eligible employee or dependent had group health coverage or other health insurance coverage on the date of initial eligibility and that person

waived participation in this Plan, that person will be eligible for a special enrollment period if such other coverage is lost for qualifying reasons. The only qualifying reasons are: a) the person was covered under a COBRA coverage continuation and the period for coverage continuation is exhausted or (b) the person is not covered under a COBRA coverage continuation and coverage is terminated as a result of loss of eligibility for coverage or employer contributions toward the coverage are terminated. Enrollment in this Plan must occur within thirty-one days of such coverage loss. Coverage under this plan will date from the day following the loss of the other coverage.

Section 2.07.02. Dependent Special Enrollment Period. If an eligible employee acquires one or more dependents by reason or marriage, birth, adoption or placement for adoption, that employee will qualify for a dependent special enrollment period. Within thirty-one days of the acquisition of a dependent as described herein, the employee may enroll himself if not already enrolled (provided that he waived coverage when initially eligible as described under Special Enrollment Period) and he may enroll all eligible dependents, whether newly acquired or not. Such coverage will date from the date triggering the dependent special enrollment period.

Section 2.08. COBRA Continuation Coverage.

Section 2.08.01. Continuation Coverage After Termination of Regular Coverage. During any Plan Year, each person who is a Qualified Beneficiary shall have the right to elect to continue

coverage under this Plan upon the occurrence of a Qualifying Event that would otherwise result in such person losing coverage under the Plan. Such extended coverage under the Plan is known as "Continuation Coverage."

Section 2.08.02(a). A Qualified Beneficiary. A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is as follows:

a. an Employee covered under the Plan;

b. the spouse of the covered Employee;

c. a dependent of the covered Employee;

d. a newborn or adopted child who becomes the covered Employee's insured dependent any time while Continuation Coverage is in effect; or

e. any pensioner, a dependent of a pensioner or the widow of a pensioner, when such individual was deemed a Qualified Beneficiary under the terms of a local plan on December 31, 1999.

A covered Employee can be a Qualified Beneficiary only if the Qualifying Event consists of the termination of the covered Employee's employment (for any reason other than gross misconduct), or a reduction of the covered Employee's hours of work below 1,000 hours during the previous Contract Year.

Section 2.08.02(b). A Non-Qualified Beneficiary. A person is not a Qualified Beneficiary if, as of the date of the Qualifying Event, such person is either:

a. covered under the Plan by virtue of the election of Continuation Coverage by another person and is not already a Qualified Beneficiary by reason of a prior Qualifying Event; or

b. entitled to Medicare coverage under Title XVIII of the Social Security Act. For these purposes, a Qualified Beneficiary is not considered to be "entitled" to Medicare until he or she has actually enrolled in Medicare, Parts B (or C), with the Social Security and is covered for both Parts A & B (or C). Further, a person who fails to elect Continuation Coverage within the Election Period shall not be considered to be a Qualified Beneficiary.

Section 2.08.03. A Qualifying Event. Any of the following shall be considered to be a Qualifying Event:

a. the death of a Covered Employee;

b. termination (other than by reason of gross misconduct) of the Covered Employee's employment or reduction of the Covered Employee's hours of employment to a level of hours that would result in a loss of coverage under the Plan;

c. the divorce or legal separation of a Covered Employee from the Employee's Spouse;

d. a Covered Employee becoming entitled to receive Medicare benefits under Title XVIII of the Social Security Act. For these purposes, a Covered Employee is not considered to be "entitled" to Medicare until the Employee has actually completed the Medicare enrollment process with the Social Security Administration and such Employee's Medicare coverage has begun; or

e. a Dependent child of a Covered Employee ceasing to be an Eligible Dependent.

In the case of a retiree who is covered under the Plan the day before the filing, the Trustees' filing of a proceeding under Title 11 of the Bankruptcy Code on or after July 1, 1986, where there is a substantial elimination of coverage with respect to a Qualified Beneficiary within one year before or after commencement of the proceeding.

In the case of any person treated as a Covered Employee but who is not a common law employee, termination of "employment" means termination of the relationship that originally made the person eligible to participate in the Plan.

Section 2.08.04. Benefits available under Continuation Coverage. Each person who is eligible to elect to continue coverage under this Section 2.08 shall have the right to continue the level of coverage in effect for the covered Employee on the day before the Qualifying Event. If a Qualified Beneficiary of another group health plan maintained by the MILA-MHCTF is prevented from receiving the previous level of benefits due to a change in Plan benefits or Plan termination, such

individual shall be entitled to elect any alternate "comparable" level of coverage available under this Plan. When two or more levels are available, the Trustees at their sole discretion shall determine which level is "comparable."

Section 2.08.05. Notice requirements. When an Employee becomes covered under this Plan, the Trustees will inform the Participant (and the Participant's Spouse, if any) in writing, of the rights to Continued Coverage, as described herein.

a. the Employer shall give the Trustees written notice of a Qualifying Event within thirty (30) days of having received notice of the occurrence of such event;

b. within fourteen (14) days of the Trustees' receipt of the Employer's notice or within forty-four (44) days of the Employer's receipt of the Qualifying Event notice, if later, the Trustees shall furnish each Qualifying Beneficiary with written notification of the termination of regular coverage under the Plan, as well as a recital of the rights of any such Beneficiary to elect Continuation Coverage, as required by Code Sec. 4980B and ERISA 601, in accordance with the terms of the Plan;

c. in the case of a Qualifying Event described in Section 2.08.03, a Covered Employee or a Qualified Beneficiary who is a Spouse or Dependent of such Employee must notify the Trustees within sixty (60) days of the occurrence of such event. The Trustees shall be considered to have received notice of other Qualifying Events on the date of their occurrence;

d. each Qualified Beneficiary who is determined, under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act, to have been disabled within the first 60 days of any Continuation Coverage period following the loss of coverage due to a Qualifying Event described in Section 2.08.03 must notify the Trustees of such determination within 60 days of the date of notice of any final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary was so disabled;

e. each Qualified Beneficiary who is determined to be disabled under the Social Security Act must notify the Trustees of a determination that the Qualified Beneficiary no longer is disabled within 30 days of the date of notice of any such final determination under Title II or Title XVI of the Social Security Act; and

f. notwithstanding any of the foregoing, notification to a Qualified Beneficiary who is a spouse of a Covered Employee is treated as notification to all other Qualified Beneficiaries residing with that person at the time notification is made.

Section 2.08.06. Certificate of Coverage. The Plan automatically will provide individuals with a Certificate in cases where they lose coverage under this Plan and are entitled to elect Continuation Coverage. Such Certificates will contain the information described in the section on certificates of creditable coverage and will be provided within the following time frames:

a. for an individual who is a Qualified Beneficiary entitled to elect Continuation Coverage, no later than when a notice is required to be provided for a Qualifying Event;

b. for an individual who is not a Qualified Beneficiary entitled to elect Continuation Coverage, within a reasonable time after coverage ceases;

c. for an individual who is a Qualified Beneficiary and who has elected Continuation Coverage, within a reasonable time after cessation of Continuation Coverage or, if applicable, after the expiration of any grace period for the payment of premiums; and

d. for special rules applicable only to Dependents, see the section on certificates of creditable coverage. That section also explains that the Plan will provide Certificates upon request if the request is made within 24 months after a Participant or Dependent loses coverage under the Plan.

Section 2.08.07. Election period. Any Qualified Beneficiary entitled to Continuation Coverage shall have 60 days from the date on which regular coverage under the Plan would have terminated by reason of a Qualifying Event in which to return to the Trustees a signed election of Continuation Coverage under the Plan.

Section 2.08.08. Self-Pay Requirements.

a. A Qualified Beneficiary who has elected Continuation Coverage under this Section must self-pay up to 102% of the actuarially determined cost for the period of coverage. In the case of an individual who is determined to have been disabled, the self-pay amount for Continuation Coverage will be 150% of the actuarially determined cost for any month after the eighteenth (18th) month of Continuation Coverage.

b. The initial self-pay amount for Continuation Coverage is due the day on which the Qualified Beneficiary makes the initial election for Continuation Coverage. There is a grace period for the payment of forty-five (45) days. Thereafter, payment is due on the first of the month for which Continuation Coverage is desired. There is a grace period for such payment of thirty-one days. If payment is not received by MILA within the grace period for such payment, Continuation Coverage will terminate. Continuation Coverage terminated for nonpayment may not be reinstated.

c. The required payment for Continuation Coverage must be paid no less frequently than monthly. However, at the Qualified Beneficiary's election, such payment may be made at some lesser frequency. However, the grace period for payment will be unaffected by such change.

Section 2.08.09. Duration of Continuation Coverage.

a. Continuation Coverage shall extend for a period of 18 months after the date that regular coverage ends due to the Employee's termination of employment or reduction of hours of employment to a level that disqualifies him or her from participation in the Plan. If the Social Security Administration (SSA) determines within the 18-month period that any Qualified Beneficiary was disabled during the first 60 days of Continuation Coverage, Continuation Coverage will be extended during such continued disability to a maximum period of 29 months. For these purposes, the duration of continuation coverage shall include the months of employee eligibility continuation during disability for Participants who are disabled. In order to secure the extended coverage after a determination of disability, the disabled Qualified Beneficiary must notify the plan administrator of the finding of the SSA within 60 days of its issue and before the end of 18 months of Continuation Coverage.

b. If the Covered Employee is entitled to Medicare benefits at the time of the Qualifying Event of his or her termination of employment or reduction of hours, each covered dependent shall be eligible to continue coverage for the greater of: (1) 18 months Continuation Coverage; or (2) Continuation Coverage until 36 months from the date the Covered Employee first became so entitled. For purposes of determining continuation coverage rights, "entitlement" means actual enrollment for Medicare benefits.

c. If, during the 18-month period, a subsequent Qualifying Event occurs, the Covered Employee and each other Qualified Beneficiary having Continuation Coverage shall be entitled to elect to continue coverage under the Plan for up to 36 months following the date coverage was originally lost due to termination of employment or reduction of hours.

d. In addition, 36 months of Continuation Coverage shall be available to: (1) the Covered Employee's spouse who loses coverage under this plan by ceasing to be a "Dependent" (as defined in Section 3.04) by virtue of a divorce or legal separation; (2) a dependent child of the Covered Employee who loses coverage by ceasing to be a dependent; (3) any covered dependent who loses coverage where the Qualifying Event is the Covered Employee's death; or (4) any covered dependent, where the Covered Employee's entitlement to Medicare benefits results in loss of coverage under this Plan. In no event, however, shall Continuation Coverage extend more than 36 months beyond the date of the original Qualifying Event.

e. In the case of a retired covered Employee who is a Qualified Beneficiary on the day before the Trust files a bankruptcy proceeding under Title 11 of the Bankruptcy Code that results in a substantial elimination of coverage for any Qualified Beneficiary within one year before or after the filing, coverage may continue until the date of death of the retired Employee, and, in the case of his or

her surviving spouse and covered Dependents, 36 months after the date of the retiree's death.

f. Any Qualified Beneficiary who was paying for Continuation Coverage to a local port health plan on December 31, 1999, which local port plan provided for Continuation Coverage of thirty-six (36) months shall be entitled to receive Continuation Coverage until the thirty-six (36) month period ends provided such individual meets all other qualifications to receive Continuation Coverage under this Plan.

Section 2.08.10. Automatic Termination of Continuation Coverage. Continuation Coverage shall automatically cease after the following:

a. the date on which the MILA-MHCTF Trustees terminate the Plan and cease to provide any group health plan to any Employee;

b. the date payment for Continuation Coverage was due after the first payment when such payment is not paid with the thirty-one (31) day grace period;

c. the date on which the Qualified Beneficiary becomes covered under another group health plan that does not exclude or limit that person's coverage based on a preexisting condition, or that has a limitation based on a preexisting condition that is inoperative by virtue of the Health Insurance Portability and Accountability Act of 1996 [PL 104-191, 8/21/1996].

d. the date on which the Qualified Beneficiary (other than the Covered Employee) becomes entitled to benefits under Title II or Title XVI of the Social Security Act. For these purposes, a Covered Employee is not considered to be "entitled" to Medicare until he or she has actually completed the Medicare enrollment process with the Social Security Administration and has been notified that his or her Medicare coverage is in effect;

e. in the case of a Qualified Beneficiary who is determined to have been disabled at the time of a Qualifying Event, the month that begins more than 30 days after the date of the final determination under Title II or Title XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled; or

f. the end on the 18, 29 or 36 month period for which the Qualified Beneficiary is entitled to Continuation Coverage.

Section 2.08.11. Continuation Coverage for Employees in the Uniformed Services. For purposes of this Section, an Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services experiences a qualifying event as of the first day of the Employee's absence for such duty. Such an individual and any of the individuals Covered Dependents shall be treated as any other Qualified Beneficiary under Section 2.08.02(a) for all purposes of COBRA. The Trustees shall furnish the Employee and the Employee's Covered Dependents a notice of the right to elect COBRA continuation coverage and shall afford the Employee the opportunity to elect such coverage. The maximum period of coverage available to the

Employee and the Employee's Dependents is 18 months beginning on the date of the Employee's absence from work.

Section 2.08.12. Commencement of COBRA Coverage Under Special Enrollment.

a. **Special Enrollment Periods.** If a COBRA Employee does not enroll for coverage for the Employee and/or the Employee's Dependents within thirty-one (31) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's Special Enrollment rules. No evidence of insurability will be required in these circumstances.

b. **COBRA Employee Special Enrollment Period.** An Employee may enroll for coverage for the Employee and all Eligible Dependents during an Employee Special Enrollment Period. The employee will qualify for such special enrollment provided that: (1) the Employee is eligible for COBRA coverage under the Plan but is not currently enrolled; (2) the Employee declined COBRA coverage under the Plan when it previously was offered and gave the existence of alternative health coverage as the reason for "Waiver of Group Health Coverage" on the Employee's original card; and (3) the alternative coverage has terminated, because either:

(i) it was COBRA continuation coverage that has been exhausted; or

(ii) eligibility for the alternative coverage was lost (for reasons other than the individual's failure to pay premiums or for cause) or employer contributions toward the cost of the coverage terminated. In this case, the Employee must submit a completed enrollment form within 31 days after the date on which (1) COBRA continuation coverage was exhausted; or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in the Plan will be effective the first day of the first calendar month beginning after the date on which the Plan receives the completed enrollment form.

c. **COBRA Dependent Special Enrollment Period.** In addition, an Employee may enroll for coverage for the Employee and all Eligible Dependents at the time of a dependent Special Enrollment Period. The employee will qualify for such special enrollment provided that: (1) the Employee is eligible for coverage under the Plan but is not currently enrolled; (2) the Employee declined coverage under the Plan when it was offered previously; and (3) another individual (a spouse or child) becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed

enrollment form within 30 days of the marriage, birth, adoption, or placement for adoption.

d. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage; (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

Section 2.09. Coverage Under a Qualified Medical Child Support Order. In the event the Health Plan receives a medical child support order (within the meaning of Section 609(a)(2)(B) of ERISA), the Fund Office shall notify the affected covered individual, and any alternate recipient identified in the order, of the receipt of the order and the Plan's procedures for determining whether such an order is a Qualified Medical Child Support Order (within the meaning of Section 609(a)(2)(B) of ERISA). Within a reasonable period, the Fund Office shall determine whether the order is a Qualified Medicare Child Support Order and shall notify the covered individual and alternate recipient of such determination.

Section 2.10. Family and Medical Leave. Notwithstanding any other provision hereof to the contrary, an Eligible Employee's eligibility for benefits shall continue during any leave of absence approved by his Employer pursuant to the Family and Medical Leave Act.

ARTICLE 3

NATIONAL CHOICE PLAN

Section 3.01. Plan of Benefits. Effective January 1, 2000, the following benefits shall be provided under the National Choice Plan:

Section 3.01.01. In-Network Benefits. The amount payable for charges incurred through a network provider will be paid in full, for the following:

a. Hospital charges: semi-private room, intensive care, pre-admission testing, other hospital services;

b. Hospital emergency room charges for a valid emergency shall be reimbursed in full after a $25 co-pay per visit. Such co-pay shall be waived if the patient is admitted within 24 hours following such visit;

c. Surgery: doctor visits for surgery, assistant surgeon, anesthesia, other surgical services and supplies;

d. Physician Office Visits: medical treatment, pap smears, diagnostic x-ray and lab, physical examination, mammograms, well-baby/newborn care (up to age 3), immunizations, routine hearing examinations. These services are subject to a $10 co-pay;

e. Specialist Visits: podiatrist, chiropractor, physical therapist, speech therapist, nutritionist, acupuncturist, nurse midwife. There services are subject to a $10 co-pay;

f. Maternity expenses including the primary care and specialists services and the hospital confinement. These services are subject to one $10 co-pay per pregnancy;

g. Home Health Care, Skilled Nursing Facility, Ambulatory Surgical Facility;

h. Ambulance;

i. Outpatient Diagnostic X-ray and Laboratory;

j. Outpatient Private Duty Nursing;

k. Durable Medical Equipment;

l. Hospice Care; and

m. Convalescent Nursing Home Care.

All care is subject to any limitation imposed by the Plan's utilization manager.

Section 3.01.02. Out-of-Network/In Area Benefits. The amount payable for charges incurred through a provider who is not a network provider will be paid at 70% of the Allowable Expenses, for the following except where noted:

a. Hospital charges: semi-private room, intensive care, pre-admission testing, other hospital services;

b. Hospital emergency room charges for a valid emergency shall be reimbursed in full after a $25 co-pay per visit. Such co-pay shall be waived if the patient is admitted within 24 hours following such visit;

c. Ambulance at 100%;

d. Surgery: doctor visits for surgery, assistant surgeon, anesthesia, other surgical services and supplies;

e. All benefits payable in (f) and after are subject to the deductible and co-insurance provisions of the plan;

f. Physician office visits: medical treatment, pap smears, diagnostic x-ray and lab, maternity;

g. Specialist visits: podiatrist, chiropractor, physical therapist, speech therapist, nutritionist;

h. Home health care, skilled nursing facility, ambulatory surgical facility;

i. Outpatient Diagnostic X-ray and Laboratory;

j. Outpatient Private Duty Nursing;

k. Durable Medical Equipment;

l. Hospice Care; and

m. Convalescent Nursing Home Care.

All care is subject to any limitations imposed by the Plan's utilization manager.

Section 3.01.03. Out-of-Network/Out-of-Area Benefits. The amount payable for charges incurred through any provider will be paid the indicated percentage of the Allowable Expenses, for the following:

a. Hospital charges: semi-private room, intensive care, pre-admission testing, other Hospital services, at 100%;

b. Hospital emergency room charges for a valid emergency shall be reimbursed in full after a $25 co-pay per visit. Such co-pay shall be waived if the patient is admitted within 24 hours following such visit, at 100%;

c. Ambulance at 100%;

d. Ambulatory surgical facility at 100%;

e. Surgery: doctor visits for surgery, assistant surgeon, anesthesia, other surgical services and supplies, at 80%;

f. All benefits payable in (g) and after are subject to the deductible and indicated co-insurance;

g. Physician Office Visits: medical treatment, pap smears, diagnostic x-ray and lab, maternity, physical examination, mammograms, well-baby/newborn care (up to age 3), immunizations, routine hearing examinations; these services are payable at 80% co-insurance;

h. Specialist Visits: podiatrist, chiropractor, physical therapist, speech therapist, nutritionist, acupuncturist, nurse midwife. These services are payable at 80%;

i. Home Health Care and Skilled Nursing Facility at 80%;

j. Outpatient Diagnostic x-ray and Laboratory at 80%;

k. Outpatient Private Duty Nursing at 80%;

l. Durable Medical Equipment at 80%;

m. Hospice Care at 100%; and

n. Convalescent Nursing Home Care at 80%.

All care is subject to any limitations imposed by the Plan's utilization manager.

Section 3.02. Deductible Amount.

Section 3.02.01. The Deductible Amount of the Plan for Out-of-Network/In Area Services. The cost is $300 per year for each covered individual. However, after Deductible Amounts totaling $600 have been applied during any calendar year to any combination of covered individuals within a family, no further Deductible Amounts will be applicable to the Eligible Employee, Pensioner or any of their Dependents for the remainder of the calendar year.

Section 3.02.02. The Deductible Amount of the Plan for Out-of-Network/Out-of-Area Services. The cost is $150 per year for each covered individual. However, after Deductible Amounts totaling $300 have been applied during any calendar year to any combination of covered individuals within

a family, no further Deductible Amounts will be applicable to the Eligible Employees, Pensioners or any of their Dependents for the remainder of the calendar year.

Section 3.03. Annual Out-of-Pocket Maximums.

Section 3.03.01. Out-of-Network/In Area Coverage. With respect to services received In Area which are Out-of-Network, a covered individual shall pay a maximum of $5,000 in any calendar year for the deductible and co-insurance. Thereafter, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year.

When a total of $10,000 in any calendar year for the deductible and co-insurance has been paid by any combination of covered individuals within a family in a calendar year, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year.

Section 3.03.02. Out-of-Network/Out-of-Area Services. With respect to services received Out-of-Area which are Out-of-Network, a covered individual shall pay a maximum of $2,500 in any calendar year for the deductible and co-insurance. Thereafter, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year.

When a total of $5,000 in any calendar year in deductibles and co-insurance has been paid by any combination of covered individuals within a family in a calendar year, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year.

Section 3.03.03. Out-Of-Pocket Maximums. In determining whether the individual or family out-of-pocket maximums have been reached in a calendar year, neither expenses above the Allowable Expenses for services, nor penalties for failure to comply with the Plan's notification rules or limits on services, shall be taken into account.

Section 3.04. Lifetime Maximum Benefits. There is no lifetime maximum for expenses with network providers. For expenses incurred Out-of-Network, the Plan shall pay a maximum of $500,000 per covered individual during his or her lifetime.

Section 3.05. Covered Charges. Covered charges under the plan include the following services and supplies.

Section 3.05.01. Hospital Room and Board Charges. Hospital room and board (including regular daily services and supplies are furnished by the Hospital). However, if confinement is in a private room, Allowable Expenses include room and board only to the extent of the Hospital's most frequently applied semi-private room daily rate. If the Hospital does not have semi-private rooms, the limit is 90% of the daily charge for its lowest rate private room.

Section 3.05.02. Hospital Other Charges. All other services and supplies, exclusive of professional services, that are required for medical care or treatment, furnished by the Hospital for medical care administered by the staff or employees of the Hospital, and received by the Participant or Eligible Dependent during a Hospital confinement for which room and board expenses are incurred by the Participant. Included in this category of Eligible Charges are operating room expenses, drugs, medicines, and dressings; oxygen and anesthetics (and the costs of administering them); the cost of x-rays and other diagnostic laboratory procedures; X-ray and radium treatments; blood transfusions, including the cost of blood and blood plasma; and X-rays and other diagnostic laboratory procedures.

Section 3.05.03. Hospital Emergency Room or Urgent Care Center for medical care and treatment received as an outpatient but only for Emergency Services or emergency care.

Section 3.05.04. Other Hospital Outpatient Expenses. Other outpatient expenses related to a subsequent Hospital stay. If, during a hospital out-patient confinement, an x-ray or other diagnostic procedure is made (a) in 10 days before a subsequent Hospital confinement for which room and board expenses are incurred, and (b) in connection with the Illness requiring the subsequent confinement, then the requirement that such services be received during a Hospital confinement for which room and board expenses be incurred by the Participant shall not apply.

Section 3.05.05. Surgery Expenses. Surgery-related Physicians' services, including:

a. the immediate preoperative examination of the Participant or Eligible Dependent by the Physician performing the procedure;

b. the actual performance of the procedure by a Physician;

c. assistance in the actual performance of the procedure by a Physician if (1) the type and complexity of the procedure or the Participant's or Eligible Dependent's condition requires such assistance, and (2) when the procedure is performed in a Hospital, the Hospital does not have available staff Physicians qualified to provide such assistance; and

d. the post-operative care required due to the procedure.

Section 3.05.06. Physician Visits. Physicians' visits, including visits by specialists, for medical care other than surgery during a Participant's or Eligible Dependent's confinement in a Hospital.

Section 3.05.07. Breast Reconstruction. Reconstruction of a breast on which a mastectomy has been performed, and surgery and reconstruction of the other breast to achieve symmetry of appearance and the purchase of prostheses following mastectomy.

Section 3.05.08. Ambulance Service. Licensed ambulance service to or from the nearest hospital, skilled nursing facility or hospice where the needed medical care and treatment can be provided.

Section 3.05.09. Free Standing Surgical Facility Services. This refers to charges made by the facility for medical care and treatment.

Section 3.05.10. Cancer Therapy. Chemotherapy, radiation and other cancer treatment therapy, whether provided by a hospital on an outpatient basis or otherwise provided.

Section 3.05.11. Other Physician Services. Physicians' professional services, including the services of specialists, for medical care as follows:

a. for surgery;

b. for care other than surgery; and

c. for care other than services performed during visits made during a confinement in a hospital.

Section 3.05.12. Dental Treatment. Physician's services rendered and x-ray examinations made for removal of impacted wisdom teeth and for treatment within twelve months of accidental injury to natural teeth in connection with dental care required as a result of such injury, to the extent that charges for such services are not covered by any dental plan (whether or not provided by the Employer).

Section 3.05.13. Private Duty Nursing. Private duty nursing services by a registered graduate nurse or licensed practical nurse (other than the Participant, his or her spouse, a child, brother, sister, or parent of the Employee or his or her spouse) made for care other than services performed in a Hospital or in a Skilled Nursing Facility. Such care will be covered for up to 70 visits per calendar

year. Any four (4) hours of nursing care whether continuous or not in a twenty-four (24) hour period, will be considered one visit.

Section 3.05.14. Speech Therapy. Restorative or rehabilitative speech therapy by a qualified speech therapist (other than the Employee, his or her spouse, a child, brother, sister, or parent of the Employee or his or her spouse), if the therapy is for speech loss or impairment due to an Illness (other than a functional nervous disorder) or to surgery on account of the Illness. Such therapy will be covered only up to 60 visits per calendar year unless the Trustees conclude that additional visits are medically necessary.

Section 3.05.15. Other Non-Hospital Services or Supplies. Non-hospital related services and charges include the following:

a. x-ray and other diagnostic laboratory examinations;

b. drugs and medicines prescribed by a Physician and dispensed by a licensed pharmacist but only as provided through the Plan's prescription drug venders and pharmacies;

c. surgical dressings;

d. oxygen and rental of equipment for providing oxygen;

e. treatment by a physiotherapist (other than the Employee, his or her spouse, a child, brother, sister, or parent of the Employee or his or her spouse);

f. artificial limbs, larynx, and eyes;

g. electronic heart pacemaker;

h. casts, splints, trusses, braces, and crutches; rental of wheelchairs, hospital beds, iron lungs, or other durable equipment required for therapeutic use;

i. prostheses determined by the patient and his or her attending physician to be necessary in connection with a mastectomy; and

j. treatments by x-ray, radium, or other radioactive substances.

Section 3.05.16. Hospital Services or Supplies. Anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at the Trustees' option, purchase of Durable Medical Equipment; prosthetic appliances; dressings; and drugs and medicines lawfully dispensed only upon the written prescription of a Physician while confined in a Hospital, excluding vitamins.

Section 3.05.17. Preventive Care. A Physician's professional services for preventive care when rendered by a Network provider or when rendered out-of-network in the out-of-area plan:

a. an annual routine physical examination;

b. immunizations;

c. an annual mammogram;

d. Papanicolaou laboratory screening tests; and

e. routine hearing examinations (1 examination in any 24 month period).

Section 3.05.18. Foot Conditions. Diagnosis and treatment of the following:

a. corns, calluses, weak or flat feet;

b. any fallen arches, chronic foot strain or instability or imbalance of the feet; and

c. toenails (including removal of nail matrix or root, or services furnished in connection with treatment of a metabolic or peripheral vascular disease or of a neurological condition).

Services described in (a) and (b) are subject to a limit of $1,000 per calendar year.

Section 3.05.19. Non-surgical TMJ. Non-surgical care for TMJ and related care, which includes care for the following:

a. Temporomandibular Joint and Craniomandibular Joint Disorders; and

b. other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves and other tissues related to that joint. Dental work, such as, but not limited to orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons is not covered. Covered Expenses will not include that portion which is more than the TMJ limit of $1,000 per calendar year.

Section 3.05.20. Rehabilitative Therapy. Rehabilitative therapy by a licensed physical, occupational or speech therapist, on an outpatient basis, not to exceed a maximum of 60 visits per calendar year.

Section 3.05.21. Family Planning. A Network Provider's professional services for voluntary family planning, including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, other medical services, information and counseling on contraception, oral contraceptives and contraceptive devices excluding injectible/implantable contraceptives, and after appropriate counseling, medical services connected with surgical therapies, including vasectomy, tubal ligation. In addition, tests performed by a Network Provider for infertility and the procedures for the correction of infertility performed by a Network Provider are covered services.

Section 3.05.22. TPN Treatment. Hyperalimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery; however, benefits will not be paid for a period of longer than 3 months unless the patient is in a course of treatment which is being managed under Case Management as described in Section 3.07.05 and such continued treatment is deemed medically necessary by the Trustees.

Section 3.05.23. Acupuncture. Treatment by acupuncture or acupressure.

Section 3.05.24. Diabetes. Diabetes education and management.

Section 3.05.25. Maternity and Neonatal Benefits. Expenses related to pregnancy and birthing are covered according to the following schedule:

a. prenatal care of the mother and/or fetus is treated as any other illness or injury covered under the Plan;

b. inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending health care provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable);

c. no authorization from the Plan need be sought by the attending provider for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as the case may be). In any case, the 48- or 96-hour limit may be exceeded with authorization of the Trustees in cases of medical necessity.

Section 3.06. Covered Charges Subject to Special Utilization or Case Management. Charges for special medical services are eligible only if rendered under the management of the Plan's utilization management venders. Eligible charges in this category are those made by:

Section 3.06.01. Skilled Nursing Facility. Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that covered expenses will not include that portion which is more than 100 days per calendar year unless the Trustees conclude that additional days are medically necessary.

Section 3.06.02. Home Health Care. A Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan, as follows:

a. part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

b. part-time or intermittent services of a Home Health Aide;

c. physical, occupational, or speech therapy; and

d. medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the hospital as a registered bed patient or confinement in a Skilled Nursing Facility.

Section 3.06.03. Hospice Care. Charges made due to Terminal Illness for the following Hospice Care Services provided under a written Hospice Care Program, as follows:

a. by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, the covered charge will not be more than the Allowable Expense;

b. by a Hospice Facility for services provided on an outpatient basis;

c. by a physician for professional services;

d. by a psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;

e. for pain relief treatment, including drugs, medicines and medical supplies;

f. by a Home Health Care Agency for the following: (1) part-time or intermittent nursing care by or under the supervision of a Nurse; (2) part-time or intermittent services of a Home Health Aide; and (3) physical, occupational and speech therapy; and (4) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

Section 3.06.04. Transplant Surgery, In-Network. Charges for expenses related to transplant surgery In-Network at a Life Source Center for the following body organs are as follows:

a. kidney;

b. heart;

c. heart/lung;

d. lung;

e. liver;

f. pancreas; and

g. autologous bone marrow and stem cell.

Section 3.06.05. Transplant Surgery-Out-of-Network Charges. This is for expenses related to transplant surgery for the following body organs coordinated through and approved by the Plan's Utilization Manager subject to current Plan maximum benefit, as follows:

a. kidney (up to $80,000);

b. heart (up to $150,000);

c. heart/lung (up to $185,000);

d. lung (up to $185,000);

e. liver (up to $230,000);

f. pancreas (up to $50,000); and

g. autologous bone marrow and stem cell (up to $130,000).

Section 3.06.06. Travel And Donor Expenses. Travel expenses associated with such transplant subject to the following conditions:

a. No travel and lodging benefits will be payable unless the patient lives at least 60 miles from the designated facility.

b. Co-payment, deductibles and Plan maximums do not apply to the travel and lodging coverage.

c. This benefit covers the patient and donor.

d. The Plan will pay for pre-approved travel and lodging to a designated transplant facility for the pre-transplant evaluation even if the transplant is not eventually certified as medically appropriate.

e. Donor medical expenses, without application of co-payment or deductibles, up to $25,000 provided the transplant surgery is coordinated and approved by the Plan's Review Organization's National Organ Transplant Program.

Section 3.07. Utilization Review Requirements. The Plan's utilization managers must review certain treatment, whether delivered through a network provider or otherwise, before the plan will provide the maximum benefit available. The following requirements apply.

Section 3.07.01. Pre-Admission Certification (PAC) and Continued Stay Review (CSR). These utilization review procedures must be followed by every Plan participant when he or she seeks care as described in this section, as follows:

a. Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which the Trustees

have contracted. PAC must be requested by the participant for each in-patient hospital admission. CSR must be requested, prior to the end of the certified length of stay, for continued in-patient Hospital Confinement.

b. Unless PAC is received: (1) prior to the date of admission; or (2) in the case of an emergency admission, by the end of the second scheduled work day after the date of admission, eligible expenses incurred for which benefits would otherwise be paid under this plan will not include 20% of Hospital charges made for each separate admission to the Hospital as a registered bed patient.

c. In addition: (1) 20 % of the hospital charges for Bed and Board which are made for any day in excess of the number of days certified through PAC or CSR will not be eligible; and (2) 20 % of the hospital charges made during any Hospital Confinement as a registered bed patient: which was not certified as medically necessary, whether or not PAC was performed, will not be eligible.

d. Those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

e. The PAC process must be started by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, the Review Organization shall be called by the end of the third month of pregnancy but such call is optional. The Review Organization will continue to

monitor the confinement until the participant is discharged from the hospital. The results of the review will be communicated to the participant, the attending physician, and the Trustees.

Section 3.07.02. Out-Patient Certification Requirements. Out-patient Certification means the process used to certify the medical necessity of the procedures or services listed, when performed as an outpatient in a free standing surgical facility or a physician's office. Out-patient certification is performed through a utilization review program by a review organization with which the Trustees have contracted. Out-patient certification must be requested only for non-emergency procedures or services, and must be requested by the participant at least 4 working days (Monday through Friday) prior to having the procedure performed or the service rendered, as follows:

a. Expenses incurred for which benefits would otherwise be paid under this plan will not include 20% of expenses incurred for the charges, including: (1) charges made for one of the listed procedures performed or services rendered unless Outpatient Certification is received prior to the date the procedure or service is performed or rendered; and (2) charges made for one of the listed procedures performed or services rendered for which Outpatient Certification was performed, but, which was not certified as medically necessary.

b. Those expenses incurred for which payment is excluded by the terms set forth in subparagraph (a) of this section will not be considered as expenses incurred for

the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

c. Out-patient certification is required for the following procedures: (1) adenoidectomy; (2) all sinus surgery; (3) carpal tunnel release; (4) cholecystectomy; (5) colonoscopy; (6) coronary angiography; (7) hernia repair; (8) hysterectomy; (9) hysteroscopy; (10) knee arthroscopy; (11) magnetic resonance imaging (MRI) of the brain, lumbar, musculoskeletal, or thoracic regions; (12) myringotomy with tube insertion; (13) pelvic laparoscopy; (14) pet scan; (15) surgical shoulder arthroscopy; tonsillectomy and/or adenoidectomy, and/or myringtotomy with tube insertion; (16) UGI Endoscopy; and (17) cataract removal.

Section 3.07.03. Utilization Review When Covered By Another Plan. If the participant is covered under another benefit plan, this plan is the secondary payor and the other plan requires the use of utilization review (UR) for the service which, under this plan would require PAC, CSR or outpatient certification as described above, then the other plan's UR will satisfy this Plan's requirement for such PAC, CSR or outpatient certification. However, if the other plan does not contain a utilization review requirement when this plan does, then this plan's review must be obtained in order to qualify for the maximum benefit under this plan.

Section 3.07.04. Second Surgical Opinion Program. A covered individual shall be permitted to receive a second opinion at the Plan's expense for any elective surgical procedure. The second opinion must be obtained within the six (6) month period immediately preceding the performance of the recommended surgical procedure, and must be performed by a Physician no later than 6 months following the initial recommendation of such surgery. One hundred percent (100%) of the Allowable Expense of the second opinion and ancillary tests will be covered by the Plan. A Covered Individual may proceed with the surgery regardless of the outcome of the second opinion; however, if the surgeon who rendered the second opinion performs the surgery, his charges in the second surgical opinion will not be considered an Allowable Expense. A third opinion may also be obtained at the covered individual's option, and will be paid in full by the Plan if the second opinion is non-concurring. If the second opinion is concurring and the third is not, the Plan will pay the full cost of the third opinion.

Section 3.07.05. Case Management Program. If a plan participant is in treatment for a catastrophic illness or injury, the Trustees shall have the right to offer case management services under this Case Management Program. Although a participant may apply for case management services, only the Trustees shall determine whether the illness or injury is catastrophic and, as such, qualifies for this program.

a. If the Trustees determine that the participant qualifies for case management services, then the Trustees shall engage the services of a care manager to consult with the patient, the family and the attending physician in order to develop a plan

of medical care for the approval of the patient's attending physician and the patient. If the care plan is approved by the patient and the patient's attending physician and the Trustees find the plan to be a reasonable alternative to the treatment previously planned, then the Trustees may approve the care plan as an alternate benefit. In considering whether to approve the alternate benefit, the Trustees shall consider the unusual circumstances of the condition, the likelihood of the success of the alternate treatment, the appropriateness of the care proposed for the condition and its probable cost as compared with the originally planned treatment. Once this alternate benefit has been approved, the Trustees will direct the Plan to reimburse for medically necessary expenses as stated in the alternate benefit plan as network benefits even if some or all of those expenses would not otherwise be covered expenses under the Plan.

b. A Case Management Program shall be unique to the participant and the circumstances for which it is approved. The Trustees shall not be obligated to approve another Case Management Program for the same participant or for another participant even if the circumstances giving rise to the new request for case management services appear identical to those of a previously approved Case Management Program.

Section 3.08. Excluded Charges. Charges incurred for the following items are not covered under the Plan and are not Allowable Expenses, as follows:

Section 3.08.01. Occupational Illness or Injury. Injuries arising out of (or in the course of) any employment for wage or profit, or diseases that are covered by any worker's compensation law, occupational disease law, or similar legislation.

Section 3.08.02. Not Medically Necessary. Services or supplies not medically necessary for the medical care of the patient's illness or injury, except in the case of a tubal ligation or vasectomy. A tubal ligation or vasectomy will be covered as will preventive medical treatment provided by a network provider.

Section 3.08.03. Cosmetic Treatment. Cosmetic surgery or treatment covered, unless: (1) to remedy a condition that is: (i) a result of accidental injuries sustained by a Participant or an Eligible Dependent; or (ii) a congenital abnormality that causes a functional defect in a Dependent child; or (2) to effect reconstruction of either a breast on which a mastectomy has been performed, or on the other breast in order to produce symmetry of appearance.

Section 3.08.04. War Injuries. Injuries to and illnesses of a Participant or an Eligible Dependent due to war or any act of war, declared or undeclared (including resistance to armed insurrection).

Section 3.08.05. Government Paid. Charges for services or supplies furnished by or on behalf of the United States or any other government, unless payment of the charge is legally required. This

includes charges that would have been paid by Medicare for any covered individual who failed to enroll, but only for those individuals for whom Medicare would be the Primary Payer.

Section 3.08.06. Certain Preventive. Preventive care when not reasonably necessary for the treatment of an Illness unless rendered by a network physician in primary care practice or unless rendered in the out-of-area plan.

Section 3.08.07. Eye Treatment. Services in connection with eye refraction or any other examinations to determine the need for, or the proper adjustment of, eye glasses or hearing aids except the Plan will cover the first purchase of eye glasses or contact lenses following cataract surgery.

Section 3.08.09. Dental Treatment. Oral surgery and care and treatment of teeth, gums, alveolar process disorder, or jaw-joint disorder except those items specifically covered by Section 3.05.12 of this Plan.

Section 3.08.10. Services or Surgery to Reverse Sterilization.

Section 3.08.11. Excess of Reasonable and Customary Charge. Any amount in excess of the reasonable and customary charge for any service or supply. The reasonable and customary charge for a service or supply is the prevailing charge in the area for a like service or supply. A like service

is a service of the same nature and duration, requiring the same skill, performed by a person with similar training and experience. The Trustees must make an independent evaluation of specific charges to determine whether they are reasonable. The Trustees shall be guided by a reasonable interpretation of plan provisions. Their decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Trustees shall be final and binding on the plan.

Section 3.08.12. Certain Military-Related Services. For charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury.

Section 3.08.13. Unlawful Payment. Where payment is unlawful where the person resides when the expenses are incurred.

Section 3.08.14. Not Required To Pay. For charges which the person is not legally required to pay.

Section 3.08.15. No Charge In Absence of Plan. For charges which would not have been made if the person had not been covered under a medical benefit plan;

Section 3.08.16. Custodial and Educational. For or in connection with Custodial Services, education or training;

Section 3.08.17. Expense Paid By Public Program. To the extent that a Participant in any way paid or is entitled to payment for those expenses by or through a public program other than Medicare or Medicaid.

Section 3.08.18. Experimental Substances. For experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use" or for any other service or supply determined by the Trustees to be experimental as defined in this Plan.

Section 3.08.19. Experimental Treatments. For or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society or any other treatment determined by the Trustees to be experimental as defined in this Plan.

Section 3.08.20. No Coverage For Non Resident. For expenses incurred outside the United States, unless the Participant is a resident of the United States, and the charges are incurred while traveling on business or for pleasure.

Section 3.08.21. Physical Fitness. For equipment or supplies made or used for physical fitness, athletic training, or general health upkeep.

Section 3.08.22. Surgical Limits. For charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one half (1/2) of the amount otherwise payable for all other surgical procedures.

Section 3.08.23. Aids To Conception. For or in connection with in vitro fertilization, artificial insemination or similar procedures.

Section 3.08.24. Expenses After Coverage Ends. For expenses incurred after the date coverage under the Plan ceases for a Participant for any reason. This is true even though the expenses relate to a condition which began while the Participant was covered.

Section 3.08.25. Testing of Blood For Future. For the testing and storage of blood for future use. However, Allowable Expenses shall include costs for giving and storage of blood for an operation of the employee or a dependent covered under this Plan if such operation is scheduled within 6 months of the donation.

Section 3.08.26. For Certain Drugs. For drugs and medicines not furnished by and administered during confinement as a bed-patient in a Hospital or provided through the Plan's prescription drug program.

Section 3.08.27. For Gender Change. For treatment or surgery to change gender or improve or restore sexual function.

Section 3.08.28. For Weight Loss. For treatment of weight loss when an underlying severe medical condition is not present. Severe medical conditions include, but will not be limited to: diabetes, hypertension, cardiovascular disease; etc. In disputed cases, the Trustees reserve the right to make the final decision.

Section 3.08.29. This Section intentionally left blank.

Section 3.08.30. For tests for infertility or treatment of infertility. Tests for infertility, when performed out-of-network/in area, are not covered services. In addition, actual or attempted impregnation, or other fertilization expenses, are not covered services whether performed in-network or out-of-network.

Section 3.08.31. For Fetal Treatment Prior to Birth. For procedures to diagnose or treat the condition of a fetus prior to birth, except when Medically Necessary for the following: (1) amniocentesis and/or chromosomal analysis; (2) fetal monitoring; (3) pregnancy-related ultrasounds; (4) alpha fetoprotein; or (5) chorionic villus biopsy.

Section 3.08.32. For Home Medical Supplies. For usual and normal home medical supplies or first aid items.

Section 3.08.33. Limits to Ancillary Surgical Fees. For charges made by an assistant surgeon in excess of 20 percent of the surgeon's Allowable Expense; or for charges made by an additional surgeon when medically necessary in excess of the surgeon's Allowable Expense plus 20 percent.

Section 3.08.34. Eye Care Limits. For charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.

Section 3.08.35. Non-Essential Treatment. For charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by the Trustees.

Section 3.08.36. Speech Therapy. For or in connection with speech therapy, if such therapy is: (1) used to improve speech skills that have not fully developed; (2) can be considered custodial or educational; or (3) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered.

Section 3.08.37. Charge By Family Member. For charges made by any covered provider who is a member of the Participant's family.

Section 3.08.38. For Certain Blood Testing. For blood testing for allergies, including but not limited to: RAST, PRIST, and RIST, unless: (1) direct skin testing is impossible because the patient has extensive dermatitis or marked dermographism; (2) direct skin testing is impossible because the patient is 4 years of age or younger; (3) direct skin testing is inconclusive and a further diagnostic test is necessary; or (4) a history of severe anaphylactic allergy (e.g.: bee sting, penicillin, etc.) exists; (NOTE Duplication of the RAST test in less than 3 years will not be allowed as a Allowable Expense).

Section 3.08.39. For Food Supplements. For food supplements unless such supplements are prescribed by the attending physician who certifies that they are required in a course of tube feeding because only they may serve as the sole or primary source of nutrition and they are required to sustain life.

Section 3.08.40. For Extraordinary Nutrition. For hyperalimentation or Total Parenteral Nutrition (TPN); (except as provided under Covered Expenses);

Section 3.08.41. No-Fault Automobile. To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Trustees will take into account any adjustment option chosen under such part by the Participant.

Section 3.08.42. Elective Abortion. For or in connection with an elective abortion unless the Physician certifies in writing that the pregnancy would endanger the life of the mother or the expenses are incurred to treat medical complications due to the abortion.

Section 3.08.43. Routine Use of Emergency Room. For hospital emergency room visits for other than valid emergencies. The Trustees will determine what constitutes a valid emergency based upon the facts and circumstances of each case.

Section 3.08.44. Home Health Care Exclusions. The following Home Health Care Charges are excluded for the following:

a. home health care visits during a calendar year, in excess of 120 visits per calendar year. (To determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and

each 4 hours of Home Health Aide services will be considered one home health care visit.);

b. care or treatment which is not stated in the Home Health Care Plan;

c. the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home; and

d. a period when a person is not under the continuing care of a Physician.

Section 3.08.45. Hospice Care Exclusions. The following charges for Hospice Care Services are not included as Covered Expenses:

a. for the services of a person who is a member of the Participant's family or the Dependent's family or who normally resides in their house;

b. for any period when a Participant is not under the care of a physician;

c. for services or supplies not listed in the Hospice Care Program;

d. for any curative or life-prolonging procedures;

e. for services or supplies that are primarily to aid the Participant in daily living;

f. for more than three bereavement counseling sessions;

g. for Hospice Care Services during any day when the patient's life expectancy is greater than six months or for more than a total of 180 days during the patient's lifetime.

Section 3.08.46. Maternity and Neonatal Expenses of Persons Other Than The Employee and Spouse. Such expenses as described in Section 3.05.25 shall not be covered unless they arise from the pregnancy of the covered employee or the employee's spouse.

ARTICLE 4

MENTAL HEALTH/CHEMICAL DEPENDENCY BENEFIT

Section 4.01. Plan of Benefits. Effective January 1, 2000, the following benefits shall be provided for treatment of mental illness or chemical dependency. These covered benefits and the associated limitations and exclusions must be read separately for the benefits for treatment of other medical conditions.

Section 4.01.01. Network Benefits. The amount payable for charges incurred through a network provider will be paid in full for the following except as noted:

a. Hospital charges: semi-private room, intensive care, pre-admission testing, other hospital services;

b. Hospital emergency room charges for a valid emergency shall be reimbursed in full after a $25 co-pay per visit. Such co-pay shall be waived if the patient is admitted within 24 hours following such visit;

c. Ambulance;

d. Surgery: doctor visits for surgery, assistant surgeon, anesthesia, other surgical services and supplies;

e. Facilities charges in institutions certified for the treatment of mental disease or chemical dependency; and

f. Out-patient treatment in an appropriate provider's office subject to a $25 co-pay.

Section 4.01.02. Out-of-Network Benefits. The amount payable for charges incurred through a provider who is not a network provider will be paid at 70% of the allowable expense except where noted:

a. Hospital charges: semi-private room, intensive care, pre-admission testing, other hospital services;

b. Hospital emergency room charges for a valid emergency shall be reimbursed in full after a $25 co-pay per visit. Such co-pay shall be waived if the patient is admitted within 24 hours following such visit;

c. Ambulance;

d. Surgery: doctor visits for surgery, assistant surgeon, anesthesia, other surgical services and supplies;

e. Facilities charges in institutions certified for the treatment of mental disease or chemical dependency; and

f. Out-patient treatment in an appropriate provider's office subject to 50% co-insurance of the lesser of: (1) the actual charge; and (2) the contract rate for such service.

Section 4.02. Deductible. There is no deductible for mental health and chemical dependency under this Plan.

Section 4.03.01. Annual Out-of-Pocket Maximums. With respect to services received Out-of-Network a covered individual shall pay a maximum of $5,000 in any calendar year for the co-insurance of 30%. Thereafter, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year. When a total of $10,000 has been paid by any combination of covered individuals within a family in a calendar year, the Plan shall pay 100% of the Allowable Expenses for Covered Charges for the remainder of that calendar year.

Section 4.03.02. Out-of-Pocket Maximums. In determining whether the individual or family out-of-pocket maximums, have been reached in a calendar year neither expenses above the Allowable Expenses for services, nor penalties for failure to comply with the Plan's notification rules or limits on services shall be taken into account.

Section 4.04. Lifetime Maximum Benefits. There is no lifetime maximum for Network providers. For expenses incurred Out-of-Network the Plan shall pay the maximum indicated below per covered individual during his or her lifetime.

Chemical Dependency	=	$ 50,000
Mental or nervous Disorders (inclusive of Chemical Dependency)	=	$500,000

Section 4.05. Covered Charges. Covered Charges under this Section 4.05 include all covered charges as set forth in Section 3.05 for the treatment of mental disorders or substance abuse. In addition, the following are also covered charges:

Section 4.05.01. Charges made by a Hospital or an accredited facility on its own behalf for room, board, and other necessary services, and supplies provided during confinement; except that any charges for room and board for any day of confinement in excess of the number of days certified by the Behavioral Health Manager shall not qualify as Covered Charges. The limit for hospital confinements is 30 days per calendar year, whether in or out of network, except where the Behavior Health Manager determines the additional days are medically necessary.

Section 4.05.02. Charges made by a physician, psychiatrist, psychologist, certified social worker, qualified therapist or counselor.

Section 4.05.03. Charges by any other provider or organization determined by the Behavioral Health Manager to be necessary or desirable to treat a covered individual in a cost-effective manner.

Section 4.05.04. Charges for family counseling for the immediate family of a covered individual who is undergoing treatment.

Section 4.05.05. Charges for the Members Assistance Plan provided by the Behavioral Health Manager.

Section 4.06. Exclusions and Limitations. Exclusions and limitations under this Section 4.06 include exclusions and limitations as set forth in Section 3.08 for the treatment of mental disorders or substance abuse. In addition, no benefits shall be payable with respect to expenses (any and all of which shall not be considered as Allowable Expenses) incurred for:

a. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified by a Physician as necessary for the therapeutic treatment of the covered individual's disablement;

b. For all days of hospital confinement in excess of 30 days per calendar year, except where the Behavior Health Manager determines that additional days are medically necessary;

c. For all out-patient visits in excess of 30 days per calendar year;

ailment based on professional standards and protocols in the geographic area in which the services are rendered, or experimental or not medically necessary;

g. For services that would have been paid by Medicare for any covered Pensioner, Dependent of a Pensioner or Widow who failed to enroll in that program;

h. For services for conditions not attributable to a mental disorder as defined in the Diagnostic & Statistical Manual, Version IV (DSM IV);

i. For behavioral health treatment that is not medically necessary including, but, not limited to, custodial care for chronic conditions, educational rehabilitation, or treatment of learning disabilities;

j. For court ordered or other externally mandated treatment, unless such treatment is medically necessary;

k. For medications and laboratory services not prescribed and dispensed or provided by ComPsych managed providers;

l. For Speech Therapy;

m. For educational evaluations;

n. For professional training;

o. For services provided by self-help groups;

p. For employment evaluations;

q. For custody evaluations;

r. For behavioral dysfunction that results primarily from organic conditions (e.g., Organic Brain Syndrome, Alzheimer's, Mental Retardation and Autism), except for acute interventions for stabilization of psychiatric conditions;

s. For experimental or investigational therapies for which professional training and standards of practice are not clearly established;

t. For marriage or stress counseling, except when rendered in connection with treatment of a DSM IV Mental Disorder;

u. For treatment for smoking cessation, weight reduction, obesity, stammering and stuttering;

v. For treatment for codependency, except when rendered in connection with treatment of a DMS IV Mental Disorder;

w. For non abstinence based and for nutritionally based chemical dependency treatment except when medically necessary;

x. For treatment for sexual addiction, except when rendered in connection with treatment of a DSM IV Mental Disorder;

y. For treatment of chronic pain, except when rendered in connection with treatment of a DSM IV Mental Disorder;

z. For treatment or consultations provided by the person's parents, siblings, children, spouse or former spouse or domiciliary partner;

aa. For ambulance services or other transportation, except when medically necessary and pre-approved by ComPsych. However, pre-approval is not necessary in the case of an emergency.

Section 4.07. Pre-Certification of Treatment. In order for a covered individual to receive the maximum benefit under this Article 4, pre-treatment certification must be obtained. Pre-treatment certification must be obtained by telephoning the Plan's Behavioral Health manager. If a covered individual does not follow this procedure, any benefits otherwise payable under this Plan shall be subject to the non-certification penalty provisions of this Article and such care shall be considered out-of-network.

Section 4.08. Non-Certification Penalties.

Section 4.08.01. Covered individuals not complying with the pre-certification requirements will have non-certification penalties applied to any benefits otherwise payable in connection with such non-certified claim.

Section 4.08.02. For in-patient care in a Hospital or accredited facility, the non-certification penalty shall be $250 per admission. If the stay is subsequently certified as necessary, the Plan shall pay for Covered Charges at the rate of 70%.

Section 4.08.03. For in-patient care in a Hospital or accredited facility which is subsequently certified as not necessary, the non-certification penalty shall be the first $250 of charges and, in addition, the Plan shall pay any remaining Covered Charges at the rate of 50%.

Section 4.09. Behavorial Health Case Management Program. If a plan participant is in treatment for a catastrophic illness resulting from mental illness or chemical dependency, the Trustees shall have the right to offer case management services under this Behavioral Health Case Management Program. Although a participant may apply for behavioral health case management services, only the Trustees shall determine whether the illness is catastrophic and, as such, qualifies for this program.

a. If the Trustees determine that the participant qualifies for behavioral health case management services, then the Trustees shall engage the services of a behavioral health care manager to consult with the patient, the family and the attending physician in order to develop a plan of medical care for the approval of the patient's attending physician and the patient. If the care plan is approved by the patient and the patient's attending physician and the Trustees find the plan to be a reasonable alternative to the treatment previously planned, then the Trustees may approve the care plan as an alternate benefit. In considering whether to approve the alternate benefit, the Trustees shall consider the unusual circumstances of the condition, the likelihood of the success of the alternate treatment, the appropriateness of the care proposed for the condition and its probable cost as compared with the originally planned treatment. Once this

alternate benefit has been approved, the Trustees will direct the Plan to reimburse for medically necessary expenses as stated in the alternate benefit plan as network benefits even if some or all of those expenses would not otherwise be covered expenses under the Plan.

b. A Behavioral Health Case Management Program shall be unique to the participant and the circumstances for which it is approved. The Trustees shall not be obligated to approve another Behavioral Health Case Management Program for the same participant or for another participant even if the circumstances giving rise to the new request for behavioral health case management services appear identical to those of a previously approved Behavioral Health Case Management Program.

Section 4.10. Member Assistance Program (MAP). The Behavioral Health Manager shall make available to plan participants and their immediate family members short term counseling under the MAP for personal or family problems. Problems suitable for MAP intervention include but are not limited to the following: marital and family conflict, grief and loss, alcohol or drug abuse, job pressure, stress and anxiety. The MAP generally will be limited to one to three counseling sessions in which the problem is defined and an appropriate treatment plan is developed. The treatment plan will be designed to employ the Plan's network benefits to the extent that such benefits constitute appropriate treatment. Charges for counseling under the MAP shall not accrue and no bill for such service will be paid either by the Plan or the participant.

ARTICLE 5

PRESCRIPTION BENEFIT

Section 5.01. Prescription Drugs Defined. Prescription Drugs shall mean any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendment thereto, only upon a written or oral prescription of a Physician or other medical provider licensed by law to administer it. Covered drugs shall also include insulin and diabetic supplies including syringes, needles and test material.

Section 5.02. Benefits Payable. Effective October 1, 1999, the Plan shall pay a benefit for prescription drugs dispensed to a covered individual while he or she is eligible for benefits. Benefits shall be provided as follows:

Section 5.02.01. For prescription drugs dispensed by a participating pharmacy the Plan will pay the total cost of the prescription after the covered individual has made the applicable co-pay.

Section 5.02.02. For prescription drugs dispensed by a pharmacy which is not a participating pharmacy, the covered individual will pay the entire cost for the prescription and obtain and submit a claim form to the Plan. After deducting the appropriate co-payment, the Plan will reimburse the covered individual the remaining amount; provided that the Plan's payment will not exceed the amount which would have been paid to a participating pharmacy.

Section 5.02.03. All prescriptions filled at a retail pharmacy shall be limited to a 30 day supply.

Section 5.02.04. All maintenance drugs shall be obtained through the Plan's mail order program in order to have benefits paid. For a maintenance drug initially prescribed after October 1, 1999 a covered individual will be able to obtain a 30 day supply plus one refill at a retail pharmacy. Thereafter, refills will only be available through the mail order program.

Section 5.02.05. All prescriptions filled under the Plan's mail order program shall be limited to a 60 day supply.

Section 5.02.06. All prescribed drugs dispensed through the mail order program shall be dispensed generically unless the prescribing Physician directs a brand name drug be dispensed (either DAW or otherwise) or there is no therapeutic generic equivalent of the prescribed drug.

Section 5.02.07. Prescription drugs required for a course of treatment of chemotherapy will not be subject to any supply limits.

Section 5.03. Co-Pay Requirements. For each prescription issued, a covered individual shall be required to make a co-payment before the Plan provides any benefit, in accordance with the following:

At a retail pharmacy	Brand Drugs	$10.00
	Generic Drugs	$ 5.00
Through the Plan's mail order program	Brand Drugs	$15.00
	Generic Drugs	$ 5.00

Section 5.04. Special Pharmacy Deductible For Pensioners, Dependents and Widows For Whom Medicare is the Primary Payor. A calendar year deductible of $500 is payable by each person's family (whether one or two persons) for whom Medicare is the primary payor before any benefit is payable under this plan. The deductible must be satisfied by charges which otherwise would be allowable under the Drug Prescription Plan.

Section 5.05 Exclusions. No prescription drug benefits shall be payable for:

a. Pharmaceuticals requiring a prescription that have not been approved by the U.S. Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, routine and frequency for which they are prescribed; or are experimental and/or investigational;

b. Non-prescription (over-the-counter) drugs or medicines or drugs dispensed without prescription drug order;

c. Drugs furnished without charge;

d. Foods and diet and nutritional supplement including, but not limited to, home meals, formulas, foods, diets, vitamins (including pre-natal vitamins), minerals, amino acid supplements, except when provided during hospitalization;

e. Naturopathic or homeopathic services, substances and supplies;

f. Drugs, medicines or devices, even though such devices may require a prescription, for contraception, cosmetic purposes, hair growth, smoking cessation and/or weight control;

g. Compounded prescriptions in which there is not at least one ingredient that is not a legend drug requiring a prescription as defined by Federal or State law;

h. Any prescription drug or medicine for which there is a generic equivalent available in non-prescription form;

i. Take home drugs or medicines provided by a hospital, emergency, ambulatory center or other health care facility free of charge;

j. Drugs for which the covered individual would have no obligation to pay in the absence of this or similar coverage;

k. Drugs or supplies that are required because of an injury or sickness resulting from an act of war or a warlike action during peacetime;

l. Drugs or supplies for which the Covered Individual is entitled to reimbursement under Worker's Compensation laws or any municipal, state or federal program;

m. Drugs covered under any other Article of this Plan or limited or excluded because they are not medically necessary or they are experimental or otherwise.

Section 5.06. Prior Authorization Drugs. A covered individual must obtain prior authorization from the Pharmacy Benefit Manager before benefits will be paid for the following drugs and/or drug classes:

a. Growth Hormone;

b. Octreotide;

c. Algucerase;

d. Erythropoetin;

e. Filgrastim;

f. GM-CSF; and

g. Fertility Medications.

ARTICLE 6

BENEFITS FOR MEDICARE ELIGIBLE

PENSIONERS AND DEPENDENTS

Section 6.01. Individuals Affected. Benefits under this Article 6 are available to Pensioners and the Dependents of Pensioners who are eligible for regular pension benefits and to Widows who are eligible for regular pension benefits where those persons are entitled to benefits under Medicare. Benefits under this Article 6 are not available to Pensioners, Dependents of Pensioners and Widows who are eligible for Initial Pensioner Benefits under this Plan; those benefits are described in Articles 3, 4 and 5 and the Medicare coordination, if applicable, is described in Article 8. However, if a person eligible for Initial Pensioner Benefits enrolls in a Medicare HMO, he shall be covered for the benefits described in Section 6.02 rather than for Initial Pensioner Benefits.

Section 6.02. Enrollment in Medicare HMO.

Section 6.02.01. Any covered individual who is eligible for Medicare may, at his or her option, enroll in an HMO which has been accepted under the Federal Medicare Program. The cost of such enrollment, if any, shall be borne by the covered individual.

Section 6.02.02. If an HMO selected under subsection 6.02.01 provides as part of its benefit package reimbursement for, or actual providing of prescription drugs, then this Health Plan shall provide reimbursement of the covered individual's Medicare Part B premium.

Section 6.02.03. Written proof of enrollment in a qualified HMO and coverage under Part B of Medicare must be submitted to the Fund Office

Section 6.02.04. For covered individuals who meet the requirements of subsection 6.0202, reimbursement shall be made on a quarterly basis, at the beginning of each calendar quarter.

Section 6.02.05. A covered individual who qualifies under this Section 6.02 shall not be entitled to benefits under Section 6.03.

Section 6.03. Benefits in Absence of Medicare HMO. A covered individual who is entitled to benefits under Medicare and to regular pension benefits and who for any reason does not enroll in a Medicare HMO shall be entitled to benefits as described in this Section 6.03.

Section 6.03.01. Subject to satisfaction of the deductible and payment of the co-insurance amount, this Health Plan shall provide benefits which supplement those provided by Medicare, as follows:

a. The annual deductible shall be $150 per individual or $300 per family each calendar year;

b. The allowable expenses are the amounts determined under the Medicare program to be allowable expenses;

c. After satisfying the annual deductible, a covered individual shall pay co-insurance at the rate of 20% of the allowable expenses until a total of $2,500 per individual or $5,000 per family has been paid in the form of medical deductibles and co-insurance expenses. Thereafter, the Health Plan shall pay the full allowable expenses incurred during the remainder of that calendar year.

d. Medicare shall make its determination and payments first, before the benefits payable under this subsection 6.03.01 shall be paid;

e. Hospital and related expenses covered under Part A of Medicare are not subject to this Plan's deductible and co-insurance provisions

Section 6.03.02. A covered individual shall receive reimbursement for prescription drugs dispensed under this Plan's special program for Pensioners and Dependents, as follows:

a. the annual deductible payable by each family unit shall be $500 per calendar year;

b. Each prescription shall be subject to a co-payment of $10.00 for brand name, and $5.00 for generic drugs at a retail pharmacy, after the annual deductible is satisfied; and

c. Each prescription obtained through the Plan's mail order program shall be subject to a co-payment of $15.00 for brand name, and $5.00 for generic drugs, after the annual deductible is satisfied.

ARTICLE 7

BENEFITS FOR PENSIONERS AND DEPENDENTS

NOT ELIGIBLE FOR MEDICARE

Section 7.01. Individuals Affected. Benefits under this Article 7 are available to Pensioners, Dependents and in certain cases Widows/Widowers who are not eligible for benefits under Part B of Medicare and are not eligible for benefits in Articles 3, 4 and 5 by virtue of current employment. For purposes of this Plan, eligibility for Medicare means absence of qualifying age or other requirements. A covered individual who would otherwise be eligible for Medicare except for failure to apply shall not be entitled to benefits under this Article 7.

Section 7.02. Full Eligibility. A Pensioner and his or her Dependents, or a Widow or Widower, who were eligible for health benefits equal to those provided for active Eligible Employees in a local Port Health Plan in effect on September 30, 1996 shall be entitled to benefits under Article 3, Article 4 and Article 5 of this Plan subject to the following:

a. Benefits will terminate when the covered individual becomes eligible for benefits under Article 6;

b. The covered individual must remain eligible for pension benefits in the local Port Pension Plan and continue to meet the requirements of the local Port Welfare Plan regarding pensioner health benefits which were in effect on September 30, 1996; and

c. A covered individual who became eligible for pension benefits on or after October 1, 1996 shall nevertheless be entitled to benefits if he or she otherwise meets the conditions for full health benefits under the Plan which were in effect on September 30, 1996 in the local Port Health Plan.

Section 7.03. Limited Coverage. A Pensioner and his or her Dependents, or a Widow or Widower, who were eligible for health benefits at a lower level than those provided for active Eligible Employees in a local Port Health Plan in effect on September 30, 1996 shall be entitled to limited health benefits under this Plan. Coverage shall be governed by the following:

a. Benefits shall be restricted to the types and amounts outlined in Appendix A, attached to this Health Plan document; and

b. The covered individual must remain eligible for pension benefits in the local Port Pension Plan.

ARTICLE 8

COORDINATION OF BENEFITS

Section 8.01. Description of Benefits. This Plan coordinates benefits with other health plans in cases where covered individuals are liable for Allowable Expense. If a covered individual is not liable for an Allowable Expense, this Plan will not coordinate benefits. Coordination of benefits shall apply to the following:

a. the benefits as set forth in Articles 3 and 4;

b. all benefits for persons covered by or eligible for Medicare, furnished by or payable by any State, Federal or other political subdivision will be coordinated in accordance with the rules set forth in Section 8.04 of this Article; and

c. Medical benefits for Eligible Employees and Dependents if both Employee and spouse are eligible as a member under the Plan.

The above benefits under this Plan will be coordinated, in accordance with the provisions set forth under this Article 8, with the benefits provided under any other group-type coverage sponsored by employers, unions, associations, organizations or government, whether insured or service type, to provide a combination of payments up to, but not exceeding, one hundred percent (100%) of the covered individuals Allowable Expenses. However, in no event shall the amount payable by the Plan exceed the amount which would have been paid if there were no other health coverage involved.

Section 8.02. Specific Definitions.

a. **Health Plan** - The term Health Plan as used herein, shall mean any program of coverage providing benefits as set forth in Articles 3 and 4 except the following: (1) Individual or family policies, or individual or family subscriber contracts; and (2) Medical payment benefits customarily included in the traditional automobile contract.

If another health plan providing benefits for a covered individual does not have a coordination of benefits or duplication of benefits provision, benefits payable for Allowable Expenses under the other health Plan will be paid in full before any benefits are paid by this Plan. The term health plan shall be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or arrangement which reserves the right to take benefits or services of other plans into consideration in determining its benefits, and that portion which does not.

b. **Allowable Expense** - The term Allowable Expense as used herein shall mean any expense or charge as defined in Section 1.01 of this Plan. When a health plan provides benefits in the form of service rather than cash payment, the reasonable

cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

c. **Preferred Provider Contract** - Preferred Provider Contract means a contract under which a medical provider contracts with a Plan to provide services at the rates specified in the contract. It does not have to be an exclusive arrangement.

Section 8.03. Determination of Benefits.

Section 8.03.01. As to any claim of a covered individual, the benefits that would be payable under this Plan in the absence of this coordination of benefits provision for Allowable Expenses for such claim shall be reduced by the amount, if any, necessary so that the sum of such reduced benefits and all benefits payable for such Allowable Expenses under all other health plans, except as provided below, shall not exceed the total of such Allowable Expenses. Benefits payable under another Health Plan shall be deemed to include the benefits that would have been payable had claim been duly made thereof.

Section 8.03.02. If another Health Plan which contains a provision for coordination of benefits that would determine its benefits after the benefits of this Plan have been determined, and the rules set forth in Section 8.03.03 below would require this Plan to determine its benefits before such other

health plan, then, the benefits of such other health plan will be ignored for the purposes of determining the benefits under this Plan.

Section 8.03.03. For the purposes of Section 8.03.02 above, the rules for establishing the order of benefit determination are:

a. **Eligible Employees, Pensioners and Spouses** - The health plan covering the person as an employee pays benefits first, as a retiree or pensioner second, and as a dependent last.

b. **Dependent Children of Eligible Employees and Pensioners** - (1) The health plan covering the parent whose birthday falls earlier in the calendar year pays first. The health plan covering the parent whose birthday falls later in the year pays second; (2) if both parents have the same date of birth, the health plan which has covered one of the parents longer will pay first, and the other parent's health plan pays second; (3); notwithstanding the above, should a Dependent Child be covered under this Plan as a dependent of a male Eligible Employee or Pensioner, and also covered under another health plan as an eligible Dependent Child, and such other Health Plan is not required by applicable state insurance statute to operate under the "birthday" coordination of benefits rule as described in (1) above, this Plan shall operate under the "gender based" coordination of benefits rules. That is, the benefits of a Health Plan which covers the claimant as a Dependent Child of a male employee shall pay first and the Health Plan

which covers such person as a Dependent Child of a female employee shall pay second; (3) when the parents are separated or divorced and the parent with the greater custody of the child has not remarried, the benefits of a health plan which covers the child as a dependent of the parent with custody shall pay first and the benefits of the health plan which covers the child as a dependent of the parent without custody pays second; (4) when the parents are divorced and the parent with the greater custody of the child has remarried, the benefits of a health plan which covers the child as a dependent of the parent with greater custody shall pay first, the benefits of a health plan which covers that child as a dependent of the step-parent shall pay second, and before the benefits of a health plan which covers that child as a dependent of the parent without or with lesser custody; (5) notwithstanding the foregoing, if there is a court decree which would otherwise establish financial responsibility for the medical or other health care expenses with respect to the child, the benefits of a health plan which covers the child as a dependent of the parent with such financial responsibility shall pay first and the benefit of any other health plan which covers the child as a Dependent Child shall pay second; (6) when rule b. of this Subsection 8.0303 does not establish an order of benefit determination, the benefits of a health plan which has covered the claimant for the longer period of time shall pay first and the benefits of a health plan which has covered such person for the shorter period of time shall pay second; and (7) the health plan which covers the claimant as an active employee

shall be primary over the Health Plan which covers the claimant as a pensioner, or COBRA continue.

Section 8.04. Medicare Eligible Covered Individuals.

a. Medicare will be the primary and exclusive payor for those benefits which are not covered by the Plan, but are covered by Medicare;

b. This Plan will be primary and Medicare secondary for eligible employees and their dependents in accordance with the Federal Medicare secondary payor provisions for older workers, individuals with end stage renal disease (ESRD) and for disabled individuals.

c. Medicare will be primary and this Plan secondary as described in Article 6 for Medicare eligible Widows, Pensioners and their Medicare eligible Dependents.

d. In the case of a person for whom Medicare is the primary payor and who is covered under this plan either because of current employment, COBRA continuation coverage or Initial Pensioner Coverage, benefits under this plan shall be determined in accordance with a benefit offset calculation. Under this method, the plan will calculate what its benefit liability would have been under Articles 3 and 4 in the absence of Medicare coverage but using Medicare determined charge levels. Then, that liability will be reduced by the benefits payable under Medicare. Other persons covered under this Plan for whom

Medicare is primary shall have their benefits determined in accordance with Article 6.

e. If an individual covered by the Plan is eligible to enroll for Medicare benefits and Medicare would be the primary payor of his benefits if he so enrolled, then this Plan will calculate his benefit as if he had timely enrolled for full Medicare benefits if he does not. The Trustees shall determine what benefit would have been payable by Medicare, Parts A and B, and their determination shall be final and binding upon the individual and the Plan.

Section 8.05. Coordination of Benefits under COBRA. In instances where COBRA Continuation Coverage has been extended pursuant to Article 2, benefits will be paid pursuant to the Coordination of Benefits provisions of this Article 8.

Section 8.06. Benefit Maximum. When the total amount of benefits otherwise payable under this Plan is reduced in accordance with this Article, only such reduced amount actually paid shall be charged against any applicable benefit limit of this Plan.

Section 8.07. Duplicate Coverage Inquiries. For the purposes of determining the applicability of implementing the terms of this Article, or any provision of similar purpose of any other plan, the Health Plan may, without consent of, or notice to, any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person

which the Plan deems to be necessary for such purpose and in so acting the Plan shall be free from any liability that might arise in relation to such action. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this Article.

Section 8.08. Direct Payment to Other Plans. Whenever payments which should have been made under this Plan in accordance with this provision have been made by any other health plans, the Plan shall have the right, exercisable alone and its sole discretion, to pay to any health plan making such other payments, any amounts the Plan shall determine to be warranted in order to satisfy the intent of this Article and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

Section 8.09. Recovery of Overpayments. Whenever payments have been made by the Plan with respect to all Allowable Expenses in a total amount, at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right, exercisable alone and at its sole discretion, to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine: any persons to, or for, or with respect to, whom Plan payments were made; any insurance companies; or any other organization.

ARTICLE 9

SUBROGATION

Section 9.01. Subrogation.

Section 9.01.01. Plan Benefits Are Subject To Right To Subrogate. In the event of any payment under this Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of the covered individual arising out of any claim or cause of action which has accrued or may accrue because of alleged negligence or any other claim against a third party for the injuries or conditions which resulted in the payments. This includes, but is not limited to, the right of the Plan to sue such third party directly in the place and stead of the covered individual, or the personal representative of same. Any such covered individual, by filing for benefits, and the personal representative of same, as follows:

a. agrees to reimburse the Plan for any and all benefits so paid hereunder, out of any and all monies recovered from such third party as the result of suit, judgment, settlement or otherwise; and whether the recovery be designated as medical expenses or otherwise;

b. agrees that no settlement will be made nor release given without prior notification to the Plan;

c. agrees to transfer and assign to the Plan all rights, title and interest in and to any and all monies that may be recovered as a result of any claim or suit arising out

of the loss or injury to the extent of any and all payments made by the Plan relating to such loss or injury and agrees to authorize that such amount be deducted from any and all recoveries that may be received by the covered individual's attorney or representative and be paid over directly to the Plan; and

d. agrees to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan may require to facilitate the enforcement of its rights.

Section 9.01.02. Notice of Possible Subrogation. The Participant or Eligible Dependent specifically agrees on behalf of him or herself (or his or her guardian or estate) to notify the Administrator, in writing, of whatever benefits are paid by this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this Section.

Section 9.01.03. Penalties for Failure to Comply. Failure to provide necessary information or to reimburse the Plan within four weeks after recovery of any sum shall disqualify the covered individual and his dependents from receiving any future benefits under the Plan.

ARTICLE 10

GENERAL PROVISIONS

Section 10.01. Proof of Claim. All benefits hereunder shall be payable only upon receipt by the Fund Office of written proof, satisfactory to the Trustees, covering the occurrence, character and extent of the event for which claim is made. Claims for benefits must be made within two (2) years after the date the covered expense is incurred.

Section 10.02. Examination. The Trustees or their duly-appointed representatives shall have the right and opportunity to examine the person of a covered individual during the pendency of a claim hereunder.

Section 10.03. Payment of Claims. Benefits hereunder shall be payable to the Eligible Employee or Pensioner or Dependent, or Widow or Widower; provided, however, that the Trustees, in their discretion, may pay such benefits (less any overpayments previously paid by the Plan), as follows:

a. To a Hospital, Physician or provider furnishing services, supplies, care or treatment for benefits; or

b. To any person, including a Dependent, who has paid the Hospital, Physician or provider for such services, supplies, care or treatment. Such payments shall constitute a full discharge of the liability of the Trustees and Plan to the extent of the benefits so paid; or

c. According to a valid assignment of benefits.

Section 10.04. Non-Assignment of Benefits. Except as provided above, no Eligible Employee, Pensioner, Dependent or Widow/Widower shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute or anticipate any benefit payment hereunder, and any such payment shall not be subject to any legal process to levy, execution upon or attachment or garnishment proceeding against for the payment of any claims.

Section 10.05. Recovery of Overpayments. In the event of any overpayments made by the Plan, the Plan shall have the right, exercisable alone and at its sole discretion, to recover such overpayments to the extent of such overpayment from among one or more of the following as the Plan shall determine: any persons to, or for, or with respect to, whom Plan payments were made; any insurance companies, providers of services, hospitals, institutions and/or organizations. Failure to reimburse the Plan for such overpayment within four weeks from the date of the demand by the Plan for repayment of the overpayment may in the Trustees' discretion disqualify the covered individual from receiving any future benefits under the Plan, and may result in the pursuit of legal action.

Section 10.06. Amendments. The Trustees shall have the right, in their discretion, to alter or terminate the amount or conditions hereof with regard to any benefit, and otherwise to amend any other provisions of this Plan Document.

Section 10.07 Interpretation. The Trustees shall have the right, in their discretion, to interpret and construe the terms and provisions of this Plan Document and any such interpretation or construction shall be final and binding upon all persons concerned.

Section 10.08 Notice of Denial. If a claim for any benefit hereunder is denied, in whole or in part, the Administrator or any other party acting on behalf of the Plan shall promptly send, in writing, a notice to such claimant, setting forth the specific reasons for such denial.

Section 10.09. Appeals Procedure.

a. Any covered Individual whose claim for benefits has been denied, in whole or in part, shall be entitled to a full and fair review by the Trustees of the decision denying the claim.

b. A request for such a review shall be made in writing to the Trustees or to the Administrator not more than 60 days after the date of the said notice of denial.

c. An Appeals Committee consisting of two Management Trustees and two Union Trustees shall be established to make an initial decision on any claim being appealed. The Committee shall meet no less frequently than quarterly.

d. All documentation on a claim being appealed shall be compiled by the Administrator and presented to the Appeals Committee.

e. A claimant and his or her authorized representative shall be permitted, upon request, to review documents pertinent to the claim and submit issues and comments in writing for the consideration of the Appeals Committee.

f. The Appeals Committee shall render all decisions on appeals in a prompt manner. Such decisions shall be made no later than the date of the Committee meeting which immediately follows the Fund Office's receipt of an appeal. If an appeal is filed within 30 days preceding the date of such meeting, a decision shall be made no later than the date of the second meeting following receipt of the appeal.

g. A claimant who disagrees with a decision of the Appeals Committee shall have the right to a final appeal to the full Board of Trustees. A written request for such a final appeal shall be made to the Fund Office within 60 days of the date the claimant receives notice of the decision of the Appeals Committee.

h. All appeals submitted to the full Board of Trustees shall be adjudicated at the next regularly scheduled meeting of the Trustees.

i. A full record of each appeal shall be maintained, in writing, by the Fund Office for the same length of time as regular claim histories of covered individuals are retained.