

**CARPENTERS
HEALTH FUND
OF WEST VIRGINIA**

**SUMMARY PLAN
DESCRIPTION**

August 2009

FOREWARD

TO ALL EMPLOYEES:

Your Union, the Employers and the Board of Trustees are pleased to provide you with this new Summary Plan Description (booklet) of benefits provided by the Carpenters Health Fund of West Virginia.

You are urged to read this Summary Plan Description (booklet) to understand the benefits provided, as well as the rules of eligibility. Several modifications to your Plan have been made and are reflected herein.

The Trustees have retained Mountain State Blue Cross Blue Shield to serve as claims administrator for the self-funded medical benefit program and to permit participants to access the Blue Cross Blue Shield network of providers. To encourage the use of network providers, the Plan now contains a benefit differential between charges from network and non-network providers. To locate a network provider, call (800) 543-7822.

Remember, the Plan requires each hospital confinement to be pre-certified, if the confinement is planned in advance. Likewise, it is necessary to contact the pre-certification service within two (2) business days of an emergency admission. Please refer to the back of the Mountain State Blue Cross Blue Shield ID card for telephone numbers to call.

American Benefit Corporation will continue to provide claim administration services for the self-funded Weekly Disability, Dental and Medicare Supplement Benefits and process contributions from employers and retiree and active participant self-contributions.

If you have any questions concerning the Plan, please contact the Fund Office at:

609 Third Avenue, Chesapeake, OH 45619
(304) 525-0331 or (800) 553-9032

The Fund Office staff will assist you in any way possible.

Sincerely,
The Board of Trustees

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GENERAL INFORMATION

WHAT IS THE NAME OF THE PLAN?

The name of the Plan is the Carpenters Health Fund of West Virginia. The address of the Fund Office is: 609 Third Avenue, Chesapeake, OH 45619.

WHEN WAS THE FUND CREATED?

The Fund was established by an Agreement and Declaration of Trust entered into on May 1, 1956, between the Trustees representing the Local Unions and by the various Employers who had entered into Labor Contracts with the Unions. Both the Unions and the Employers appointed an equal number of persons, called Trustees, who formed a joint Board of Trustees. The Agreement and Declaration of Trust was amended effective January 1, 1982, to change the name of the fund from the Construction Industry Insurance Fund of Western Maryland and West Virginia to the Carpenters Health Fund of West Virginia.

WHO IS THE “PLAN SPONSOR” AND “ADMINISTRATOR” OF THE PLAN?

The “Plan Sponsor”/”Administrator” is the joint Board of Trustees. The names and mailing addresses of the Trustees are as follows:

Union Trustees

M. Scott Brewer
205-A Tennessee Avenue
Charleston, WV 25302

Mark Estlack
1812 Garfield Avenue
Parkersburg, WV 26101

William C. Halbert
8500 Pennsylvania Avenue
Upper Marlboro, MD 20772

Employer Trustees

James Brown
G.A. Brown & Son, Inc.
215 Mill Street
Fairmont, WV 26554

Brian Smith
Dougherty, Inc.
600 50th Street SE
Charleston, WV 25304

Glenn Jeffries
Cornerstone Interiors
P.O. Box 412
Eleanor, WV 25070

Union Trustees

Jim King
5038 West Washington Street
Cross Lanes, WV 25313

Orphy Klempa
56 19th Street
Wheeling, WV 26003

Rick Eppard
3801 Jefferson Davis Highway
Richmond, VA 23234

Employer Trustees

Keith McClanahan
BBL Carlton, Inc.
P.O. Box 1153
Charleston, WV 25324

Joe Whipkey
Blackhawk Interiors
3500 Morgantown
Industrial Park
Morgantown, WV 26501

John Wiseman
Wiseman Construction
Company
1616 Sixth Avenue
Charleston, WV 25312

Upon written request, Participants and Beneficiaries may receive from the Fund Office information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the appropriate address.

WHAT IS THE EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER?

The Employer Identification Number (EIN) assigned to the Fund is 55-0621800. The Plan Number is 501.

WHAT TYPES OF BENEFITS ARE PROVIDED?

The Plan provides certain health benefits — for example, Life, Accidental Death and Dismemberment, Weekly Disability, and Comprehensive Major Medical Benefits. The specific benefits listed in this booklet are revised periodically by the Trustees. Information will be supplied to you by the specific claims administrator, without cost, regarding the current benefit allowance, if any, for any particular claim.

The Fund does **not** provide a pension; it is only a Health Fund.

WHAT IS THE TYPE OF ADMINISTRATION?

The day-to-day operation of the Fund is conducted by contract administrators (Mountain State Blue Cross Blue Shield and American Benefit Corporation) retained by the Board of Trustees.

Contribution and Eligibility Administration:

American Benefit Corporation

609 Third Avenue

Chesapeake, OH 45619

(304) 525-0331 or (800) 553-9032

Medical Benefit Claims Administration:

Mountain State Blue Cross Blue Shield

P. O. Box 7026

Wheeling, WV 26003-7026

(800) 344-5123

Dental, Disability, Medicare Retiree

Supplement Claims Administration:

American Benefit Corporation

3150 U. S. Route 60

Ona, WV 25545

(304) 525-0331 or (800) 553-9032

WHO ARE THE AGENTS FOR SERVICE OF LEGAL PROCESS?

Kimberly L. Bradley, Esquire

Abato, Rubenstein & Abato, P.A.

809 Gleneagles Court, Suite 320

Baltimore, MD 21286

Mark W. Carbone, Esquire

Carbone & Blaydes, PLLC

2442 Kanawha Boulevard East

Charleston, WV 25701

WHAT ARE THE SOURCES OF CONTRIBUTIONS TO THE FUND?

There are two sources of contributions to the Plan. First, a small source of contributions to the Plan is self-contributions from Participants. Second, the largest source of contributions to the Plan is employer contributions made pursuant to written agreements. The amount of contributions to be made by an Employer is determined by multiplying the hourly rate of contributions specified in the applicable Collective Bargaining Agreement times the total number of hours worked for the Employer by covered Employees during the payroll period.

WHAT IS THE IDENTITY OF THE FUNDING MEDIUM USED FOR THE ACCUMULATION OF ASSETS THROUGH WHICH BENEFITS ARE PROVIDED?

United National Bank, West Virginia, is the depository of funds for the provision of benefits.

WHAT IS THE PLAN'S FISCAL YEAR END?

The Plan's fiscal records begin on October 1 and end September 30 of the following year.

WHAT IS THE SCOPE OF THE PLAN?

The Plan's provisions of coverage will be limited to those benefits as provided herein. It is to be understood all sicknesses and accidents to employees determined to be the direct result of employment shall not be covered and no benefits will be provided by the Fund, with the exception of Life Insurance Benefits and Accidental Death and Dismemberment Benefits, which are payable on a twenty-four (24) hour basis.

MAY THE BENEFITS BE CONVERTED TO INDIVIDUAL COVERAGE IF I LEAVE THE FUND?

Because of the self-funded status of the fund, the only benefits which may be converted are the Life Insurance Benefits. The other benefits provided herein are not capable of being converted to individual coverage. (See "Your Rights Under COBRA.")

ARE ANY OF THE BENEFITS PROVIDED BY THE FUND INSURED?

The Life Insurance and Accidental Death and Dismemberment benefits are insured by Boston Mutual Life Insurance Company.

IMPORTANT NOTICE — ANY CLAIM NOT SUBMITTED WITHIN ONE YEAR OF COMMENCEMENT OF INJURY OR SICKNESS WILL BE DENIED. THE CLAIM WOULD HAVE TO BE SUBMITTED TO THE BOARD OF TRUSTEES ON AN APPEAL BASIS FOR CONSIDERATION.

SECTION I DEFINITIONS

The following is a list of terms used frequently throughout this booklet:

I.01: DURABLE MEDICAL EQUIPMENT:

The term “Durable Medical Equipment” will mean equipment which:

1. Can stand repeated use; and
2. Is primarily and customarily used to serve a medical purpose; and
3. Is generally not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the home; and
5. Is not primarily and customarily for the convenience of the claimant; and
6. Provides direct aid or relief of the claimant’s medical condition; and
7. Is recommended by a doctor.

I.02: ELIGIBLE DEPENDENT OR DEPENDENT:

The term “Eligible Dependent” or “Dependent” shall include only the following, provided they are not eligible to be covered under the Plan as Participants and, if previously covered as Participants, are not eligible to receive any benefits under the Plan as a result of a disability existing when coverage as a Participant was discontinued.

1. Participant’s legal spouse while not divorced from the Participant.
2. The term “children” shall include your natural (biological) child. In addition, it shall also include:
 - (a) your stepchild, provided the child lives with you (and has lived with you for at least three (3) consecutive months immediately prior to any claim incurred), in a regular parent/child relationship, the child is dependent upon you for at least fifty percent (50%) or more of the cost of his or her maintenance and support and no other person is legally responsible to

- provide medical coverage or pay claims on behalf of such child;
- (b) your legally adopted child (including a child placed with you for the duration of the probationary period, regardless of whether the adoption becomes legally final);
 - (c) a child for whom you have been appointed legal guardian and custodian, if related to you by blood or marriage, provided the child lives with you (and has lived with you for three (3) consecutive months immediately prior to any claim submitted), in a regular parent/child relationship, the child is dependent upon you for at least fifty percent (50%) or more of the cost of his or her maintenance and support and no other person is legally responsible to provide medical coverage or pay claims on behalf of such child; and
 - (d) a child named in a Qualified Medical Child Support Order satisfying all conditions outlined in the Omnibus Budget Reconciliation Act of 1993.
3. Participant's unmarried children who are over nineteen (19) years of age but less than twenty-three (23) years of age, provided that such children are enrolled in a full-time accredited educational institution on a full-time basis and are dependent upon the Participant for their support. Proof of enrollment in such institution shall be required by the Plan.
4. Participant's unmarried children who are dependent on the Participant for support and maintenance because of a physical handicap or mental retardation as certified by a physician. The Fund may request a statement indicating the extent of support and maintenance. For benefits to be effective, the disability must have occurred before the child reached the age of nineteen (19), or age twenty-three (23) if covered under (3) above.

The Plan may request documentation to verify a claim that a child meets the requirements of a Dependent as outlined above.

A Participant's dependent shall become eligible for coverage at the same time the Participant becomes eligible or at the time they become dependents, whichever is the latter.

I.03: EMPLOYEE:

The term "Employee" shall mean all persons on whose account an Employer is, or has been required, to make contributions into the Health Fund, including Business Representatives of the Unions and any other employee of the Unions while employed in a paid capacity by the Unions or affiliate thereof.

I.04: EMPLOYER:

The term "Employer" shall mean an Employer who is bound by a Collective Bargaining Agreement with the Unions providing for the establishment of a Health Plan and Health Fund and for the payment of contributions to such fund.

The term "Employer" shall in addition mean:

- (a) An Employer in the Building Construction Industry who employs Employees as defined herein (i) who has in force or who executed an Agreement with the Union, providing for such Employer's participation in and his adoption of the Trust Agreement and Health Plan or (ii) who shall, with the consent of the Trustees, execute a form furnished by the Trustees undertaking all the duties of an Employer participating in this Trust. It is understood and agreed all Employers who become an Employer under the Terms of the Trust Agreement agree to abide by all provisions, rules and regulations set forth in the said Trust Agreement and further agree the Employer Trustees shall act as their representative in connection with this Trust Estate during their term of trusteeship.
- (b) The Unions which for the purpose of making the required contributions into the Health Fund shall be considered as the Employer of the Employees of the Union for whom the Unions contribute to the Health Fund.

1.05: EMPLOYER CONTRIBUTIONS:

The term “Employer Contributions” shall mean any and all payments made by all Employers to the Health Fund in accordance with or as required by any Collective Bargaining Agreement or other agreement or arrangement between the Employer and the Union or any of its affiliated Local Unions or between the Fund and an Employer, Local Union or affiliated organization, such as a joint apprenticeship and training fund, for the uses and purposes set forth in the Trust Agreement.

1.06: EXTENDED CARE FACILITY:

The term “Extended Care Facility” shall mean an institution licensed under local or state law and operated primarily for the purpose of providing skilled nursing care and treatment for individuals who are convalescing from injury or sickness. An Extended Care Facility is not a rest home, a home for the aged, or a place for treatment of mental diseases, drug addiction or alcoholism.

1.07: EXPENSE INCURRED:

The term “Expense Incurred” includes only those charges made for services and supplies which a prudent person would consider to be reasonably priced and reasonably necessary in light of the injury or sickness being treated.

1.08: HEALTH FUND OR FUND:

The term “Health Fund” or “Fund” shall mean the Carpenters Health Fund of West Virginia and shall consist of all employer contributions to the Trust Fund received under the Trust Agreement or otherwise, and any additional contributions thereto that may hereafter be agreed upon by the parties under any collective bargaining agreement or other agreements or any modification, supplement, amendment, revision or extension thereof, together with all income, increments, earnings, dividends, interest and profits there from and all other funds as herein defined, received by the Trustees for the uses, purposes and trusts set forth in the Trust Agreement.

1.09: HEALTH PLAN OR PLAN:

The term “Health Plan” or “Plan” shall mean a plan, program, method and procedure for providing benefits to or from Participants, or their Beneficiaries, in

accordance with such rules and regulations relating to eligibility requirements, amounts of benefits, character of benefits, general administration and operation of the Health Fund and related matters as the Trustees may from time to time put into effect, adopt, enact or promulgate. The funds shall not be used for any other purpose.

1.10: HOSPITAL:

The term "Hospital" means only an institution lawfully engaged in providing, for payment from its patients, care and treatment for sick and injured people as bed-patients, which provides care by registered graduate nurses on duty or on call at all hours of the day and night, has a staff of one or more doctors available at all times, and has on its immediate premises (except in the case of a hospital specializing in the care and treatment of mental or nervous disorders) an operating room and related equipment for performing surgery. "Hospital" does not include any establishment (even though it may be called a hospital) which is primarily a place for any of the following: rest, convalescence, custodial care, the aged, training, schooling, or occupational therapy.

1.11: HOSPITAL CONFINEMENT:

The term "Hospital Confinement" shall mean a person is considered to be hospital confined if a room and board charge is made.

1.12: LEGALLY QUALIFIED DOCTOR OF MEDICINE, PHYSICIAN OR SURGEON AND LEGALLY QUALIFIED PHYSICIAN OR SURGEON:

The term " Legally Qualified Doctor of Medicine," "Physician or Surgeon" and "Legally Qualified Physician or Surgeon" mean a person licensed to prescribe and administer all drugs and to perform all surgery, or any other licensed practitioner performing services which would be payable under the Plan if performed by a physician or surgeon operating within the scope of their license.

1.13: LICENSED PHARMACIST:

The term "Licensed Pharmacist" shall mean a person who is licensed by the state or other legal jurisdiction to prepare, preserve, compound and dispense drugs.

1.14: LICENSED PRESCRIBER:

The term "Licensed Prescriber" shall mean a person licensed by the state or other jurisdiction to prescribe drugs for human use. Licensed Prescriber includes Physicians, Dentists, Podiatrists and Doctors of Osteopathy when so licensed.

1.15: MEDICALLY NECESSARY:

The term "Medically Necessary" shall mean services and supplies which are:

1. Consistent with the symptom or diagnosis and treatment of the Participant's or Covered Dependent's condition, disease, ailments or injuries;
2. Appropriate with regard to standards of good medical practice;
3. Not solely at the choice of or for the convenience of a Participant or Dependent, Physician, Hospital or other provider; and
4. The most appropriate supply or level of service which can be safely provided to the Participant or Dependent. When applied to the care of an inpatient, most appropriate means that the Participant's or Dependent's medical symptoms or conditions require that the services or supplies cannot be provided as an outpatient in a Physician's office or in another facility.

Benefits will not be provided for Hospital stays, when based upon the primary reason for the admission, the hospitalization is not Medically Necessary, as determined by the Plan.

THE FACT THAT A PHYSICIAN HAS PRESCRIBED, ORDERED, RECOMMENDED OR APPROVED A SERVICE, TREATMENT, HOSPITALIZATION OR SUPPLY DOES NOT, OF ITSELF, MAKE SUCH SERVICE, TREATMENT, HOSPITALIZATION OR SUPPLY MEDICALLY NECESSARY NOR DOES IT MAKE THE CHARGE A COVERED EXPENSE. THE PLAN RESERVES THE RIGHT TO MAKE THE FINAL DETERMINATION OF MEDICAL NECESSITY ON THE BASIS OF FINAL DIAGNOSIS AND SUPPORTING MEDICAL DATA.

1.16: NON-LEGEND, PATENT OR PROPRIETARY MEDICINE:

The term “Non-Legend, Patent or proprietary shall mean any drug, medicine or medication which does not contain a label bearing the legend “Caution, Federal Law prohibits dispensing without a Prescription,” or similar words.

1.17: NON-OCCUPATIONAL:

The term “Non-Occupational” shall mean an injury or sickness which does not arise out of and/or in the course of any employment for wage or profit.

1.18: PARTICIPANT:

The term “Participant” shall mean any person who meets the eligibility rules as adopted by the Trustees and as set forth herein.

If a husband and wife are both eligible Participants due to meeting the eligibility requirement, the wife shall be considered a dependent of the husband and the husband shall be considered a dependent of the wife. Children of such members shall be considered dependents of both the husband and the wife.

1.19: PSYCHOLOGIST:

The term “Psychologist” shall mean an individual who is licensed (or certified as a Psychologist in areas where certification exists) and qualified as a professional Psychologist by a recognized psychological association.

1.20: REASONABLE AND CUSTOMARY:

The term “Reasonable and Customary” shall mean the usual charge made by a physician, dentist, optometrist or supplier of services, medicines or supplies and will not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within an area in which the charge is incurred for sickness, injury or treatment comparable in severity and nature to the sickness, injury or treatment being administered within a geographical area.

1.21: SPECIAL CARE FACILITY:

The term “Special Care Facility” shall mean an institution (not a Hospital) specializing in rehabilitation of injured or sick persons or providing diagnosis and treatment of mental illness or functional nervous disorder. It

qualifies as an Extended Care Facility and a provider or services under Medicare. It maintains on its premises all facilities necessary to provide for the medical treatment of injury or sickness. It has the supervision of Physicians and nursing service by registered graduate nurses or licensed practical nurses.

I.22: SURGICAL PROCEDURE:

The term “Surgical Procedure” shall mean only the following:

1. A cutting operation;
2. Suturing of a wound;
3. Treatment of a fracture;
4. Reduction of a dislocation;
5. Radiotherapy (including radioactive isotope therapy if used in lieu of a cutting operation for removal of a tumor);
6. Electrocauterization;
7. Diagnosis and therapeutic endoscopic procedures; or
8. Injection treatment of hemorrhoids, varicose veins and bursa.

When more than one surgical procedure is performed during an operation, the allowable amount will be paid for a major procedure and the allowable amount for a second procedure will be reduced by 50%.

Payment will not be made for secondary procedures through the same incision that are determined to be incidental.

I.23: TRUST AGREEMENT:

The term “Trust Agreement” shall mean the Agreement and Declaration of Trust established to create the Fund and detailing the procedures and funding of the Fund and the powers of the Trustees.

I.24: TRUSTEE:

The term “Trustee” shall mean the Trustees designated by the Trust Agreement and their successors who may or shall be designated and appointed in accordance with the terms and provisions therein.

I.26: UNION OR LOCAL UNION:

The term “Union” shall mean the various Local Unions who have Collective Bargaining Agreements in effect with various employers providing for the establishment of a Health Plan and Health Fund and for their payments of contributions to such Fund.

SECTION II
ACTIVE PARTICIPANT ELIGIBILITY
DETERMINATION

2.01: ELIGIBILITY BY CONTRIBUTIONS:

Contributions from Employers for each hour worked will be credited to an individual's Dollar Bank upon receipt of the employer's payment. Credit will only be granted for contributions actually paid to the Fund on an individual's behalf.

The required amount of contributions for eligibility is determined from time to time by the Board of Trustees. Contact the Fund Office to obtain the current required amount, as this amount is reviewed annually and may vary depending on the type of coverage provided under the Plan.

Participants will become eligible for benefits on the first day of the second Benefit Month following crediting of at least the required amount to the Participant's Dollar Bank.

Benefits will be effective on the first day of the Benefit Month if the bank balance on the first day of the preceding month, the Eligibility Date, is the required amount or more. For example, a new Participant who accumulates an account balance of the required amount or more during the month preceding the Eligibility Date of February 1, will be eligible for the ensuing Benefit Month of March. Below are the Eligibility Determination Dates and the Schedule of Benefit Months:

ELIGIBILITY DETERMINATION DATE
BENEFIT MONTH

January 1	February
February 1	March
March 1	April
April 1	May
May 1	June
June 1	July
July 1	August
August 1	September
September 1	October
October 1	November
November 1	December
December 1	January

A Participant's eligibility will continue on a month-by-

month basis in accordance with the Schedule of Benefit Months above. For each Benefit Month of eligibility, the Participant's Dollar Bank Balance will be reduced by the required amount as of the Eligibility Determination dates shown above.

If a Participant was not eligible for the preceding Benefit Month and the balance in his Dollar Bank as of the next Eligibility Determination date is at least \$75, he will be permitted to make a payment equal to the difference between the required amount and the balance in his Dollar Bank to become eligible for benefits during the corresponding Benefit Month. If eligibility is not purchased, the Dollar Bank balance will be forfeited. If an Eligibility Determination Date falls on a weekend or a holiday, eligibility will be determined on the next business day.

All employer contributions received on a Participant's behalf will be credited to his Dollar Bank, subject to a maximum accumulation of \$10,000.

2.02: TERMINATION OF INDIVIDUAL COVERAGE:

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

- (a) The date the Plan terminates;
- (b) The date of expiration of the period for which the last payment is made on account of the Participant;
- (c) The date on which the Participant enters full-time military, naval or air service, or;
- (d) The date the Participant ceases to be within the classes of persons eligible for benefits under the Plan.

When a Participant enters the military, naval or air service of the United States, as the result of an election by the Participant any accumulated eligibility to the credit of such employee may be kept on the records of the Fund and shall be made available to the Participant when he returns from military service, provided the Participant notifies the Fund in writing that he is entering military service pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act. (See Section 19.04 for additional information

2.03: EFFECTIVE DATE OF DEPENDENT COVERAGE:

In order to be covered for Dependent benefits, a Participant must be covered for benefits. Coverage for his Eligible Dependents shall become effective on the latest of the following dates:

- (a) On the date the Plan became effective;
- (b) On the Participant's effective date; or
- (c) On the date the Employee first acquires an eligible Dependent.

If a participant acquires a Dependent while he is eligible for dependent coverage, such Dependent shall become covered automatically.

2.04: TERMINATION OF DEPENDENT COVERAGE:

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

- (a) The date such Dependent cease to be an eligible dependent;
- (b) The date the Participant's coverage terminates;
- (c) The date the Dependent enters an armed service on full-time active duty; or
- (d) The date the Plan is terminated.

See Sections 2.08, 2.09 and 2.10 for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

2.05: QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A "QMCSO" is a medical child support order that:

- a. Creates or recognizes the right of an "alternate recipient" to receive benefits for which a Participant or Dependent is eligible under a group health plan or assigns to an alternate recipient the right of a Participant or Dependent to receive benefits under a group health plan; and
- b. Is recognized by the group health plan as "qualified" because it includes information and

meets other requirements of the QMCSO provisions.

Any child of a Participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such Participant is an alternate recipient.

A medical child support order must contain the following information in order to be qualified:

- a. The name and last known mailing address of the Participant and each alternate recipient, except that the order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- b. A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined) ; and
- c. The period to which the order applies.

An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

Contact the Fund Office for additional information.

2.06: CONTINUED ELIGIBILITY DURING DISABILITY PERIODS:

If, after you become eligible, you cannot work because of a disability for which you receive a Weekly Disability Benefit under this Plan and your Dollar Bank balance has been depleted to maintain eligibility to the equivalent of the cost of coverage for three (3) months, you will be credited with deposits to your Dollar Bank for each full day of disability for a maximum period of twenty-six (26) weeks during any period of continuous disability. The amount credited to your Dollar Bank each week will represent the weekly cost of continued coverage through the Plan so that for each month of disability the credit to the Dollar Bank will be sufficient to purchase an additional month of eligibility.

2.07: TERMINATION OF A BARGAINING UNIT:

If a Local Union, District Council or Contributing Employer ceases to participate in the Fund with respect to one or more bargaining units, the eligibility of the Employees of that unit will terminate as of the date the Local Union, District Council or Contributing Employer ceases to participate. A Local Union, District Council or Contributing Employer will be considered to have ceased participation in the Fund as of the last day for which its collective bargaining agreement, or other written agreement, requires Employer contributions to be paid to the Fund. In no event does any extension of benefits pertain to people affected by termination of a bargaining agreement.

2.08 – MEDICAL BENEFITS CONTINUANCE PROVISIONS: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Medical Benefits as used in this provision means Comprehensive Major Medical, Prescription Drug and Dental Benefits provided under the Plan on an expense-incurred basis and Life Insurance.

Continuation of Group Medical Benefits:

1. You may elect to continue medical benefits for yourself and/or your eligible Dependents for as long as twenty-four (24) months from the day your eligibility ends because:
 - (a) your employment ends (other than due to gross misconduct) or
 - (b) you no longer satisfy the requirements for hours worked.
2. You or your eligible spouse may elect to continue medical benefits for yourself and your eligible Dependents for an additional period of five (5) months if you or an eligible Dependent are deemed totally disabled and you have been awarded Social Security Disability Benefits, provided disability commenced prior to the qualifying event or within sixty (60) days of the date the continuance period began. Proof of total disability must be provided to the Fund Office prior to the expiration of the twenty-four (24) month continuance period described above and within sixty (60) days of receipt of the disability award from the Social Security Administration.

3. Your eligible spouse and/or any Dependent child may elect to continue medical benefits for as long as thirty-six (36) months from the day eligibility ends because:
- (a) you die;
 - (b) you become entitled to and elect Medicare benefits, even though you remain an active employee;
 - (c) you and your spouse are legally separated;
 - (d) your marriage is ended by divorce; or
 - (e) a child is no longer an eligible Dependent.

You are responsible for notifying the Fund Office within sixty (60) days of when medical benefits end in accordance with 3(c), 3(d), or 3(e) above.

The Fund Office will send you or your eligible spouse, within fourteen (14) days of being notified of a qualifying event, written notice of the right to continue medical benefits.

Notice of the right to continued coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

The Fund Office will send you or your eligible spouse written notice of the right to continue medical benefits. The Fund Office must receive you or your Dependent's written request to continue medical benefits by the later of:

- (a) sixty (60) days after the day medical benefits end; or
- (b) sixty (60) days after the notice is received.

Continued coverage may only begin on the day after medical benefits under the Plan ends. You or your Dependents must pay the required premium, including any retroactive premium, from the day the coverage would have otherwise ended. The premiums must be paid to the Fund Office within forty-five (45) days after the day continued coverage is elected. The Fund Office will inform you or your Dependent of the monthly premium to be paid.

If elected, the maximum period for continued coverage for a "qualifying event" involving termination of employment or reduced working hours is twenty-four (24) months. However, if a second qualifying event occurs within twenty-four (24) months, the period of

coverage may be extended to thirty-six (36) months from the first qualifying event.

For all other “qualifying events,” the maximum period is thirty-six (36) months.

4. Continued medical benefits will end at midnight on the earliest of:

- (a) the day the Fund ceases to provide any group health plan;
- (b) the day premium is due and unpaid;
- (c) the day you are covered under another group health plan, and any pre-existing condition limitation or exclusion of that plan does not apply or is satisfied by you. (A plan’s pre-existing conditions limitation period will be reduced for each month that you and your Dependents had continuous health coverage (including COBRA) with no break in coverage greater than sixty-three (63) days. When your coverage ends, you will receive certification of the duration of your COBRA coverage. This provision applies individually to each person with COBRA coverage.);
- (d) the day a covered person again becomes covered under the Plan on the basis of employment;
- (e) the day a covered person is entitled to benefits under Medicare;
- (f) the day medical benefits have been continued for the period of time provided in 1, 2, and 3 under continuation of group Medical Benefits.

NOTE: In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.

COBRA payments are to be remitted to the Carpenters Health Fund of West Virginia, P.O. Box 11344, Charleston, WV 25339. LATE PAYMENTS CANNOT BE ACCEPTED.

2.09: ACTIVE PARTICIPANT ELIGIBILITY DETERMINATION UNDER COBRA:

1. If the balance in a Participant’s Dollar Bank on an Eligibility Determination Date is less than the required amount and he was eligible for the last Benefit Month, he will be permitted to make a COBRA payment (equal to the difference of

his Dollar Bank and the cost of the COBRA continuance) to remain eligible for the next Benefit Month.

2. If a Participant has begun making COBRA payments to purchase continuous eligibility and on an Eligibility Determination Date his Dollar Bank is at least \$225, the payment of the required COBRA amount for coverage the corresponding Benefit Month will not count in the determination of the maximum continuance period under COBRA.
3. In the event a Participant has insufficient dollars in his Dollar Bank on any Eligibility Determination Date to maintain eligibility and he fails to make a COBRA payment for the corresponding Benefit Month, his Dollar Bank will be closed and any balance in the account will be forfeited immediately.

YOUR DOLLAR BANK AND FUTURE ELIGIBILITY DETERMINATION ARE FROZEN UNTIL YOU MAKE THE APPROPRIATE COBRA ELECTION AND PAYMENT.

2.10: SPECIAL LIFE INSURANCE CONTINUANCE

In lieu of the full COBRA continuance of benefits, you may elect to purchase continuation of the \$30,000 Life Insurance benefit only. Coverage for a maximum of twenty-four (24) consecutive months is allowed under this provision. Your payment must be received in the Fund Office before the first day of each month of coverage being purchased. You will not receive any notice to remind you of the payment due; late payments will not be accepted and the Life Insurance benefit can only be reinstated upon requalification as an active participant.

In order to exercise this special continuance, complete the enrollment form and return it to the Fund Office with your payment.

SECTION III
ELIGIBILITY FOR RETIRED AND DISABLED
PARTICIPANTS AND SURVIVING SPOUSES
(Those Not On COBRA)

Retired and disabled Participants and surviving spouses of Participants who died while eligible for benefits under the Plan will be permitted to make self-contributions to the Plan to continue their eligibility for benefits. Self-contributions will only be accepted from those retired or disabled Participants or surviving spouses who were eligible for benefits under the Plan at the time of their retirement, disability, or the death of the eligible Participant. If a retired or disabled Participant or surviving spouse fails to make the required self-contribution when due, all benefits under the Plan will terminate and such Participant will not be allowed the opportunity to reinstate their eligibility.

A RETIRED PARTICIPANT OR SURVIVING SPOUSE WHO TERMINATES COVERAGE WILL NOT BE PERMITTED TO REINSTATE COVERAGE AT A LATER DATE.

3.01: ELIGIBILITY FOR RETIRED PARTICIPANTS:

- A. If you retire prior to attaining age sixty-five (65) under a qualified pension plan associated with the Union and you were eligible for benefits in twenty-four (24) of the last thirty-six (36) months prior to your retirement date, you may continue your eligibility by making self-contributions to the Plan until you attain age sixty-five (65) or otherwise qualify for benefits under Medicare. You may also purchase benefits for your spouse and other Dependents through self-contribution, regardless of whether your spouse or other Dependents are or are not eligible for Medicare benefits. Benefits for a spouse and other Dependents who are not eligible for Medicare will be the same as those provided to the Dependents of active Participants not eligible for Medicare.
- B. If you become totally and permanently disabled while eligible for benefits, and such disability entitles you to Social Security Disability benefits, you may continue your eligibility for benefits under the Plan through self-contribution. Your eligibility for

normal benefits under the plan will continue until you attain age sixty-five (65) or become eligible for benefits under Medicare due to your disability. You may also purchase benefits for your spouse and Dependents, regardless of whether or not they are eligible for Medicare benefits.

- C. If you continued your eligibility for benefits through self-contribution until the time you became eligible for Medicare, or if you were eligible for Medicare on the date of your retirement, you may purchase benefits through the Fund to supplement those provided by Medicare. Please refer to the Schedule of Benefits for Medicare Eligible Retirees and Spouses for a description of the benefits provided.

NOTES:

1. You will be permitted to purchase benefits under the Plan for your spouse and other Dependents you have at the time of your retirement or disability and to purchase benefits for a spouse and other Dependents you acquire after your retirement or disability. In order for coverage to be available for newly acquired Dependents, you must notify the Fund Office within thirty (30) days of the date of the marriage (or adoption or birth of a child) and pay any additional amount due.
2. Continuation of benefit eligibility through self-contribution will be permitted until the earlier of:
 - (a) the date the Retired and Disabled Participants program is discontinued;
 - (b) the date the Fund is terminated;
 - (c) the date the retired or disabled Participant is re-employed; or
 - (d) the date ending the last period for which the required self-contribution is made.
3. The Trustees are empowered to change the amount required to purchase eligibility on a self-contribution basis as deemed necessary. You will be advised of any change in the amount of self-contribution required to continue your eligibility for benefits under the Plan.

3.02: SURVIVING SPOUSE ELIGIBILITY:

If an active eligible Participant dies while eligible for benefits under the Plan, his surviving Dependents

would be entitled to benefits through the end of the Benefit Month of his death, at no additional cost. The surviving Dependents of such a deceased Participant will be permitted to make self-contributions to the Plan to continue their eligibility for benefits thereafter, provided they otherwise meet the definition of an Eligible Dependent absent the death of the Participant.

1. Continuation of benefit eligibility through self-contribution will be permitted until the earlier of:
 - (a) the date the spouse or Dependent obtains group coverage under another plan by virtue of their employment; or
 - (b) the date the spouse remarries; or
 - (c) the date the Dependent child becomes another person's dependent; or
 - (d) the date the Dependent child no longer satisfies the Dependent definition.
2. The Trustees are empowered to change the amount required to purchase eligibility on a self-contribution basis as deemed necessary. You will be advised of any change in the amount of self-contribution required to continue your eligibility for benefits under the Plan.

3.03: COBRA CONTINUATION RIGHTS:

Retired or disabled Participants or surviving Dependents of an active Participant will be permitted the opportunity to purchase continuation of benefits, as mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA), on a monthly basis, in lieu of continuation under the self-contribution provisions described above. Please be advised the continuation of coverage under COBRA will terminate for any individual upon their eligibility for Medicare Benefits, eligibility for benefits under another group health plan, or when the maximum continuation period expires. Such individual would not then be permitted to reinstate eligibility under the Plan upon termination of COBRA continuation coverage.

3.04: MEDICARE RETIREE BENEFIT PLAN:

1. ELIGIBILITY

All retired or disabled members receiving Medicare Parts A, B and D are eligible to purchase the Medicare Retiree Benefit Plan on their behalf and on behalf of their spouse if receiving Medicare Parts A, B and D Benefits.

2. BENEFITS

Benefits to supplement the benefits paid by Medicare are provided in accordance with the SCHEDULE OF BENEFITS for Medicare Eligible Retirees and Spouses. No benefits are payable for prescription drug expenses, unless enrolled in a Medicare Part D program.

3. TERMINATION

- a. the date the Medicare Retiree Benefit Program is terminated;
- b. the date the Fund is terminated;
- c. the date the retiree is re-employed in the industry; or
- d. the date ending the last period for which the required self-contribution was made.

4. LIMITATIONS

- a. Retired or disabled members who do not enroll for Medicare Parts A, B and D Benefits will not be eligible to purchase the Medicare Retiree Benefit.
- b. Continuity of eligibility for the Medicare Retiree Benefit is required.

ALL CLAIMS SUBMITTED UNDER THE MEDICARE RETIREE BENEFIT PLAN MUST BE ACCOMPANIED BY THE RELATED MEDICARE EXPLANATION OF BENEFITS STATEMENT.

**SECTION IV
SCHEDULE OF BENEFITS**

**EMPLOYEES AND DEPENDENTS,
ACTIVES AND RETIREES
NOT ELIGIBLE FOR MEDICARE**

Active Coverages	Retiree Coverages
Participant Only	Retiree Only
Death Benefit	
\$30,000	\$30,000
Accidental Death and Dismemberment Benefit	
\$30,000	\$30,000

NOTE: The Life Insurance and Accidental Death & Dismemberment Insurance are underwritten by Boston Mutual Life Insurance Company. See description at Sections VI and VII.

Accident and Sickness Benefit	
Amount per week	
\$200	None
Maximum weeks.....	26
Elimination (waiting) Periods	
Accidents	0 days
Sickness	7 days

**HEALTH BENEFITS FOR ACTIVE
EMPLOYEES AND DEPENDENTS AND FOR
RETIRES AND DEPENDENTS**

Lifetime Maximum Benefit.....	\$1,000,000
Calendar Year Deductible.....	\$250 per individual \$500 aggregate per family

**PRE-ADMISSION CERTIFICATION
IS REQUIRED FOR ALL HOSPITAL
CONFINEMENTS. THE BENEFITS
DESCRIBED BELOW WILL BE REDUCED
IF THE TERMS AND CONDITIONS OF
THE PRE-ADMISSION CERTIFICATION
PROGRAM ARE NOT FOLLOWED.**

Fund's Percentage of Payment:

Network Provider Charges	80%
Non-Network Provider Charges	70%

Emergency Room Illness Deductible:
 \$150 per incidence, unless patient is immediately
 admitted to a hospital

Patient's Percentage of Payment:
 20% or 30% of allowed expense in each calendar year,
 based upon the network affiliation of the provider,
 after the deductible, not to exceed \$2,000 per
 calendar year per individual or \$4,000 per calendar
 year per family. (Excludes Dental expenses.)
 Out-of-Pocket expenses payable to network and non-
 network providers will apply towards satisfaction of
 the maximum payment required by an individual or
 family.

Hospital Charges

- Semi-private Room and Board
- Intensive Care
- Daily Private Room (at average semi-
private rate)
- Necessary Ancillaries during confinement
- Ancillaries for required outpatient surgery
- Ancillaries for outpatient medical
emergency treatment
- Pre-admission tests
- Outpatient diagnostic laboratory and X-ray
services
- Routine Nursery Charges

Allowed Physician Charges

- Surgery and Operative Procedures
- Office Visits
- Anesthesia Administration
- Radiology
- Special Consultations
- Second Surgical Opinions
- Medical Treatment in the Home and
Hospital
- Pathology
- Routine Pediatric Newborn Care Charges
- Chiropractic care (Limited to \$500 per
calendar year.)

Other Allowed Medical Care: Prescription Drugs
Private Duty Registered Nurses
Rental or Purchase of Durable Medical
Equipment
Blood and Blood Plasma (not replaced
or donated)
Oxygen and Oxygen Equipment
Licensed Physiotherapists
Braces, Crutches
Artificial Eyes and Limbs (initial)
Surgical Dressings, Casts & Splints
Skilled Nursing Facility
Home Health Care
Hospice Care
Diabetes Education Refresher Courses
Prescription Smoking Deterrents

Preventive Care: Payable at 100% up to a combined maximum of \$500 per individual per calendar year (not subject to deductible).

Mammogram (limited to one such exam during a calendar year)

Pap Smear (limited to one such exam during a calendar year)

Well-Child Care (examinations and immunizations as recommended by the child's pediatrician)

Routine Physical Exams (limited to one such exam during a calendar year)

Colorectal Cancer Exams (limited to once every five (5) years for individuals over age 50) NOT SUBJECT TO THE \$500 CALENDAR YEAR LIMIT.

Mail Order Prescription Program

Co-Payments Per Prescription Per Fill

Generic \$10 per fill

Brand Name \$20 per fill

Lab Card Program (paid at 100% for laboratory testing sent to LabOne for analysis)

OPTIONAL DENTAL BENEFIT PROGRAM

Applicable only to participants and retirees associated with certain Local Unions and Employers purchasing this coverage

Preventive Care	100%
Basic/Routine Care	80%
Major Care	50%

The maximum benefit payable for all covered expenses incurred in a calendar year is \$1,000 per Participant or Dependent.

SECTION V
SCHEDULE OF BENEFITS
MEDICARE ELIGIBLE RETIREES & SPOUSES

Medicare Part A

Supplement Benefit

Plan Pays:

61st to 90th Day:
of Confinement

Daily Coinsurance Charge
(25% of Medicare Part A
Deductible per day)

Lifetime Reserve Period:

Daily Coinsurance Charge
(25% of Medicare Part A
Deductible per day)

After Lifetime Reserve Period:

100% of Hospital
Expenses for an
additional 365 days lifetime

Blood Deductible Benefit:

First three (3) pints
of blood under Medicare
Part A or Part B

Medicare Part B

Supplement Benefit

Medical Care:

20% of Medicare Eligible
Expenses after the Medicare
Part B deductible

Additional Benefits

Medicare Part A Deductible:

1st to 60th Day of Confinement

Medicare Part A
Deductible

Skilled Nursing Facility:

Actual billed charges
up to the Daily

1st to 100th Day of Confinement

Coinsurance
Amount (12½% of Medicare
Part A Deductible per day)

Medicare Part B Deductible:

Medicare Part B
Deductible

Medicare Part B Excess Charges:

100% of the
difference between the
actual Medicare Part B
charge as billed and the Medicare
approved Part B charge

Part D (Prescription Drug) Expenses Plan Pays:

Deductible Amount	Part D Deductible Amount
Initial Coverage Level	No Coverage
Coverage Gap Level	75% of the covered charges
Catastrophic Coverage Level	No Coverage

The Deductible Amount and thresholds for the Initial Coverage Level, Coverage Gap Level and the Catastrophic Coverage Level are determined by Medicare and are based upon the Part D coverage policy purchased by the individual.

SECTION VI LIFE INSURANCE

6.01: BENEFIT:

In the event of your death while insured, Boston Mutual Life Insurance Company, upon receipt of proof of death, will pay your Beneficiary the amount of Personal Life Insurance shown in the Schedule of Insurance.

Payment will be made in one sum unless you elect an optional method of settlement through agreement with Boston Mutual Life Insurance Company. If you do not make such an election, your Beneficiary may do so when a claim for benefits is made.

6.01: BENEFICIARY:

You alone have the right to designate your Beneficiary and you may change that designation at any time by written notice to the Fund Office. You must clearly identify your Beneficiary. If two (2) or more individuals are to share a death benefit, you must specify the portion that is to be paid to each person.

If you have not named a Beneficiary, or if your Beneficiary is no longer living, or if your Beneficiary is unable to give a valid release (such as a minor), your insurance will be paid in accordance with the terms of the Group Policy.

Boston Mutual Life Insurance Company may elect to pay as much as \$250 of any death benefit to any person or persons who, in Boston Mutual's judgment, incurred expenses in connection with your fatal illness or burial. In this event, Boston Mutual's liability will be discharged to the extent of the amount paid and your Beneficiary will be entitled only to the remainder of the death benefit.

6.03: WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY:

In this section, Total Disability means your disability which is due to an accidental bodily injury or disease that begins while you are insured and prevents you from engaging in any occupation for compensation or profit or qualify for Social Security Disability Benefits.

If your death should occur within a period of twelve (12) months after the Policyholder discontinues premium payments for your Personal Life Insurance, and if satisfactory proof is submitted that your death occurred during a period due to total disability which began while you were insured and under age sixty (60), Boston Mutual Life Insurance Company will pay your Beneficiary the amount of Personal Life Insurance provided by this section.

If, before or within twelve (12) months following the Policyholder's discontinuance of premium payments for your Personal Life Insurance, satisfactory proof is submitted to Boston Mutual Life Insurance Company that you became totally disabled while insured and under age sixty (60), and that such disability existed continuously for at least nine (9) months, the amount of Personal Life Insurance provided by this section will be continued without payment of premiums during the continuance of such disability for a period of one (1) year after receipt of such proof.

If your Personal Life Insurance has been continued in accordance with the preceding paragraph, such insurance will be continued without payment of premiums during the continuance of your total disability for additional periods of one (1) year each, provided that satisfactory proof of your continued total disability is submitted to Boston Mutual Life Insurance Company during the three (3) months preceding each date to which insurance has been continued.

The amount of your insurance under this section is the amount of your Personal Life Insurance on the date of your total disability, except that if the Schedule of Benefits provides for a reduction of Personal Life Insurance upon retirement or attainment of a specified age, your insurance under this section will be accordingly reduced at that time.

Boston Mutual Life Insurance Company may require satisfactory proof of your continued total disability at reasonable intervals while your insurance is continued under this section. Boston Mutual Life Insurance company may also require your examination, by doctors it designates, at reasonable intervals, during the first two (2) years of continuance and not more often than once each year thereafter.

If an individual policy of life insurance has been issued to you in accordance with the Conversion Privilege section of these provisions, you will not be eligible for continuance of insurance under this section unless that individual policy is surrendered without claim except for refund of the premiums paid for it.

No death benefit will be paid under this section unless Boston Mutual Life Insurance Company receives satisfactory proof of continuous total disability and death within twelve (12) months after your death occurs.

Whenever your total disability ceases, or you do not furnish required proof of its continuance, or you refuse to be medically examined as provided in this section, your insurance under this section will terminate. If you attain normal retirement age and retire under a formal pension plan of the Policyholder, your insurance will terminate unless continuance of Personal Life Insurance during retirement is specifically provided in the Schedule of Insurance.

If, within thirty-one (31) days after the date your Personal Life Insurance under this section is terminated, you do not again become eligible for insurance as an active employee, you may exercise your Conversion Privilege as though your employment had ceased on that date.

Discontinuance of the Group Policy or the Personal Life Insurance part of the Group Policy after you become totally disabled will not affect your rights under this section.

6.04: CONVERSION PRIVILEGE:

You can obtain an individual policy of life insurance as described in this section without evidence of insurability by making written application and paying the first premium to Boston Mutual Life Insurance Company within thirty-one (31) days after (a) all of your Personal Life Insurance is discontinued due to termination of your employment or your transfer to a classification ineligible for Personal Life Insurance, or (b) a part of your Personal Life Insurance is discontinued due to your retirement or attainment of a specified age.

Such an individual policy will not include disability benefits and shall be one of the forms then customarily issued by Boston Mutual Life Insurance Company except term insurance, though you may elect that the individual policy consists of single premium term insurance during its first year. You may elect that the individual policy be in any amount up to the amount of your discontinued Personal Life Insurance. The premium for the individual policy shall be the premium applicable to the class of risk to which you belong at the time your individual policy is issued and to the form and amount of the policy at your attained age on the effective date of the individual policy.

If your Personal Life Insurance is discontinued due to discontinuation of the Group Policy, discontinuance of the Personal Life Insurance part of the Group Policy, or an amendment of the Group Policy that excludes from Personal Life Insurance the classification of which you are a member, and if you have been continuously insured for Personal Life Insurance for at least three (3) years and that part of the Group Policy has been in effect at least five (5) years, you shall be entitled to a conversion privilege. Your conversion privilege shall, in this event, be the same as though your employment had terminated on the date your Personal Life Insurance is discontinued, but the amount of your individual policy shall not exceed (a) the amount of your discontinued Personal Life Insurance reduced by any new life insurance you may become eligible for under this or any other group insurance plan within the next thirty-one (31) days or (b) \$2,000.00, whichever is less.

Any individual policy issued to you in accordance with this section shall become effective at the end of the thirty-one (31) day period during which application for it may be made.

The maximum amount you are entitled to convert will be paid to your beneficiary in the event of your death during the thirty-one (31) day period in which application for an individual policy could have been made, whether or not you have made such an application.

**SECTION VII
ACCIDENTAL DEATH AND
DISMEMBERMENT INSURANCE**

7.01: BENEFIT:

If, as the result of an accidental injury which occurs while you are insured, you incur the loss of life, limb or sight within ninety (90) days following the injury, Boston Mutual Life will pay the benefit specified in the following Schedule of Losses and Benefits. Benefits are payable to you, except in the event of loss of life the benefit will be paid to your beneficiary.

Payment will be made for each loss without regard to previous losses, except as provided in this paragraph. The total amount payable for all losses resulting from any single accident will not exceed the Principal Sum shown in the Schedule of Insurance, except that in the event of loss of life, as described first in the Schedule of Losses and Benefits, the total amount payable for all losses incurred in that accident will be as described there.

7.02: SCHEDULE OF LOSSES AND BENEFITS:

Loss of Life due to injury sustained while a passenger in or upon a public conveyance being operated by a common carrier to transport passengers for hire
..... Twice the Principal Sum

Loss of Life as a result of injury which occurs under circumstance other than as provided above
..... Principal Sum

Loss of Two Hands..... Principal Sum
Loss of Two Feet..... Principal Sum
Loss of Sight of Two Eyes Principal Sum
Loss of One Hand and One Foot Principal Sum
Loss of One Hand and Sight of One Eye. Principal Sum
Loss of One Foot and Sight of One Eye.. Principal Sum
Loss of One Hand..... One-half the Principal Sum
Loss of One Foot..... One-half the Principal Sum
Loss of Sight of One Eye... One-half the Principal Sum

7.03: BENEFICIARY

You alone have the right to designate your Beneficiary and you may change the designation at any time by written notice to the Fund Office. Be sure to clearly identify your Beneficiary. If two (2) or more individuals are to share a death benefit, you must specify the portion that is to be paid to each person.

If you have not named a Beneficiary, or if your Beneficiary is no longer living, or if your Beneficiary is unable to give a valid release, your insurance will be paid in accordance with the terms of the Group Policy.

7.04: LIMITATIONS

No Personal Accidental Death and Dismemberment Insurance benefit will be payable for a loss resulting from or caused directly, wholly or partly by any of the following causes:

1. Disease or bodily or mental infirmity, or medical or surgical treatment of such conditions.
2. Suicide or intentionally self-inflicted injury.
3. Participation in the commission of a felony.
4. Any act of war, whether declared or undeclared.
5. Travel in or descent from any moving aircraft aboard which you
 - (a) are giving or receiving training
 - (b) have any duties or
 - (c) are being flown for the purpose of descent from such aircraft while it is in flight

SECTION VIII MEDICAL BENEFIT PROVISIONS

8.01: COORDINATION OF BENEFITS

All Medical Benefit provisions are subject to the COORDINATION OF BENEFITS provision.

If a Participant or an eligible Dependent is entitled to benefits under any other plan (as defined below) which will pay part or all of the expense incurred, the amount of benefits payable under the Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount of benefits paid under the Plan exceed the amount which would have been paid if there were no other Plan involved.

The term "Plan" includes any plan providing benefits or services for or by reason of hospital, medical or dental care or treatment, which benefits or services are provided by: (a) group, blanket or franchise insurance coverage, (b) CareFirst BlueCross BlueShield and other prepayment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

The rules for determining which plan is the primary carrier plan are as follows: (in order of their application)

- (1) A plan without a non-duplication clause always pays first.
- (2) The plan covering the patient as Participant (rather than as Dependent) pays first
- (3) The plan covering a child as Dependent of the parent whose birthday occurs first during the calendar year pays first. In the case of divorced parents, the following line of benefit determination is applied:
 - (a) A Dependent of the (natural) parent with custody.
 - (b) A Dependent of the step-parent with custody.
 - (c) A Dependent of the (natural) parent without custody.
- (4) The plan covering the person as an employee who is neither laid off nor retired, or a Dependent of such

person, will pay before the plan covering the person as a laid off or retired employee, or Dependent of such person. If the other plan does not have this rule, it is ignored.

- (5) The plan not covering a person under a right of continuation provision pursuant to federal or state law will pay before the plan covering a person under a right of continuation provision. If the other plan does not have this rule, it is ignored.
- (6) Except insofar as three (3) may apply first, when a Participant is covered as an employee under two (2) plans, or as a Dependent under two (2) plans, the plan under which the patient has been covered the longer time pays first. In determining the length of time the individual has been covered under a given plan, we will consider two successive plans covering a given group to be one continuous plan so long as the claimant concerned was eligible for coverage within twenty-four (24) hours after the prior plan was terminated.

If there is a court decree which would otherwise establish financial responsibility for the health care expenses with respect to a child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a Dependent child.

In applying the rules for determining which plan is the primary carrier, the provisions of any plan which would attempt to shift the status of this Plan from secondary to primary by excluding from coverage under such other plan any Participant or Dependent eligible under this Plan shall not be considered.

In the event the other plan is determined to be primary and such other plan is either not financially able or refuses to discharge its responsibility, such action shall not cause this Plan to assume primary status.

In the event an eligible Participant or Dependent fails or refuses to comply with the terms and conditions of another plan, thereby resulting in that other plan reducing or denying benefits, this Plan will only provide benefits which the other plan would have provided if the Participant or Dependent has fully and properly complied with the terms and conditions of the other plan.

8.02: SUBROGATION

In the event of any payment under this Plan, the Plan shall be subrogated to all the right of recovery therefore of either a Participant or Dependent against any person or entity responsible. Prior to the payment of any benefits arising as a result of injury for which a third party is responsible, the Plan may request and the Participant or Dependent will execute a document in writing acknowledging the subrogation rights of the Plan. Neither the Participant nor the Dependent shall do anything after a loss to prejudice the Plan's right.

If requested in writing by the Plan, the Participant or Dependent shall take, through any representative designated by the Plan, such action as may be necessary or appropriate to recover from any person or entity all (100%) of benefits paid together with costs and attorney fees incurred by the Plan in connection therewith. The right is hereby given the Plan to receive from any third party(ies), attorney(s) or insurance company(ies) an amount equal to all (100%) of benefits paid on behalf of the Participant or Dependent.

The Plan shall be entitled, to the extent of any payment made to a Participant or Dependent, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a Participant or Dependent against any person or entity legally responsible for the injury, sickness or condition for which such payment is made.

8.03: FUND'S RIGHT OF RECOVERY

The Fund shall have the right to deduct from, or offset against, the payment of any benefits to which a Participant, his or her Dependents or designated Beneficiary, shall be entitled, any sum to which the said Participant, Dependent or designated Beneficiary is indebted to the Fund for any purpose whatsoever.

The Fund shall also have the right to recover from any Participant, Dependent or Beneficiary payments made as a result of misrepresentation, mistake or error, irrespective of the party causing any such mistake or error.

8.04 – GENERAL EXCLUSIONS

No benefits are payable for the following:

1. Treatment or service not prescribed by a physician.

2. Treatment or service which is paid for or furnished by any government agency, unless a charge is imposed against the covered Participant.
3. Treatment or service which is due to sickness or injury arising out of or in the course of any employment for wage or profit.
4. Treatment or service resulting from any war or any act of war, declared or undeclared.
5. Treatment or service by a dentist or dental surgeon, except as specifically provided for in this Plan.
6. Hearing aids, or the fitting of hearing aids.
7. Charges for corrective lenses, contact lenses, fitting or eye refractions, except when following cataract surgery.
8. Charges incurred for medical care and treatment required as the consequence of an intentional self-inflicted injury, unless the injury is the direct result of a medical condition (such as depression).
9. Charges for or in connection with custodial care, education or training.
10. Charges the person is not required to pay.
11. Charges in excess of the usual, reasonable and customary amount as determined by the Plan.
12. Charges for cosmetic services, unless necessary as a result of an accident or congenital birth defect.
13. Charges for medical care and treatment required as the result of an injury sustained in the commission, or attempted commission, of a felony, unless the injury is the direct result of a medical condition (such as depression).
14. Charges for Preventive Care Services for a Medicare eligible Participant.
15. Non-legend, patent or proprietary medicine.
16. Claims for benefits under more than one benefit of the Plan.
17. Treatment of pregnancy for Dependent daughters.
18. Claims submitted after one (1) year from date of service.
19. Treatment of weight control, unless the individual is deemed to be morbidly obese as evidenced by documentation of a Body Mass Index of forty (40) or more.
20. Charges for completion of claim forms or unkept office visits.
21. Convenience items not primarily medical in nature.
22. Weekend hospital admissions, unless for an

- emergency or when deemed medically necessary.
23. Charges for services or supplies which are not deemed by the Plan to be medically necessary.
 24. Deductible expenses under the Mail Order Prescription Drug Benefit.
 25. Treatment for sexual transformations or any treatment related to sexual dysfunction.
 26. Radial keratotomy, lasek and similar procedures.
 27. Any charge or expense for the promotion of fertility, including but not limited to:
 - (a) Fertility tests;
 - (b) Reversal of surgical sterilization; or
 - (c) Any attempts to cause pregnancy by hormone therapy, artificial insemination, in-vitro fertilization or embryo transfer.
 28. Personal hygiene and convenience items such as, but not limited to, air conditioners, dehumidifiers, allergy-free pillows, whirlpools, air purifiers, swimming pools, electric heating units, orthopedic mattresses, exercise equipment or health club memberships, elevators or stair lifts, scales, elastic bandages or thermometers.
 29. When multiple surgeries are performed during the same operative session, charges in excess of 50% of the allowable amount for all secondary procedures.
 30. Birth control medications and devices.

8.05: PRE-EXISTING CONDITIONS LIMITATION

A pre-existing condition is an injury or illness for which you or your Dependent receive medical care or treatment, including prescribing of drugs, or for which a diagnosis was made in the six (6) month period prior to the effective date of your coverage. The Plan will pay up to \$2,000 for covered expenses relating to a pre-existing condition. No further benefits will be provided for a pre-existing condition until you or the Dependent have gone six (6) months without treatment for the pre-existing condition or until you or your Dependent have been continuously covered by the Plan for twelve (12) months.

This pre-existing conditions limitation will apply to all Plan participants and their Dependents upon their initial eligibility date for Plan benefits and will reapply to all Plan participants and Dependents upon reinstatement of their eligibility for Plan benefits following a break of eligibility of more than six (6) consecutive months.

This pre-existing conditions limitation will NOT apply to covered maternity expenses incurred by an employee or spouse or to covered expenses of a newborn or newly adopted child under age eighteen (18) if enrolled within thirty (30) days of birth or adoption.

Credit will be given for a prior period of continuous health coverage if the period between the termination of the prior coverage and the date of eligibility under this Plan is less than sixty-three (63) days. A Certificate of Creditable Coverage, as provided for in the Health Insurance Portability and Accountability Act of 1996, will be required.

8.06: PRE-ADMISSION CERTIFICATION

Before entering the hospital for elective surgery or other services, you or your doctor must contact the precertification service purchased by the Fund through Mountain State Blue Cross Blue Shield. **Their toll-free telephone number is shown on the back cover of this booklet and on your Identification Card.** If you contact them personally, please have your attending physician's name and telephone number available so the precertification service can contact your attending physician's office. Usually your physician contacts the precertification service and you will need to do nothing as the precertification service will gather all necessary medical information from your physician. However, you are ultimately responsible to ensure your physician cooperates with the precertification service.

The precertification service will determine the appropriateness of your hospitalization and assign a length of stay appropriate to your diagnosis. After making this determination, they will send a letter of authorization with all appropriate information to your attending physician, the hospital you plan to use, the Fund Office and yourself. This letter will indicate if the hospitalization was necessary and the number of days assigned.

After you enter the hospital, the precertification service will be in contact with the hospital and your attending physician to follow your progress.

If you do not follow the Pre-Admission Certification guidelines for a non-emergency admission, the Plan will deduct fifty percent (50%) of the benefits normally

payable. You will have to pay the excess, which will not count toward any out-of-pocket limit.

If you are admitted to a hospital due to an emergency, the precertification service must be notified within two (2) business days of your admission. Failure to comply with this provision will result in the application of the penalty set forth above.

The precertification service provides a program for pregnant women whose maternity care will be covered by the Plan. This program suggests hospital pre-admission certification in the first trimester of pregnancy and again upon entering the hospital.

Pre-admission certification does not assure that proposed hospital admission is covered under the Plan. Please read the coverage provisions carefully.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION IX COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

Active and Retired Participants and Dependents Not Enrolled in Medicare Supplement

9.01: BENEFIT

The Fund will pay Comprehensive Major Medical benefits in the amount of eighty percent (80%) of covered charges for the services of a provider in the Blue Cross Blue Shield network and seventy percent (70%) of covered charges for all other providers after you have met the deductible for any calendar year. You are required to pay the remaining twenty percent (20%) or thirty percent (30%).

The Fund will pay one hundred percent (100%) of covered charges once out-of-pocket covered expenses of \$2,000 have been incurred by an individual in a calendar year after the deductible, or \$4,000 have been incurred by a family in a calendar year after the deductible.

Covered charges include:

1. Semi-private hospital room and board.
2. Confinement in a hospital intensive care unit.
3. Private hospital room and board, not to exceed most common semi-private rate.
4. Routine nursery charges for a covered infant.
5. Charges made by a hospital for necessary services other than room and board.
6. Charges by a hospital or professional ambulance service for transportation to and from the nearest hospital where the necessary medical care can be provided and for extraction from a motor vehicle is limited to \$500, payable after benefits provided by an individual's automobile insurance carrier.
7. Treatment provided by a Skilled Nursing Facility, Hospice Care Facility or Home Health Care Provider.
8. Charges for hospital outpatient services, diagnostic X-rays and laboratory examinations or X-ray, radium and radioactive isotope therapy.
9. Charges of a physician or surgeon for professional services.
10. Charges of a legally licensed physiotherapists

and graduate nurses, provided the nurse is not a member of your family.

11. Charges for surgical dressings, casts, splints, braces, crutches, initial purchase of artificial limbs, initial purchase of artificial eyes, rental or purchase of wheelchair, hospital-type bed, artificial respirator and other Durable Medical Equipment.
12. Expenses for blood, blood plasma not replaced or donated, its administration and the cost to rent equipment for its administration.
13. Charges of a dentist or dental surgeon for the repair of damage to jaw and natural teeth which are the direct result of an accident and are incurred within six (6) months after the accident.
14. Charges of a dental surgeon for removal of impacted teeth only.
15. Charges for anesthesia and its administration.
16. Inpatient services for alcohol or drug rehabilitation limited to sixty (60) days per calendar year.
17. Prescription drugs, including smoking cessation medications (Please contact the Fund Office for details concerning the discount retail pharmacy program).
18. Diabetes Education Refresher Course.
19. Medical and surgical services provided to a covered person in connection with a mastectomy:
 - (a) reconstruction of the breast on which the covered mastectomy was performed;
 - (b) surgery and reconstruction of the other breast, if desired, to produce a symmetrical appearance, and
 - (c) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.
20. The Plan will provide coverage for a minimum period of hospitalization of forty-eight (48) hours for a normal vaginal delivery and ninety-six (96) hours for a cesarean section delivery.
21. Hospital services, including drugs and supplies, provided in the home or in a hospice facility, if the following conditions are satisfied:
 - (a) the patient's life expectancy, as certified by a physician, is six (6) months or less,
 - (b) pain control and symptom relief, rather than curative care, is considered by the Physician to be more appropriate and the Physician refers the patient to the hospice program, and

- (c) the patient is formally admitted to the hospice program and the Physician concurs with the treatment plan.
- 22. Charges for routine sigmoidoscopy or routine colonoscopy in accordance with American Cancer Society guidelines.
- 23. Charges for chiropractic treatment, limited to benefits payable of \$500 during a calendar year.

NOTE: Providers in the Blue Cross Blue Shield network have a contractual agreement which prevents them charging you an amount in excess of the professional allowance in the agreement for the covered service. You will only be responsible for any outstanding deductible and copayment amount applicable to the covered charge. If, however, you receive treatment or services from a provider who is not signatory to the Blue Cross Blue Shield agreement, you will be responsible for any difference between the professional allowance and the actual charge, in addition to any applicable deductible and copayment amount. You are encouraged to utilize a network provider whenever possible.

9.02: DEDUCTIBLE

The deductible is the amount of covered medical expenses which you must incur before Comprehensive Major Medical is payable. The amount of the deductible is shown in the Schedule of Benefits.

The deductible applies only once in any calendar year, even though you may have several different injuries or illnesses.

9.03: COMMON ACCIDENT

If one (1) or more persons in your family have expenses as a result of the same accident, only (1) deductible will be applied to all covered charges resulting from that accident and for the remainder of that calendar year. If there is a multiple birth, and as a result of a premature birth, abnormal congenital conditions or sickness or injury commencing within thirty (30) days after the multiple birth, there will only be one (1) deductible applied to all of the covered charges during the calendar year.

9.04: FAMILY DEDUCTIBLE AMOUNT

The calendar year Family Deductible amount is shown

in the Schedule of Benefits. The Family Deductible is satisfied based on covered charges incurred by all members of the family in the aggregate. It is not necessary that any family member satisfy the Individual Deductible.

9.05: DEDUCTIBLE CARRY OVER

Any expense incurred in October, November and December which is used to satisfy the deductible for that calendar year, in full or part, will also be used to satisfy the deductible for the following calendar year.

9.06: LIFETIME MAXIMUM BENEFIT

The maximum benefit for all covered charges incurred during the lifetime of any person is shown in the Schedule of Benefits.

If Comprehensive Major Medical covered charges are paid for any covered person, a portion of the coverage can be restored on January 1st in each of the following calendar years. The amount restored will be the benefits actually paid or 10% of the lifetime maximum, whichever is smaller, but not to exceed the amount set forth in the Schedule of Benefits.

9.07: EXCLUSIONS

Not covered charges under the Comprehensive Major Medical Benefits of the Fund are items listed in Section 8.04 and:

1. Benefits payable under any other section of the Plan.
2. Payments for services due to mental or nervous disorders in excess of forty (40) treatments per calendar year while the patient is not confined to a hospital.
3. Payments for services for outpatient treatment of alcohol and substance abuse in excess of forty (40) treatments per calendar year while the patient is not confined to a hospital.
4. Hospital private room charge that are in excess of the average semi-private rate of the hospital.
5. Charges for chiropractic care once the plan has paid benefits of \$500 during a calendar year.

SECTION X WEEKLY DISABILITY BENEFIT FOR ACTIVE PARTICIPANTS

When you are totally disabled due to a non-occupational accident or sickness, and are under the care of a legally qualified Physician, the Weekly Benefit will be paid to you beginning on the day shown in the Schedule of Benefits and up to the maximum number of weeks payable during disability as specified in said Schedule of Benefits. You are totally disabled when you are unable to perform each and every duty pertaining to your occupation and when you receive no remuneration for any other work or service.

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

The Weekly Disability Benefits does not apply to retired Participants.

SECTION XI MAIL ORDER PRESCRIPTION DRUG PROGRAM

Prescription drugs can be obtained under a mail order program subject to a co-payment per name brand prescription and generic prescription. The applicable co-payment amounts are shown in the Schedule of Benefits. The co-payment applies to each fill or refill of a medication.

SECTION XII LAB CARD PROGRAM FOR NON-MEDICARE PARTICIPANTS AND DEPENDENTS

Lab Card is a program administered by LabOne, Inc., which provides full coverage for necessary laboratory tests performed on an outpatient basis. When LabOne performs the testing of specimens, the Plan will pay 100% of the charge from LabOne. In addition, the bill from LabOne is sent directly to the Fund Office without your having to complete and file a claim form,

and possibly pay the cost of the test in advance, if so required by the provider.

Your Lab Card covers routine outpatient laboratory testing, such as pap smears, throat cultures, and blood and urine testing. This program **does not** cover charges for lab work performed by another laboratory, ordered during a hospital confinement or needed on an emergency (STAT) basis.

You should have received a packet of information describing this program more fully from the Fund Office. Please feel free to contact the Fund Office for additional supplies or if you have any questions about this program. Also, you can call LabOne at 1-800-646-7788 toll-free to ask questions you may have.

SECTION XIII HUMAN ORGAN TRANSPLANT POLICY FOR NON-MEDICARE PARTICIPANTS AND DEPENDENTS

The human organ transplants detailed below are covered under a separate insurance policy purchased by the Fund. Termination of that policy will result in the elimination of coverage for the human organ transplants described below.

Covered human organ transplant procedures:

1. heart transplant
2. liver transplant
3. heart/lung transplant
4. lung transplant
5. pancreas transplant
6. bone marrow transplant

The policy provides benefits only:

- (a) if you or your Dependent receives two opinions on the need for transplant surgery from Board Certified specialists in the involved field;
- (b) if the specialist certifies alternate procedures, services or courses of treatment would not be effective in the treatment of the patient's condition;
- (c) if the procedure was not related to a pre-existing condition which existed within three (3) months of the last date the patient became covered under the policy; and

- (d) for charges incurred during the period beginning five (5) days prior to the date of the organ or tissue transplant and ending eighteen (18) months after the procedure

The Trustees have the right to terminate the human organ transplant policy at any time without prior notice to you. The Plan will have no obligation to provide benefits for the procedures listed above.

**SECTION XIV
PREVENTATIVE CARE BENEFIT
FOR ACTIVE AND RETIRED PARTICIPANTS
AND DEPENDENTS
NOT ENROLLED IN MEDICARE
SUPPLEMENT**

If you or your Dependent, while eligible for benefits, incur(s) charges for the following Preventative Care items, the Fund will pay, subject to the Reasonable and Customary guidelines, 100% of up to \$500 per calendar year per individual.

1. Pap smear and office visit, limited to one (1) per calendar year.
2. Routine physical exam, including prostate exam, X-rays and laboratory tests, limited to one (1) per calendar year.
3. Mammogram, limited to one(1) per calendar year.
4. Routine well-child exams and standard immunizations as recommended by the child's pediatrician.
5. Expenses of a vision exam for retinopathy for a patient with diabetes, limited to one (1) exam per calendar year.
6. Colorectal Cancer Exams, limited to once per five (5) years for individuals over age fifty, without application of the \$500 calendar year maximum benefit. (All other colorectal cancer exams will be considered under the Comprehensive Major Medical Expense Benefit.)

SECTION XV

DENTAL BENEFITS AVAILABLE ONLY TO PARTICIPANTS, INCLUDING RETIREES AND SPOUSES, ASSOCIATED WITH A LOCAL UNION OR EMPLOYER PURCHASING THIS COVERAGE

15.01: ELIGIBILITY:

Dental Benefits are provided to Participants who's affiliated Local Union voted to participate in the Dental Plan. The monthly required amount for coverage includes an additional amount covering these benefits.

15.02: PAYMENT:

Payment will be made at the applicable percentage rates indicated below for the covered dental expenses outlined herein and incurred by an eligible participant or Dependent for those covered charges up to the maximum amount of \$1,000 per eligible person per calendar year:

Preventive Care.....	100%
Basic/Routine Care.....	80%
Major Care.....	50%

Except as described in the section entitled "After Eligibility Terminates", such expenses must be incurred and the services and supplies furnished while the employee or Dependent are eligible.

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished, except that such charge will be deemed incurred:

1. with respect to fixed bridgework, crowns, inlays, onlays or gold restorations, on the first date of preparation of the tooth or teeth involved;
2. with respect to full or partial dentures, on the date the impression was taken; and
3. with respect to endodontics, on the date the tooth was opened for root canal therapy.

15.03: COVERED DENTAL CHARGES:

Covered dental charges are the charges of a dentist or physician for the services and supplies listed below required for dental care and treatment of any disease, defect or preventive dental care.

Not included is any charge in excess of the Reasonable and Customary charges made:

1. for similar services and supplies by dentists or physicians in the locality concerned or
2. where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

15.04: TREATMENT PLAN:

Participants are encouraged to request a Pre-treatment Estimate of benefits payable, when the total cost associated with the proposed dental work is expected to exceed \$200. The dental claim form contains a provision for requesting such information prior to the date treatment is rendered.

A treatment plan is a plan of dental services (including x-rays) which indicates the patient's dental needs, gives a written description of the proposed treatment necessary in the professional judgment of the attending dentist, and shows the cost of the proposed treatment.

The filing of a treatment plan should help to avoid any misunderstanding as to the extent of coverage. This process identifies coverage and clarifies benefit specifications, such as deductibles, coinsurance and limits. Also, it gives the patient and dentist an opportunity to review the proposed treatment and the extent of coverage before any work is started.

15.05: PREVENTIVE AND DIAGNOSTIC CARE:

- a) Charges for cleaning and scaling of teeth, but not more often than twice in a calendar year.
- b) Charges for fluoride application for Dependent children's teeth through age eighteen (18), but not more often than once in a calendar year.
- c) Charges for space maintainers and their fittings.
- d) Charges for diagnostic X-rays.
- e) Charges for emergency treatment for relief of dental pain on a day for which no other benefit other than for X-rays is payable hereunder.
- f) Oral examinations, but not more often

than twice in a calendar year.

- g) Charges for sealants for Dependent children through age eighteen (18).
- h) Study models and diagnostic casts (other than for orthodontics)

15.06: BASIC/ROUTINE CARE:

- a) Initial amalgam, silicate, acrylic or composite restorations.
- b) Replacement of an amalgam, silicate, acrylic or composite restorations.
- c) Charges for extraction of one or more teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examination.
- d) Charges for treatment of gums and supporting structure of the teeth.
- e) Charges for root canals and other endodontic treatment.
- f) Charges for general anesthetics and their administration in connection with oral surgery, periodontics, fractures or dislocations.
- g) Local anesthesia (not in connection with operative or surgical procedures), regional block and trigeminal division block anesthesia or analgesia.
- h) Charges for injectable antibiotics administered by a dentist or physician.
- i) Charges for recementing inlays or crowns at least 90 days after the date the inlay or crown was provided.
- j) Relining, rebasing or repairing of an existing prosthesis (fixed bridgework, removable partial or complete dentures) at least ninety (90) days after the date the installation or repair of the prosthesis was performed.
- k) Consultation required by the attending dentist.

15.07: MAJOR CARE:

- a) Charges for fillings and crowns necessary to restore the structure of teeth broken down by decay or injury, but the charge for a crown or gold filling will be limited to the charge for a silver, porcelain or other filling unless the tooth cannot be restored

with such other material and the charge for replacement of a crown or gold filling is covered only if the crown or filling is over five (5) calendar years old.

- b) Charges for full or partial dentures, fixed bridges, or adding teeth to an existing prosthesis if required because of loss of natural teeth while the person is covered for this benefit and to replace such teeth or to replace an existing prosthesis which is over five (5) calendar years old and cannot be made serviceable.
- c) Charges for bone grafting, regardless of cause or purpose.
- d) Charges for specialized techniques involving precision attachments, personalization or characterization are not covered. Additional charges for adjustments within six (6) months from installation are not included as covered dental charges.

15.08: AFTER COVERAGE TERMINATES:

The benefits described herein are also provided for covered dental charges:

- a) for services or supplies furnished within ninety (90) days after coverage terminates if the charges were incurred while coverage was in force and
- b) incurred within ninety (90) days after coverage terminates if an accident resulting in injury to natural teeth sustained while coverage was in force causes continuous total disability from the date of termination; provided benefits are not payable for such expenses under any other group plan.

15.09: EXCLUSIONS (Services that are not covered):

- a) Dental procedures, which are included as covered medical expenses under any other comprehensive or major medical plan provided by the Plan Administrator.
- b) Treatment by someone other than a dentist or physician, except where performed by a duly qualified technician under the direction of a dentist or physician;
- c) Dental treatment required as a result of

- self-inflicted injury, war, whether declared or not, riot or insurrection.
- d) Charges for broken appointments or form preparation.
 - e) Services and supplies cosmetic in nature.
 - f) Training in or supplies used for dietary counseling, oral hygiene or plaque control.
 - g) Replacement of an existing prosthesis (fixed bridgework, removable partial or complete dentures), which has been lost, mislaid or stolen.
 - h) Dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute.
 - i) Replacement of existing prosthodontic appliances unless:
 - (1) necessitated by the extraction of additional natural teeth while covered under this plan;
 - (2) the existing appliance is at least five (5) calendar years old and cannot be made serviceable;
 - (3) the existing appliance is temporarily installed after the effective date of this plan;
 - (4) the replacement appliance is made necessary as the result of an initial placement of an opposing denture; or
 - (5) the replacement is made necessary as a result of an accidental injury.
 - j) Services or supplies, which do not meet accepted standards of dental practice including charges for services or supplies which are experimental in nature.
 - k) Examinations for use by a third party.
 - l) Emergency prescriptions or other drugs and/or medicaments.
 - m) Dental procedures, which do not directly involve the teeth or the tissues or bones, which support the teeth.
 - n) Surgical implants of any type.
 - o) Charges for athletic mouth guards.
 - p) Charges for any duplicate prosthetic device or any other duplicate appliance.
 - q) Services and supplies furnished in a U.S. Government Hospital.
 - r) Services which the employee or Dependent would not be required to pay if there were no plan.

- s) Services and supplies furnished in connection with injuries sustained while engaged in any occupation for remuneration or profit, or disease for which worker's compensation or similar benefits are payable.
- t) Services for which a Dependent is entitled to benefits as an employee or former employee.
- u) Dental treatment received from a dental or medical department maintained by an employer, association, or similar type of group.
- v) Services and supplies rendered for full mouth reconstruction, orthognathic surgery or for a correction of temporal mandibular joint dysfunction (TMJ).
- w) Veneers.
- x) Orthodontic treatment of any kind.

SECTION XVI SETTLEMENT OF CLAIMS

16.01: PAYMENT OF CLAIMS

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

Indemnity or loss of life of the Participant, resulting from accidental bodily injuries, shall be paid to the beneficiary designated by the Participant or if there is no beneficiary designated or surviving, to the estate of the Participant.

All other indemnities shall be payable to the Participant. Consent of the Participant's beneficiary, if one be named, shall not be requisite to any change of beneficiary or to any changes in the Plan.

16.02: MEDICAL EXAMINATION

The Fund shall have the right, through its medical examiner, to examine the Participant or Dependents so often as it may reasonably require during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

16.03: NOTICE AND PROOF OF CLAIMS

IMPORTANT NOTICE — Any claim not submitted within one year of treatment will be denied.

16.04: NOTICE OF ACCIDENT OR SICKNESS

Written notice of injury or sickness for which claim is made must be given to the Fund Office within sixty (60) days after the date of the accident or within sixty (60) days after the commencement of the sickness. Please note any claims not submitted within one year of such injury or sickness cannot be considered unless submitted to the Board of Trustees on an appeal basis.

16.05: NOTICE OF ACCIDENTAL DEATH

In the event of accidental death, written notice thereof must be given to the Fund Office within twenty (20) days after the date of death.

16.06: PROOF OF LOSS FOR DISABILITY BENEFITS

Proof of injury or sickness must be furnished to the Fund Office within ninety (90) days after the end of the period of disability for which claim is made.

FAILURE TO FURNISH NOTICE OR PROOF WITHIN THE REQUIRED TIME SHALL NOT INVALIDATE NOR REDUCE ANY CLAIM IF IT SHALL BE SHOWN THAT NOTICE OR PROOF WAS FURNISHED AS SOON AS WAS REASONABLY POSSIBLE.

The Fund will furnish such forms as are usually furnished by it for filing proofs of loss.

16.07: LEGAL PROCEEDINGS

No action at law or in equity shall be brought for recovery under the Plan prior to the expiration of sixty (60) days after written proof of loss has been filed in accordance with the requirements of the Plan, and no such action shall be brought at all unless brought within three (3) years of the expiration of the time within which proof of loss is required by the Plan.

16.08: CLAIM PROCEDURES

Definitions

- I. Urgent claims are requests for eligibility status or for medical care or treatment of an emergency nature, which could

seriously jeopardize the life or health of the claimant or would subject the claimant to severe pain.

2. A pre-service claim is a request for eligibility status or for benefits for which a Plan requires pre-approval, such as pre-admission certification for a hospital admission or a predetermination of benefits for major dental care.
3. A post-service claim is a request for a benefit following the claimant's receipt of services.

Time Limits

1. A decision with respect to an urgent care claim will be made within seventy-two (72) hours. If the claim is not complete, the Plan will so notify you of the additional information required within twenty-four (24) hours.
2. A decision on pre-service claim will be made within fifteen (15) days. The Plan will advise of a defective or incomplete filing of pre-service claim within five (5) days of receipt. The Plan may take an additional fifteen (15) days, if it is determined an extension is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.
3. A decision on a post-service claim will be made within thirty (30) days. The plan will advise of a defective or incomplete filing of a post-service claim within thirty (30) days of receipt. You will have forty-five (45) days to provide the required information. The Plan may take an additional fifteen (15) days, if it is necessary due to matters beyond the control of the Plan and you are advised of the need for the extension.

Concurrent Care Decisions

1. If the Plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the Plan of such course of treatment before the end of the period or number of treatments previously agreed to will be considered a denial. The Plan will notify you of this

action in advance of the application of the reduction or termination and advise of the appeal rights to permit a review prior to the date the benefit is reduced or terminated.

2. A decision on the previously agreed to course of treatment for an urgent care claim will be acted upon as soon as possible. The Plan will advise of a defective or incomplete filing of pre-service claim within twenty-four (24) hours, provided the claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

16.09: CLAIM DENIAL PROCEDURE

If your claim is denied or partially denied, you will be notified in writing and provided an opportunity for a review. The written notice of denial will provide:

1. The specific reason(s) for the denial;
2. The specific Plan provision on which the determination is based;
3. A description of additional information or information necessary for the Participant to perfect the claim and an explanation of why this additional information is necessary;
4. A statement that the specific rule, guideline, protocol or other criterion relied upon in making the determination, if applicable, will be provided at no cost upon request;
5. A statement advising that an explanation of the scientific or clinical judgment relied upon and the names of the individuals from whom opinion(s) were secured, if a determination is based upon medical necessity or experimental treatment, or similar exclusion or limit, will be provided at no cost; and
6. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement regarding the Participant's right to bring a civil action under section 502(a) of ERISA.

16.10: CLAIM REVIEW PROCEDURES

If the Participant's claim has either been denied or partially denied and he is not satisfied with the decision,

he may appeal the decision and request a review of the claim. The matter shall be referred to the Trustees for decision. The appeal:

1. Must be in writing and can be made by the Participant or the Participant's duly authorized representative;
2. Should be mailed or delivered to the Fund address shown in the Summary Plan Description;
3. Should state the reasons the Participant believes the initial determination was incorrect;
4. Should include any written comments, documents, records and other information relating to the claim for benefits; and
5. Must be submitted within one hundred and eighty (180) days of the date the Participant received the notice of denial or partial denial.

You will be provided access to and copies of all documents, records and other information relevant to your claim at a reasonable charge.

1. A decision on review of an urgent care claim will be made within seventy-two (72) hours after receipt of the Participant's request for review.
2. A decision on review of a pre-service claim will be made within thirty (30) days of receipt of the Participant's request for review.
3. A decision on review of a post-service claim will be made during the course of the regular quarterly Trustees' meeting following receipt of the request for review and the Participant will be notified of the decision within five (5) days of the date of such meeting. (If the request for review is received within thirty (30) days of the next regular quarterly Trustees' meeting, the decision on review will be made no later than the date of the second meeting following the Plan's receipt of the request for review.) If special circumstances require an extension of time, a decision will be rendered no later than the next following quarterly Trustees' meeting. The Participant will be advised of the special circumstances and the date the decision is expected to be made.

THE DECISION OF THE TRUSTEES ON REVIEW WILL BE MADE IN GOOD FAITH AND WILL BE FINAL AND BINDING ON ALL ISSUES. THE PARTICIPANT OR THE PARTICIPANT'S DULY AUTHORIZED REPRESENTATIVE WILL BE REQUIRED TO EXHAUST THE ENTIRE CLAIM REVIEW PROCEDURE BEFORE INSTITUTING ANY OTHER FORM OF ACTION.

16.11: STATUTE OF LIMITATIONS

After you have received the final written decision of the Board of Trustees you will have a period of one hundred and eighty (180) days after the date of the written decision to commence Legal action for a Court of appropriate jurisdiction to review the decision of the Trustees. If you fail to commence such an action you will be barred from further review.

SECTION XVII RIGHTS AND PROTECTIONS UNDER ERISA

17.01: YOUR RIGHTS

As a Participant in the Carpenters Health Fund of West Virginia you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

17.02: RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

ERISA provides that all Plan Participants shall be entitled to: Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

17.03: ADDITIONAL RIGHTS

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that the Genetic Information Nondiscrimination Act of 2008 (GINA), prohibits a group health plan from discriminating on the basis of genetic information, which includes an individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Genetic information cannot be used as a basis to determine eligibility for insurance coverage, or to adjust premium or contribution amounts for the group. However, a group health plan may increase the premium for an employer based on the manifestation of a disease of an individual who is enrolled in the plan, provided it does not further increase the premium based upon other family members covered under the plan. GINA also prohibits a health plan from requesting or requiring an individual or an individual's family member to undergo a genetic test with the exception that a plan may request (but not require) a Participant or Beneficiary to undergo a genetic test for the purpose of research if certain requirements are met. A group health plan is further prohibited from requesting, requiring or purchasing genetic information prior to an individual's enrollment in the plan, or for underwriting purposes. This restriction does not prohibit a group health plan from the incidental collection of genetic information such as obtaining and using the results of a genetic test in making a determination regarding payment.

Be informed that under the Mental Health Parity Act of 1996 (MHPA), group health plans, insurance companies and HMOs offering mental health benefits will not be allowed to set annual or lifetime limits on mental health benefits that are lower than any such limits for medical or surgical benefits. Plans may continue to set the terms and conditions for the amount, duration and scope of mental health benefits.

Be informed that the Plan complies with the HIPAA Privacy Regulations concerning the use and disclosure of Protected Health Information, as is set forth in detail in the Plan's Notice of Privacy Practices. If you need another copy of this Notice, please contact the Fund Office.

Be informed that under Michelle's Law, a Dependent student, defined as a Dependent under the plan and enrolled on the basis of being a student at a postsecondary institution, who takes a medically necessary leave of absence shall be entitled to continued coverage until the date that is the earlier of: i) the date that is one (1) year after the first day of the medically necessary leave of absence; or ii) the date on which such coverage would otherwise terminate under the terms of the plan. The term "medically necessary leave of absence" means a leave of absence from a postsecondary educational institution, or any other change in enrollment of such Dependent that: 1) commences while such child is suffering from a serious illness or injury; 2) is medically necessary; and 3) causes such Dependent to lose student status for purposes of coverage under the terms of the plan. Written certification from a treating physician stating the Dependent is suffering from a serious illness and that the leave of absence is medically necessary must be submitted to the plan to continue coverage.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to

use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to mastectomies shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

17.04: CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

17.05: PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

17.06: ENFORCE YOUR RIGHTS

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

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

17.07: ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SECTION XVIII
HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT
NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your protected health information, and describes your rights to access and control your protected health information.

Protected health information (or “PHI”) is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact: Kenneth L. Joos, 3150 US Route 60, Ona, WV 25545.

EFFECTIVE DATE:

This Notice of Privacy Practices became effective April 14, 2003.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information, and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information

that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for you.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how we are most likely to use and/or disclose your protected health information.

1. Payment and Health Care Operation
We have the right to use and disclose your PHI for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.
2. Payment
We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if treatment that you received was medically necessary.
3. Health Care Operations
We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about one of our disease management programs; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.
4. Business Associate
We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use or disclose PHI, but only after we require the Business Associates to agree in writing to contract

terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our Business Associates would be our Third Party Administrator, American Benefit Corporation, which will be handling many of the functions in connection with the operation of our Group Health Plan, our Claims Administrator, Mountain State Blue Cross Blue Shield or our Prescription Drug Benefit Manager, Express Scripts, Inc.

5. Other Covered Entities

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

1. Plan Sponsor

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by law.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosure of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER POSSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

1. Required by Law

We may use or disclose your PHI to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

2. Public Health Activities

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

3. Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

4. Abuse or Neglect

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

5. Legal Proceedings

We may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a

discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

6. Law Enforcement

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (3) it is necessary to provide evidence of a crime that occurred on our premises.

7. Coroners, Medical Examiners, Funeral Directors, and Organ Donations

We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose information to organizations that handle organ, eye, or tissue donation and transplantation.

8. Research

We may disclose your PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to insure the privacy of the information; and (2) approved the research.

9. To Prevent a Serious Threat to Health or Safety

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

10. Military Activity and National Security, Protective Security

Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member

of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

11. Inmates

If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

12. Workers' Compensation

We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

13. Others Involved in Your Health Care

Using your best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following is a description of disclosures that we are required by law to make.

1. Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

2. Disclosures to You

We are required to disclose to you most of your PHI in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We are also required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authority.

We will disclose your PHI to an individual who has been designated by you as your personal representative upon submission of a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney). We will recognize certain individuals as personal representatives without completion and submission of a representative form. For example, we will recognize spouses covered under the plan as personal representatives for each other. Likewise, a covered parent or guardian will be considered a representative of any covered dependent.

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative would endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already

have used or disclosed, relying on the authorization.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

1. Right to Request a Restriction

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by writing to Kenneth L. Joos, 3150 US Route 60, Ona, WV 25545. It is important that you direct your request for restriction to this address so that we can begin to process your request. We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) that information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

2. Right to Request Confidential Communications

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or location. For example, you may ask that we only contact you at your work address or via your work email.

You may request a restriction by writing to Kenneth L. Joos, 3150 US Route 60, Ona, WV 25545. It is important that you direct your request for confidential communications to this address so we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part

of your PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, “reasonableness” will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment. Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

Once we receive all information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days. Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an Explanation of Benefits (“EOB”). Therefore, it is extremely important that you contact us at the number listed in the summary page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for all your PHI that we hold, including information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

3. Right to Inspect and Copy

You have the right to inspect and copy your PHI that is contained in a “designated record set.” Generally, a “designated record set” contains medical and billing records, as well as other records that are

used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons or offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

4. Right to Amend

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing to Kenneth L. Joos, 3150 US Route 60, Ona, WV 25545. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request to this number/address so that we can begin to process your request. Requests sent to persons or offices, other than the one indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a

statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

5. Right of an Accounting

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, therefore, will not be subject to your right to an accounting. There are also other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure. You may request an accounting by submitting your request in writing to Kenneth L. Joos, 3150 US Route 60, Ona, WV 25545. It is important that you direct your request for an accounting to this address so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request. Your request may be for disclosures made up to six (6) years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

6. Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed in this Notice. A copy of a complaint form is available from this contact office.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

SECTION XIX MISCELLANEOUS MANDATED PROVISIONS

19.01: FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), your eligibility may be continued provided your employer makes the required contribution on your behalf. Eligibility may be up to twelve (12) weeks during the twelve (12) month period, for any of the following reasons:

- a. To care for your child after the birth or placement of a child with you for adoption or foster care, so long as such leave is completed within twelve (12) months after the birth or placement of the child;
- b. To care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- c. For your own serious health condition.

In the event you and your spouse are both covered as Eligible Employees, the continued coverage may not exceed a combined total of twelve (12) weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of twelve (12) weeks.

You are eligible to continue your coverage under FMLA if you have worked for your employer for at least one (1) year; have worked at least 1,250 hours over the previous twelve (12) months for such employer; your employer employs at least fifty (50) Employees within seventy-five (75) miles of your work site and your employer continues to pay your required contributions.

If, on the day your eligibility is to begin, you are already on an FMLA leave, you will be considered actively at work. Benefits for you and any eligible Dependents (if applicable) will be in accordance with the terms of the Plan as set forth herein.

You and your Eligible Dependents (if applicable) are subject to conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

FMLA continuation ends on the earliest of the day you return to work, the day you notify your employer that you are not returning to work, the day your coverage would otherwise end under the Plan or the day coverage has been continued for twelve (12) weeks.

Military Caregiver Leave

A covered employer must grant an eligible employee who is a spouse, son, daughter, parent or next of kin of a covered servicemember with a serious injury or illness up to a total of 2 workweeks of unpaid leave during a “single 12-month period” to care for the servicemember.

A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

A serious injury or illness is one that was incurred by a servicemember in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank or rating.

The “single 12-month period” for leave to care for a covered servicemember with a serious injury or illness begins on the first day the employee takes leave for this reason and ends 12 months later, regardless of the 12 month-period established by the employer for other types of *FMLA* leave.

An eligible employee is limited to a combined total of 26 workweeks of leave for any *FMLA*-qualifying reason during the “single 12-month period.” (Only 12 of the 26 weeks total may be for a *FMLA*-qualifying reason other than to care for a covered service member.)

“Qualifying Exigency” Leave

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid leave during the normal 12-month period established by the employer for *FMLA* leave for “qualifying exigencies” arising out of the fact that the employee’s spouse, son, daughter or parent is on active duty, or has been notified of an impending call or order to active duty, in support

of a contingency operation. Under the terms of the statute, qualifying exigency leave is available to a family member of a military member in the National Guard or Reserves; it does not extend to family members of military members in the Regular Armed Forces.

“Qualifying exigencies” include:

- a. Issues arising from a covered military member’s short notice deployment (i.e., deployment on seven or less days of notice) for a period of seven days from the date of notification;
- b. Military events and related activities, such as official ceremonies, programs or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations or the American Red Cross that are related to active duty or call to active duty status of a covered military member;
- c. Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on a non-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member;
- d. Making or updating financial and legal arrangements to address a covered military member’s absence;
- e. Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member;
- f. Taking up to five days of leave to spend time with a covered military member who is on short-term temporary, rest and recuperation leave during deployment;
- g. Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of 90 days following the

termination of the covered military member's active duty status and addressing issues arising from the death of a covered military member; or

- h. Any other event that the employee and employer agree is a qualifying exigency.

19.02: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Under the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, COBRA coverage can be terminated when a Participant becomes covered under another group health plan even though that plan may have exclusions and limitations for pre-existing conditions. However, those plans that do have pre-existing condition limitations or exclusions must now conform to the provision of the HIPAA which (a) limits pre-existing exclusion period to a maximum of twelve (12) months and (b) requires all plans to give credit for a prior period of "continuous health coverage." A period of prior coverage is considered "continuous health coverage". A period of prior coverage is considered "continuous" if the period between the date of termination under the prior plan and the date of eligibility under the new plan is less than sixty-three (63) days.

19.03: UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Continuation Coverage for Participants On Leave With The Uniform Services

- (a) Pursuant to 38 U.S.C. 4301 et seq., the Fund shall provide continuing coverage for members on military leave from work due to required service for one of the uniformed services. "Military Leave" means any service in the uniformed services including the performance of duty on a voluntary or involuntary basis with all types of military training or service. Specifically, this includes services, performed under competent authority, in the nature of active duty, active duty for training, initial active duty for training, inactive duty training, full-time national guard duty, and a time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

- (b) “Uniformed Services” refer to the US armed services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive day training, and the commissioned core of the public health service. Moreover, the President is authorized to expand the categories of covered services through the exercise of emergency war powers.
- (c) This continuation of coverage is similar to “Continuation Coverage” provided by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA) except as follows:
 - 1) Continuation coverage is to last for twenty-four (24) months beginning on the first day missed because of uniformed service.
 - 2) Charges to Employee – for up to thirty-one (31) days missed service, the employer may not charge the Employee any more than the Employee’s regular rate paid for participating in the Fund; after thirty-one (31) days missed, the employer may charge the Employee up to one hundred two percent (102%) of the full premium of the Fund as derived under COBRA.
 - 3) A Plan member who returns to work is covered on the same terms and conditions as other members who have not been on military leave in that no waiting time or pre-existing condition requirement may be applied to the member on uniformed services leave in addition to any such requirement as existed when one first became a member.
 - 4) The Plan reserves the right to exclude coverage for any injury that is determined by the Secretary of Veterans Affairs to have been incurred or aggravated by the Participant’s military service.

SECTION XX OTHER MISCELLANEOUS PROVISIONS

20.01: CONTRIBUTIONS FROM SELF-EMPLOYED

Contributions from self-employed individuals shall not be permitted.

20.02: ASSIGNMENT OF BENEFITS

Benefits under this Plan may be assigned by you or your Eligible Dependent, but only to a physician, hospital or other medical care provider and only on written authorization.

20.03: AMENDMENT AND INTERPRETATION OF PLAN

The Trustees are empowered to amend the Plan and the benefits provided thereunder from time to time and at any given time as they in their sole discretion determine appropriate. Participants and Beneficiaries will be advised of any material modifications to the Plan by notice forwarded to his or her last known address by first class mail, postage prepaid.

The Trustees are empowered to construe and interpret the Plan and this Summary Plan Description, and any such construction and interpretation adopted by the Trustees in good faith shall be binding upon the Union, Employers, Employees, Participants, Dependents and Beneficiaries.

20.04: APPLICATION OF LAW

The provisions of the Plan and this Summary Plan Description are to be interpreted in accordance with the Laws of the United States of America and the State of West Virginia.

20.05: PHYSICAL EXAMINATION AND AUTOPSY

The Fund, at its own expense, shall have the right and opportunity to examine the Participant or Dependent whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder, and to make an autopsy, in case of death, where it is not forbidden by law.