HAWAII TEAMSTERS HEALTH & WELFARE TRUST

(ACTIVES AND RETIREES UNDER AGE 65)

HMO Plan Document (Self-Funded)

Effective September 1, 2011

SECTION 1
DEFINITIONS

In accordance with all applicable policies of the Hawaii Teamsters Health & Welfare Trust, the Participant and any Dependents listed on the enrollment card or added thereto, are entitled to medical, surgical, hospital, and other benefits according to the terms, conditions and limitations set forth in this Plan.

When used in this Plan, in the enrollment card, in each Participant's card, and in any supplements to this Plan:

1.1 "Beneficiary" means any Participant or Dependent covered by this Plan.

1.2 "Calendar Year" means the period beginning January 1 and ending December 31 of the same year. The first Calendar Year for a new Beneficiary shall begin on that Beneficiary's Effective Date and end December 31 of the same year.

1.3 "Child" means the Participant's:
- (a) natural child;
- (b) adopted child or child placed in the home in anticipation of adoption;
- (c) step-child; or
- (d) any other child with whom the Participant has a parent-child relationship.

1.4 "Claims Administrator" means that entity contracted by the Trust Fund to provide managed care services, prior authorization certification, and to process and pay claims as provided under this Plan.

1.5 "Clinical Laboratory" means a facility which:
- (a) is certified or licensed as a Clinical Laboratory by the proper governmental authority;
- (b) meets the requirements of the Federal Medicare program; and
- (c) is approved by the Claims Administrator.

1.6 “Clinical Social Worker” means a person licensed in the practice of social work and certified in clinical social work by a recognized national organization.

1.7 “Contracted Provider” means a provider of services who agrees with the Trust Fund that his or her fee for a service covered by the Plan shall not exceed the Eligible Charge for that service.

1.8 "Copayment" means a fixed dollar amount or fixed percentage of the Eligible Charge, as determined by the Trust Fund that is not paid as a benefit for

covered services. The Beneficiary owes this amount to the provider of services.

1.9 "Dentist" means a doctor of dentistry or dental surgery who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license. A dentist is considered a "Physician" under this Plan, but only with respect to those Surgical Services which he or she is legally authorized to perform.

1.10 "Dependent" means the Participant's spouse and each eligible Child under 26 years of age who is not eligible to enroll in another employer-sponsored health plan other than a group health plan of a parent.

1.11 "Effective Date" means the date on which a person is accepted as a Beneficiary, as established and recorded by the Trust Fund, and is the date, subject to all applicable waiting periods provided under this Plan, on which such Beneficiary's eligibility for benefits under this Plan begins.

1.12 "Eligible Charge" means the charge determined by the Trust Fund according to the criteria in Section 3.7 and is the charge used to calculate the benefit payment for a covered service.

1.13 "Home Health Agency" means an agency which:

(a) is certified or licensed as such by the proper governmental authority;
(b) meets the requirements of the Federal Medicare Program; and
(c) is approved by the Claims Administrator.

1.14 "Hospital" means any inpatient acute care institution (but does not include any nursing or rest home, intermediate care facility, or Skilled Nursing Facility) which:

(a) is primarily engaged in providing facilities for surgery and for medical diagnosis and treatment of injured or ill persons by or under the supervision of Physicians;
(b) has registered nurses on duty;
(c) is certified or licensed as a Hospital by the proper governmental authority; and
(d) is recognized as a Hospital by the American Hospital Association.

1.15 “Individually Identifiable Health Information” means information that either actually identifies the individual or creates a reasonable basis to believe that the information would identify the individual, as defined in 45 CFR §164.501.

1.16 "Injury" means a physical damage which results from an external force (such as a blow, collision, or impact) and which is of sufficient magnitude to require the services of a Physician within 48 hours. Subjective symptoms which occur spontaneously or from trivial movement or exercise such as localized pain of joints, pain from nerves, disturbances of circulation, muscle pains and aches, or headaches and which are of physiological, pathological, toxic, or infective origin are not to be considered the result of external force and therefore shall not be considered an Injury.

1.17 “Licensed Mental Health Counselor” means a person who engages in the practice of mental health counseling and who is certified to render professional services for alcohol dependence, drug dependence or mental illness pursuant to Chapter 453D, HRS.

1.18 “Marriage and Family Therapist” means a person who is licensed in the practice of marriage and family therapy and certified to render professional services for alcohol dependence, drug dependence or mental illness pursuant to Chapter 451J, HRS.

1.19 "Participant" means the person who executes the enrollment card which must be accepted by the Trust Fund.

1.20 "Physician" means:

(a) a doctor of medicine (M.D.); or

(b) a doctor of osteopathy (D.O.); or

(c) a doctor of podiatric medicine (D.P.M.)

who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license.

1.21 "Plan" means this document and any supplemental Riders, as may be amended from time to time by the Trust Fund.

1.22 “Plan Year” means the period beginning September 1 and ending August 31 of the following calendar year. The first Plan Year for a new Beneficiary shall begin on that Beneficiary’s Effective Date and end the following August 31.

1.23 “Primary Care Physician (PCP)” means the Contracted Provider chosen by a Beneficiary to act as his or her personal health care provider and coordinator of health care services. A Beneficiary may select any available Contracted Provider who is engaged in family practice, general practice, obstetrics and gynecology, internal medicine, or pediatrics as the Beneficiary’s PCP. For a child, a Contracted Provider who specializes in pediatrics may be designated as the child’s PCP.

1.24 “Protected Health Information” means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted in any other form or medium, as defined in 45 CFR §164.501.

1.25 "Psychiatrist" means a doctor of medicine (M.D.):

(a) who is certified by or has at least three (3) years of psychiatric training acceptable to the American Board of Psychiatry and Neurology;

(b) who is appropriately licensed to practice by the proper governmental authority and who renders services within the lawful scope of such license; and

(c) whose practice is limited solely to psychiatry or psychiatry and neurology.

1.26 "Psychologist" means a person who is appropriately certified or licensed to provide psychodiagnostic or psychotherapeutic services by the proper governmental authority and who renders services within the lawful scope of such certificate or license.

1.27 "Registered Bed Patient" means a Beneficiary who has been admitted to a Hospital or Skilled Nursing Facility upon the recommendation of a Physician for any Injury or illness covered by this Plan and who is registered by the Hospital or Skilled Nursing Facility as an inpatient.

1.28 “Service Area” means the islands of Hawaii, Maui, and Oahu.

1.29 "Skilled Nursing Facility" means an inpatient care facility which:

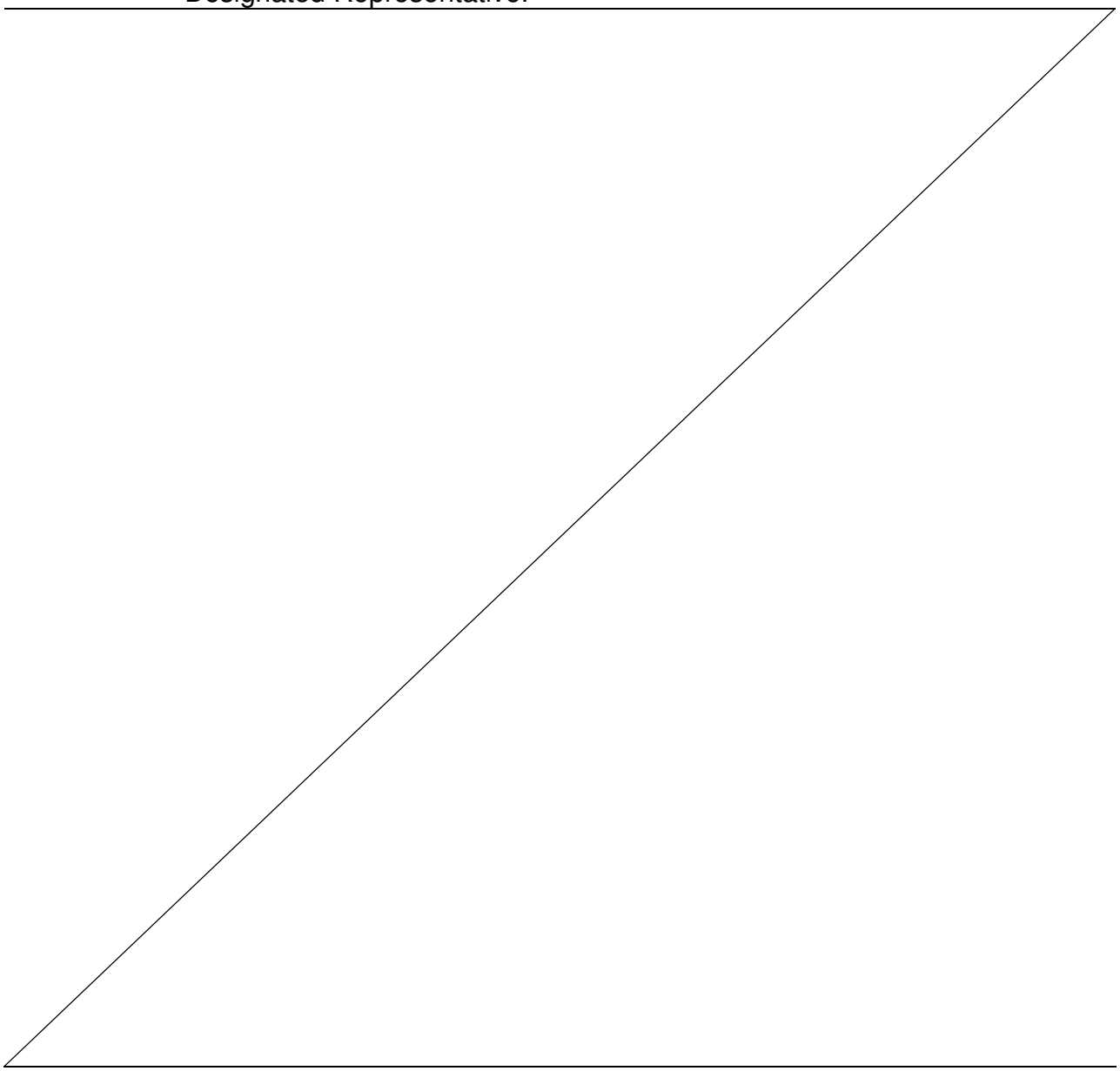
(a) is certified or licensed as such by the proper governmental authority;

(b) meets the requirements of the Federal Medicare Program; and
(c) is approved by the Claims Administrator.

1.30 "Spouse" means a person who is lawfully married to the Participant and is qualified as a spouse in accordance with the Internal Revenue Code.

1.31 "Surgical Services" means professional services necessarily and directly performed by a Physician in the treatment of an Injury or illness requiring cutting; suturing; diagnostic and therapeutic endoscopic procedures; debridement of wounds including burns; surgical management or reduction of fractures and dislocations; orthopedic casting; manipulation of joints under general anesthesia; or destruction of localized surface lesions by chemotherapy (excluding silver nitrate), cryotherapy, or electrosurgery.

1.32 "Trust Fund" means the Hawaii Teamsters Health & Welfare Trust or its Designated Representative.



SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Coverage under this Plan is available only to those individuals determined to be eligible by the Trust Fund. Enrollment hereunder shall cease upon termination of eligibility or termination of the Plan.

2.2 The Participant, Participant's Spouse, and each of the Participant's Children under 26 years of age who are not eligible to enroll in another employer-sponsored health plan other than a group health plan of a parent are eligible for coverage under this Plan. Coverage is available to a child without regard to marital status, dependency upon a parent (or anyone else) for financial support, residency with a parent, or full-time student status. A child's own spouse and child do not qualify for coverage. The Participant must enroll a Dependent with the Trust Fund within 30 days of the date of eligibility. If a Dependent is not enrolled within 30 days of the date of eligibility, he or she may be enrolled only at the next open enrollment period, which is held once a year. However, if a dependent who is covered under a plan other than the Trust Fund subsequently loses coverage under that plan, such dependent need not wait until the next open enrollment period but must enroll within 30 days of the loss of coverage under that plan. Failure to enroll within this 30-day period will result in the dependent having to wait until the next open enrollment period.

2.3 Coverage under this Plan shall cease upon the earliest of the following events:

(a) For the Participant - upon the Participant's termination of eligibility,

(b) For the Participant's Spouse - upon the Participant's termination of coverage or upon the dissolution of the marriage,

(c) For the Participant's Children - upon the Participant's termination of coverage, or when a Child reaches 26 years of age or becomes eligible to enroll in another employer-sponsored health plan other than a group health plan of a parent prior thereto, unless such Child meets the provisions of Section 2.4 below.

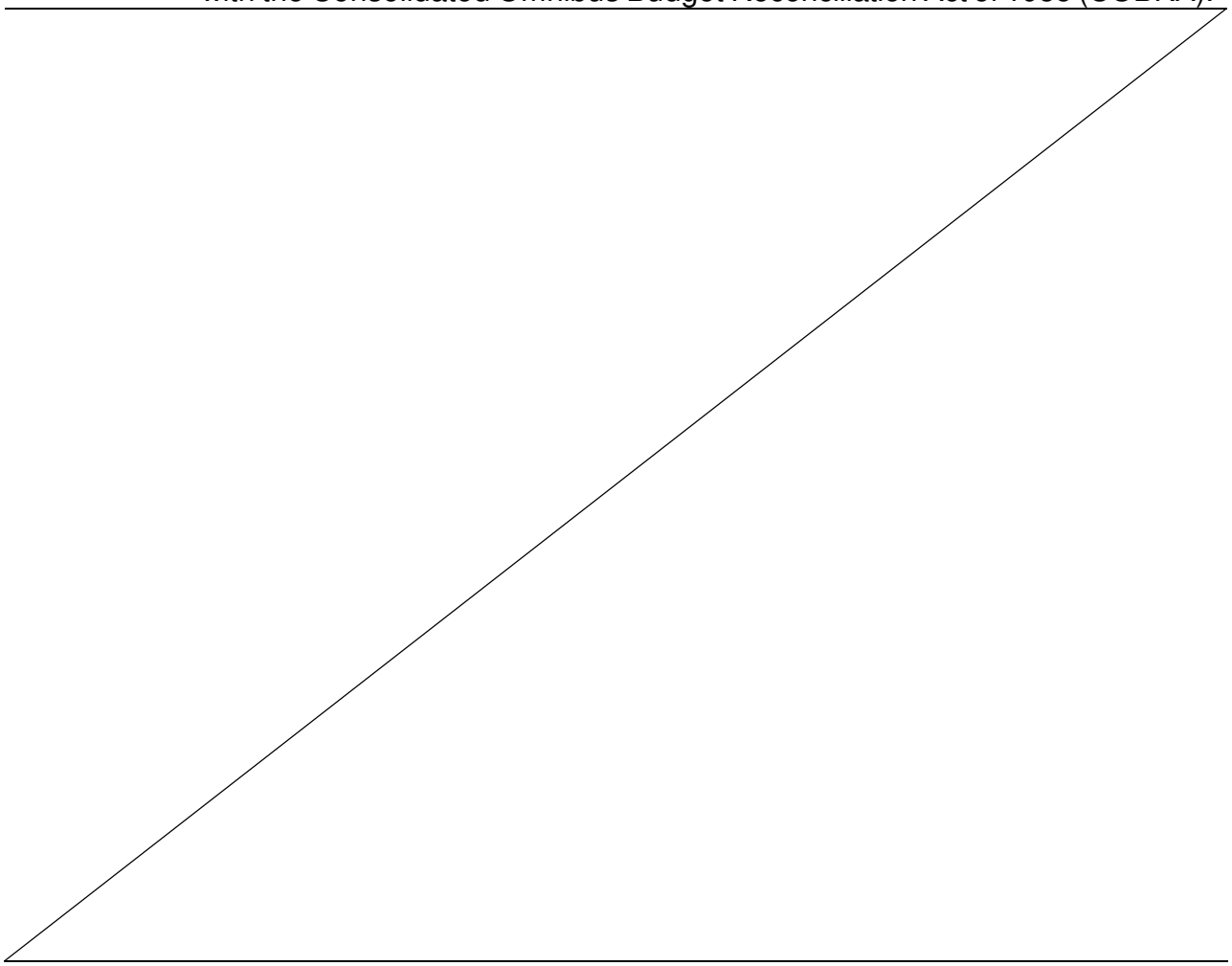
2.4 If a Child, upon reaching 26 years of age, is incapable of self-sustaining employment because of a mental or physical disability which was incurred prior to age 19, is chiefly dependent upon the Participant for support and maintenance, and is unmarried, the Child shall be allowed continued coverage under this Plan so long as the Child continues to be so incapacitated, dependent, and unmarried. The Participant must furnish written evidence of such incapacity, dependency, and marital status to the Trust Fund within 31 days of the Child's reaching 26 years of age, and at any time thereafter upon request by the Trust Fund. The Child's coverage shall terminate when the Participant's coverage terminates or when the Child marries or is no longer incapacitated and dependent.

2.5 If a Dependent ceases to be eligible for benefits, the Participant shall inform the Trust Fund, in writing, on or before the first day of the month following the

month in which eligibility ceased. If the Participant fails to inform the Trust Fund of the Dependent's ineligibility, and the Plan makes payments for services rendered to the ineligible Dependent, the Participant shall reimburse the Plan for the amount of such payments and any legal expenses incurred to recover such payments. If proceedings to adopt a Child are not successful, the Participant shall notify the Trust Fund within 21 days. Coverage for such Child shall terminate as of the first day of the month following the date of notification or the date when notification should have been given.

2.6 Coverage for the Participant and any Dependents initially listed on the application card shall begin as of the Participant's Effective Date, provided that the Trust Fund has received the proper documentation and has accepted the Participant's application by giving written notice to the Participant of his or her Effective Date. By submitting the application card, the Participant also accepts and agrees to be bound by the provisions of the Plan as now in force and as hereafter amended.

2.7 Continuation of Coverage. Upon termination of eligibility, Participants and Dependents may elect to continue coverage under this Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).



SECTION 3
CLAIM AND PAYMENT FOR SERVICES

3.1 Covered Services.

(a) Within the Service Area.

(i) Only services provided by Clinical Laboratories, Home Health Agencies, Hospitals, Physicians (M.D., D.O., or D.P.M.), Psychiatrists, Psychologists, and Skilled Nursing Facilities who qualify as such under the requirements of the Federal Medicare Program, are certified or licensed by the proper government authority, render services within the lawful scope of their respective license, and are approved by the Claims Administrator or Trust Fund as Contracted Providers, will be covered. Benefits may be available for services rendered by other Contracted Providers as shown in specific sections of this Plan.

(ii) Services rendered by providers who are not contracted or otherwise recognized by the Plan ("non-contract provider") are not covered.

(iii) Except in the case of Emergency services and obstetrical or gynecological care, Plan benefits are available only for services received from or arranged by the Beneficiary's Primary Care Physician. A Beneficiary may access routine gynecological care from a Contracted Provider who specializes in obstetrics or gynecology without prior authorization or referral. Emergency services do not require prior authorization.

(iv) When the Beneficiary's Primary Care Physician determines that the Beneficiary's condition requires the services of a specialty provider or facility, the PCP will refer the Beneficiary to an appropriate Contracted Provider. Prior authorization is required for referrals to specialty providers or facilities as provided under Section 5, Managed Care Program. Benefits for referred care are limited to those covered services described in this Plan.

(b) Outside the Service Area. Benefits for medical services rendered outside the Service Area are limited to the following conditions:

(i) If, in the judgment of the Plan, a Beneficiary requires medical or hospital services covered by this Plan which require skills not available through Contracted Providers, then, upon written referral by the Beneficiary's Primary Care Physician to the facility or practitioner designated by the Plan, and upon the Beneficiary receiving prior written authorization from the Claims Administrator, payment in lieu of medical service benefits may be made for prescribed medical services within

the coverage of this Plan. This may include referral to sources outside the Service Area if deemed medically necessary by the Plan.

(ii) If a Beneficiary requires emergency care as described under Section 8.2 or urgent care as described under section 6.4, then, upon timely notification, as required, and submission of a claim to the Claims Administrator, payment may be made for emergency or urgent care services rendered within the coverage of this Plan.

3.2 Submission of Claim. No claim for services covered by this Plan will be paid unless it is supported by the provider's report regarding the services rendered. The Contracted Provider is responsible for furnishing this report to the Claims Administrator, on the forms prescribed by the Trust Fund, within one (1) year of the date the services are rendered. In the case of emergency or urgent care services rendered outside the Service Area, the Participant is responsible for ensuring that the provider furnishes this report to the Claims Administrator within one (1) year of the date the services are rendered.

3.3 Payment for Services.

(a) Contracted Provider. When covered services are rendered by a Contracted Provider, the Plan will pay benefits directly to the Contracted Provider. Contracted Providers have agreed to limit their charges for covered services to not more than a specified amount. In addition, Contracted Providers have agreed not to collect from any Beneficiary an amount exceeding the Beneficiary's Copayment specified in this Plan, except for non-covered services.

Payment of claims for Emergency Services and Urgent Care Services rendered by a Veterans Administration Medical Center and/or Uniformed Military Services Facility will be adjudicated (processed) on a Contracted Provider basis using the same or comparable Contracted Provider Eligible Charge, but in no event shall the Trust Fund pay the Veterans Administration Medical Center and/or Uniformed Military Services Facility any differently than the Trust Fund's Contracted Provider Eligible Charges, and payments are to be made directly to the Veterans Administration Medical Center and/or Uniformed Military Services Facility.

(b) Non-contract Provider. The Plan's benefit payments for services rendered by non-contract providers are limited to the conditions specified under section 3.1(b), and will be made in accordance with section 3.7. The Beneficiary is responsible for paying the specified Copayment plus any amount of the provider's charge which exceeds the Eligible Charge. Payment of claims for services covered by this Plan and rendered by a non-contract provider:

(i) are not assignable; and

(ii) shall be made by the Plan, in its sole discretion, either directly to the provider or directly to the Participant or to the Dependent or, in the case of the Participant's death, to his or her executor,

administrator, provider, Spouse, or relative.

3.4 Reimbursement for Services. If a Beneficiary has paid for services covered by this Plan the Participant will be reimbursed in accordance with the terms of this Plan. To receive payment for such services, a Participant must submit a claim within one (1) year after the last day on which such services were rendered.

3.5 Late Claims. No payment will be made on any claim submitted to the Claims Administrator or Trust Fund more than one (1) year after the last day on which the services were rendered unless it shall be shown to the satisfaction of the Trust Fund that there was unusual and justifiable cause for such late submission.

3.6 Medical Necessity of Services. This Plan covers only medically necessary services; the Plan will not cover any unnecessary services nor will the unnecessary portion of any charge be paid. The fact that a Physician may prescribe, order, recommend, or approve a service does not in itself constitute medical necessity or make a charge an allowable expense under this Plan. The Beneficiary's Primary Care Physician or the specialty provider, upon a referral by the Beneficiary's Primary Care Physician, may write to the Claims Administrator for a determination regarding the medical necessity of a service before it is performed. The Claims Administrator will determine the medical necessity of the test or treatment. To be considered medically necessary, a service must meet all of the following criteria:

(a) The service or treatment must follow standard medical practice and be essential and appropriate for the diagnosis or treatment of an illness or Injury. Standard medical practice, with respect to a particular illness or Injury, means that the service was given in accordance with generally accepted principles of medical practice in the United States at the time furnished.

(b) The service or treatment must not be "experimental," (e.g., used in research or on animals) or "investigative," (e.g., used only on a limited number of people or where the long-term effectiveness of the treatment has not been proven in scientific, controlled settings, and, where applicable, has not been approved by the appropriate government agency).

(c) If there is more than one (1) medically appropriate method of treating a Beneficiary, the Plan's coverage is limited to the most cost effective method. If the Beneficiary elects a more expensive method of treatment, the Beneficiary shall be responsible for the total cost of the services. Similarly, if the services could be provided in more than one (1) type of facility or setting (e.g., Hospital or Physician's office), the Plan's coverage is limited to the most cost effective facility or setting.

(d) The service or treatment is being covered by Federal government health plans.

3.7 Eligible Charges. The Plan's benefit payments for covered services are based on the Eligible Charge for the services. The Plan will not pay the portion of any charge that exceeds the Eligible Charge.

(a) Definition.

(i) The charge for a covered service made by a Contracted Provider will be considered eligible when it complies with the fee schedule established by the Trust Fund and the provisions contained in the agreement between the Claims Administrator and such Contracted Provider.

(ii) The Eligible Charge for a covered service made by a non-contract provider who is a Physician, Psychiatrist, Psychologist, or Clinical Laboratory will be the lesser of the following two (2) charges:

a. the charge established by the Trust Fund, or
b. the actual charge for the service.

(iii) The Eligible Charge for a covered service rendered by a non-contract facility that is a Hospital, Skilled Nursing Facility, ambulatory surgical center, birthing center, Home Health Agency, or other similar facility will be the lesser of the following two (2) charges:

a. the charge established by the Trust Fund, or
b. the actual charge for the service.

(b) Claims for Services Provided Outside the Service Area. Benefit payments for covered services rendered outside the Service Area will be made as though such services had been rendered within the Service Area; provided, however, for covered services rendered by out-of-state providers, the Eligible Charges will not exceed 150% of Eligible Charges for the same or comparable services rendered within the Service Area. Prior authorization is required to receive non-emergency services outside the Service Area.

3.8 Qualified Medical Child Support Orders. Any claim for benefits with respect to a Child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the Child or by the Child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the Participant with respect to any such claim shall be payable to the Child's custodial parent or court-appointed guardian.

3.9 Review of Claims. The Trust shall have discretionary authority to determine all questions of eligibility of Beneficiaries, to determine the amount and type of benefits payable to any Beneficiary or provider in accordance with the terms of this Plan, and related regulations, and to interpret the provisions of this Plan, as is necessary to determine benefits.

3.10 Claims and Appeals Procedures.

(a) Designation of an Authorized Representative. The Beneficiary may designate another person to act as the Beneficiary's authorized representative in the handling of benefit claims. In order for the Beneficiary to designate another individual to be an authorized representative, the Beneficiary must complete and file a form with the Claims Administrator. If the Beneficiary designates an authorized representative to act on the Beneficiary's behalf, all correspondence

and benefit determinations will be directed to the authorized representative, unless the Beneficiary directs otherwise. The Plan will also provide information to both the Beneficiary and the Beneficiary's authorized representative, if so requested. In the case of a claim for urgent care as defined in Section 3.10(b)(i), where the Beneficiary is unable to act on his or her own behalf, the Plan will recognize a health care professional with knowledge of a Beneficiary's medical condition as the Beneficiary's authorized representative. A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with State law.

(b) Initial Claims. Upon the filing of a benefit claim, the Plan must make a decision on the claim within the following time periods:

(i) Urgent Care Claims. Any claim for urgent care must be determined within 72 hours of its receipt. The Plan may orally notify the Beneficiary of the determination, but must provide a written notice within three (3) days following the oral notification. If the Beneficiary's claim is improperly filed or incomplete, the Plan must provide notice to the Beneficiary orally, or in writing if requested, within 24 hours of the date the claim was received. The notification will indicate the proper claims filing procedures and/or the information needed to complete the claim. Once the information has been provided, the determination should be made within 48 hours from the earlier of: 1) the time the Plan receives the necessary information from the Beneficiary; or 2) the expiration of the 48-hour period provided to the Beneficiary to submit the necessary information.

A claim will be regarded as an "urgent care" claim if any one of the following circumstances exist: 1) where failure to provide the service could seriously jeopardize the Beneficiary's life, health, or ability to regain maximum functions, or could subject the Beneficiary to serious pain that could not be managed without the requested care; or 2) where failure to provide the requested care, in a physician's opinion with knowledge of the Beneficiary's medical condition, would subject the Beneficiary to serious pain that could not be managed without the requested care; or 3) if the Beneficiary's treating physician deems it as urgent; or 4) if the Plan, in applying the judgment of a "prudent layperson who possesses an average knowledge of health and medicine," determines the claim to be one involving urgent care.

(ii) Pre-Service Claims. Any claim involving a requirement or request for approval prior to service being rendered must be processed within fifteen (15) days from the receipt of the claim. This includes pre-authorizations and utilization reviews. If the

claim is improperly filed, the Plan must provide notice to the Beneficiary orally, or in writing if requested, within five (5) days of the date the claim was received. The notification will indicate the proper procedures for filing claims. The Plan may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Plan's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Plan must provide a notice of extension to the Beneficiary which must state the circumstances which provide the basis for the extension, and the date the Plan expects to render a decision. The Plan must provide such notice prior to the extension period taking effect. The Beneficiary must be given at least forty-five (45) days from the date notification of the missing information is received to provide such information.

(iii) Post-Service Claims. Any claim submitted after services have been performed will be determined within thirty (30) days from the receipt of the claim. The Plan may extend the time to respond to the Beneficiary by fifteen (15) days, if circumstances exist beyond the Plan's control that interfere with the timely determination of the claim, or if information necessary to complete the claim is missing. The Plan must provide a notice of extension to the Beneficiary which must state the circumstances which provide the basis for the extension, and the date the Plan expects to render a decision. The Plan must provide such notice prior to the extension period taking effect. The Beneficiary must be given at least forty-five (45) days from the date notification of the missing information is received to provide such information.

(iv) Concurrent Claims. If a Beneficiary is receiving ongoing treatment under the Plan, the Plan must provide advance notice of any determination to terminate or reduce the Beneficiary's treatment. The Plan must provide notice to the Beneficiary sufficiently in advance to allow the Beneficiary to appeal the determination and have a decision rendered prior to any reduction or termination of the Beneficiary's treatment. Any claim a Beneficiary makes which involves both urgent care and a continuing course of treatment previously approved by the Plan, must be decided as soon as possible, given the urgency of the medical conditions involved. The Plan must provide the Beneficiary with notice of its determination on such claims within 24 hours of its receipt, if the claim was received at least 24 hours prior to the expiration of the Beneficiary's treatment. If the Beneficiary's claim was received less than 24 hours prior to the expiration of treatment, the Plan must provide notification of its decision to the Beneficiary within 72

hours of the receipt of the claim.

(c) Notice of Initial Benefit Determination. When the Plan makes an adverse benefit determination, the Plan must give the Beneficiary written notice of the determination. The Claims Administrator must take appropriate measures to ensure actual receipt of the notice by the Beneficiary, and inform the Beneficiary of the significance of the notice and the right to receive the notice free of charge. The Plan must also provide the Beneficiary with the notice, free of charge, upon the Beneficiary's request. The notice must be in plain language and include the following information:

(i) the specific reason(s) for the adverse benefit determination;

(ii) references to specific plan provisions on which the determination was based;

(iii) a description of any additional information or information that is needed for the Beneficiary to perfect the claim, and an explanation of why the information is necessary;

(iv) a description of the plan's review procedures and the time limits that apply to such procedures as well as a statement about the Beneficiary's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

(v) a statement that an explanation of the scientific or clinical judgment for the determination, which specifically applies the terms of the plan to the Beneficiary's medical circumstances, will be provided free of charge upon the Beneficiary's request, for determinations involving medical necessity or exclusions for experimental treatment, or other similar exclusion or limit;

(vi) the identification of any specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Beneficiary free of charge, upon the Beneficiary's request; and

(vii) a description of the expedited review process if the claim is an urgent care claim.

(d) Appeal of Claims. Any determination that a benefit is unnecessary or otherwise not payable shall be reviewed at the Beneficiary's request by the Benefits and Appeals Committee that is appointed and approved by the Trust. The Beneficiary must submit a written request for review unless the claim is one involving urgent care, in which case the Beneficiary may make an oral request to the Plan for review. A Beneficiary has 180 days from the date the Trust processed the Beneficiary's initial claim to request this review. Any determination made by the Benefits and Appeals Committee shall be a full and fair determination that will be conclusive upon all parties. Any request for review after 180 days from the date the Claims Administrator processed the Beneficiary's initial claim will be denied.

(e) Decision making of Appeals.

(i) Appeal of Urgent Care Claims. If the Beneficiary is appealing an urgent care claim, the Plan must allow the Beneficiary to submit either an oral or written request for appeal. The Plan will communicate all necessary information to the Beneficiary through the most expedient means available (e.g., telephone or fax). The decision must be made no later than 72 hours from the time the appeal is received.

(ii) Appeal of Pre-Service Claims. If the Beneficiary is appealing a pre-service claim, the Benefits and Appeals Committee must issue its decision no later than thirty (30) days from the time the appeal is received.

(iii) Appeal of Post-Service Claims. If the Beneficiary is appealing a post-service claim, the Benefits and Appeals Committee must issue its decision no later than sixty (60) days from the time the appeal is received.

(f) Required Procedures for Appeals.

(i) A full and fair review will be conducted on all appeals by the Benefits and Appeals Committee, with no preferential treatment given to the initial determination. The Benefits and Appeals Committee shall consider all evidence submitted by the Beneficiary or the Beneficiary's authorized representative, regardless of whether such evidence was previously submitted or considered at the initial benefit determination.

(ii) The determination on appeal will be made by individuals who were not involved in the determination of the initial claim, and who are not subordinates of anyone that was involved in the determination of the initial claim.

(iii) The Benefits and Appeals Committee must consult with healthcare professionals who have the appropriate training and experience in the field of medicine if the initial determination under review involved medical judgment (e.g., whether the drug is medically necessary or appropriate, investigational, or experimental). If a healthcare professional is required to be consulted in the appeal, the professional must not be the same individual that was involved in the initial determination of the claim, nor a subordinate of that individual.

(g) Right to Submit Information. In appealing a denied claim, the Beneficiary has the right to submit written comments, documents, records, and other information relating to the claim under review whether or not such document, record, or other information was previously submitted at the initial benefit determination.

(h) Beneficiary's Right to Access Information. Upon the Beneficiary's request, the Plan shall provide, at no cost to the Beneficiary, the following:

(i) The identity of any medical or vocational experts that were

hired on behalf of the Plan to provide advice in connection with the initial benefit determination, regardless of whether the advice was relied upon or not in making the initial determination; and

(ii) Reasonable access to, and copies of, all documents, records and other information relevant to the claim, without regard to whether that information was submitted or considered as part of the initial adverse benefit determination, free of charge. A document, record or other information will be considered relevant if it: 1) was relied upon in the initial adverse benefit determination; 2) was submitted, considered, or generated in the course of making the benefit determination, regardless of whether it was relied upon or not; or 3) demonstrates compliance with administrative processes and safeguards required for purposes of making a benefit determination.

(i) Notification of Determination on Appeal. The Plan will provide written notification to the Beneficiary of the determination of the appeal. The notification will be written in understandable language and contain the following:

(i) the specific reason(s) for the benefit determination;

(ii) references to specific plan provisions on which the determination was based;

(iii) a statement that the Beneficiary is entitled to receive free, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Beneficiary's claim for benefits;

(iv) a statement of the Beneficiary's right to bring a civil action under section 502(a) of ERISA;

(v) a statement that an explanation of the scientific or clinical judgment for the determination which specifically applies the terms of the plan to the Beneficiary's medical circumstances, will be provided free of charge, upon the Beneficiary's request, for determinations involving medical necessity or exclusions for experimental treatment, or other similar exclusion or limit;

(vi) the identification of any specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to the Beneficiary, free of charge, upon the Beneficiary's request; and

(vii) a statement that reads: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

SECTION 4
ANNUAL LIMITATIONS

4.1 Maximum Annual Copayment. Whenever a Beneficiary makes Copayments for services covered under Sections 6 through 16 of this Plan that equal $2,000 in any Plan Year, the Beneficiary owes no Copayment for such services for the remainder of the Plan Year. In the case of a family, the Maximum Annual Copayment for a family of three or more shall not exceed $6,000 for a Plan Year. A Beneficiary's Copayments or additional expenses incurred by any benefit denial resulting from any failure to satisfy a Managed Care Program review or notice requirement described in Section 5 will not be counted as Copayments toward meeting the Maximum Annual Copayment.

4.2 Annual Maximum per Plan Year. There is no annual maximum benefit under this Plan.

4.3 Maximum Lifetime Benefits. There is no lifetime maximum benefit under this Plan.

SECTION 5
MANAGED CARE PROGRAM

5.1 Managed Care Program and Prior Authorization Reviews. A prior review must be obtained from the Claims Administrator for certain types of medical services before the services are received. The Beneficiary's Primary Care Physician or the specialty provider, upon a referral by the PCP, shall be responsible for initiating and submitting all requests and documentation necessary for obtaining a required Managed Care Review or prior authorization review on the Beneficiary's behalf. The following benefits and services require prior review and authorization by the Claims Administrator before services are received:

(a) Referrals to specialists for consultations and office visits, including all out-of-state services;
(b) All inpatient admissions including acute, skilled and observation stays;
(c) Outpatient services to include Imaging scans (MRI, MRA or PET), Gamma knife or X-knife procedures, greater than three (3) OB ultrasounds per pregnancy, In vitro fertilization;
(d) Outpatient Rehabilitation services including Physical Therapy, Speech Therapy or Occupational Therapy;
(e) Other Medical services to include Appliances and Durable Medical Equipment, Hospice Care, Home Health Care, Human Growth Hormone Therapy, Dialysis, Chemotherapy, Radiation Therapy, Reconstructive Surgery, Transplants, intravenous administration of medication or nutrient solutions, Orthotics and Prosthetics;
(f) Mental Illness and Alcohol or Drug Dependence services (requires a treatment plan);
(g) Inter-island Travel benefits; and
(h) Such other benefits and services as may be required by the Plan.

5.2 Benefit Denials. The Plan will deny payment of benefits in cases where prior review of covered services is required, but not obtained if the services or devices do not meet the Plan's payment determination criteria. Additional expenses incurred by a Beneficiary as a result of any benefit denial made by the Plan pursuant to this Section 5 shall not count toward the Maximum Annual Copayment. Furthermore, if the Beneficiary is required to pay for any services because of a benefit denial, those services will not be eligible for increased benefits even if the Beneficiary has met the Maximum Annual Copayment.

5.3 Preadmission Review.

(a) Before admission to a Hospital for any treatment that can be scheduled in advance, the Beneficiary's Physician shall notify the Claims Administrator and request a Preadmission Review. If a Preadmission Review is not obtained, the Plan may deny payment of benefits, as indicated in Section 5.2 above.

Where the admission cannot be scheduled in advance, e.g., in cases

of emergency or maternity, the Beneficiary, the Beneficiary's Physician, or the Hospital shall notify the Claims Administrator as soon as practical after admission, but in no event later than 48 hours or one (1) working day after the admission, whichever is later.

(b) Approval of benefits for a Hospital admission will be based on whether the Hospital admission recommended by the Beneficiary's Physician is medically necessary and whether the care can be provided safely and effectively out of the Hospital.

(c) The Claims Administrator will notify the Beneficiary's Physician in writing if the payment of benefits for the admission is approved. The Beneficiary's Physician will also be notified if payment of benefits for the admission is not approved. The Beneficiary shall be responsible for all charges related to any Hospital admission for which the Plan has indicated it will not pay benefits.

5.4 Surgical Review.

(a) The Plan has identified certain kinds of Surgical Services which are sometimes performed even though nonsurgical treatment may be equally effective. A list of these Surgical Services has been provided to Contracted Providers and is available from the Claims Administrator. Before scheduling any of the listed Surgical Services, the Beneficiary's Physician shall notify the Claims Administrator and request a Surgical Review. Where the surgery cannot be scheduled in advance, e.g., in cases of emergency or maternity, the Beneficiary, the Beneficiary's Physician, or the Hospital shall notify the Claims Administrator as soon as practical after the surgery, but in no event later than 48 hours or one (1) working day after the surgery, whichever is later.

(b) The Claims Administrator will notify the Beneficiary and the Beneficiary's Physician of the results of its Surgical Review. The Claims Administrator may approve or deny payment of benefits on the Beneficiary's receiving a second opinion on the necessity of the surgery. A Beneficiary may receive a second opinion at no cost to the Beneficiary if the second opinion is arranged by the Claims Administrator for the following surgeries: Inpatient Cholecystectomy (gall bladder surgery), Varicose Vein surgery, Blepharoplasty (eyelid surgery), Septoplasty/Rhinoplasty (nose surgery), and Scar Revision surgery. After receiving a second opinion, the Beneficiary and the Beneficiary's Physician may decide whether to proceed with the surgery. The second opinion does not need to confirm the recommended surgery. The Beneficiary shall be responsible for all charges related to any listed Surgical Services for which the Plan has indicated it will not pay benefits. If a Surgical Review is required but not obtained, the Plan may deny payment of benefits, as indicated in Section 5.2 above.

5.5 Inpatient Review.

(a) The Claims Administrator will review each Beneficiary's Hospital

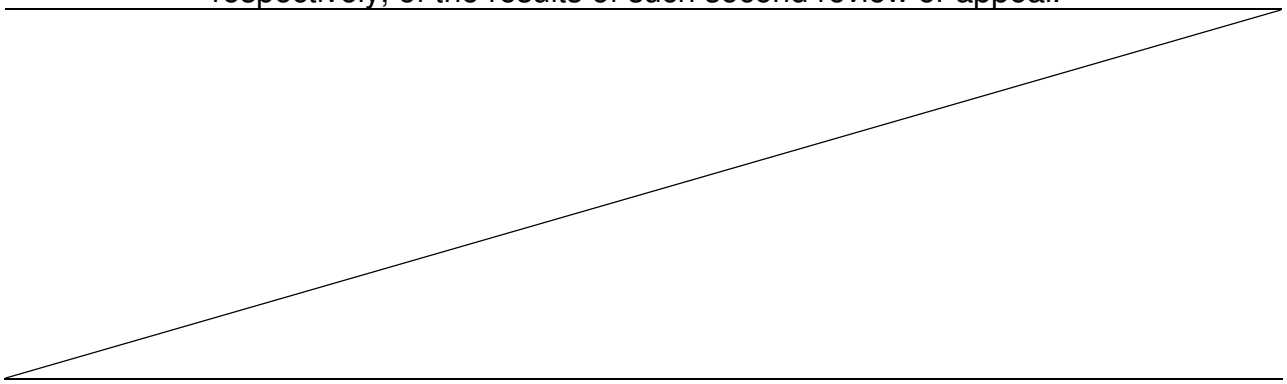
admission for the appropriateness of the inpatient care provided to the Beneficiary and the appropriateness of continuing hospitalization. This review will occur within 48 hours after admission and at set intervals, until the Beneficiary is discharged from the Hospital. The Claims Administrator will also review discharge plans for the appropriateness of after-Hospital care.

(b) This review of the appropriateness of inpatient care and after-Hospital care is for benefit payment purposes. If the Claims Administrator has a question regarding the appropriateness of continuing hospitalization or after-Hospital care, or if the Claims Administrator determines that benefits are not payable, the Beneficiary and the Beneficiary's Physician will be notified. If the Claims Administrator decides that the continuation of any service or care is not medically necessary or appropriate, benefits under this Plan will not be payable for that continued service or care.

5.6 Benefits Management Program. The Plan may assist a Beneficiary by providing benefits for alternative services that are medically appropriate, but may not otherwise be covered under this Plan. Benefits for any alternative services for a Beneficiary's illness or Injury will be paid in lieu of benefits for regularly covered services and will not exceed the total benefits otherwise payable for regularly covered services.

These alternative services will be paid at the Plan's discretion as long as the Beneficiary and the Beneficiary's Physician agree that the recommended alternative services are medically appropriate for the illness or Injury. Payment for alternative services in one (1) instance does not obligate the Plan to provide the same or similar benefits for the same or any other Beneficiary in any other instance. Payment of these alternative benefits is made as an exception and in no way changes or voids the Plan benefits, or terms and conditions.

5.7 Second Review or Appeal. If a Beneficiary does not agree with a benefit determination made by the Claims Administrator under the Preadmission Review, Surgical Review, or Inpatient Review provisions above, the Beneficiary may ask for a second review by the Claims Administrator or file an appeal with the Trust Fund as provided under section 3.10. The Beneficiary will be notified by the Claims Administrator or the Trust Fund, respectively, of the results of such second review or appeal.



SECTION 6
MEDICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following medical benefits:

6.1 Medical Services. The medical benefits provided are visits to or by a Physician for such medical (nonsurgical) services as the Beneficiary may require in the diagnosis or treatment of any Injury or illness not requiring cutting, incision, excision, or suturing (such as contusions, abrasions, sprains, strains, insect bites or stings, or nonsurgical lacerations or fractures). Physician visits for medical services will be covered as follows:

(a) Home, Office, or Emergency Room Visit.

(i) Office visits for primary care are provided upon payment of a $14.00 copayment per visit.

(ii) When arranged by a Beneficiary's Primary Care Physician, office visits for specialty care are provided upon payment of a $14.00 copayment per visit.

(iii) Office visits for a second opinion on the necessity of surgery when required and arranged by the Claims Administrator are provided without charge.

(iv) Physician house calls are provided upon payment of a $14.00 copayment per visit. A house call is provided only when the Beneficiary's Physician determines that necessary care can best be provided in the home.

(v) Within the Service Area, Physician emergency room visits are provided in accordance with Section 8.2 Emergency Room Benefits. Outside the Service Area, the Plan will pay 80% of Eligible Charges for Physician emergency room visits.

(b) Preventive Services. Office visits for health maintenance, such as ear examinations to determine the need for hearing correction, are provided upon payment of a $14.00 copayment per visit. The following office visits are provided without charge:

(i) Well-baby office visits. Eight (8) routine well-baby visits during the first two (2) years of a Child's life (at birth and ages 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months). When a well-baby visit cannot be scheduled within an above designated benefit period, the visit may be covered if rendered within thirty (30) days of the benefit period, as long as the total number of well-baby visits allowed by the Plan is not exceeded.

(ii) One preventive care office visit per calendar year for Beneficiaries age 2 and older.

(iii) One gynecological office visit per calendar year for female Beneficiaries of child bearing age.

6.2 Immunizations.

(a) Prescribed immunizations for the prevention of disease are provided without charge for Beneficiaries who are under 19 years of age on the date the immunization dose is administered, and are provided at $10.00 per immunization dose for Beneficiaries who are 19 years of age and older on the date the immunization dose is administered, if the following immunization criteria are met. The immunizations must be:

(i) Routine vaccinations, as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Morbidity and Mortality Weekly Report (MMWR) by the Centers for Disease Control and Prevention (CDC), in accordance with published criteria, guidelines or restrictions.

(b) Immunizations in keeping with "prevailing medical standards", as defined by State law, for children 5 years of age and younger are provided without charge.

(c) Influenza and Pneumococcal immunizations are provided without charge if the immunization criteria in Section 6.2(a)(i) above are met. Effective: 09/01/11 Adopted: 08/03/12

(d) Unexpected mass immunizations are provided upon payment of 50% of Eligible Charges if the immunization criteria in Section 6.2(a) above are met.

(e) Immunization office visits are provided without charge for immunizations covered under Sections 6.2 (a), (b), (c), and (d) above.

(f) Travel immunizations are not covered; however, travel immunization office visits are provided upon payment of a $14.00 copayment per visit.

6.3 Home Health Care. Subject to the limitations listed below, the Plan covers without charge, home health care visits by a qualified Home Health Agency.

(a) Prior approval from the Claims Administrator is required for home health care as provided in Section 5, Managed Care Program. The Beneficiary's Physician must certify in writing that a Beneficiary:

(i) is homebound due to an Injury or illness,

(ii) requires part-time skilled health services, and

(iii) would require inpatient Hospital or Skilled Nursing Facility care if there were no home health care visits. The Federal Medicare definition of homebound shall apply.

(b) If a Beneficiary requires home health care visits for more than (thirty) 30 days, the Beneficiary's Physician must recertify that additional visits are required and must provide a continuing plan of treatment at the end of each 30-day period of care.

(c) Visits must be provided by a qualified Home Health Agency.

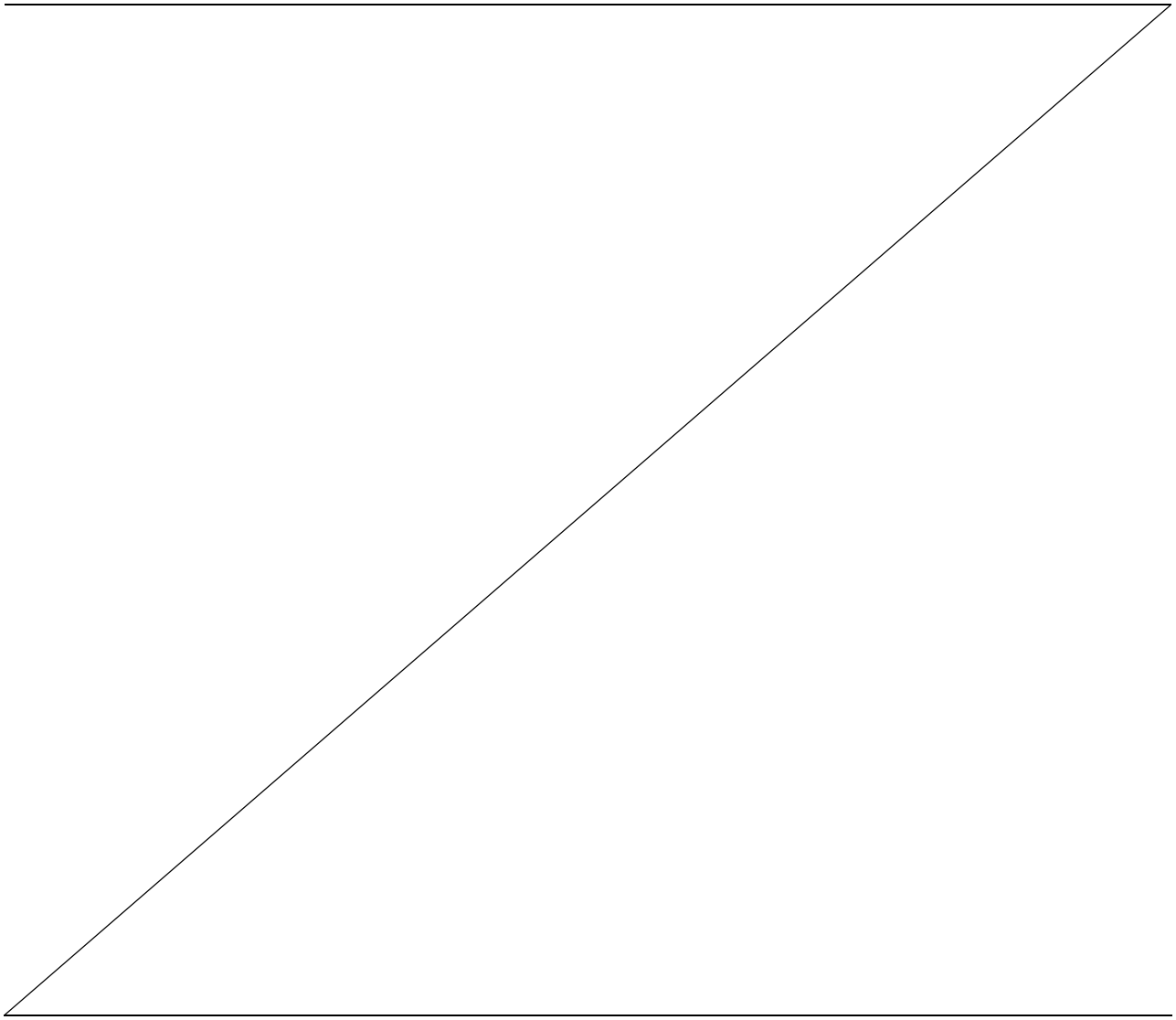
(d) No payment will be made for home health care services furnished primarily to assist the Beneficiary with personal, family, or domestic needs, such as general household services, meal preparations, shopping, bathing, or dressing.

6.4 Urgent Care Services outside the Service Area. Subject to the following conditions and limitations, the Plan will pay 80% of Eligible Charges for Urgent Care Services received when the Beneficiary is temporarily outside the Service Area as substantiated by the Physician's claim or a written Hospital report.

(a) "Urgent Care Services" means initial care for a sudden and unforeseen illness or Injury when the Beneficiary is temporarily away from the Service Area, which is required to prevent serious deterioration of the Beneficiary's health and cannot be delayed until the Beneficiary is medically able to safely return to the Service Area.

(b) If the Beneficiary is admitted to a Hospital, the Beneficiary must notify the Claims Administrator within 48 hours or by the next business day.

(c) Continuing or follow-up treatment from a provider that is not contracted or otherwise recognized by the Plan is not covered unless treatment meets the criteria for Emergency Services or Urgent Care Services.



SECTION 7
SURGICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following surgical benefits:

7.1 Surgical Services. Except where otherwise stated below, Surgical Services required for the diagnosis or treatment of a Beneficiary's Injury or illness will be covered as follows:

(a) Prescribed surgery and procedures performed in a Physician's office are provided upon payment of a $14.00 copayment per visit.

(b) Prescribed surgery and procedures performed in a Hospital or Ambulatory Surgery Center are provided in accordance with Section 8, Hospital Benefits.

7.2 Limiting Conditions for Surgical Benefits.

(a) The Plan has payment restrictions and rules that apply to multiple Surgical Services, services of an assistant surgeon, and payment for preoperative and postoperative care for major and minor Surgical Services. A Surgical Review is required for Surgical Services as provided under Section 5, Managed Care Program.

(b) Transplants.

(i) Subject to compliance with each of the conditions set forth in Section 7.2(b)(iii) below, Medical, Surgical, Hospital, and other benefits as provided elsewhere in this Plan are available to a Beneficiary for the following covered transplants: kidney; cornea; bone marrow, excluding bone marrow transplants associated with high dose chemotherapy for solid tissue tumors, except for germ cell tumors and neuroblastoma in children; liver; heart; heart-lung; lung; simultaneous kidney-pancreas; small bowel; and small bowel-liver transplants. All other transplants, including artificial or non-human organ transplants, are not covered under this Plan.

(ii) Transplant Evaluation. No benefits will be paid in connection with bone marrow, liver, heart, heart-lung, lung, simultaneous kidney-pancreas, small bowel, or small bowel-liver transplant evaluations without the prior approval of the Claims Administrator. Transplant evaluation means those procedures, including laboratory and diagnostic tests, consultations, and psychological evaluations, which a Hospital or facility uses in evaluating a potential transplant candidate.

(iii) No benefits will be paid in connection with bone marrow, liver, heart, heart-lung, lung, simultaneous kidney-pancreas, small bowel, and small bowel-liver transplants without the prior approval from the Claims Administrator. No transplant benefits will be approved unless each of the following conditions is met:

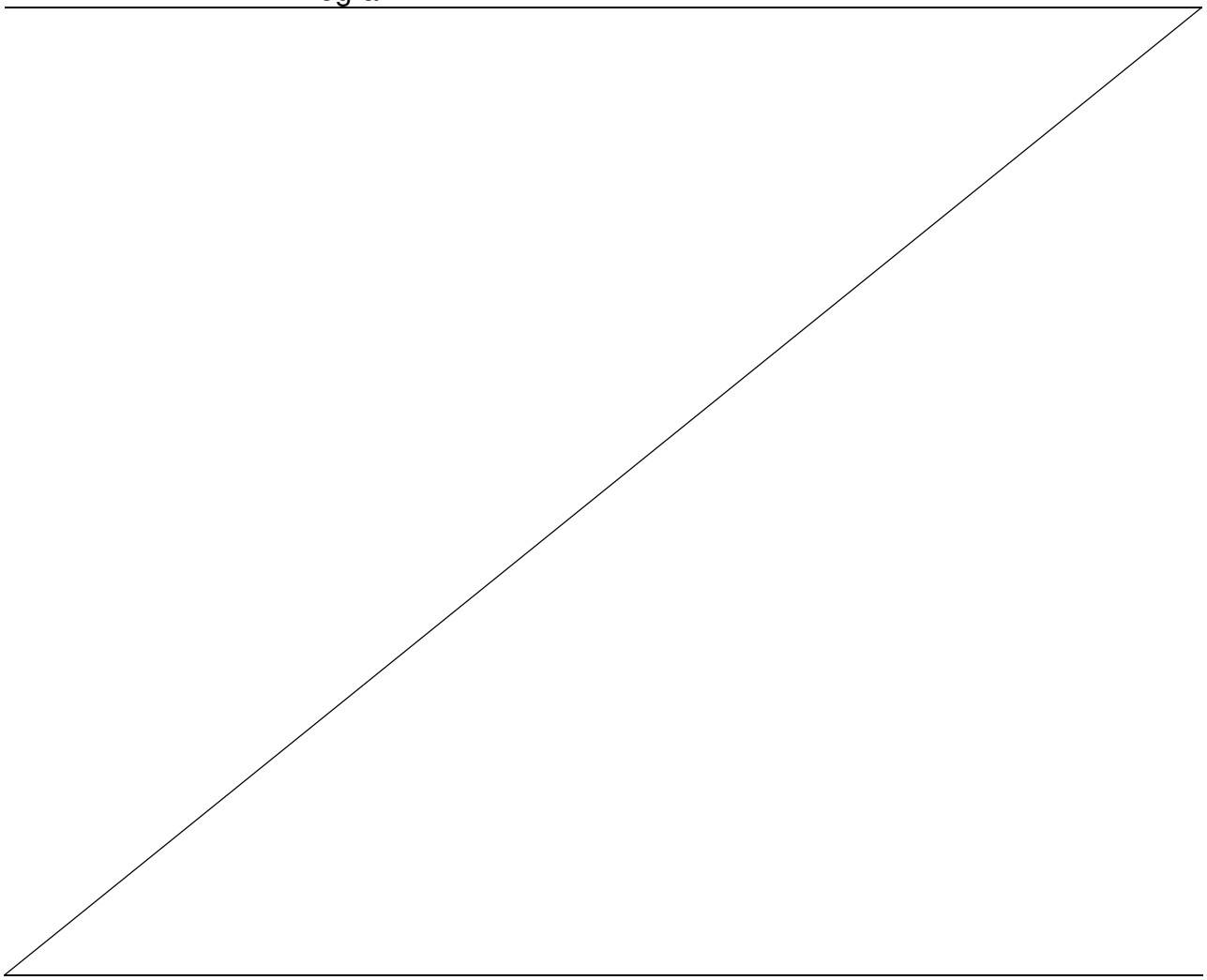
a. Both the Beneficiary and the specific transplant must

meet the "medical necessity" criteria set forth in Sections 3.6(a) and (c).

b. The transplant must be performed at a transplant facility that is approved by the Claims Administrator for that type of transplant and the contracted transplant facility has accepted the Beneficiary as a transplant candidate;

c. Any transplant that is classified as "experimental" or "investigative" in the circumstances presented, or as not proven to be safe and effective, will not be covered.

(c) Reconstructive Surgery. The Plan will cover reconstructive surgery only when it is required to restore, reconstruct, or correct any bodily function that was lost, impaired, or damaged as a result of an illness or Injury. Reconstructive surgery for congenital anomalies (i.e., defects present from birth) will be covered only when the defect severely impairs or impedes normal, essential bodily functions and is medically necessary. Prior approval from the Claims Administrator is required for these services as provided in Section 5, Managed Care Program.



SECTION 8
HOSPITAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following Hospital benefits:

8.1 Inpatient Hospital Services. This Plan provides coverage for a maximum of 365 days per Calendar Year for Hospital services received by a Beneficiary confined as a Registered Bed Patient.

(a) When prescribed, the following Inpatient Hospital services are provided upon payment of a $100 copayment per admission:

(i) Room and board based on semiprivate room rate.

(ii) Intermediate care unit.

(iii) Isolation unit.

(iv) Intensive care or coronary care unit (must be equipped and operated according to generally recognized Hospital standards acceptable to the Claims Administrator).

(v) Operating room; surgical supplies; Hospital anesthesia services and supplies; drugs; dressings; oxygen; antibiotics; diagnostic and therapy services; and Hospital blood transfusion services.

(b) "Life Bed" Services. Benefits for Life Bed services will be covered when available, subject to prior notification of the Claims Administrator. Failure to give prior notice will result in no benefit payment.

(c) Mental Illness, Alcohol and Drug Dependency Services. Inpatient Hospital services for a Beneficiary being treated for mental illness, alcohol dependency, or drug dependency are covered under Section 13, Mental Illness and Alcohol or Drug Dependence Benefits, and are subject to the benefits, conditions and limitations specified in Section 13.

(d) Transplants. Benefits, conditions and limitations for transplants are described in Section 7.2(b).

8.2 Emergency Room Benefits. The Plan provides coverage for use of a Hospital's emergency room facilities in connection with an Injury or illness requiring emergency or urgent surgical or medical attention as substantiated by the Physician's claim or a written Hospital report. The Plan will not pay charges incurred for use of the Hospital's emergency room facilities in connection with nonemergency surgical or medical services.

(a) Emergency Services received within the Service Area, to include use of emergency room facilities and Physician services, are provided upon payment of a $30.00 copayment per visit.

(b) For Emergency Services received outside the Service Area, the Plan will pay 80% of Eligible Charges for use of emergency room facilities and Physician services.

(c) The term "Emergency Services" means medically necessary health

services that meet the prudent layperson standard and were immediately required because of unforeseen illness or Injury. The prudent layperson standard is met when a medical condition manifests itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) Serious risk to the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child);

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(d) If the Beneficiary is admitted to a Hospital for inpatient care, the Beneficiary, Beneficiary's Physician, or Hospital must notify the Claims Administrator within 48 hours or by the next business day.

(e) Continuing or follow-up treatment is not covered under this Section 8.2 unless treatment meets the criteria for Emergency Services. Payment is limited to Emergency Services which are required before the Beneficiary can, without medically harmful consequences, be transported to a Contracted Provider within the Service Area or another provider designated by the Plan.

8.3 Ambulatory Surgery Center Benefits. Prescribed surgery and procedures performed in an Ambulatory Surgery Center or The Queen's Outpatient Facility are provided without charge.

Effective: 09/01/11
Adopted: 08/03/12

SECTION 9
SKILLED NURSING FACILITY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following skilled nursing facility benefits:

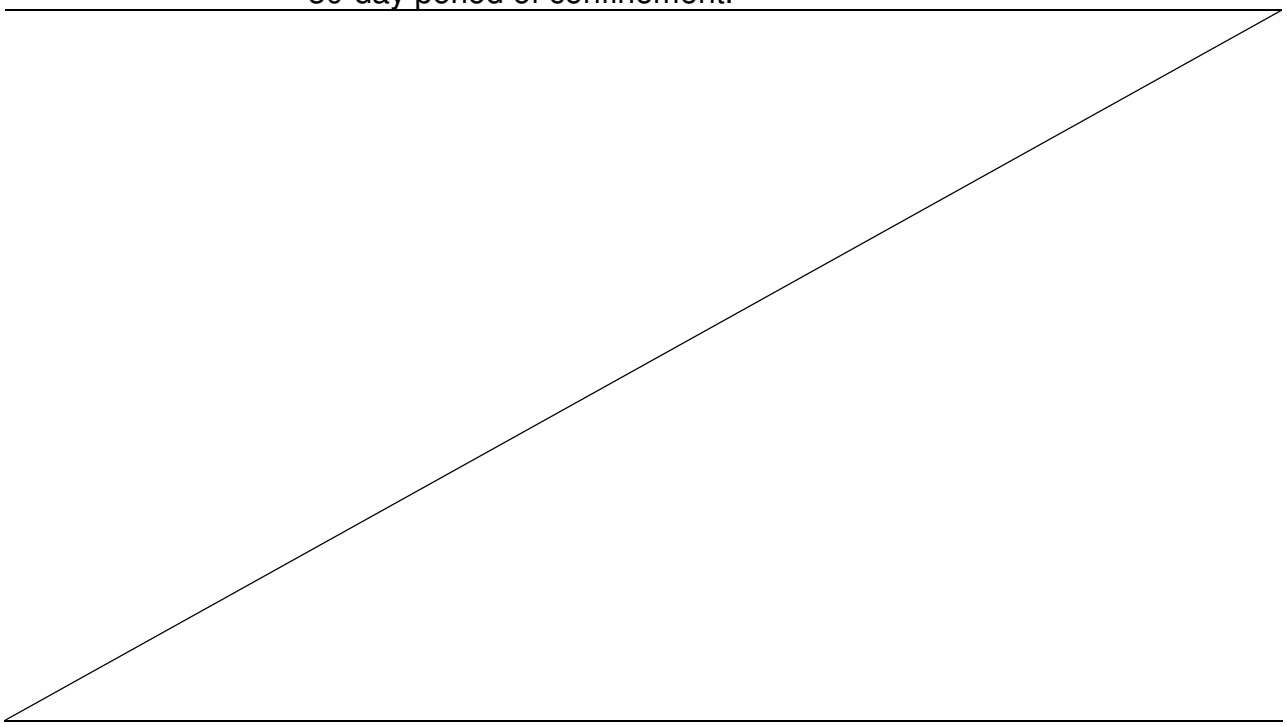
9.1 Skilled Nursing Facility Benefits. Up to a maximum of 120 days of confinement in a licensed and approved facility are provided without charge each Calendar Year. Benefits are based on a single, all-inclusive amount per day. Covered inpatient services include room and board based on semiprivate room rate, routine surgical supplies, drugs, dressings, oxygen, antibiotics, blood transfusion services, and diagnostic and therapy services. If a Contracted Provider's diagnostic and therapy services are not included in the single, all-inclusive amount per day, the Plan will cover diagnostic and therapy services in accordance with Section 11, Outpatient Diagnostic and Therapy Benefits.

9.2 The Plan will pay benefits under this Section 9 as long as all of the following requirements are met:

(a) The Beneficiary is admitted upon the authorization of the Beneficiary's Physician, with prior approval from the Claims Administrator; is attended by a Physician; and is confined as a Registered Bed Patient;

(b) Confinement in the facility is not primarily for comfort, convenience, rest cure, or domiciliary care; and

(c) If a Beneficiary remains in such facility more than 30 days, the attending Physician must submit to the Claims Administrator an evaluation report concerning the Beneficiary at the end of each such 30-day period of confinement.



SECTION 10
HOSPICE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following hospice benefits:

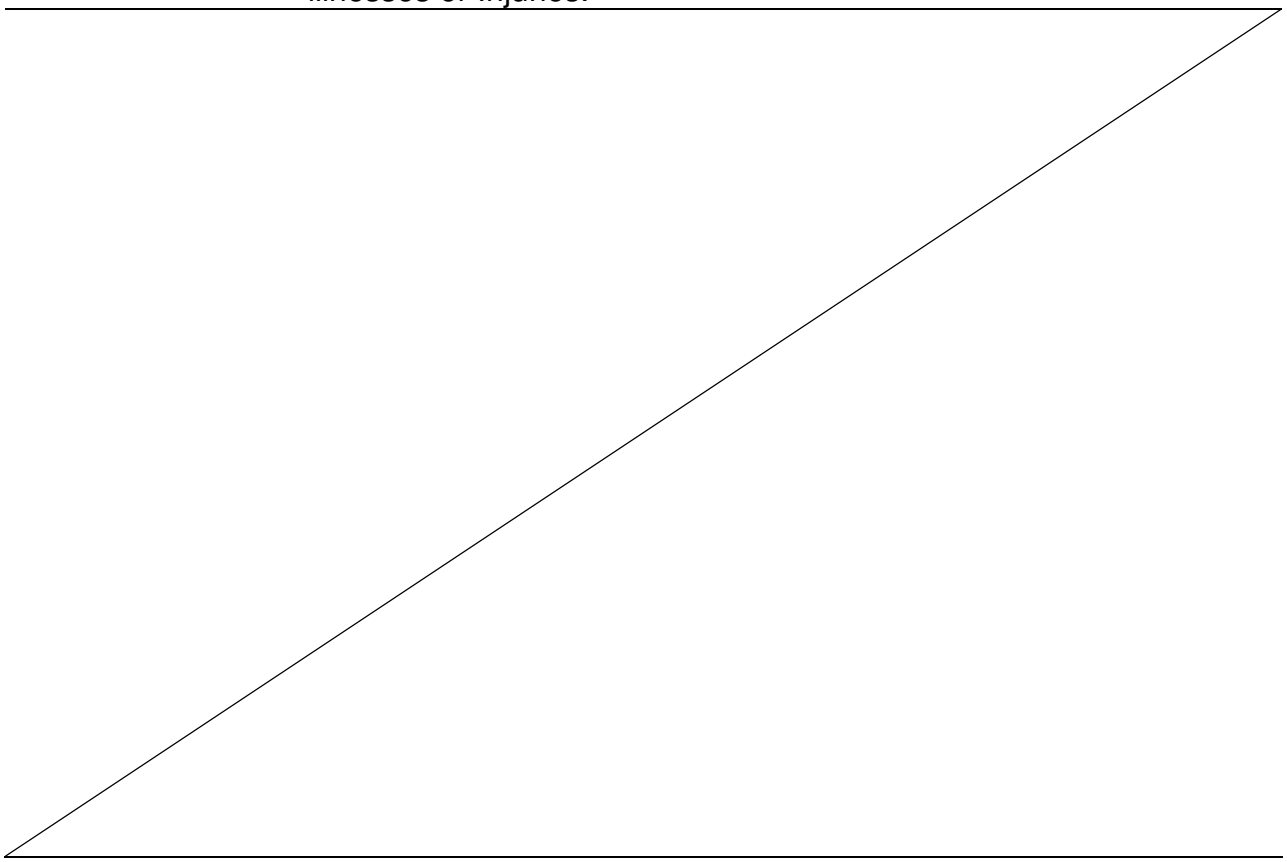
10.1 Hospice Benefits. Hospice services are provided without charge for Beneficiaries diagnosed with a terminal illness, with plan payment based on an all inclusive daily rate. Prior approval from the Claims Administrator is required for hospice care as provided in Section 5, Managed Care Program.

10.2 Limitations.

(a) All hospice services must be received from a hospice agency that is currently under contract with the Claims Administrator to provide hospice benefits and is operated under generally accepted standards for hospices.

(b) The hospice agency and the Beneficiary's Physician must certify in writing that the Beneficiary is terminally ill and has a life expectancy of six (6) months or less.

(c) A Beneficiary who elects hospice benefits shall not be eligible for any other benefits for the treatment of the terminal illness while the hospice election is in effect, except medical services benefits from a Physician. A Beneficiary may continue to receive benefits for all other illnesses or Injuries.



SECTION 11
OUTPATIENT DIAGNOSTIC AND THERAPY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following outpatient diagnostic and therapy benefits provided that these services are ordered by a Physician in the diagnosis or treatment of an Injury or illness.

11.1 Laboratory Services and Diagnostic Tests. Except where otherwise stated in this Plan, prescribed outpatient laboratory and testing services will be provided upon payment of a $14.00 copayment per service per day, subject to the following clarifications and limitations:

(a) Laboratory tests in connection with well-baby care visits are limited to the following tests through age five (5): two (2) tuberculin tests, two (2) blood tests (hemoglobin or hematocrit), and one (1) urinalysis.

(b) Routine Pap Smear. Limited to one (1) per Calendar Year provided without charge.

(c) Prostate Specific Antigen Test. Limited to one (1) per Calendar Year for men age 50 and above.

(d) Tuberculin Test. Limited to one (1) per Calendar Year.

11.2 Imaging Services. Except where otherwise stated in this Plan, prescribed imaging services will be provided upon payment of a $14.00 copayment per service per day. Prior approval from the Claims Administrator is required for the following services as provided in Section 5, Managed Care Program:

(a) MRI, MRA, and PET scans.

(b) Gamma knife or X-knife procedures.

(c) Greater than three (3) OB ultrasounds per pregnancy.

11.3 Radiotherapy. Prescribed radiotherapy services will be provided upon payment of a $14.00 copayment per service per day. Prior approval from the Claims Administrator is required for radiotherapy services as provided in Section 5, Managed Care Program.

11.4 Screening by Low-Dose Mammography. Screening by low-dose mammography is provided without charge for female Beneficiaries, subject to the following clarifications and limitations:

(a) One (1) baseline mammogram during ages 35 through 39, and one (1) screening mammogram every 12 months beginning at age 40.

(b) When a mammography test cannot be scheduled within the above designated benefit periods, the mammography test may be covered if rendered within ten (10) days of the benefit period, as long as the total number of mammography tests allowed by the Plan is not exceeded.

(c) A female Beneficiary of any age with a history of breast cancer, or with an increased risk of breast cancer, or whose mother or sister has had a history of breast cancer, is eligible for a mammogram upon the recommendation of a Physician.

SECTION 12
MATERNITY BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following maternity benefits:

12.1 Pregnancy, Childbirth, and Related Medical Conditions. Medical, Surgical, Hospital, and other benefits as provided elsewhere in this Plan are available to a Beneficiary for pregnancy, childbirth or other termination of pregnancy, and related medical conditions with the following clarifications and limitations:

(a) Routine Pregnancy and Childbirth. Upon confirmation of pregnancy, Physician services for routine obstetrical care, including prenatal visits, delivery, and postpartum visit will be provided without charge. All other care will **not** be considered routine obstetrical care and will be provided upon payment of the applicable copayment.

(b) Nurse-Midwife Services. Physician services benefits as described in section 12.1(a) above for routine obstetrical care are also available for Nurse-Midwife services. Services must be rendered by a certified Nurse-Midwife who is properly licensed, is certified by the American College of Nurse-Midwives, and is formally associated with a Physician for purposes of supervision and consultation. Benefits for Nurse-Midwife services are in lieu of benefits for Physician services.

(c) The Eligible Charge for delivery includes prenatal and postnatal care. If payments for prenatal care are made separately prior to delivery, these payments will be considered an advance payment and will be deducted from the maximum allowance for delivery.

(d) Birthing Center Services. Hospital benefits described in Section 8 are also available for services of a properly licensed birthing center approved by the Claims Administrator when such birthing center is used instead of regular Hospital facilities for childbirth. Benefits for birthing center services are in lieu of benefits for inpatient Hospital services.

(e) Diagnostic tests for an unborn Child are eligible for payment under Section 11 only when medically necessary.

12.2 Newborn Child. Benefits as provided elsewhere in this Plan are available to a Child from the date of birth for routine nursery care, circumcision, premature birth care, illness, Injury, or birth defect if the Child is enrolled as a Beneficiary with the Trust Fund within 30 days after birth.

12.3 Family Planning Services. Family planning services, including abortion counseling and information on birth control are provided at Physician offices upon payment of a $14.00 copayment per visit.

12.4 Involuntary Infertility Services. Involuntary infertility services are provided at Physician offices upon payment of a $14.00 copayment per visit.

12.5 Artificial Conception Services.

(a) Artificial Insemination. Artificial insemination is provided upon payment of a $14.00 copayment per visit.

(b) In Vitro Fertilization. In vitro fertilization for a female Beneficiary is provided upon payment of 20% of Eligible Charges, subject to the following limitations:

(i) Services for in vitro fertilization are covered for Beneficiaries who have been covered under the Plan for 12 consecutive months immediately preceding the in vitro fertilization procedure. Coverage is limited to one (1) procedure per lifetime, whether successful or not.

(ii) Prior approval from the Claims Administrator is required for in vitro fertilization as provided in Section 5, Managed Care Program. Requirements and criteria for in vitro fertilization include, but are not limited to, the following:

a. The Beneficiary's oocytes are to be fertilized with the Beneficiary's Spouse's sperm;

b. The Beneficiary and the Beneficiary's Spouse have a history of infertility of at least five (5) years' duration; or infertility is associated with one (1) or more of the following medical conditions:

1. Endometriosis;
2. Exposure in utero to diethylstilbestrol, commonly known as des;
3. Blockage of, or surgical removal of, one (1) or both fallopian tubes (lateral or bilateral salpingectomy); or
4. Abnormal male factors contributing to the infertility.

c. The Beneficiary has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under this Plan.

d. The in vitro fertilization procedure is performed at a medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

e. The term "Spouse" means a person who is lawfully married to the patient and is qualified as a spouse in accordance with the Internal Revenue Code.

(c) The following costs and services are excluded from coverage:

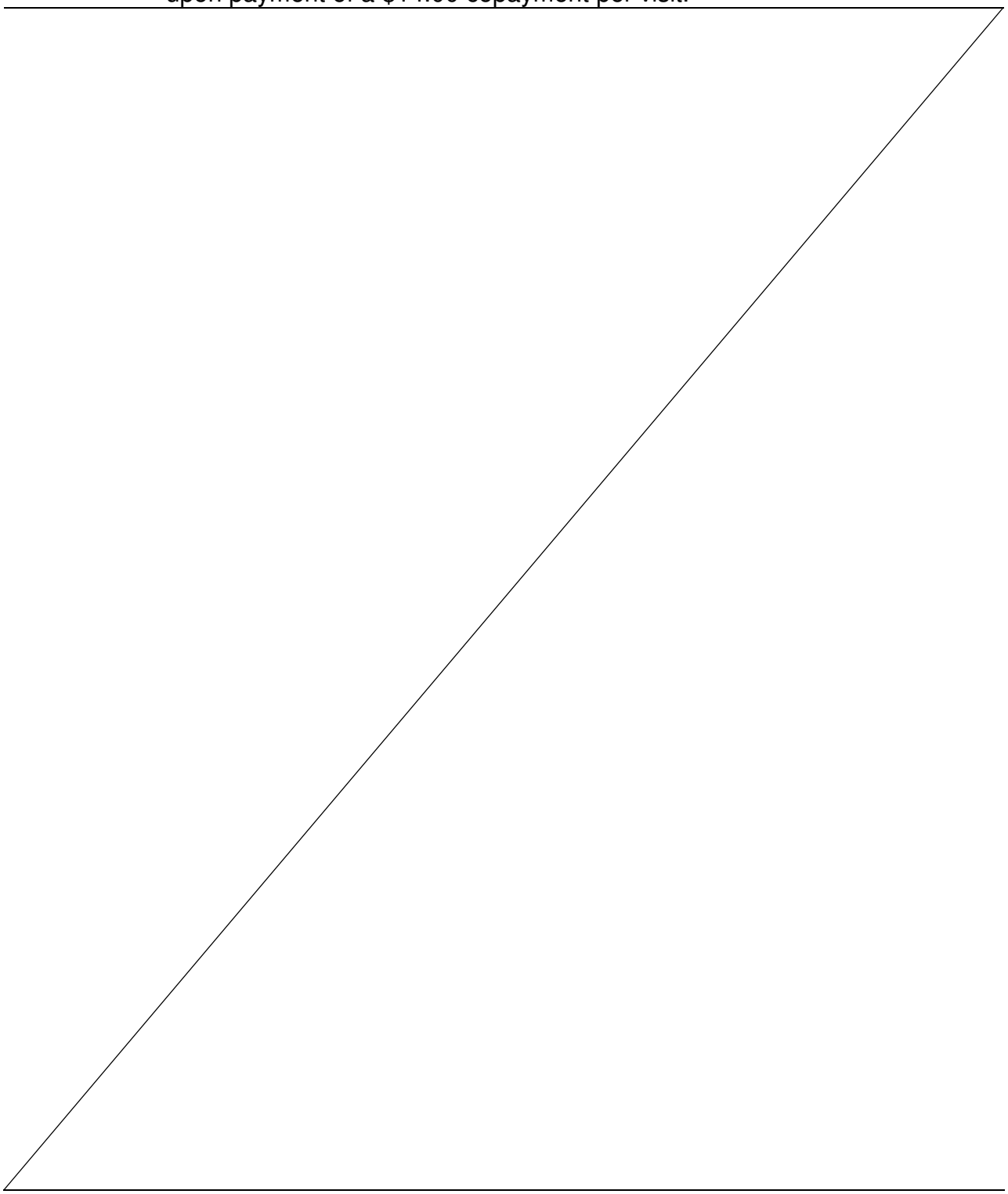
(i) The cost of equipment and of collection, storage and processing of sperm.

(ii) In vitro fertilization using either donor sperm or donor eggs.

(iii) Artificial insemination using donor sperm.

(iv) Services related to conception by artificial means, other than artificial insemination and in vitro fertilization as specified above.

12.6 Contraceptive Devices. When prescribed, Federal Food and Drug Administration (FDA) approved contraceptive devices used to prevent unwanted pregnancies are provided upon payment of 50% of Eligible Charges per device. Office visits for contraceptive devices are provided upon payment of a $14.00 copayment per visit.



SECTION 13
MENTAL ILLNESS AND ALCOHOL OR DRUG DEPENDENCE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to only the following benefits in connection with mental illness treatment and alcohol or drug dependence treatment:

13.1 Mental Illness Benefits.

(a) Inpatient Benefits.

(i) Benefit Maximums. Inpatient Hospital or facility services received by a Beneficiary confined as a Registered Bed Patient shall count against the 365 days per Calendar Year maximum Inpatient Hospital benefits allowed under Section 8.

(ii) Inpatient Hospital or Facility Services. Benefits for room and board, inpatient services, and diagnostic x-rays and laboratory testing services in a Hospital or Qualified Treatment Facility approved by the Claims Administrator are in accordance with Section 8, Hospital Benefits. A Qualified Treatment Facility means an inpatient or outpatient facility for the treatment of mental illness that has been accredited as such by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities and, if the facility is residential, has been licensed as a special treatment facility by the proper government authority.

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(iii) Inpatient Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist Services. The Plan will pay 90% of Eligible Charges for services of a Contracted Provider for Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist visits to a Beneficiary being treated for mental illness in a Hospital or Qualified Treatment Facility, up to one (1) visit per day while the Beneficiary is hospitalized in the Hospital or Qualified Treatment Facility.

(b) Outpatient Benefits.

(i) Outpatient Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor, or Marriage and Family Therapist Services. Outpatient mental health services provided by a Qualified Treatment Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist contracted by the Claims Administrator are provided upon payment of a $14.00 copayment per visit.

(ii) Psychological Testing. When prescribed, outpatient psychological testing services are provided upon payment of a $14.00 copayment per service per day.

(c) Specialized Facility Services. When prescribed, services in a specialized mental health treatment unit or facility approved by the Claims Administrator are covered as follows:

(i) Day treatment or partial hospitalization services are provided upon payment of a $14.00 copayment per visit.

(ii) Non-hospital residential services are provided upon payment of a $100 copayment per admission.

13.2 Alcohol and Drug Dependence Treatment Benefits. Mental illness benefits are available to a Beneficiary for alcohol and drug dependence treatment services including detoxification. Benefits for alcohol and drug dependence treatment services shall count against the inpatient benefit maximums under Section 13.1 above, and shall be subject to the following clarifications and limitations.

(a) Inpatient Benefits.

(i) Inpatient Hospital or Facility Services. When prescribed, benefits for room and board, inpatient services, and diagnostic x-rays and laboratory testing are in accordance with Section 8, Hospital Benefits, for services in a Hospital or Qualified Treatment Facility approved by the Claims Administrator.

(ii) Inpatient Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist Services. The Plan will pay for up to one (1) visit per day for services of a Contracted Provider for Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist visits to a Beneficiary being treated in a Hospital or Qualified Treatment Facility.

(b) Outpatient Benefits.

(i) Outpatient Facility, Psychiatrist, Psychologist Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist Services. Outpatient alcohol or drug dependency treatment services, provided by a Qualified Treatment Facility, Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist contracted by the Claims Administrator are provided upon payment of a $14.00 copayment per visit.

(ii) Psychological Testing. When prescribed, outpatient psychological testing services are provided upon payment of a $14.00 copayment per service per day.

(c) Specialized Facility Services. When prescribed, services in a specialized alcohol or drug dependency treatment unit or facility approved by the Claims Administrator are covered as follows:

(i) Day treatment or partial hospitalization services are provided upon payment of a $14.00 copayment per visit.

(ii) Non-hospital residential services are provided upon payment of a $100 copayment per admission.

13.3 Limiting Conditions. Benefits for mental illness and alcohol or drug dependence services shall be payable only if the following conditions are satisfied:

(a) General Limitations.

(i) For inpatient Hospital or facility services, benefits will be limited to room and care charges and no additional benefits will be payable for intensive or special care psychiatric units.

(ii) For inpatient Hospital or facility services, the Beneficiary's Physician must notify the Claims Administrator and obtain a Preadmission Review by the Claims Administrator as required under Section 5.

(b) Mental Illness Limitations. No mental illness services shall be eligible for payment hereunder unless:

(i) the Beneficiary has a nervous or mental disorder classified as such in the current version of the Diagnostic and Statistical Manual of the American Psychiatric Association, and

(ii) the services are provided under an individualized treatment plan approved by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist.

Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances do not in and of themselves constitute a mental disorder.

(c) Alcohol or Drug Dependence Services Limitations.

(i) Program Providers. The Claims Administrator has contracted with a limited number of providers to become Program Providers of alcohol and drug dependence services. Benefits shall be paid only for services rendered by such Program Providers.

(ii) Outpatient alcohol or drug dependence services must be provided under an individualized treatment plan approved and performed by a Psychiatrist, Psychologist, Clinical Social Worker, Licensed Mental Health Counselor or Marriage and Family Therapist who is a certified substance abuse counselor.

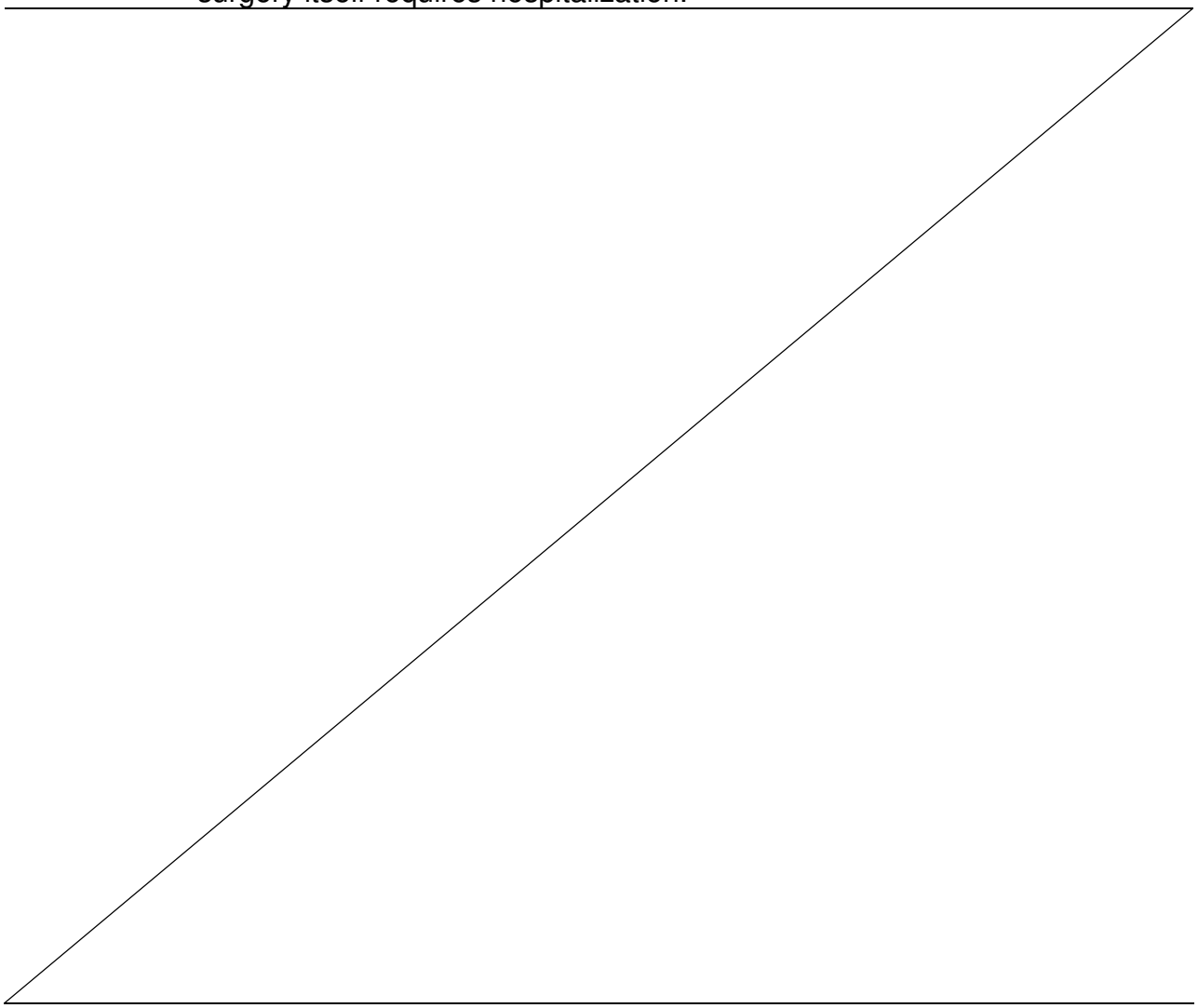
(iii) The cost of educational programs to which drunk or drugged drivers are referred by the judicial system and any and all services performed by mutual self-help groups shall not be eligible for payment hereunder.

SECTION 14
ORAL SURGICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to limited benefits as listed below. For the purposes of this Section 14, a Dentist means a doctor of dentistry (D.M.D.) or dental surgery (D.D.S.) who is appropriately licensed to practice by the proper government authority and who renders services within the lawful scope of such license.

14.1 Surgical Benefits. Benefits as provided in Section 7 for oral Surgical Services performed by a Dentist shall be payable only when the Dentist is performing emergency or Surgical Services that could also be performed by a Physician (M.D. or D.O.).

14.2 Hospital Inpatient Benefits as provided in Section 8 are available for dental services only when a Physician certifies in writing that the Beneficiary has a separate medical condition, such as hemophilia, that makes hospitalization necessary for the Beneficiary to safely receive dental services or that the oral surgery itself requires hospitalization.

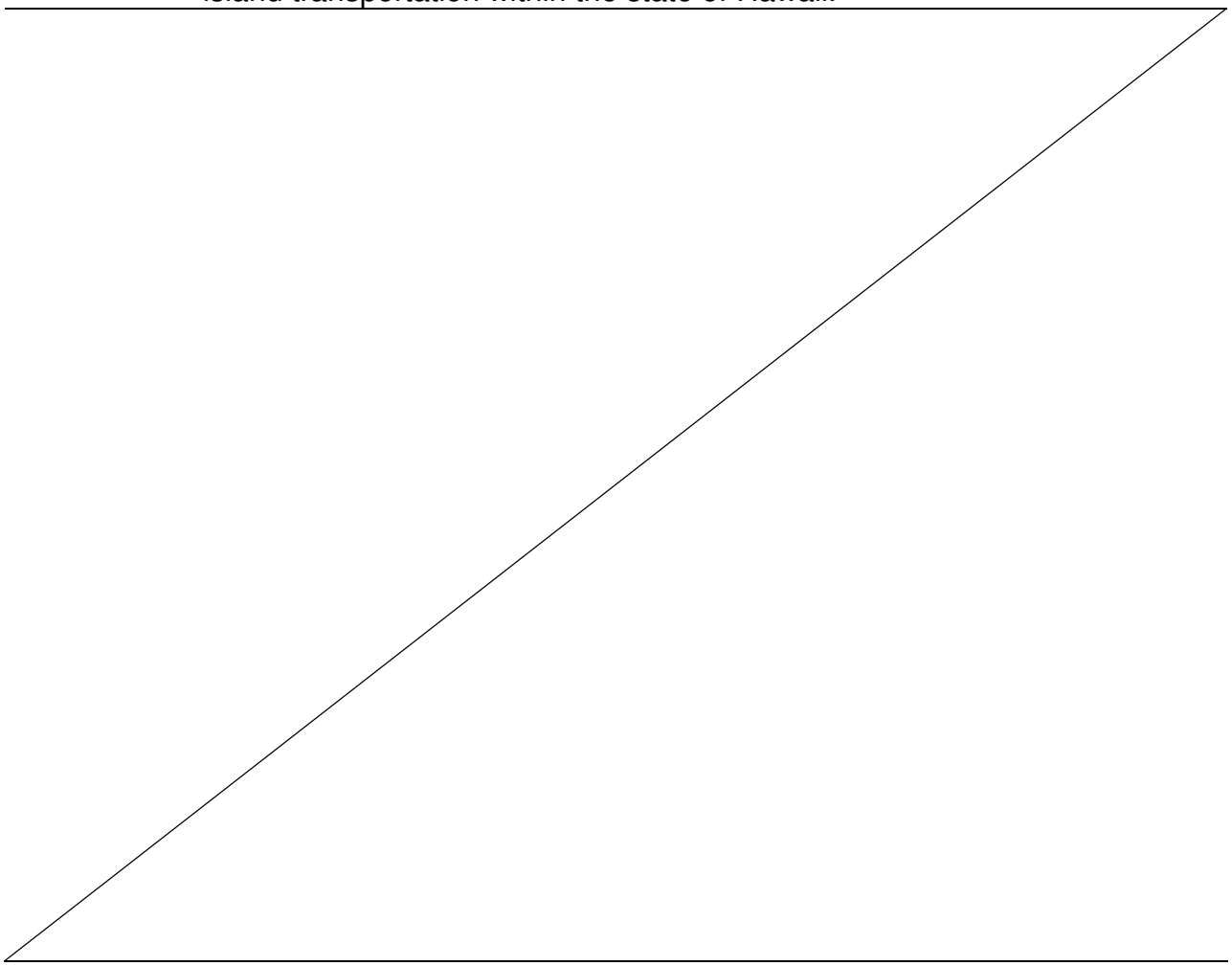


SECTION 15
AMBULANCE BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following ambulance benefits:

15.1 Ground Ambulance Services. The Plan will pay 80% of Eligible Charges for services of a properly licensed automobile ambulance for the purpose of transporting the Beneficiary from the place where an Injury occurred or an illness first required care to the nearest facility equipped to furnish immediate emergency treatment for such illness or Injury, if benefits under Sections 8.1 or 8.2 are allowed for such Injury or illness.

15.2 Air Ambulance Services. The Plan will pay 90% of Eligible Charges for services of a properly licensed or certified air ambulance. Air ambulance services must be ordered by a Physician for the purpose of transporting the Beneficiary from the place where Injury occurred or illness first required care to the nearest facility equipped to furnish immediate emergency treatment for such illness or Injury. Air ambulance service benefits shall be limited to inter-island transportation within the state of Hawaii.



SECTION 16
OTHER MEDICAL BENEFITS

Subject to the provisions of this Plan, a Beneficiary is entitled to the following other medical benefits:

Except where otherwise stated below, the Plan will pay 90% of Eligible Charges for the following medical services.

16.1 Allergy Testing and Treatment Materials. Limited to one (1) series of tests per Calendar Year provided upon payment of a $14.00 copayment per visit.

16.2 Blood and Blood Products (except when donated) and Blood Bank Service Charges. Blood, including blood processing is provided without charge. Any additional charges for autologous blood (reserved for the Beneficiary who donated the blood) are excluded as a benefit.

16.3 Chemotherapy for Malignancy (Outpatient). Chemical agents (other than oral) for treatment of malignancy are provided without charge when skilled administration is required. A $14.00 copayment per office visit applies. Prior approval from the Claims Administrator is required for chemotherapy services.

16.4 Dialysis and Supplies (Outpatient). Dialysis for chronic conditions is provided only in facilities certified by Medicare. Prior approval from the Claims Administrator is required for dialysis services and supplies to be covered.

16.5 Diabetes Equipment. When prescribed, the Plan will pay 70% of Eligible Charges for medically necessary and appropriate diabetes equipment and supplies necessary to operate the equipment. Coverage is limited to the standard item of diabetes equipment in accord with Medicare guidelines that adequately meets the needs of the Beneficiary.

16.6 Appliances and Durable Medical Equipment. The Plan will pay 80% of Eligible Charges for the initial provision and replacement of the following appliances and durable medical equipment: artificial limbs, eyes, and similar non-experimental appliances; casts, splints, trusses, braces, and crutches; oxygen and rental of equipment for its administration; rent or purchase of wheelchair and hospital-type bed; and charges for use of an iron lung, artificial kidney machine, pulmonary resuscitator, and similar special medical equipment. ~~For the initial provision and replacement of hearing aids, the Plan will provide a $500 allowance (~~Benefits for hearing aids are limited to one device per ear every three years~~)~~. Implanted internal prosthetics, devices and aids such as cardiac pacemakers, hip joints, surgical mesh, and stents, are provided without charge. The Plan will pay only for the appliances and durable medical equipment listed above. All appliances and durable medical equipment must be for services covered under this Plan and must be ordered by the Beneficiary's Physician. However, the Plan must agree that the ordered item is medically necessary for the treatment of the Beneficiary's illness or Injury. The Plan will not pay for any convenience items. Prior approval from the Claims Administrator is required for appliances and durable medical equipment covered by the Plan.

Affordable Care Act
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16.7 Medical Foods. The Plan will pay 80% of Eligible Charges for medical foods and low-protein modified food products for treatment of inborn metabolic disorders in accordance with State law.

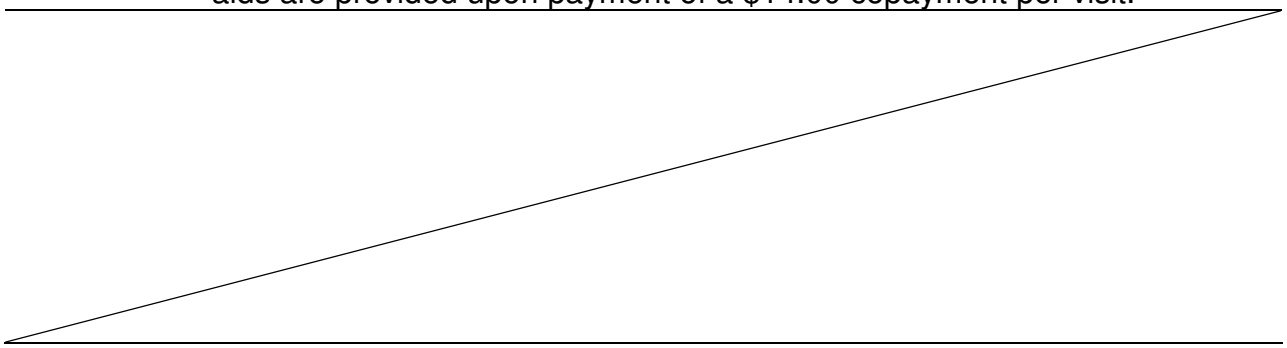
16.8 Outpatient Injections. Outpatient injections or intravenous administration of medication or nutrient solutions for primary diet are provided without charge when skilled administration is required. A $14.00 copayment per office visit applies.

16.9 Outpatient Physical Therapy Services. Outpatient physical therapy services rendered by a registered physical therapist (R.P.T) or registered occupational therapist (O.T.R.) are provided upon payment of a $14.00 copayment per visit, subject to the following limitations. Services must be ordered by a Physician under an individual treatment plan; be medically necessary to restore a musculoskeletal function that the Beneficiary lost or had impaired by illness or Injury; and are reasonably expected to improve the patient's condition through short-term care. Long-term therapy, maintenance therapy, and group exercise programs are not covered. Prior approval from the Claims Administrator is required for outpatient physical therapy services.

16.10 Outpatient Speech Therapy Services. Outpatient speech therapy services rendered by a speech therapist holding a Certificate of Clinical Competence from the American Speech and Hearing Association are provided upon payment of a $14.00 copayment per visit, subject to the following limitations. Services must be ordered by a Physician under an individual treatment plan, be medically necessary to restore a Beneficiary's speech or hearing function which was lost or impaired by illness or Injury, and are reasonably expected to improve the patient's condition through short-term care. Long-term therapy, maintenance therapy, and speech therapy for Children with developmental learning disabilities (developmental delay) are not covered. Prior approval from the Claims Administrator is required for outpatient speech therapy services.

16.11 Transplant Donor Services. Eligible medical and Hospital costs of the donor or services of an organ bank only when a Beneficiary is the recipient. Covered expenses for screening of donors shall be limited to expenses associated with the actual donor. If the donor is covered under another medical plan, that other plan shall be the primary plan and its benefits shall apply, and there is no coverage under this Plan.

16.12 Evaluations for the Use of Hearing Aids. Evaluations for the use of hearing aids are provided upon payment of a $14.00 copayment per visit.



SECTION 17
NON-EMERGENCY OFF-ISLAND TRAVEL BENEFITS

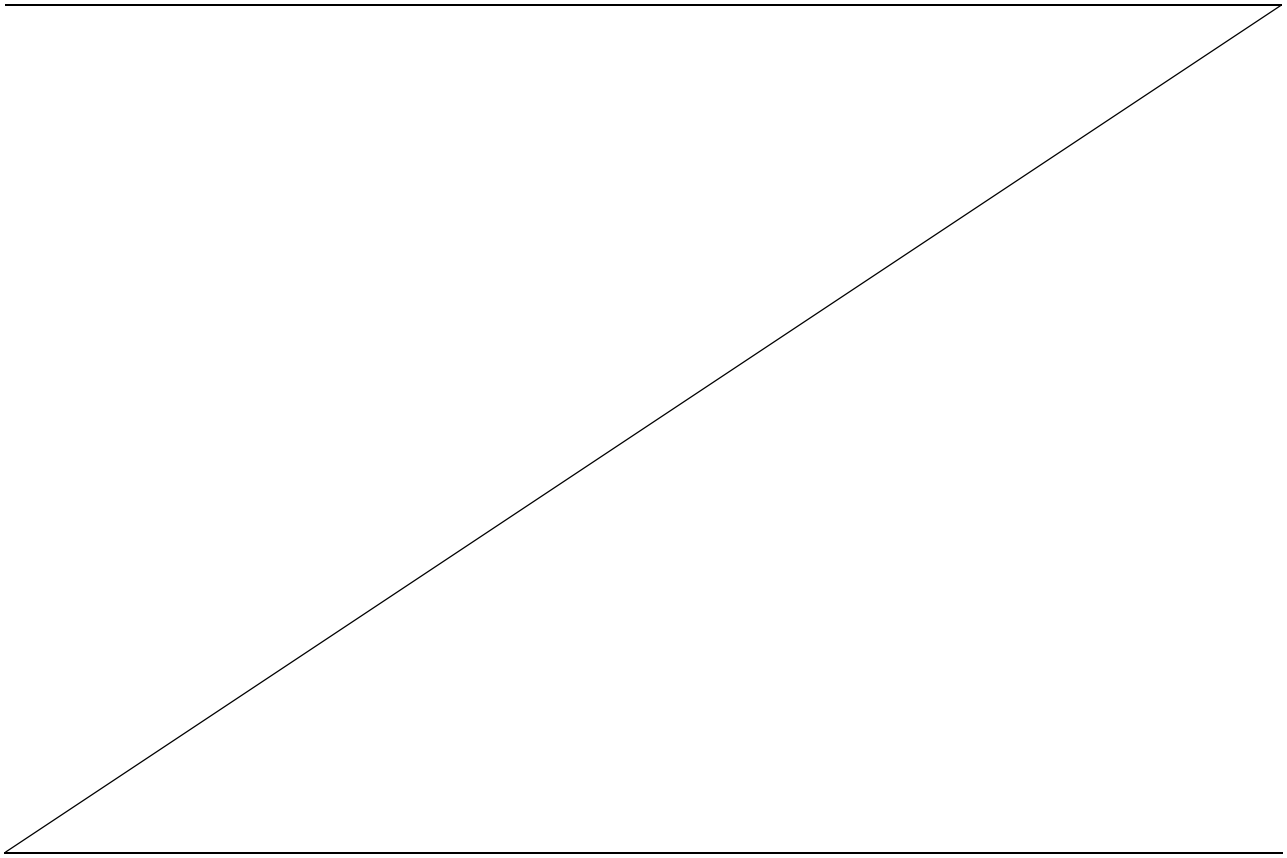
Subject to the provisions of this Plan, travel expenses related to medically necessary care required by Beneficiaries who do not reside on the island of Oahu may be reimbursed as follows:

17.1 Non-Emergency Off-island Travel Reimbursement. A Beneficiary who does not reside on the island of Oahu, and who requires non-emergency medical services (for the diagnosis or treatment of an illness or Injury) which are not available on the island where the Beneficiary resides, may be reimbursed for qualified travel expenses related to obtaining the medically necessary care. The following benefit will be provided, subject to prior review and authorization by the Claims Administrator:

(a) Reimbursement for air travel of up to $200.00, or the actual cost of the fare, whichever is less.

(b) Reimbursement for taxi fare to and from the airport of up to $50.00, or the actual cost of the fare, whichever is less.

(c) When the Beneficiary seeking off-island travel benefits is a minor Child under 18 years of age, the Plan will also reimburse qualified travel expenses for one accompanying parent or guardian up to the benefit limitation.



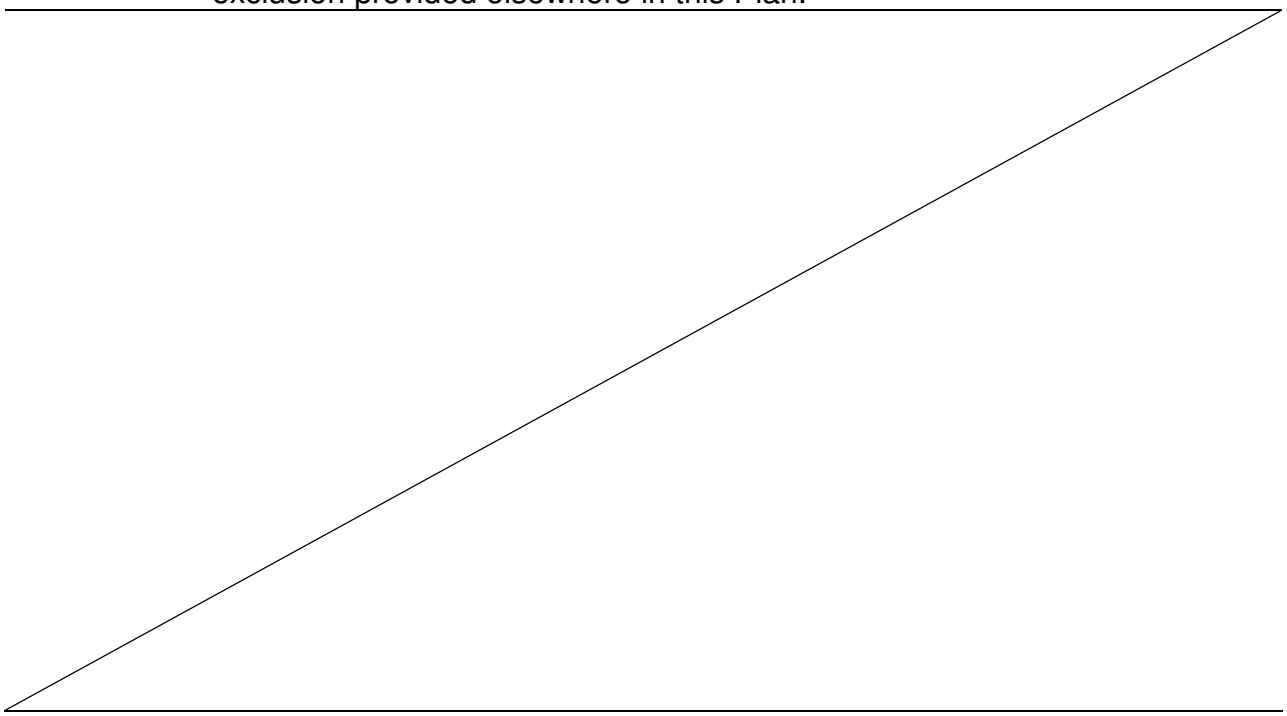
SECTION 18
EXCLUSIONS DURING WAITING PERIODS

18.1 If a Beneficiary is confined in a Hospital or in a Skilled Nursing Facility, or other inpatient facility at the time his or her coverage under this Plan begins and was not a beneficiary under some other medical plan of the Trust Fund immediately prior to the Effective Date of such coverage, the Beneficiary shall be entitled to benefits for the Injury or illness which required such confinement from the effective date of eligibility under this Plan. However, if the Beneficiary had other insurance or coverage immediately prior to the effective date under this Plan, which extends coverage for any services related to the hospitalization or other inpatient facility, the Plan will provide coordination of benefits in accordance with the National Association of Insurance Commissioner (NAIC) primary and secondary rule for beneficiary's existing coverage until the termination of Beneficiary's existing coverage. Thereafter, the Plan will provide coverage in accordance with the Plan document and plan of benefits.

18.2 A Participant's newborn Child, including an adopted newborn, is not subject to the above waiting period exclusion provided that the Child is enrolled as a Beneficiary within 30 days after the date of birth.

18.3 An adopted Child who is not a newborn Child described above is not subject to the above waiting period exclusion provided that the Child is enrolled as a Beneficiary within 30 days after the date of placement for adoption in the home.

18.4 The exclusion provided under this Section 18 shall be in addition to any exclusion provided elsewhere in this Plan.



SECTION 19
GENERAL PROVISIONS

19.1 General Limitations and Exclusions. The limitations and exclusions provided under this Section shall be in addition to any limitations and exclusions provided elsewhere in this Plan.

(a) The Plan will not pay benefits for any services when the Beneficiary is entitled to receive disability benefits or compensation under any Workers' Compensation or Employer's Liability Law for Injury or illness. In the event the Beneficiary formally appeals the denial of a claim for Workers' Compensation, the Beneficiary shall notify the Trust Fund of such appeal. Upon the execution and delivery to the Trust Fund of all papers it requires to secure its rights of reimbursement, benefits will be provided under this Plan. However, such payment of benefits shall be considered only as an advance or loan to the Beneficiary. If the claim is declared eligible for benefits under Workers' Compensation or Employer's Liability Law or if the Beneficiary reaches a compromise settlement of the Workers' Compensation claim, the Beneficiary agrees to repay 100% of the advance or loan, without any deduction for legal fees incurred or paid by the Beneficiary, within 10 calendar days of receiving payment. If reimbursement is not made as specified, the Plan, at its sole option, may:

(i) take legal action to collect 100% of any payments made plus any legal fees incurred or paid by the Plan in pursuit of reimbursement, or

(ii) offset future benefit payments by the amount of such reimbursement plus any legal fees incurred or paid by the Plan in pursuit of reimbursement.

(b) The Plan will not pay benefits for any services:

(i) when services for an Injury or illness are provided without charge to the Beneficiary by any federal, state, territorial, municipal, or other government instrumentality or agency, or

(ii) when services for an Injury or illness would have been provided without charge or collection but for the fact that the person is a Beneficiary under this Plan.

(c) The Plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the Plan pays such benefits before learning of any false statement, the Participant agrees to reimburse the Plan for 100% of such payment, without any deduction for legal fees incurred or paid by the Beneficiary. In addition, the Beneficiary agrees to reimburse the Plan for any legal fees incurred or paid by the Plan to secure reimbursement. If reimbursement is not made as specified, the Plan,

at its sole option, may:

(i) take legal action to collect 100% of any payments made plus any legal fees incurred or paid by the Plan in pursuit of reimbursement, or

(ii) offset future benefit payments by the amount of such reimbursement plus any legal fees incurred or paid by the Plan in pursuit of reimbursement.

(d) The Trust Fund is not an insurer against nor liable for the negligence or other wrongful act or omission of any provider, provider's employee, or other person, or for any act or omission of any Beneficiary.

(e) The Trust Fund does not guarantee the availability or quality of or undertake to provide any services of any third party including the availability of Participating Providers.

(f) The Plan will not pay benefits for services required in the treatment of an Injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists, or that occurs during a period of active duty exceeding 30 days in the service of any armed force of any state or nation.

(g) The Plan will not pay benefits in connection with: services not described as covered in this Plan; cosmetic services (services, supplies, or drugs that may improve the physical appearance, but do not restore or materially improve a bodily function, including related services such as laboratory tests, anesthesia, and hospitalization - this exclusion also applies to cosmetic services because of psychological or psychiatric reasons); treatment of any complications as a result of previous cosmetic, experimental, investigative services or other services not covered under this Plan regardless of how long ago such services were performed; treatment of baldness, including hair transplants and topical medications; eye refractions; eyeglasses or contact lenses; refractive eye surgery to correct visual problems; rest cures; treatment with nonionizing radiation; ~~routine physical examinations or health appraisals and services related thereto except for well-baby care and preventive care services as provided under Section 6, the screening services provided under Section 11, and physical examinations required by an educational institution for students in grades K through 6;~~ dental services generally done only by Dentists and not by Physicians (including orthodontia; dental splints and other dental appliances; dental prostheses; osseointegration and all related services; removal of impacted teeth; and any other procedures involving the teeth, structures supporting the teeth, and gum tissues) except for Oral Surgical Benefits as provided in Section 14; any services in connection with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaw) regardless of the symptoms or illnesses being treated; reversal of sterilization; services and drugs relating to

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conception by artificial means (except for one (1) in vitro fertilization procedure per qualified married couple per lifetime); all services and prosthetic devices related to sexual transformation or treatment of sexual dysfunction regardless of cause; biofeedback and other forms of self-care or self-help training and any related diagnostic testing; human growth hormone therapy (except for replacement therapy services to treat hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection, or radiation therapy, approved by the Claims Administrator); weight loss or weight control programs; services from a member of the Beneficiary's immediate family or household; a Physician's waiting or stand-by time; outpatient prescription drugs; private duty nursing; and foot orthotics, except for specific diabetic conditions.

(h) The Plan shall not be required to pay any claim until it determines that the Beneficiary was provided services covered by this Plan. Payment will not be made for services not actually rendered.

(i) The Plan will not pay benefits when confinement in a Hospital or in a Skilled Nursing Facility is primarily for custodial or domiciliary care. Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services, and other forms of self-care or supervisory services by a Physician or nurse for a person who is not under specific medical, surgical, or psychiatric treatment to reduce such person's disability and to enable such person to live outside an institution providing such care. However, benefits for confinement in a Hospital or Skilled Nursing Facility will be paid if such confinement is required because of a concurrent Injury or illness (whether related or not) which requires medical or Surgical Services otherwise provided as benefits under this Plan.

19.2 <u>When a Beneficiary Has Other Health Coverage (Coordination of Benefits)</u>.

(a) If a Beneficiary is covered by "this Plan" and any "other plan" that provides benefits for medical, surgical, Hospital or other services, the benefits of "this Plan" and those of the "other plan" may be coordinated so that the combined benefits are not more than the Eligible Charge for the covered service.

(i) "This Plan" shall mean this document.

(ii) "Other plan" shall mean the Federal Medicare Program, any "no-fault" or other type of motor vehicle insurance, or any group health plan including another group plan of the Trust Fund. It shall not include any other non-group health plan.

(b) The Plan’s determination of which health plan is primary is modeled according to the current guidelines provided by the National Association of Insurance Commissioners (NAIC), which are integrated into this Plan.

(i) For an employee under this Plan, this Plan will be primary.

(ii) For a working spouse who has coverage through his or her employer’s plan or another group plan, the “other plan” will be

primary.

(iii) For a child who is covered by both parents, the plan of the parent whose birthday occurs first in a calendar year will be primary.

(iv) This Plan will not pay benefits on a secondary basis.

(c) Special Provisions Relating to Medicaid. In determining or making any payment for a Beneficiary hereunder, eligibility for, or provision of, State provided medical assistance shall not be taken into account.

(d) Special Provisions Regarding Medicare. The Federal Medicare Program will be considered the primary plan unless the Beneficiary is an active employee covered under a group health plan. Where an employee or Dependent is covered by both Medicare and a group health plan, applicable Federal statutes will determine which plan is primary.

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Adopted: 05/03/13

Federal rules on Medicare for the working aged, the disabled, or patients with end stage renal disease (ESRD) shall apply. For the working aged and disabled, these rules take into consideration the employment status of the employee covered by the group health plan as well as the number of part-time and full-time employees of the group health plan.

(i) If an employer or group employs 20 or more active employees and the Beneficiary is age 65 or older and eligible for Medicare only because of the Beneficiary's age, this Plan will pay first before Medicare, as long as coverage is based on the Beneficiary's status as a current active employee or the status of the Beneficiary's spouse as a current active employee.

(ii) If a Beneficiary is under age 65 and eligible for Medicare only because of ESRD, this Plan will pay first before Medicare, but only for the first 30 months of ESRD coverage. After 30 months, Medicare shall be the primary coverage. When Medicare is allowed by law to be the primary payer, no coverage is afforded by this Plan.

(iii) If an employer or group employs 100 or more active employees and if a Beneficiary is under age 65 and eligible for Medicare only because of a disability (and not ESRD), this Plan will pay first before Medicare as long as coverage is based on the Beneficiary's status as a current active employee, the status of the Beneficiary's spouse as a current active employee, or the current active employment status of the person from whom the Beneficiary is a dependent.

(e) Special Provisions Regarding Motor Vehicle Insurance Coverage.

(i) Any motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the Plan pays benefits for an Injury covered by motor vehicle insurance, the Beneficiary must provide the Claims Administrator with a list of the medical expenses that the motor

vehicle insurance covered according to the date on which the expenses were incurred. The Claims Administrator will review the list of expenses to verify that benefit maximums are depleted. Upon verification of depletion, covered services received by the Beneficiary will be eligible for benefits in accordance with this Plan.

(ii) If another person caused the motor vehicle accident and the Beneficiary may recover damages pursuant thereto, any benefits for which the Beneficiary may be eligible shall be subject to the provisions of Section 19.3, Injury or Illness Involving Third Parties. Under Section 19.3, the Plan is not liable to pay any benefits for injuries caused by another person. However, the Plan may assist the Beneficiary by making an interest-free loan in the form of benefit payments once motor vehicle insurance benefits have been depleted as described in subparagraph (e)(i) above.

(f) For the purposes of enforcing or determining the applicability of this Section 19.2, the Participant, on his or her own behalf, or on behalf of his or her Dependents:

(i) will disclose all coverage under any "other plan";

(ii) consents to the Claims Administrator or Trust Fund's releasing to any party, or obtaining from any party, any information which the Claims Administrator or Trust Fund deems necessary for such purposes;

(iii) authorizes direct reimbursement to or from the "other plan" when such direct payment is appropriate and necessary to facilitate the coordination and adjustment of this Plan's and "other plan's" payments under this section; and

(iv) will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.

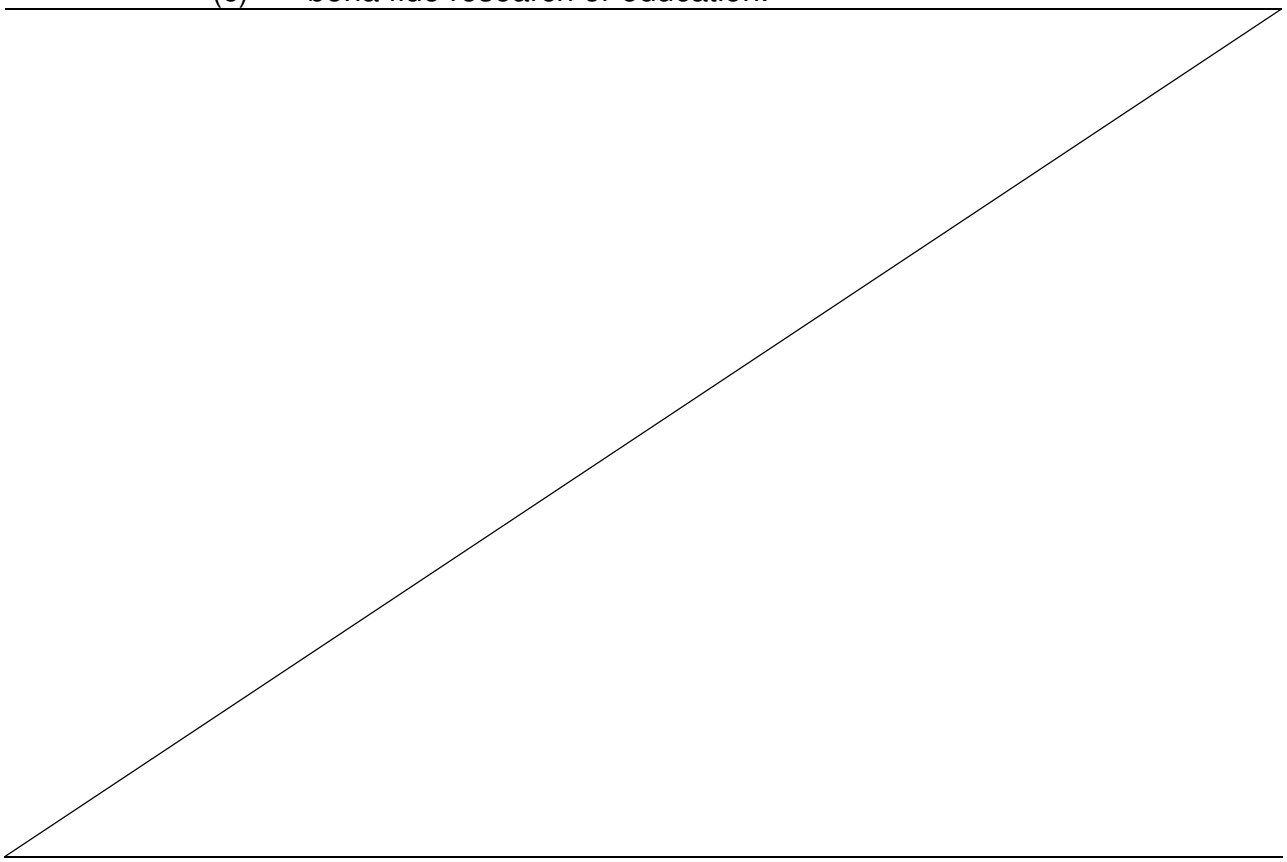
19.3 Injury or Illness Involving Third Parties. If an Injury or illness of a Beneficiary is or may have been caused by another person or party and the Beneficiary has or may have a right to recover damages pursuant thereto, the Plan shall not be liable to pay any benefits. However, upon the execution and delivery to the Trust Fund of all documents it requires to secure the Trust Fund's rights of reimbursement, including without limitation, a Loan Agreement in the form attached hereto as Exhibit B, the Plan may pay benefits in connection with such Injury or illness. Such payment shall be considered only as an advance or loan to the Beneficiary. The Plan shall be reimbursed for 100% of this advance or loan, without any deduction for legal fees incurred or paid by the Beneficiary from any recovery received pursuant to such Injury or illness, including recovery from any under-insured or uninsured motorist coverage, even if the award or settlement does not make the Beneficiary whole or does not specifically include medical expenses. The Beneficiary promises not to waive or impair any of the rights of the Fund

without written consent. In addition, the Plan shall be reimbursed for any legal fees incurred or paid by the Trust Fund to secure reimbursement of the advance or loan.

If the Plan pays any benefits because of such Injury or illness, the Trust Fund shall have reimbursement rights and shall have a lien against any recovery to the extent of such payments, including any legal fees incurred or paid by the Plan to secure reimbursement. Such lien may be filed with such other person or party, his or her agent or insurance company, or the court; and such lien shall be satisfied from any recovery received by the Beneficiary, however classified or allocated. If reimbursement is not made as specified, the Plan, at its sole option, may take any legal action to recover the amount that was paid for the Beneficiary's Injury or illness (including any legal expenses incurred or paid by the Plan) and/or may offset future benefit payments by the amount of such reimbursement (including any legal fees incurred or paid by the Plan).

19.4 Release of Information. By accepting benefits described in this Plan, the Beneficiary agrees that the Claims Administrator or Trust Fund may examine and copy the Beneficiary's medical records, including records containing mental health, substance abuse, and AIDS related information, for the purposes of:

(a) administering the Plan between the Trust Fund and the Beneficiary;
(b) complying with government requirements; and
(c) bona fide research or education.



SECTION 20
PROTECTED HEALTH INFORMATION

20.1 Permitted Uses of Protected Health Information.
The trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives may use or disclose the protected health information of a Beneficiary for the purposes of treatment, payment, or health care operations of the Plan without the consent of the Beneficiary, or as otherwise permitted by the HIPAA Privacy Rule. Any use or disclosure of protected health information by the trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives will be generally limited to the minimum amount necessary to accomplish the intended purpose of the use or disclosure.

20.2 Persons Authorized to Access Protected Health Information.
Only trustees of the Trust Fund and/or appropriate employees of the Trust Fund's designated representatives will have the authority to access protected health information for the purpose of administering the Plan or processing claims for benefits under the Plan.

20.3 Impermissible Uses or Disclosures.
Any impermissible use or disclosure of protected health information by the Trust Fund or its designated representatives shall be reported to the Trust Fund's designated Privacy Official for appropriate handling in accordance with the policies and procedures established by the Trust Fund and applicable law.

20.4 Disclosure of Protection Health Information to the Trust Fund.
The Plan will disclose protected health information to the Trust Fund only upon receipt of a certification that the plan documents have been amended to incorporate the agreement of the Trust Fund in the form attached as Exhibit A.