# STEELWORKERS HEALTH AND WELFARE PLAN

Amended and Restated Effective January 1, 2003

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# STEELWORKERS HEALTH AND WELFARE PLAN

Effective September 15, 1944, the predecessor to the United Steelworkers of America, AFL-CIO-CLC ("Union") established the Steelworkers Health and Welfare Fund ("Fund") to offer health and other welfare benefits ("Benefits") to individuals employed under collective bargaining agreements between the Union and a participating employer, and to certain other individuals.

Benefits from the Fund are funded primarily by employer contributions, which are held in trust in accordance with the terms and conditions of the Agreement and Declaration of Trust ("Trust Agreement"). Benefits may be paid directly by the Fund from trust assets or by insurance carriers with whom the Fund has contracted and to whom the Fund pays premiums from trust assets.

The Fund is managed by a group of individuals chosen by the Union and known as the Board of Trustees. The Board of Trustees, whose duties are set forth in the Trust Agreement, is authorized to delegate certain duties, including the day-to-day Plan administration, to another individual or entity ("Administrator").

This document, known as the Steelworkers Health and Welfare Plan ("Plan"), contains definitions and general administrative procedures that govern the Fund. The Benefits are described in more detail in the Summary Plan Description. In the event of any conflict between the Summary Plan Description and this Plan, the terms of the Plan shall be controlling.

This Plan is intended to qualify as a "welfare benefit plan" within the meaning of Section 419(e) of the Internal Revenue Code of 1986, as amended, and to meet the requirements of any other applicable provisions of law including Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended, and as a voluntary employees' beneficiary association within the

meaning of section 501(C)(9) of the Internal Revenue Code of 1986, as amended.

This Plan is maintained for the exclusive benefit of employees under the applicable provisions of this Plan document and the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

This Plan as amended and restated effective January 1, 2003 amends and restates the Plan in effect as of March 1998, and its terms and provisions shall be effective January 1, 2003 except as otherwise provided herein.

## ARTICLE 1
## DEFINITIONS

When used herein, the following terms shall have the meanings set forth below, unless a contrary meaning is clearly intended by the context. Other terms not defined herein may be defined in the Summary Plan Description.

1.01 **"Administrator"** means the person(s) or entity(ies) designated by the Board to administer the Plan on a day-to-day basis.

1.02 **"Benefit"** means each of the benefits available to a Participant as described in Section 4.02.

1.03 **"Board" or "Board of Trustees"** means the group of individuals appointed pursuant to the Trust Agreement to manage the operation and administration of the Fund.

1.04 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time, and regulations issued thereunder.

1.05 "**Dependent"** means:

(a) the Employee's spouse;

(b) except as otherwise specified in the Fund Letter, the Employee's unmarried children, including any stepchild, legally adopted child or child placed for adoption with the Employee, and child for whom the Employee has been appointed legal guardian, who is either:

(i) under age 19, or under age 25 if such child is enrolled and recorded as a full-time student at an accredited high school, college, university or vocational training school, and resides with and

is wholly dependent on the Employee for financial support, or

(ii) over age 19 and incapable of self-support as the result of physical or mental incapacity that existed prior to reaching 19 years of age and who is wholly dependent on the Employee for support, but only if proof of such incapacity acceptable to the Board or its delegate is provided to the Board or its delegate no later than 31 days of the date on which the child's status as Dependent would otherwise terminate.

The Board of Trustees or its delegate may require proof of Dependent status at the time of enrollment, and from time to time as it deems appropriate or necessary, but in a uniform and consistent manner applicable to individuals in like circumstances.

1.06 **"Employee"** means an individual who is, or at one time was, the common law employee of an Employer and who works or worked in a job classification covered by the applicable Participation Agreement.

1.07 **"Employer"** means an employer that is [or was] party to a Participation.

1.08 "**ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

1.09 **"Fund"** means the Steelworkers Health and Welfare Fund.

1.10 **"Participant"** means any Employee who has met the requirements in Section 2.01 to be eligible for Benefits from the Fund, and whose eligibility for Benefits has not terminated as specified in Section 2.03.

1.11 **"Participation Agreement"** means an agreement entered into by an Employer and a union and accepted by the Board under which the Employer and the union agree to participate in the Fund.

1.12 **"Plan"** means the Steelworkers Health and Welfare Plan as herein set forth.

1.13 **"Summary Plan Description"** means the booklet describing the terms of the Plan and including a detailed description of the available Benefits.

1.14 **"Trust Agreement"** means the Steelworkers Health and Welfare Fund Agreement and Declaration of Trust, as amended from time to time, which establishes the funding vehicles for the Fund and sets forth the rights and obligation of the Board of Trustees.

1.15 **"Union"** means the United Steelworkers of America, AFL-CIO-CLC, or any successor thereto.

## ARTICLE 2
## ELIGIBILITY AND PARTICIPATION

2.01 **Eligibility to Participate.**

(a) An Employee shall become a Participant on the first day for which contributions are made to the Fund on his or her behalf under the terms of a Participation Agreement. In no event may the effective date of participation precede the month in which contributions are first made except as otherwise provided in an insurance contract between the Fund and the applicable carrier.

(b) If an Employee is eligible to become a Participant as set forth in subsection (a) above under the terms of a Participation Agreement, but declines to become a Participant on the earliest date possible, he or she may become a Participant on the earliest to occur of: (i) a date that is during any annual enrollment period set forth in the Participation Agreement or as otherwise determined by the Fund; (ii) the date on which he or she acquires a Dependent (or 30 days from such date); (iii) the date on which he or she loses coverage, including COBRA coverage, under another group health plan for any reason (or 30 days from such date); or (iv) the date on which employer contributions under another group health plan covering the participant terminate (or 30 days from such date). Notwithstanding the foregoing, the Summary Plan Description shall control to the extent that it permits more frequent enrollment dates with respect to coverage under a health maintenance organization.

2.02 **Eligibility Requirements for Dependents**

Subject to the terms of a Participation Agreement, a Dependent shall become eligible for Benefits on the date upon which the Employee becomes a Participant.

2.03 **Termination of Participation**

(a) Subject to the provisions of subsections (b) and (c) below, a Participant shall cease to be a Participant on the earliest to occur of the following dates:

(1) the date on which he or she is discharged from employment or quits, except as otherwise provided in a Participation Agreement.

(2) The last day of the month in which the Employer ceases to be obligated to make contributions on his or her behalf for any reason, including work stoppages or layoffs.

(3) The last day of the month preceding the month for which the Fund fails to receive the contributions that are required to be made on his or her behalf under the terms of a Participation Agreement, except that one or more insured Benefits may be continued to the extent provided in an insurance contract between the Fund and the applicable carrier.

(4) The date the Plan terminates.

(b) A Participant may elect to continue to receive medical coverage either by self-paying for coverage in accordance with procedures established by the Board or by electing COBRA continuation coverage under Section 2.04 or, if the Participant is eligible under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), by electing USERRA continuation coverage in accordance with procedures established by the Board.

(c) Once a Participant has ceased to be a Participant, Benefits will cease to be paid for any claims incurred following termination of participation, except as otherwise provided in the Summary Plan Description.

2.04 **Continuation of Coverage under COBRA**

(a) Certain individuals may elect to continue coverage under the Plan

to the extent such continuation is required for a group health plan by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), and in accordance with the terms and conditions of continuation coverage provided by COBRA and this Section 2.04. The provisions of this Section 2.04 shall be effective regardless of any other provision herein.

(b) For purposes of this Section 2.04, the following terms shall have the meaning set forth below unless a contrary meaning is clearly indicated:

(1) "Covered Employee" means any individual who is or was a Participant under the Plan.

(2) "Election Period" means the period beginning on the date a Qualified Beneficiary's coverage terminates under the Plan by reason of a Qualifying Event, ending 60 days after the later of such date or the date the Qualified Beneficiary is notified of his or her rights under this Section 2.04 regarding the Qualifying Event.

(3) "Qualified Beneficiary" means any individual who is covered by the Plan on the day before the Qualifying Event as:

(A) the Covered Employee;

(B) the spouse of a Covered Employee;

(C) a Dependent child of the Covered Employee, including a child who is born to or placed for adoption with the Covered Employee during the continuation period under this Section 2.04;

(D) a surviving spouse of the Covered Employee for purposes of Section 2.04(b)(4)(F) only.

(4) "Qualifying Event" means any of the following which results in the loss of coverage under the Plan for a Qualified Beneficiary:

(A) The Covered Employee's death;

(B) Termination or reduction of hours of the Covered Employee's employment (except termination for gross misconduct);

(C) Divorce or legal separation of the Covered Employee and his or her spouse;

(D) The Covered Employee becoming entitled to Benefits under Title XVIII of the Social Security Act;

(E) Dependent child ceases to qualify as a Dependent under the terms of the Plan; or

(F) An Employer's commencing bankruptcy proceedings under Title 11, United States Code, with respect to a Covered Employee who is a retiree of the Employer.

(c) A Qualified Beneficiary who would lose coverage under a group health plan due to a Qualifying Event may elect continuation coverage under such group health plan during the Election Period from the date of the Qualifying Event to the earliest of:

(1) The date which is 18 months after an event described in Section 2.04(b)(4)(B) (or 29 months after such event if a Qualified Beneficiary is determined to be "disabled" under Title II or Title XVI of the Social Security Act within 60 days of the Qualifying Event and provides adequate proof of such disability no later than 60 days of the determination and within the initial 18 months of continuation coverage);

(2) The date which is 36 months after the date of an event described in Section 2.04(b)(4)(B) if a second Qualifying Event (except an event described in Section 2.04(b)(4)(F)) occurs during the 18-month period following the event described in Section 2.04(b)(4)(B) or during the 29-month period under Section 2.04(c)(1);

(3) The date which is 36 months after the Covered Employee's death, for a spouse or Dependent child of a Covered

Employee for an event described in Section 2.04(b)(4)(A);

(4) The date which is 36 months after the date of the Qualifying Event except an event described in Section 2.04(b)(4)(B) or Section 2.04(b)(4)(F);

(5) The date which is 36 months after an event described in Section 2.04(b)(4)(D) for Qualified Beneficiaries other than the Covered Employee;

(6) The date on which coverage ceases due to failure of the Qualified Beneficiary to make timely premium payments;

(7) The date the Qualified Beneficiary first becomes entitled to Benefits under Title XVIII of the Social Security Act;

(8) The date the Qualified Beneficiary first becomes covered under any other group health plan which does not contain any pre-existing condition limitation;

(9) The month that begins more than 30 days after the final determination date that the Qualified Beneficiary is no longer "disabled" under Title II or Title XVI of the Social Security Act for a Qualified Beneficiary who is disabled at termination (except termination for gross misconduct or reduction in hours of a Covered Employee);

(10) If the Employer withdraws from the Plan, the date on which the Employer makes group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered under the Plan; or

(11) The date on which the Employer ceases to provide any group health plan to any employee.

(d) A Qualified Beneficiary who elects continuation coverage under this Section 2.04 shall pay 102% of the "applicable premium" as defined in Section 604 of ERISA. For a Qualified Beneficiary who is "disabled" under Title II or Title XVI of the Social Security Act, the

applicable premium shall be 150% for each month of continuation coverage after the initial 18-month period in Section 2.04(c)(1) or Section 2.04(c)(2). Payment shall be due monthly on the first of the month. The first payment shall include all past due payments for continuation coverage during the Election Period. Payment shall be considered late if made more than 30 days after the payment due date, except that the first payment shall be considered late if made more than 45 days after the election date.

(e) Written notice of COBRA rights shall be provided to each Covered Employee and spouse, if any:

(1) within 30 days after coverage begins under a group health plan; and

(2) within 14 days after a Qualified Beneficiary notifies the Plan that a Qualifying Event has occurred. A Qualified Beneficiary must notify the Plan of a Qualifying Event:

(A) within 30 days of an event in Section 2.04(b)(4)(A), Section 2.04(b)(4)(B) or Section 2.04(b)(4)(D); or

(B) within 60 days of an event in Section 2.04(b)(4)(C) or Section 2.04(b)(4)(E).

(f) A Qualified Beneficiary who receives continuation coverage based on the determination that he or she is "disabled" under Title II or Title XVI of the Social Security Act shall notify the Plan of any determination that he or she is no longer "disabled."

(g) Special Rule for Individuals Eligible for Trade Act Assistance. The special rule set forth in this subsection (g) applies to each Qualified Beneficiary where: (a) the Employee is certified by the Department of Labor as eligible for trade act assistance (TAA) benefits under the Trade Act of 1974 on or after November 4, 2002; (b) the Qualified Beneficiary lost coverage under the Fund due to the Employee's job loss that resulted in eligibility for TAA benefits; and (c) the Qualified Beneficiary did not elect COBRA coverage during

the initial election period resulting from that job loss. Each Qualified Beneficiary who satisfies the requirements set forth in the foregoing sentence will have a second opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which the Employee was certified, provided that the election is made within six months after the date Fund coverage is lost. If a Qualified Beneficiary elects COBRA coverage under this subsection (g), it will begin on the first day of the sixty (60) day election period and will last the same length of time as if an election had been made based on the original Qualifying Event.

2.05 **Qualified Medical Child Support Orders**

Benefit coverage shall be provided in accordance with the provisions of any court order, judgment or decree that:

(a) requires group health coverage for an Employee's child, whether or not the Employee is a Participant; and

(b) meets the requirements of Section 609(a) of ERISA as a qualified medical child support order. Benefit coverage shall be provided for as long as the child satisfies the definition of Dependent for the applicable Benefits, the required Employee contributions are made to the Fund for the period of coverage indicated in the qualified medical child support order, and the qualified medical child support order is effective.

2.06 **Health Insurance Portability and Accountability Act of 1996**

The Fund will comply with the applicable terms and conditions of the Health Insurance Portability and Accountability Act of 1996, including but not limited to, the requirement that it provide Participants and their dependents with a certificate of coverage showing creditable coverage under the Fund upon all of the following events: (i) loss of eligibility for Medical Benefits; (ii) the expiration of COBRA coverage; and (iii) upon the

written request of a Participant or former Participant on or before the expiration of the 24 months following the date he or she loses eligibility for Medical Benefits.

## ARTICLE 3
## FUNDING

3.01 **Funding**

The Plan is funded by contributions made to the Fund by Employers, and by investment earnings on those contributions.

3.02 **Establishment of Funding Policy**

The Board of Trustees shall establish, carry out and revise, from time to time, the funding policy of the Plan. The Board may, in its discretion, purchase insurance contracts to provide any or all of the Benefits under this Plan.

3.03 **Contributions**

Contributions shall be made in such amounts and at such times as required under the terms of the applicable Participation Agreement, and in accordance with Article 7 of the Trust Agreement.

## ARTICLE 4
## BENEFITS

4.01 **Benefits Provided by the Plan**

The Plan provides a number of different Benefits, as follows:

(a) Medical Benefits;

(b) Prescription Drug Benefits;

(c) Dental Benefits;

(d) Vision Benefits;

(e) Accidental Death and Dismemberment Benefits;

(f) Death Benefits; and

(g) Short-term Disability Benefits.

4.02 **Description of Benefits**

Detailed descriptions of the Benefits provided through the Plan under Section 4.01 above are contained in the following written instruments, which are incorporated herein by reference but only to the extent that they describe the terms and conditions of Benefits and only to the extent that they do not contradict an express provision set forth in this Plan: the Participation Agreement, Summary Plan Description, schedules of benefits, and insurance contracts.

4.03 **Change in Benefits**

In the event that any Benefits are modified or amended, any summary of material modification, amendment to any instrument specified in Section 4.02, or other Participant notice shall be automatically incorporated herein by reference and made part of this Plan. The terms of such modification or amendment shall supersede any contrary terms of any other Benefit description until such time as such other Benefit description shall be changed to incorporate such modification or amendment.

## ARTICLE 5
## ADMINISTRATION

5.01 **Authority**

The Board of Trustees shall have the authority to control and manage the administration of this Plan, and to delegate authority as permitted by the Plan and ERISA, and pursuant to the terms of the Trust Agreement. The members of the Board of Trustees shall be the "named fiduciaries," within the meaning of Section 402(a) of ERISA, and the "plan administrator" and "plan sponsor," within the meaning of Sections 3(16)(a) and (b) of ERISA, of the Plan and Fund.

5.02 **Discretionary Authority**

The Board (or, where applicable, its delegate) shall have the exclusive authority, in its sole and absolute discretion, to administer and interpret the Plan and Trust Agreement, to decide all matters arising in connection with the operation or administration of the Plan, and to take such actions as are described in Article 4 of the Trust Agreement. All determinations of the Board (or its authorized delegate) shall be final and binding on all parties affected thereby.

5.03 **Delegation of Power**

The Board may delegate to other fiduciaries the responsibilities or duties involved in the operation or administration of the Fund under the direction of the Board (other than trustee responsibilities or duties, as defined in section 405(c)(3) of ERISA); may engage such person or persons as it may deem necessary or desirable as the Administrator to conduct the day-to-day operations of the Plan and the Fund and delegate such of its administrative duties to such persons, agents or organizations as it may deem advisable; and may delegate any of its ministerial powers or duties under the Trust Agreement to any one or more agents or employees.

5.04 **Standard of Care**

The Board shall exercise its authority under this Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. All actions with respect to Benefits or with respect to the classification of Employees shall be uniform in nature and applicable to all persons similarly situated, and non-discriminatory in favor of highly compensated individuals or against an individual based solely on health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; or disability.

## ARTICLE 6
## COORDINATION OF BENEFITS AND SUBROGATION

6.01 **Coordination of Benefits in General**

(a) Benefits payable under this Plan for expenses of a covered person who is also covered under another group health plan or governmental program shall be coordinated so that the total amount payable from all plans shall not exceed 100 percent of covered Benefits or expenses actually incurred, whichever is the lesser amount. When this Plan is a secondary plan, this Plan shall provide Benefits for covered expenses that were not payable under the primary plan or any other health plan, subject to any co-payment, deductible, and coinsurance amounts, regardless of whether the primary plan actually meets its obligation to pay for covered expenses. In no event shall the benefits provided by this Plan exceed the benefits that would have been provided by this Plan as the primary plan.

(b) If the Plan is secondary and the primary plan establishes to the satisfaction of the Board that it is unable to pay the claim in question, then the Plan may be in the sole discretion of the Board pay a portion or all of the claim that would ordinarily be a covered expense of the primary plan.

(c) Notwithstanding the coordination of benefits provisions of this Article 6, to the extent that they are inconsistent with the coordination of benefits provisions with respect to any insured benefit set forth in the Summary Plan Description or any insurance contract, the provisions of the Summary Plan Description or insurance contract will control.

6.02 **Definitions**

For purpose of this Article, certain terms are defined as follows:

(a) "Primary plan" means a health plan which is responsible for payment of covered expenses first, without regard to benefits payable by any other health plan.

(b) "Secondary plan" means any health plan which is responsible for payment of covered expenses following payment by the primary plan.

6.03 **Order of Responsibility**

Except as otherwise expressly provided herein, the following shall be the order of responsibility for payment of covered expenses for purposes of coordination of benefits:

(a) Any health plan which does not have a coordination of benefits provision shall be the primary plan and this Plan shall be the secondary plan.

(b) Any health plan, including this Plan, which covers the covered person as an employee shall be the primary plan, and nay health plan which covers the covered person in any other capacity shall be the secondary plan for purposes of providing benefits on behalf of the employee.

(c) Any health plan, including this Plan, which covers the covered person in any capacity other than as a dependent shall be the primary plan, and a health plan which covers the covered person as a dependent shall be the secondary plan for purposes of providing benefits to that dependent.

(d) Any health plan, including this Plan, which covers a child as a dependent of the person whose birthday falls earlier in the calendar year shall be the secondary plan for purposes of providing benefits on behalf of such dependent child. This provision shall apply only if the other health plan also follows this "birthday rule."

(e) In cases of divorce or legal separation:

(i) If the parent with legal custody of the child has not

remarried, the benefits of the health plan which covers the child as a Dependent of the custodial parent shall be the primary plan and the health plan which covers the child as a Dependent of the noncustodial parent shall be the secondary plan for purposes of providing benefits on behalf of such Dependent child.

(ii) If the custodial parent of the child has remarried, the benefits of the health plan which covers the child as a Dependent of the custodial parent shall be the primary plan and the health plan which covers the child as a Dependent of the custodial parent's spouse shall be the secondary plan for purposes of providing benefits on behalf of the Dependent child. The health plan which covers the child as a Dependent of the noncustodial parent shall pay benefits after the secondary plan for purposes of providing benefits on behalf of the Dependent child.

(iii) Notwithstanding these provisions, if a court order, judgment or decree establishes financial responsibility for the medical, dental, or other health care expenses of a child, the health plan designated by the court to cover the child shall be the primary plan. Any other health plan which covers that child as a Dependent shall be the secondary plan or pay after the secondary plan pursuant to the foregoing for purposes of providing benefits on behalf of the Dependent child.

(f) Where the order of responsibility cannot be determined pursuant to the provisions set forth above, the health plan which has covered the covered person for the longest period of time shall be the primary plan, and the health plan which has covered the covered person for the shorter period of time shall be the secondary plan for purposes of providing benefits on behalf of the covered person.

(g) Where there are two or more secondary plans, the order of responsibility in subsections (a) through (f) above shall be repeated until this Plan's responsibility has been determined with respect to each other health plan.

(h) When this Plan is the primary plan, the benefits payable by any secondary plan shall be ignored for the purpose of determining the benefits payable under this Plan.

6.04 **Coordination with No-fault Auto Insurance**

Where covered expenses are payable by a no-fault automobile insurer, or other automobile insurer which pays without regard to fault, this Plan shall always be the secondary plan.

6.05 **Coordination with Medicare**

Medicare shall be the secondary plan with respect to any covered employee who is Medicare-eligible and with respect to any Dependent of such covered employee, except with respect to a Dependent who is eligible for Medicare. Medicare shall be the primary plan with respect to a covered retiree and any Dependent who is Medicare-eligible. Both the covered employee and the Dependent have the option of rejecting the Plan in order to retain Medicare as the primary plan. For eligible persons covered by Medicare because of end-stage renal disease, Medicare is secondary only for the first 12 months of Medicare coverage; after that time, Medicare will pay first.

6.06 **Coordination with Champus**

In any case in which a covered person is also eligible for coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), CHAMPUS shall be the secondary plan.

6.07 **Service Benefits**

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered a covered expense. A secondary plan that provides benefits in the form of services may recover the reasonable case value of providing the services from the primary plan to the extent that benefits for the services are covered by the primary plan and have not already been paid. Nothing in this provision shall be interpreted to require the Plan to reimburse a covered person in cash for the value of service provided by a plan that provides benefits in the form of service.

6.08 **Right to Information**

For the purpose of determining the applicability of, and implementing this Article 6 or any provision of similar purpose of any other health plan, the Board of Trustees without the consent of or notice to any person, may release to or may obtain from any insurance company, organization or person any information which the Board of Trustees deems necessary for such purposes. Any individual claiming benefits from this Plan shall furnish, upon request, to the Board of Trustees in writing such information as may be necessary to implement this provision. This Plan shall not be required to determine the existence of any other health plan or the amount of benefits for covered expenses payable under any other health plan. Should the Board of Trustees not be provided with full and complete information, the Board of Trustees reserves the right to withhold any and all Benefit payments until such information is provided.

6.09 **Right to Make Payments**

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other health

plan, the Board of Trustees shall have the right, exercisable alone and at its sole discretion, to pay over to any organization making such other payments or, if appropriate, to a covered person, any amounts it shall determine to be warranted in order to satisfy the intent of this Article, and amounts so paid shall be deemed to be benefits provided under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

6.10 **Subrogation and Reimbursement**

(a) If the Plan pays benefits to any covered person or assignee for any injury, illness, expense or loss caused by a third party, the Plan will be subrogated for the full amount of such payments to all rights the covered person and/or assignee against any person, firm corporation or other entity in connection with any claim related to the injury, illness, expense or loss. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's recovery will not be reduced for any reason unless the Board of Trustees agrees in writing to a reduction.

(b) Prior to payment by the Plan to a covered person or assignee of benefits for any injury, illness, expense or loss caused by a third party, the covered person and/or assignee may be asked to execute a written assignment to the Plan of all rights, claims, interests, or causes of action which the covered person and/or assignee has to the full extent of such benefits. Further, the covered person and/or assignee may be asked to authorize the Plan, at the Plan's expense, to sue, compromise or settle, in his or her name or otherwise, all such rights, claims, interests or causes of action to the full extent of the benefits paid and shall do nothing to prejudice the Plan's rights under this Article. In addition, the covered person and/or assignee may be asked to covenant that he

or she has not discharged or released any such rights, claims, interests or causes of action. Failure to request or obtain any such document prior to payment by the Plan to a covered person or assignee of benefits for any injury, illness, expense or loss caused by a third party will not in any way diminish the Plan's rights of subrogation and reimbursement.

(c) Pursuant to directions received from the Board of Trustees, or its designee, a covered person and/or assignee shall assist the Plan. Such cooperation shall include, if requested, the institution of legal proceedings against any appropriate persons, firms corporations or other entities.

(d) If the Plan pays Benefits to any covered person or assignee for any injury, illness, expense or loss caused by a third party, and the covered person and/or assignee later obtains any recovery in connection with the injury, illness, expense or loss, the Plan shall be entitled to full reimbursement from the covered person and/or assignee to the extent of the Plan's payments. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for Benefits paid. The Plan's recovery shall not be reduced for any reason unless the Board of Trustees agrees in writing to a reduction.

## ARTICLE 7
## CLAIMS PROCEDURES AND APPEALS

7.01 **General**

The provisions of Section 7.02 through 7.07 shall apply to claims by a Participant, Dependent or duly authorized representative ("Claimant") for Medical Benefits, Prescription Drug Benefits; Dental Benefits; Vision Benefits; and Short-term Disability Benefits (collectively, “Medical or Disability Claims”). The provisions of Section 7.08 through 7.13 shall apply to claims by a Claimant for Death Benefits and Accidental Death and Dismemberment Benefits (collectively, “Other Claims”).

7.02 **Making Medical and Disability Claims**

(a) A Claimant must file a Medical or Disability Claim in accordance with the procedures described in the Summary Plan Description.

(b) In the case of a Pre-Service Claim (as described in Section 7.03(c) below), if a person or organizational unit customarily responsible for handling benefit matters on behalf of the Fund receives a communication by a Claimant that names (i) a specific Participant or Dependent; (ii) a specific medical condition or symptom; and (iii) a specific treatment, service, or product for which approval is requested, but that otherwise fails to follow the Fund’s procedures for filing a Pre-Service Claim, the Board (or its designee) will notify the Claimant of the failure and the proper procedures to follow in filing a claim for benefits as soon as possible, but no later than 5 days (or 24 hours in the case of an Urgent Care Claim as described in Section 7.03(a)) following the failure.

7.03 **Timing of Notification of Decision – Medical and Disability Claims**

The Board (or its designee) will notify the Claimant of the Fund's decision on a claim under Section 7.02 no later than the date set forth in this Section 7.03.

(a) Urgent Care Claims. In the case of a claim for medical care or treatment with respect to which the application of the time periods set forth in (b), (c) or (d) below could seriously jeopardize the life or health of the Participant or Dependent or his or her ability to regain maximum function, or would (in the opinion of a physician with knowledge of the Participant's or Dependent's medical condition) subject the Participant or Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim ("Urgent Care Claim"), the Board (or its designee) will notify the Claimant of the Fund's decision as soon as possible but no later than 72 hours after receipt of the claim (or 24 hours after receipt of a claim to extend the course of treatment beyond the period of time or number of treatments approved by the Fund, if the claim is received at least 24 hours before the expiration of the approved period of time or number of treatments). Notwithstanding the foregoing sentence, if the Claimant does not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Board (or its designee) will notify the Claimant of the specific information necessary to complete the claim as soon as possible but no later than 24 hours after receipt of the claim. The Claimant will then have 48 hours (or such longer time as is reasonable in the circumstances) to provide the specified information, and the Board (or its designee) will notify the Claimant of the Fund's decision as soon as possible, but no later than 48 hours after the Fund's receipt of the information (or the end of the period afforded the Claimant to provide the specified additional information if the

Claimant fails to do so).

(b) Concurrent Care Decisions. If the Fund has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the Board (or its designee) will notify the Claimant sufficiently in advance of any reduction or termination of the course of treatment (other than by Plan amendment or termination) to allow the Claimant to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

(c) Pre-Service Claims. In the case of a claim for a benefit not described in (a) or (b) above for which receipt is conditioned upon approval in advance of obtaining medical care ("Pre-Service Claim"), the Board (or its designee) will notify the Claimant of the Fund's decision within a reasonable period of time but no later than 15 days after the Fund's receipt of the claim, or 30 days after receipt of the claim if the Board (or its designee) determines that such extension is necessary due to matters beyond control of the Fund. In this circumstance, the Board (or its designee) will, within the initial 15-day period, notify the Claimant of (i) the circumstances requiring the extension of time; (ii) the date by which the Fund expects to render a decision and, if applicable; and (iii) any additional information to be required from the Claimant, and the Claimant will have 45 days from receipt of the notice to provide the specified information.

(d) Post-Service Claims. In the case of a claim for a benefit that is not described in (a), (b) or (c) above ("Post-Service Claim"), the Board (or its designee) will notify the Claimant of the Fund's denial of a claim within a reasonable period of time but no later than 30 days after receipt of the claim, or 45 days after receipt of the claim if the Board (or its designee) determines that such extension is necessary due to matters beyond control of the Fund. In this circumstance, the Board (or its designee) will, within the initial 30-day period,

notify the Claimant of (i) the circumstances requiring the extension of time; (ii) the date by which the Fund expects to render a decision and, if applicable; and (iii) any additional information to be required from the Claimant, and the Claimant will have 45 days from receipt of the notice to provide the specified information.

(e) Disability Claims. In the case of a claim for disability benefits ("Disability Claim"):

(i) The Board (or its designee) will notify the Claimant of the Fund's decision within a reasonable period of time but no later than 45 days after receipt of the claim.

(ii) The 45-day period may be extended an additional 30 days if the Board (or its designee) determines that such extension is necessary due to matters beyond control of the Fund, and provides the notice described in (iv) below within the initial 45-day period.

(iii) The determination may be extended an additional 30 days if the Board (or its designee) determines that, due to matters beyond the control of the Fund, a decision cannot be made within the first 30-day extension period, and provides the notice described in (iv) below within the first extension period.

(iv) Any notice of an extension past the initial 45-day period will explain: (i) the standards on which entitlement to a benefit is based; (ii) the circumstances requiring the extension of time; (iii) the date by which the Fund expects to render a decision; and (iv) the unresolved issues that prevent a decision on the claim; and the Claimant will have 45 days from receipt of the notice to provide the specified information.

7.04 **Content of Notification of Claim Denial – Medical and Disability Claims**

If a claim made under Section 7.02 is denied, the notification described in Section 7.03 will be in written or electronic form (or oral form in the case of an Urgent Care Claim, provided that a written or electronic notification is provided within 3 days) and will include:

(a) The specific reason(s) for the denial;

(b) Reference to the specific Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following a denial of an appeal;

(e) The internal rule, guideline, protocol, or other similar criterion (collectively, "Rule") relied upon in making the decision, if any, or a statement that such a Rule was relied on and that a copy of the Rule will be provided free of charge to the Claimant on request; and

(f) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

7.05 **Appeal of Claim Denials – Medical and Disability Claims**

If a claim made under Section 7.02 is denied, the Claimant may appeal the denial by filing a written appeal with the Board (or its designee)

within 180 days of receipt of notification of the denial. The following procedures will apply to the appeal:

(a) In support of the appeal, the Claimant may submit written comments, documents, records and other information relating to the claim, and the Fund will provide the Claimant upon request and at no charge with reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to the claim.

(b) In reviewing the appeal, the Board (or its designee) will: (i) take into account all materials and information submitted by the Claimant relating to the claim (even if not submitted or considered in connection with the initial claim); (ii) consider the claim *de novo,* without any deference to the initial claim denial; and (iii) ensure that the review is not conducted by the individual who denied the initial claim (or that individual's subordinate).

(c) If the initial claim denial was based in whole or in part on a medical judgment, the Board (or its designee) will consult with a health care professional who has appropriate training and experience in the relevant field and who was neither consulted in connection with the initial benefit decision nor is the subordinate of such person.

(d) The Board (or its designee) will, upon the Claimant's request, identify any medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the initial claim denied.

(e) In the case of an Urgent Care Claim, the Claimant may request an expedited review process in which the Claimant submits the request for appeal orally or in writing, and all necessary information will be transmitted between the Fund and the Claimant by telephone, fax, or other similarly expeditious method.

7.06 **Timing of Notification of Decision on Appeal – Medical and Disability Claims**

The Board (or its designee) will notify the Claimant of the Fund's decision on the appeal no later than the date set forth in this Section 7.06.

(a) Urgent Care Claims. In the case of an Urgent Care Claim, the Board (or its designee) will notify the Claimant of its decision on the appeal as soon as possible but no later than 72 hours after receipt of the appeal.

(b) Pre-Service Claims; Concurrent Care Decisions. In the case of Pre-Service Claim or a Concurrent Care Decision the Board (or its designee) will notify the Claimant of its decision on the appeal no later than 30 days after receipt of the appeal.

(c) Post-Service Claims; Disability Claims.

(i) In the case of a Post-Service Claim or Disability Claim that is to be decided by the Board (or a Committee thereof), the Board or Committee will make a decision no later than the date of its next meeting following receipt of the appeal, unless the request for review is filed within 30 days of that meeting, in which case a decision will be made no later than the date of its second meeting following receipt of the appeal. Notwithstanding the foregoing, if special circumstances require a further extension of time for processing, the decision will be made no later than the date of its third meeting following receipt of the appeal, and the Board or Committee will provide written notice of the extension to the Claimant before the commencement of the extension, describing the special circumstances and the date by which the decision will be made. The Board or its Committee will notify the Claimant of its decision no later than 5 days after the decision is made.

(ii) In the case of a Post-Service Claim or Disability Claim that is

to be decided by the Board's third-party designee, the Board (or its designee) will notify the Claimant of its decision on the appeal within a reasonable period of time, but no later than 45 days (in the case of a Disability Claim) or 60 days (in the case of a Post-Service Claim) after receipt of the Claimant's request for review. If the designee provides for two levels of appeals, a 30-day period will apply instead of the 45-day and 60-day periods.

7.07 **Content of Notification of Decision on Appeal – Medical and Disability Claims**

The notification described in Section 7.06 will be in written or electronic form and will include, in the case of an adverse decision:

(a) The specific reason(s) for the adverse decision;

(b) Reference to the specific Plan provisions on which the decision is based;

(c) A statement that the Claimant is entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to the Claimant's claim for benefits;

(d) A statement of the Claimant's right to bring an action under section 502(a) of ERISA;

(e) the internal rule, guideline, protocol, or other similar criterion (collectively, "Rule") guideline relied upon in making the decision, if any, or statement that such a Rule was relied on and that a copy of such Rule will be provided free of charge to the Claimant on request;

(f) If the adverse benefit decision is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision (applying the terms of the Plan to the Claimant's medical

circumstances), or a statement that such explanation will be provided free of charge upon request; and

(g) The following statement: "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.

7.08 **Making Other Claims**

A claimant must file an Other Claim in accordance with the procedures described in the Summary Plan Description.

7.09 **Timing of Notification of Decision – Other Claims**

The Claimant will be notified of the Fund's decision on a claim made under Section 7.08 within a reasonable period of time, but no later than 90 days after receipt of the claim, or 180 days after receipt of the claim if the Board (or its designee) determines that such extension is necessary due to matters beyond control of the Fund. In this circumstance, the Board (or its designee) will, within the initial 90-day period, notify the Claimant of the special circumstances requiring an extension of time and the date by which the Fund expects to make a decision.

7.10 **Content of Notification of Claim Denial – Other Claims**

The notification described in Section 7.09 will include:

(a) The specific reason(s) for the adverse decision;

(b) Reference to the specific Plan provisions on which the decision is based;

(c) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and

(d) A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following a denial of an appeal.

7.11 **Appeal of Claim Denials – Other Claims**

If a claim made under Section 7.08 is denied, the Claimant may appeal the denial by filing a written appeal with the Board (or its designee) within 120 days of receipt of notification of a denial. The following procedures will apply to the appeal:

(a) In support of the appeal, the Claimant may submit written comments, documents, records and other information relating to the claim, and the Fund will provide the Claimant upon request and at no charge with reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to the claim.

(b) In reviewing the appeal, the Board (or its designee) will take into account all materials and information submitted by the Claimant relating to the claim (even if not submitted or considered in connection with the initial claim).

7.12 **Timing of Notification of Decision on Appeal – Other Claims**

(a) In the case of an Other Claim that is to be decided by the Board (or a Committee thereof), the Board or Committee will make a decision no later than the date of its next meeting following receipt of the appeal, unless the request for review is filed within 30 days of that meeting, in which case a decision will be made no later than the date of its second meeting following receipt of the appeal. Notwithstanding the foregoing, if special circumstances require a further extension of time for processing, the decision will be made no later than the date of its third meeting following receipt of the

appeal, and the Board or Committee will provide written notice of the extension to the Claimant before the commencement of the extension, describing the special circumstances and the date by which the decision will be made. The Board or its Committee will notify the Claimant of its decision no later than 5 days after the decision is made.

(b) In the case of an Other Claim that is to be decided by the Board's third-party designee, the Board (or its designee) will notify the Claimant of its decision on the appeal within a reasonable period of time, but no later than 60 days after receipt of the Claimant's request for review. The 60-day period may be extended up to an additional 60 days if special circumstances require an extension of time for processing the claim, in which case the Board (or its designee) will provide written notice of the extension to the Claimant before the commencement of the extension, describing the special circumstances and the date by which the Fund expects to render a decision.

7.13 **Content of Notification of Decision on the Appeal – Other Claims**

The notice described in (a) will be in written or electronic form and will include, in the case of an adverse decision:

(a) The specific reason(s) for the adverse decision;

(b) Reference to the specific Plan provisions on which the decision is based;

(c) A statement that the Claimant is entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to the Claimant's claim for benefits; and

(d) A statement of the Claimant's right to bring an action under section 502(a) of ERISA.

7.14 **Appeals to the Board of Trustees**

(a) This Section 7.14 provides for an additional, voluntary appeal to the Board (or a Committee thereof) of a decision by the Board's third-party designee to reject an appeal made under Section 7.05 or 7.11.

(b) A Claimant may bring an appeal under this Section 7.14 by filing a written appeal with the Board within 120 days of receipt of notification of a denial. The following procedures will apply to the appeal:

(i) In support of the appeal, the Claimant may submit written comments, documents, records and other information relating to the claim.

(ii) In reviewing the appeal, the Board (or its designee) will take into account only materials and information submitted by the Claimant relating to the claim or considered in connection with the initial claim or a prior appeal.

(c) If a Claimant files an appeal under this Section 7.14, any statute of limitations or defense with respect to the claim based on timeliness is tolled during the time that such appeal is pending.

(d) The Plan will provide to the Claimant, upon request, sufficient information relating to his or her appeal under this Section 7.14 to enable the Claimant to make an informed judgment about whether to make an appeal under this Section 7.14, including a statement that the decision of a Claimant as to whether or not to make an appeal under this Section 7.14 will have no effect on his or her rights to any other benefits under the Plan.

(e) No fee or cost will be imposed on the Claimant with respect to his or her appeal under this Section 7.14.

(f) The Board will not treat a Claimant's failure to file an appeal under this Section 7.14 as a failure to exhaust his or her administrative remedies under the Plan with respect to the claim.

## ARTICLE 8
## PLAN AMENDMENT AND TERMINATION

8.01 **Amendment or Termination of Plan**

The Board of Trustees, at a meeting held either in person or by telephone or other electronic means, or by unanimous written consent in lieu of a meeting, reserves the right at any time and from time to time, and retroactively if deemed necessary or appropriate, to amend, suspend or terminate the Plan for any reason, in whole or in part, and to adopt any amendment or modification thereto, all without the consent of any Employee or other person. Any action taken by the Board of Trustees shall be consistent with the terms of the Trust Agreement. Upon termination of the Plan, any assets remaining in the Fund may be used to provide welfare benefits to Employees, Dependents or Beneficiaries as the Board of Trustees determines in its sole and absolute discretion.

## ARTICLE 9
## PRIVACY REQUIREMENTS

9.01 **General; Definitions**

(a) General. The provisions of this Article 9 will be interpreted in accordance with the regulations issued by the Department of Health and Human Services ("DHHS") under 45 CFR parts 160-164, which are incorporated herein by reference.

(b) Definitions.

(1) Protected health information ("PHI") shall have the meaning set forth in 45 CFR § 164.501 – generally, information that relates to an individual's medical condition, the provision of medical care for that individual, or the payment for that individual's medical care that identifies the individual to whom it relates and is created or received by the Fund, a health care provider, an employer, or a health care clearinghouse.

(2) Privacy Officer shall mean the individual designated by the Executive Director to develop and implement the Fund's privacy policies and procedures, including responding to and to provide more information about matters covered by the privacy notice required by 45 CFR § 164.520 and responding to: (i) complaints under Section 9.3(b)(2), (ii) requests for access to PHI under Section 9.2(f) and 9.3, (iii) requests for amendments to PHI under Section 9.2(f) and 9.4, and (iv) requests for accounting of disclosures under Section 9.2(f) and 9.5.

(3) Designated Record Set shall have the meaning set forth in 45 CFR § 164.501.

9.02 **Uses and Disclosures of Personal Health Information By the Board**

(a) The Fund will disclose PHI to the Board only for the purposes of plan administration functions that the Board performs for the Fund as described in (b) below. For purposes of this Section 9.2, disclosure to the Board includes disclosure to the Fund's Executive Director, Director of Fund Administration, Director of Fund Development, Information Processor/Clerk, Member Inquiry Representative, Member Services Coordinator, and Marketing Coordinator, all of whom are under the control of the Board.

(b) PHI may be used and disclosed by the Board only for the purposes of plan administration functions, including without limitation quality assurance, claims processing, and auditing and monitoring Fund service providers and monitoring Fund employees. The Board will not use or disclose PHI except as permitted or required by the Plan or by law, and will not use or disclose PHI for any employment-related actions or in connection with any other employee benefit plan.

(c) Disclosure of PHI to the Board is conditioned upon Board certification that the Plan has been amended to incorporate the provisions of this Section 9.2 and that the Board agrees to comply with the provisions.

(d) The Board will ensure that any agents or subcontractors to whom it provides PHI received from the Fund agree to the restrictions that apply to the Board's receipt of PHI.

(e) The Board will report to the Privacy Officer any use or disclosure inconsistent with the uses or disclosures permitted under this Section 9.1.

(f) The Board will make PHI available for inspection, will make PHI available for amendment, and will make available the information required to provide an accounting of disclosures on the same terms as the Fund does so under Section 9.3, 9.4 and 9.5 below,

respectively.

(g) The Board will make its internal practices and records relating to the use and disclosure of PHI received from the Fund available to the U.S. Department of Health and Human Services upon request.

(h) Except as otherwise required by law, the Board will return or destroy all PHI that it receives from the Fund and shall retain no copies of such information when no longer needed for the purpose for which disclosure was made.

(i) If any individual receiving PHI under this Section 9.2 fails to comply with the provisions of this Section 9.2, the Board shall determine the consequences of such noncompliance based on the particular facts and circumstances of the noncompliance, including without limitation discipline up to and including termination of employment in the case of a Fund employee and prohibition on the future receipt of PHI in the case of a Trustee.

9.03 **Participant Access to PHI**

(a) Subject to the provisions of (b)(2) below, a Participant may obtain access to inspect and obtain a copy of PHI about the Participant in a Designated Record Set (not including psychotherapy notes and information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding) by filing a written request with the Privacy Officer.

(b) The Fund will act on the request within 30 days of receipt of the request (or 60 days in the case of requests for PHI maintained off-site), as follows:

(1) If the Fund grants the request, it will inform the Participant and permit the Participant in a timely manner to inspect and/or obtain a copy of the requested PHI in the form or format requested by the Participant, if readily producible in such form or otherwise in a readable hard copy form or such other form as agreed to by the Fund and the Participant.

(2) The Fund may deny the Participant's request for access for reasons permitted under 45 CFR §164.524(a)(2) (unreviewable grounds for denial) or §164.524(a)(3) (reviewable grounds for denial), in which case it will provide the Participant with a written denial explaining the basis for the denial, a statement of the Participant's review rights (if applicable), and a description of how the Participant may complain to the Fund.

(3) If the Fund is unable to act on the request within the required time, it will extend the time by no more than 30 days and will provide notice to the Participant of the reasons for the delay and the date by which the Fund will complete its action.

(4) If the Fund does not maintain the PHI that is the subject of the request but knows where it is maintained, the Fund will inform the Participant where to direct the request.

(c) In the case of a reviewable denial, the Participant may request in writing that the Fund have the denial reviewed by a licensed health care professional who is designated by the Fund to act as a reviewing official and who did not participate in the original denial decision. The Fund will provide the Participant with written notice of the determination of the reviewing official and will comply with such determination.

9.04 **Amendment of PHI**

(a) A Participant may request the Fund to amend his or her PHI or a record about the Participant in a Designated Record Set by filing a written request, including the reason for the request, with the Privacy Officer.

(b) The Fund will act on the request within 60 days after receipt of the request, as follows:

(1) If the Fund accepts the amendment, it will make the appropriate amendment and so notify the Participant, along with (after consulting with and obtaining the Participant's agreement) any the relevant persons who need the amendment.

(2) The Fund may deny the request if it determines that the PHI or the record that is the subject of the request was not created by the Fund (unless the Participant provides a reasonable basis to believe that the originator is no longer available to act on the request); is not part of the Designated Record Set; would not be available for inspection under 45 CFR §164.524; or is accurate and complete. Any denial will be provided to the Participant in writing and will include: (i) the basis for the denial; (ii) an explanation of the Participant's right to submit a written statement disagreeing with the denial; (iii) a statement that, if the Participant does not submit such a statement, the Participant may request the Fund to provide the request and denial along with any future disclosures of the PHI that is the subject of the proposed amendment; and (iv) a description of how the individual may complain to the Fund. The Fund may reasonably limit the length of a statement of disagreement, and may prepare a written response to such statement. The PHI that is the subject of the amendment will be appended to include the request for amendment, statement of disagreement and rebuttal, and the Fund will include such appended material (or a summary thereof) with any subsequent disclosure of the PHI if the Participant has so requested or has filed a statement of disagreement.

(3) If the Fund is unable to act on the amendment within 60 days, it will extend the time by no more than 30 days and will

provide notice to the Participant of the reasons for the delay and the date on which the Fund will complete its action.

9.05 **Accounting of Disclosures of PHI**

(a) The Fund will, upon a Participant's written request to the Privacy Officer, provide the Participant with an accounting of disclosures of the Participant's PHI made by the Fund within the prior six-year period, including the date of disclosure; the name (and address, if known) of the entity or person who received the PHI; a brief description of the PHI disclosed; and a brief statement of the purpose of the disclosure (or a copy of the request for disclosure, if any). Disclosures to individuals or entities to whom the Fund has made multiple disclosures during the accounting period for a single purpose, and disclosures for a particular research purpose for 50 or more individuals, are subject to the special rules set forth in 45 CFR §164.528(b)(3) and (4).

(b) Subsection (a) shall not apply to disclosures to carry out treatment, payment and health care operations; to Participants about their own PHI as provided in 45 CFR §164.502; incident to a use or disclosure otherwise permitted or required under 45 CFR §164.502; pursuant to an authorization as provided in 45 CFR §164.508; to persons involved in the individual's care or for other notification purposes as provided in 45 CFR §164.510; for national security or intelligence purposes; or to correctional institutions or law enforcement officials, as part of a limited data set in accordance with 45 CFR §164.514(e); or that occurred prior to April 14, 2003.

(c) The Fund will provide the Participant with the accounting requested within 60 days after receipt of the request or, if the Fund is unable to act on the amendment within 60 days, it will extend the time by no more than 30 days and will provide notice to the Participant of the reasons for the delay and the date by which the Fund will provide the accounting.

## ARTICLE 10
## GENERAL PROVISIONS

10.01 **No Diversion of Assets**

Except as provided in Section 8.01 of this Plan and Section 2.2(b) of the Trust Agreement, it shall be impossible at any time for any assets of the Plan to be used for or diverted to any purpose other than for the exclusive benefit of persons entitled to Benefits under the Plan, or to inure (other than through payments made pursuant to the Plan) to the benefit of any private individual.

10.02 **Employee Rights**

Nothing contained in this Plan shall give any Employee the right to be retained in the employment of an Employer or affect the right of an Employer to dismiss the Employee at any time and for any reason. The adoption and maintenance of this Plan shall not constitute a contract between an Employer and any Participant or Dependent or consideration for, inducement to or condition of the employment of any Employee.

10.03 **Physical or Other Disability**

If the Board of Trustees shall find that any person to whom an amount is payable under the Plan is unable to care for his or her affairs because of illness or accident, or is a minor, or has died, then any payment due him or her, or his or her estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to his or her spouse, a child (in accordance with the Uniform Gifts to Minors Act or State "gifts to minors" act, if applicable), a relative, an institution maintaining or having custody of such person, or any other person deemed by the Board of Trustees to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall constitute a complete discharge of the liability of the Union, the Fund,

the Board of Trustees and the Plan.

10.04 **Right to Recover Payments**

If, for any reason, payments are made to any person or entity in excess of the amount payable under this Plan, the Board shall have full authority to recover the amount of overpayments. That authority shall include, but shall not be limited to, the right to reduce benefits payable in the future to the person who received the overpayments.

10.05 **Transmittal of Notices**

All notices, statements, reports and other communications from the Board of Trustees to any Participant or Dependent or other person, required or permitted under the Plan, shall be deemed to have been duly given when delivered to such Participant or Dependent or other person, or mailed to him or her at the address last appearing on the records of the Board of Trustees.

10.06 **Controlling Law**

This Plan and all rights thereunder shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, except where applicable Federal laws and regulations control.

10.07 **Liability of Plan**

The use of services of any health care provider is the voluntary act of the Participant or Dependent, even in cases where the Plan limits coverage to certain providers. The health care providers rendering service in connection with this Plan are independent contractors, and the Plan makes no representation regarding the quality of service or treatment of any provider and is not responsible for the negligence of any provider rendering services or supplies in connection with this Plan.

10.08 **Text Prevails Over Captions**

The headings and subheadings of the Articles and Sections of the Plan are included herein solely for the convenience of reference and if there is any conflict between such headings and subdivisions and the text of this Plan, the text shall control.

10.09 **Counterparts**

This Plan may be executed in several counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one and the same instrument which may be sufficiently evidenced by any one counterpart.

10.10 **Successor and Assigns**

This Plan shall inure to the benefit of and be binding upon the parties hereto and their successors and assigns.

10.11 **Construction**

Notwithstanding any other provision of this Plan, no provision of this Plan shall be construed so as to violate the requirements of ERISA, the Code, or other applicable law.

10.12 **Successor Provisions of Law**

Any references to a section of ERISA or the Code (or any other statute), or to any other regulations or administrative pronouncements thereunder, shall be deemed to include a reference to any successor provision of ERISA or the Code (or of any successor federal law), or to any successor regulations or administrative pronouncements thereunder.

IN WITNESS WHEREOF, the Board of Trustees of the Steelworker Health and Welfare Fund has caused this instrument to be executed this 1st$^{th}$ day of March, 2004.

**BOARD OF TRUSTEES**

_____
Leon Lynch, Chair

_____
Dennis Fleming

_____
Eldon Kirsch

_____
Ann Flener

_____
William Harriday

_____
Joseph Murphy

_____
Raymond Jastrzab

_____
Thomas Pittman