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INSURANCE PLAN AGREEMENT

THIS AGREEMENT, entered into as of April 28, 2005, between CATERPILLAR INC. and INTERNATIONAL ASSOCIATION OF MACHINISTS AND AEROSPACE WORKERS, AFL-CIO, and LOCAL LODGE NO. 851 (hereinafter referred to as the "Union"),

WITNESSETH THAT:

Section 1. Definitions. When used herein:

- (a) "Bargaining Unit" means the unit for collective bargaining purposes covered by certification of the National Labor Relations Board dated May 18, 1951, in Case No. 13-RC-1925.
- (b) "Basic" Agreement" means the Agreement between the Company and the Union covering terms and conditions of employment of Employees (other than terms and conditions which are the subject of special supplemental agreements such as pensions, group insurance and supplemental unemployment benefits).
- (c) "Company" means Caterpillar Inc.
- (d) "Employee" means any person who is in the Bargaining Unit covered by this Agreement who is a regular full-time employee and actively employed by the Company, or who is on the Seniority List for such Bargaining Unit, on or after the Effective Date specified in Section 8 hereof.
- (e) "Insurance Carrier" means a legal reserve life insurance company selected by the Company to issue a policy or policies of group insurance pursuant hereto.
- (f) "Plan" means the Group Insurance Plan 2005 as set forth in Exhibit I attached hereto and made a part hereof.
- (g) "Seniority List" means the seniority list provided for in the Basic Agreement.

Section 2. Applicability to Group Insurance Plan 2005. Subject to the succeeding provisions of this Agreement, the Company agrees to maintain for eligible Employees the Group Insurance Plan 2005 for the term of this Agreement.

Section 3. Modifications Necessary to Maintain Approval from Governmental Insurance Department. In the event that any revisions of the Group Insurance Plan 2005 are necessary in order to obtain or maintain such approval as may be necessary from any state department of insurance or from any similar or other official body, or in order to satisfy the requirements of the Insurance Carrier as to the minimum number of participants, the Company may make such revisions with the agreement of the Union insofar as Employees in the Bargaining Unit are concerned, adhering as closely as possible to the intent of the parties as expressed in this Agreement (including the Group Insurance Plan 2005).

Section 4. Complete Agreement Not Subject to Strike. During the term of this Agreement neither the Union nor any of its officers, agents, or representatives, nor any of the Employees or their agents or representatives, shall engage or continue to engage in or in any manner sanction or encourage any strike, work stoppage, slowdown, or other interruption or impeding of work, or engage or continue to engage in any other use of economic force, for the purpose of securing any modification, change, or termination of this Agreement or of the Group Insurance Plan 2005, or for the purpose of securing the establishment of any new, different or additional plan for insurance or other benefits for death, sickness, accident, hospitalization or surgical or other medical services, or other welfare plans for the benefit of Employees. During the term of this Agreement, the Company shall have no obligation to negotiate or bargain with the Union or with the Employees or any representative of the Employees with respect to any of the subject matters of this Agreement (except as otherwise expressly provided herein), the right to bargain with respect to any such matters being expressly waived.

Section 5. Exclusive Plan. The Group Insurance Plan 2005 shall be the exclusive plan for insurance or other benefits for death, sickness, accident, hospitalization or surgical or other medical services, or other welfare benefits for Employees to be provided by the Company, in whole or in part, except such pension or other welfare benefits as may be provided for in other agreements between the Company and the Union.

Section 6. Conformance of Plan with State and Federal Legislation. In the event that there is hereafter enacted any law providing benefits for Employees who are disabled by sickness or accident (except benefits for occupational disabilities under workers' compensation and occupational disease laws and benefits for total and permanent disability under the Federal Social Security Act), the Company and the Union will negotiate with respect to the changes, if any, that should be made in the Group Insurance Plan 2005 in the light of such law.

Section 7. Procedure for Review of Disputed Claims. To afford Employees a means by which they can seek review and possible reconsideration of a disputed disability, medical, dental, vision, catastrophic medical expense, or a hearing aid claim, or a life insurance, or accidental death or dismemberment benefit claim which is denied the following procedure will apply:

Step 1. Should the Employee, following receipt of the notification letter which advises him that all or a portion of his claim for benefits has been denied, be unable to secure a satisfactory explanation from his Employer or the Insurance Carrier (or such other organization as shall be responsible for providing the benefit in dispute) of the reason for such denial, the Employee may then request the designated local union insurance representative to review the reasons for denial with the designated management representative.

Step 2. The management representative will review the Employee's claim with the local union insurance representative. If needed, more details with respect to the reasons for denial will be obtained by the management representative. If appropriate, he will advise the local union insurance representative what type of additional information is needed to support a claim for payment of benefits. Copies of all available material pertinent to the claim, including the denial letter, will also be furnished upon request.

Step 3. If, after discussion with the management representative, the local union insurance representative feels that the claim was improperly denied, he may notify in writing the District

Lodge, and the management representative that he would like the claim further reviewed by the District Lodge and the designated representative of the Company. The management representative will then direct a memorandum describing the discussions which have taken place (a copy of which will be sent to the local union insurance representative and to the District Lodge) to the Company representative and will also forward the entire claim file to the representative. Thereupon, the District Lodge should contact the Company representative to arrange for a meeting at a mutually convenient time for the purpose of further discussion of the claim.

Step 4. If, after discussion between the representative of the District Lodge and the designated Company representative of the Company, the parties cannot resolve the claim in dispute and the representative of the District Lodge continues to feel that the claim was improperly denied, such representatives shall appoint an impartial person to review the claim in dispute and to determine whether or not denial was proper. In the event of the inability of the parties to agree upon such an impartial person within a period of thirty days after it is determined that such an impartial person should be appointed, the parties shall ask the American Arbitration Association to furnish a suggested list of names of five persons, from which list the parties shall select one person to serve. Such selection shall be by agreement, if possible; otherwise, by the District Lodge and the Company alternately eliminating names from said list. After each party has eliminated the names of two persons from said list, the remaining one shall be appointed to act.

There shall be no appeal from any ruling by the impartial person so designated. Each such ruling shall be final and binding on the collective bargaining representatives, on the Employee, retired Employee or dependent involved, any other persons claiming benefits under the Plan and the Employers; and shall be based solely on the written facts submitted relating to the case in dispute and such ruling shall apply solely to the case in dispute and shall not be used as a precedent for future cases. No ruling in any one case nor any initial determination in any one case shall create a basis for retroactive adjustments in any other cases. The collective bargaining representatives will discourage any attempt of their respective members and any other persons and will not encourage or cooperate with any of its members and any other persons, in any appeal to any court or administrative board or agency from a ruling of such impartial person.

The fees and expenses of such impartial person, and any clerical or stenographic expense mutually agreed to, shall be borne equally by the Company and the District Lodge.

Section 8. Term of Agreement.

- (a) Subject to subparagraph (b), this Agreement shall be effective May 2, 2005 and shall remain in force through April 30, 2012, and thereafter from April 30 of one year through April 30 of the next succeeding year, unless at least 60 (but not more than 90) days prior to April 30, 2012, or at least 60 (but not more than 90) days prior to April 30 of any succeeding year, any party gives written notice to the other that it desires a modification or termination. In the event that any negotiations following such notice do not result in an agreement for renewal, with or without modification, prior to the April 30 next succeeding such notice, this Agreement shall terminate at the end of any term (including any one-year extension in accordance with the foregoing) unless further extended by mutual agreement.

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- (b) If at any time any of the approvals referred to in Section 4 (regarding governmental approval) ceases to be in effect, or there is a failure to satisfy the requirements of the Insurance Carrier and the Claims Administrator as to the minimum number of participants, the Employers (unless revisions made pursuant to Section 4 result in the complete reinstatement of such approval or satisfaction of said requirements) may terminate this Agreement by giving at least sixty (60) (but not more than 90) days' written notice thereof to the Union (which notice shall specify the effective date of the termination). In the event that any such notice of termination is given, the parties shall meet for the purpose of negotiating regarding the matters covered hereby within not less than thirty (30) nor more than sixty (60) days prior to the termination date specified in such notice.

Agreed and subscribed to as of the day and year first above written.

MEMORANDUM OF AGREEMENT RELATING TO
IMPLEMENTATION OF GROUP INSURANCE PLAN 2005

The Company and the Union agree that the following modifications to the Insurance Plan Agreement effective May 2, 2005 (the "Agreement") and the Company's Group Insurance Plan 2005 (the "Plan") that is an Exhibit to the Agreement are necessary to accomplish the transition of eligible employees and their dependents to the Plan. Any capitalized term that is not defined shall have the same meaning as in the Plan.

Notwithstanding any provision of the Agreement or the Plan:

1. Except as provided below, the Plan shall become effective January 1, 2006, and only for any person who is a regular full-time employee and actively employed in the Bargaining Unit covered by the Agreement, or an employee who is hired or transferred into the Bargaining Unit after May 2, 2005, other than (i) an individual with coverage in effect before May 2, 2005 under the Supplemental Agreement dated as of April 30, 1999, and the Group Insurance Plan that is an Exhibit thereto, or (ii) a "Supplemental employee" as defined Letter of Agreement 16 to the Basic Agreement.
2. The Insurance Plan Agreement dated as of May 2, 2005, and the Group Insurance Plan that is an Exhibit thereto, and related Agreements and Understandings, shall remain in effect through December 31, 2005 for the individuals described in paragraph 1, above, and their Dependents.
3. The Company and the Union further agree and acknowledge that this Memorandum of Agreement will expire upon its terms and have no further force and effect as of January 1, 2006.

EXHIBIT I
GROUP INSURANCE PLAN 2005

SECTION I
DEFINITIONS

When used herein, the terms defined below shall have the meanings so indicated:

- 1.1. "Basic Agreement" shall have the meaning defined in the agreement to which this Plan is an exhibit.
- 1.2. "Claims Administrator" means the Company, or its designee, that provides certain claim administration services for the Plan.
- 1.3. "Company" means Caterpillar Inc.
- 1.4. "Continuous Service" means the time elapsed since the last date of hiring or rehiring following a break in continuity of service. Continuity of service shall be broken by the occurrence of any event (regardless of when such event occurred or occurs) which breaks continuity of service for the purpose of determining seniority under the Basic Agreement in force at the time of such occurrence, or, with respect to any period during which no such agreement is in force, under the last such agreement in force prior to such period.
- 1.5. "Cosmetic" means procedures or services that change or improve appearance without significantly improving physiological function.
- 1.6. "Covered Medical Expenses" means the Usual and Customary charges for the types of medical services and supplies provided under Section V of this Plan.
- 1.7. "Days" means calendar days.
- 1.8. "Dependent" means (1) an Employee's spouse; or (2) an unmarried child of an Employee, provided, however, that if an Employee and the Employee's spouse are both Employees of the Employer or any subsidiary of the Employer only one Employee may register the child as a Dependent. A child is an eligible Dependent only if the following requirements are met:
 - (a) Minor Child - such child is under 19 years of age, or
 - (b) Student - such child is 19 years of age or more but under 25 years of age, and is a full-time student in a high school, college or trade school; students who work between semesters, trimesters or quarters shall be considered full-time students for the purpose of this subsection 1.8; or
 - (c) Disabled Child - such child is 19 years of age or more, and
 1. is incapable of sustaining employment by reason of mental or physical disability, excluding in any case, any Child on account of whom such Employee has not furnished evidence satisfactory to the Company or its

designee of the disability and the residence and support described in 2 and 3 below, and

2. legally resides with such Employee (or legally resides in a licensed special care home or facility which specializes in the treatment of physical or mental disabilities), and
3. receives from the Employee more than one-half (1/2) of his or her support.

Support, for purposes of subparagraph (c)3 above, is calculated by the following: The total family expenses for lodging, food and utilities (but not real estate taxes, mortgage interest and insurance) will be divided by the number of persons living in the home. This quotient, plus the cost of such child's clothing, education, medical care (which is not covered by insurance), and travel shall be compared to the total income of the child, and if the income exceeds one-half (1/2) the expenses determined by the above calculation, the child will not be a Dependent.

A child who is a Dependent by reason of this paragraph (c) shall continue to be a Dependent until he fails to satisfy this paragraph (c).

“Child” means any (i) natural child, (ii) legally adopted child, or (iii) stepchild who resides in the covered Employee's household. For the purposes hereof, an unmarried child shall be deemed to be under 19 or 25 years of age until the end of the month in which falls his or her 19th or 25th birthday.

- 1.9. “Dependent Coverage” means coverage in accordance with Section V providing benefits with respect to an illness or injury suffered by a Dependent of an Employee.
- 1.10. “Employee” for purposes of this Plan, means any person who is a regular full-time employee and actively employed by an Employer in a Bargaining Unit covered by the Agreement to which this Plan is an exhibit who is hired or transferred into a Bargaining Unit after April 30, 2005; provided that the following employees shall not be eligible to participate in the Plan:
 - (a) persons with coverage in effect before May 2, 2005 under the group insurance plan in effect under the Insurance Plan Agreement dated as of April 30, 1999; or
 - (b) employees classified by the Company as “supplemental employees” as described in Letter of Agreement 16 to the Basic Agreement.

Persons who have retired from active employment with an Employer are not eligible to participate in this Plan.

- 1.11. “Experimental or Investigational” means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

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- (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
 - (b) subject to review and approval by any institutional review board for the proposed use.
 - (c) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- 1.12. “Insurance Carrier” means a legal reserve life insurance company selected by the Company.
- 1.13. “Medical Emergency” means a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness that is both of the following:
- (a) arises suddenly; and
 - (b) in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.
- 1.14. “Office Call” means a visit with a Physician for the purpose of examination or consultation or the administration of a test or medication, other than one for which reimbursement is specifically provided hereunder.
- 1.15. “Participant” means an Employee or Dependent who is covered under the Plan pursuant to subsection 3.1. For purposes of Section V, an Employee is a Participant only if he enrolls for medical expense coverage in a manner prescribed by the Company or its designee. Similarly, a Dependent is a Participant only if the Employee has enrolled such Dependent as prescribed by the Company or its designee.
- 1.16. “Personal Coverage” means coverage in accordance with Section V providing benefits with respect to an illness or injury suffered by an Employee.
- 1.17. “Physician” means any doctor of medicine, doctor of osteopathy, podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who is properly licensed and qualified by law and acts within the scope of his license.
- 1.18. “Plan” means, for the purposes of this document, this Group Insurance Plan 2005.
- 1.19. “Usual and Customary” means the lesser of: (i) the provider’s usual charge for furnishing the service or supply or (ii) the charge the Claims Administrator determines in its discretion to be reasonable for such service or supply. Such determination shall take into account the prevailing range of fees in the local geographic area of providers of similar training or experience for like services or supplies. The Claims Administrator will utilize an independent national company to determine these prevailing ranges, and shall establish from time to time a percentile measure (or different measures for different types

of charges) that shall constitute the highest Usual and Customary charge. In the case of a network provider, as described in subsection 5.7, when there is a negotiated network charge for the service or supply, Usual and Customary for all purposes means that negotiated network charge.

SECTION II AVAILABILITY OF PLAN TO EMPLOYEES

- 2.1. Availability of Plan to Employees. Subject to the provisions of any document of which this may be a part and the succeeding provisions hereof, the Company will maintain the Plan herein described either through a group policy or policies issued by an Insurance Carrier or through a self-insured plan which may or may not be trusted either wholly or in part, or through a combination of either of the aforementioned means. Except to the extent that a benefit may be payable to him therefrom, no individual shall have any other interest in or right to the assets of any trust fund established as a part of the Plan.
- 2.2. Accumulation of Limits. Notwithstanding any provision to the contrary, any amounts accumulated by a Participant towards any maximum annual limits (including but not limited to, any co-insurance amount, deductible amount, day limit, or dollar limit) or lifetime limits under another group insurance plan sponsored by the Company that correspond to such limits in this Plan, shall apply to the corresponding limits under this Plan.

SECTION III ELIGIBILITY FOR AND EFFECTIVE DATE OF COVERAGE

- 3.1. Eligibility and Effective Date of Coverage. An Employee shall be eligible for coverage under the Plan on the first day he is actively at work except that he will become eligible for coverage under subsection 4.5 (Weekly Accident and Sickness Benefits) following completion of the probationary period as described in the Basic Agreement. An Employee must elect coverage by enrolling in accordance with the procedures established by the Company or its designee. In the event that the Employee declines to enroll within 30 Days of first becoming eligible for coverage and later elects to enroll, that coverage will be subject to an 18-month Pre-existing Condition exclusion period instead of the 12-month period described in the succeeding paragraph. An Employee's Dependent who is not enrolled at the time the Employee first enrolls for coverage shall be eligible for coverage as described in subsection 3.2 below.

Notwithstanding anything in this subsection 3.1 to the contrary, Medical Expense Benefits under Section V will not be payable for expenses related to the treatment of a Pre-existing Condition that existed within six months prior to the date benefits for that Participant became effective. "Pre-existing Conditions" are conditions for which medical advice or treatment was recommended by a Physician or received from a Physician (including, for Employees, in the course of an employment physical) within the six-month period preceding the effective date of coverage under the Plan for that Participant's enrollment date. Pre-existing Conditions do not include conditions for which medical advice or treatment was recommended by a Physician in connection with pregnancy or, in cases involving newborn children or newly adopted children. Any

medical expenses covered under Section V incurred on or after the end of a period of three consecutive months after the effective date of benefits for that Participant, during which time that person has not received medical treatment for that condition, or was not advised to receive medical treatment for that condition, shall not be subject to this limitation. The maximum period that such Pre-existing Conditions will not be covered is 12 months after the Participant's enrollment date. This 12-month maximum limitation shall be reduced by one month for each month of prior creditable coverage as long as the Participant did not incur a break in coverage exceeding 63 days (excluding any waiting periods). Creditable coverage includes coverage under any employer-sponsored health plan (including COBRA coverage), an individual health policy, Medicare, Medicaid, or a governmental plan for which the Participant has a certification acceptable to the Company or its designee from the employer-sponsored health plan, individual health insurer, Medicare, Medicaid, or governmental plan.

- 3.2. Effective Date of Dependent Coverage. A Dependent for whom an Employee makes written application for Dependent Coverage under Section V shall, subject to the payment of monthly costs and the additional provisions of this paragraph, become covered as follows:
- (a) If the Employee makes such written request within the 30-day period immediately following the first day of such Employee's eligibility, Dependent Coverage shall be effective on the date Employee coverage is effective.
 - (b) The Employee's newborn child will be covered from the moment of birth, provided the Employee has coverage in effect under the Plan that provides for the participation of one or more Child. If coverage described in the preceding sentence is not in effect at the time of birth, the Child will only be covered prior to a subsequent annual enrollment period if the Employee applies for Dependents' Coverage within 30 days of the birth, which coverage shall be retroactive to the date of birth.
 - (c) A child adopted by the Employee, or placed with the Employee for adoption, will be covered from the date the Employee has custody of the child, provided the Employee has coverage in effect under the Plan that provides for the participation of one or more Child. For this purpose, "custody" means the child has been placed with the Employee for adoption and the Employee is legally responsible for medical expenses incurred by the child. If coverage described in the preceding sentence is not in effect on the date the Employee acquires custody, the Child will only be covered prior to a subsequent annual enrollment period if the Employee applies for Dependents' Coverage within 30 days of such custody date, which coverage will be retroactive to the custody date.
 - (d) If a Dependent is acquired other than at the time of his birth due to a court order or decree or marriage, coverage for the new Dependent will be effective on the date of such court order or decree or marriage, provided the Employee has coverage in effect under the Plan that provides for the participation of one or more Child. If coverage described in the preceding sentence is not in effect on the date of the court order or decree or marriage, and the Employee applies for

Dependents' Coverage within 30 days of such court order or decree or marriage, such Dependents' Coverage will be effective on the first day of the month coincident with or next following the date of the court order or decree or marriage.

Notwithstanding anything in this Plan to the contrary, the Plan shall provide medical expense benefit coverage in accordance with a qualified medical child support order. Subject to any continuation rights provided hereunder, Dependents' Coverage will end when the related Employee's coverage ends.

- 3.3. Additional Life Insurance Coverage. Additional Life Insurance in accordance with Section IV will be made available to any Employee who files with his Employer proper request therefor. In the case of an Employee requesting reinstatement of Additional Life Insurance terminated pursuant to subsections 6.5 (Discontinuance of Coverage) or 7.3 (Failure to Make Contributions), the requested insurance shall take effect only if evidence of insurability satisfactory to the Insurance Carrier or the Company is furnished with respect to such Employee. In any case, requested insurance shall take effect on the first day on which the Employee is actively at work coinciding with or following the date on which the Insurance Carrier or the Company accepts as satisfactory the evidence of his insurability. No Additional Life Insurance will be provided after the first day of the month following the calendar month in which the Employee attains age 65 years.
- 3.4. Reinstatement of Additional Life Insurance Coverage. In the case of an Employee whose Additional Life Insurance has terminated pursuant to paragraph 6.1(a) (Termination of Coverage) and who thereafter requests reinstatement of such insurance, his Additional Life Insurance shall become effective on the date request therefor is filed with his Employer, provided such request is filed within the first thirty Days he is actively at work subsequent to such termination. If such request is not filed with his Employer within said thirty Days, the requested Additional Life Insurance shall take effect upon the receipt of acceptable evidence of insurability pursuant to the rules of subsection 3.3.
- 3.5. Reemployment. An Employee who suffers a break in continuity of service and who is subsequently reemployed shall be treated as a new Employee in the same manner as though he had never previously been employed.
- 3.6. Reinstatement from Military Leave. For the purpose of this Plan, if an Employee reports for reinstatement to his job with an Employer in accordance with the terms of a military leave of absence and is immediately placed on layoff, he will be deemed to have been actively at work on the day he so reported.

SECTION IV
 LIFE INSURANCE, LONG TERM DISABILITY BENEFITS,
 ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
 AND ACCIDENT AND SICKNESS BENEFITS.

4.1. Contribution and Schedule of Benefits.

- (a) The amount of Basic Life Insurance, long term disability benefits, accidental death and dismemberment benefits and weekly accident and sickness benefits in accordance with this Section will be provided by the Employers to Employees, except as otherwise provided in subsection 6.1 (Termination of Coverage). The Employee shall contribute for Additional Life Insurance at the full cost of the coverage, as determined by the Insurance Carrier, on a schedule determined by the Company.
- (b) The amounts of the insurance coverages are as set forth below in the Schedule of Benefits. The amount of an Employee's insurance coverage shall be determined by his base annual earnings. An Employee's base annual earnings shall be determined under the formula: the greater of his (i) straight-time hourly rate or (ii) guaranteed hourly rate (as defined in the Basic Agreement) (excluding any cost-of-living allowance or night shift or other premium), multiplied by 40 hours, multiplied by 4.33 weeks, multiplied by 12 months.

SCHEDULE OF BENEFITS

Basic Life Insurance	100% of base annual earnings up to a maximum benefit of \$75,000
Additional Life Insurance	100% or 200% of base annual earnings up to a maximum benefit of \$150,000
Accidental Death & Dismemberment Insurance	
One Member	50% of base annual earnings up to a maximum benefit of \$37,500
Two Members or Death	100% of base annual earnings up to a maximum benefit of \$75,000

- (c) On the first of the month following an active Employee's attainment of age 70 years, the Basic Life Insurance and Accidental Death and Dismemberment coverage shall reduce to 50% of the amounts in effect at age 70, and if such Employee continues to be actively at work, subsequent reductions shall take place based upon the following schedule:

- (i) on the first of the month following attainment of age 75, 35% of the Basic Life Insurance and Accidental Death and Dismemberment coverage in effect at age 70 shall remain in force;
- (ii) on the first of the month following attainment of age 80, 25% of the Basic Life Insurance and Accidental Death and Dismemberment coverage at age 70 shall remain in force;
- (iii) on the first of the month following attainment of age 85, 20% of the Basic Life Insurance and Accidental Death and Dismemberment coverage at age 70 shall remain in force; and
- (iv) on the first of the month following attainment of age 90, 15% of the Basic Life Insurance and Accidental Death and Dismemberment coverage at age 70 shall remain in force.

4.2. Increase or Decrease in Amount of Coverage.

Each Employee insured in accordance with this Section shall be insured for the exact amounts of insurance applicable to him. In the event of an increase or decrease in a covered Employee's hourly rate of pay, which changes his base annual earnings, the amounts of his insurance shall be automatically increased or decreased (without change, however, in the type of life insurance coverage -- Basic or Basic and Additional -- theretofore applicable to him), with such increase or decrease in the amounts of insurance to become effective on the first day on which he is actively at work coinciding with or following the date of such increase or decrease in his hourly rate of pay; provided, however, during the period that an Employee, while at work, is receiving payments under any workers' compensation or occupational disease law for loss of pay occasioned by his being assigned to a lower rated job as a result of an occupational disability, his insurance shall not be decreased as aforesaid but shall be based upon his hourly rate of pay at the time of the compensable injury unless, at his option, he files a written request during such period (on a form provided by the Company) for reduction in the amounts of his insurance to the amounts provided in which his rate decrease places him.

4.3. Long Term Disability Benefits.

- (a) Long Term Disability benefits will be payable if an Employee, while coverage in accordance with this Section is in effect with respect to him, becomes and remains totally disabled and files a claim for benefits under this subsection 4.3 of the Plan, supported by medical evidence acceptable to the Company or the Insurance Carrier within 30 days of the date of eligibility for such long term disability Benefit. An Employee will be considered totally disabled if he is not engaged in regular employment or occupation for remuneration or profit (excluding employment or occupation which is determined to be for purposes of rehabilitation) and if it is determined on the basis of medical evidence satisfactory to the Company that such Employee is totally disabled by bodily injury or disease so as to be prevented thereby from engaging in any regular occupation or employment with the Company. Long Term Disability benefits will be payable

only upon receipt by the Insurance Carrier or Company of such notice and such due proof, as shall be from time to time required, of such disability. Benefits will not be payable for any period of disability during which the Employee is retired pursuant to a pension plan of the Company and is receiving a pension payment thereunder except where such pension payment is a disability pension benefit under the Non-Contributory Pension Plan. Benefits payable in accordance with this subsection 4.3 shall not be payable for any disability directly or indirectly caused by:

- (i) insurrection, rebellion, terrorist act, war, whether declared or undeclared, or act of war;
- (ii) active participation in a riot;
- (iii) intentionally self-inflicted injury;
- (iv) attempted suicide; or
- (v) commission of or attempt to commit a felony.

The amount of monthly benefits payable under subsection 4.3 shall be 50% of the Employee's base annual earnings as defined in subsection 4.1(b) divided by 12.

- (b) The first payment shall be made after receipt of due proof of such disability, and after payment, by reason of such disability, of weekly accident and sickness benefits pursuant to subsection 4.5 (Weekly Accident and Sickness Benefits) has terminated because benefits for the maximum number of weeks have been paid thereunder. Payments pursuant to this paragraph shall continue while such disability continues until the earliest to occur of:

- (i) the termination of the period of such disability,
- (ii) the date the Employee fails to furnish due proof of continuance of total disability upon the written request of the Insurance Carrier or Company within 30 calendar days of such request,
- (iii) for an Employee with one or more years of seniority at the date his disability commences, the expiration of a period (including within such period the 26-week period during which weekly accident and sickness benefits were paid) equivalent to the greater of (1) the Employee's seniority when first disabled or (2) eighteen months,
- (iv) for an Employee with less than one year of seniority at the date his disability commences, the expiration of a one-year period (including within such period the 26 week period during which weekly accident and sickness benefits were paid),

- (v) the date in which the Employee has been disabled for a continuous period of twenty four months (including the 26 week period during which weekly accident and sickness benefits were paid or payable).
- (c) The amount of each monthly benefit (in accordance with the Schedule of Benefits) shall be reduced by
 - (i) primary benefits paid or payable under the Federal Social Security Act,
 - (ii) disability benefits under any state or other governmental program (other than benefits under any law designed to compensate veterans of the military, naval, or merchant marine services of the United States for service-connected disability),
 - (iii) benefits (other than hospitalization or medical benefits) under any other Company-sponsored plan which are paid or payable for any period of disability occurring within the same month for which a benefit is payable under this subsection 4.3, and
 - (iv) benefits under any workers' compensation, occupational disease or similar law which are paid or payable for any period of disability occurring within the same month for which a benefit is payable under this subsection 4.3, except payments under such law for (1) the loss of, or permanent and complete loss of use of, or the permanent partial loss of use of any bodily member or permanent partial disability payments for a work-related disability unrelated to the disability for which benefits under this subsection 4.3 are payable, (2) hospitalization or medical expense, or (3) disfigurements.

For the purpose of determining the amount of any of the reductions for governmental benefits specified in items (i), (ii), and (iv) above, and any pension benefits specified in (iii) above, any such amount shall be determined as of the first day for which Long Term Disability benefits are payable for each period of disability under this subsection 4.3 (or as of the first day on which the amount of each one of such governmental or pension benefits for which such a reduction is made is initially determined, if later) and thereafter any such amount of governmental or pension benefits for each period of disability shall not be changed because of changes of law or pension plan amendments or scheduled increases in pension amounts which are enacted and approved or made after such first day and any changes in amount as a result of such change of law or pension plan amendments or scheduled increases (whether prospectively or retroactively) shall be disregarded, but all or any portion of any increase in pension amounts which represents a recalculation or adjustment of the number of years of credited service upon which pension benefits are calculated shall not be disregarded.

- (d) Unless an Employee has returned to work for a period of active full-time work of not less than 45 calendar days during which the Employee works all normally scheduled days of work as described in the Basic Agreement, a succeeding period

of disability due to the same or related cause or causes shall be considered a continuation of the previous period of disability.

- (e) Any benefits due for periods other than a whole calendar month shall be such proportion of the monthly benefit as the number of workdays that the Employee is disabled in such calendar month bears to the entire number of workdays in that calendar month. "Workdays" as used in the preceding sentence shall include any holidays falling within an Employee's regular workweek.

4.4. **Accidental Death or Dismemberment Benefits.** Benefits for accidental death or accidental dismemberment will be payable if an Employee, while such insurance in accordance with this Section is in effect with respect to him, sustains bodily injuries through violent, external and accidental means (subject to the limitations customarily contained in such policies issued by the Insurance Carrier), and within three hundred and sixty-five days thereafter suffers, as a direct result of such bodily injuries, independently of all other causes, the loss of a hand by severance at or above the wrist joint, the loss of a foot by severance at or above the ankle joint, the total and irrecoverable loss of the sight of an eye, or loss of life, to the extent provided in the insurance policy. This insurance does not cover losses caused wholly or partly by disease or bodily or mental infirmity, or by medical or surgical treatment or diagnosis thereof; by ptomaine or by bacterial infection (except only septic infection of and through a visible wound sustained solely through violent, external and accidental means); by hernia (no matter how or when sustained); by insurrection, war or any act of war; or by or resulting from intentional self-destruction or intentionally self-inflicted injury, while sane or insane.

4.5. **Weekly Accident and Sickness Benefits.** Weekly accident and sickness benefits will be payable if an Employee, while such coverage in accordance with this Section is in effect with respect to him, becomes wholly and continuously disabled, so as to be prevented from performing any and every duty of his occupation, by an injury or by sickness, provided that during the period of such disability he is under treatment therefor by a Physician and the claim is filed with supporting medical evidence acceptable to the Company within thirty calendar days of the first day of disability. Weekly benefits will be payable in an amount equal to 66.67% of the Employee's straight time hourly rate, excluding any cost-of-living allowance, night shift premium and any other premium multiplied by 40. Such benefits will be payable only while the Employee is so disabled and under such treatment, beginning on the eighth day of such disability except that benefits will begin on –

- (i) the first day he is confined as a patient in a legally constituted hospital upon the order of a Physician,
- (ii) the first day during the period of disability on which he is under treatment by a Physician if (1) the disability is the result of (aa) a non-occupational injury directly caused by accidental means (i.e., an injury will be recognized as having occurred accidentally if the Employee furnishes a satisfactory history of an unexpected event of such a nature as to cause disability, and sprains, strains, wrenches and the like will be so recognized where visible evidence is lacking but there is satisfactory medical

evidence to establish the existence of disability), or (bb) an occupational injury occurring as a result of employment with the Company and (2) the Employee is wholly and continuously disabled so as to be prevented from performing any and every duty of his occupation from the time the injury occurs,

- (iii) the first day he undergoes a surgical operation approved by the Company or its designee for first-day benefits, or
- (iv) the first day he is confined as a patient in an Approved Residential Facility as defined in subsection 5.9 (Alcoholism and Drug Abuse Benefits) upon the order of a Physician.

For purposes of this subsection 4.5 any day an Employee works four hours or more will not be considered as a day of disability. In the case of an Employee who is scheduled for workweeks of three twelve-hour workdays or four ten-hour workdays, benefits shall be paid for days of absence during that work schedule on the basis of a three-day workweek or four-day workweek, as determined by the work schedule assigned by the Employer. In the case of any other Employee, benefits shall be paid on the basis of a five-day workweek, Monday through Friday, provided that if one of such days is not included in an Employee's regular workweek, Saturday shall be substituted for that day and if two of such days are not included in the Employee's regular workweek, Saturday and Sunday shall be substituted for such two days.

The benefits will not be payable for more than the lesser of:

- (i) 26 weeks, or
- (ii) a period equal to the Employee's seniority as of the day he first becomes disabled,

for any one continuous period of disability (whether for one or more causes) or for successive periods of disability due to the same or related cause or causes unless the succeeding period of disability commences after the Employee has returned to work for a period of active full-time work of not less than 45 calendar days during which the Employee works all regularly scheduled hours he was scheduled to work (any absence on any such day of work on which the Employee would have worked except that he was excused by the Company and compensated for such absence under the provisions of the Basic Agreement regarding vacation, jury duty and witness service, temporary military service, or bereavement shall be deemed to be days of work for purposes of this subsection 4.5); provided, however, if an Employee is confined as a registered bed patient in a legally constituted hospital or an Approved Residential Facility upon the order of a Physician, or if statutory benefits are payable to the Employee for the same disability under any workers' compensation, occupational disease, or similar law because of employment with his Employer at the date of expiration of the maximum period for which he is entitled to receive benefits pursuant to item (ii) above, benefits shall continue to be payable while such Employee continues to be so confined or continues to be eligible for such statutory benefits, but in no case beyond the end of the applicable 26

weeks' period specified in item (i) above. In addition, benefits will not be payable for any period of disability during which the Employee is retired pursuant to a pension plan of the Employers and receiving a pension payment thereunder.

Benefits payable in accordance with this subsection 4.5 during any Period of Disability will be reduced by the amount, if any, of benefits paid or payable to the Employee during the same Period of Disability under any workers' compensation, occupational disease, or similar law (except payments under such law for (i) the loss of, or the permanent and complete loss of use of, any bodily member or permanent partial disability payments for a work-related disability unrelated to the disability for which benefits under this subsection 4.5 are payable; (ii) hospitalization or medical expense; (iii) disfigurements), and for the purposes of this sentence, a Period of Disability means a period commencing on Monday and ending on the next following Sunday. Benefits otherwise payable for any period of disability shall be reduced by the weekly equivalent of any Disability Insurance Benefits or Old-Age Insurance Benefits (primary insurance amount only) to which the Employee is entitled for the same period under the Federal Social Security Act or any future legislation providing similar benefits, except old-age benefits reduced because of the age at which received. For purposes of such reduction, the weekly equivalent of benefits paid on a monthly basis is computed by dividing the monthly benefit rate by 4.33. Benefits payable in accordance with this subsection 4.5 to an Employee on layoff shall be reduced by the amount of any disability benefit which such Employee is entitled to receive (or could become entitled to receive by making a proper application therefore) for the same week of disability or any portion thereof under a plan financed in whole or in part by any other employer.

Benefits payable in accordance with this subsection 4.5 shall not be payable for any day of disability for which the Employee receives holiday pay for the same day of disability; however, such day(s) shall be counted as waiting period day(s) for the purposes of the eight-day waiting period above.

Benefits payable in accordance with this subsection 4.5 shall not be payable for any day of disability that the Employee receives pay from an Employer for the same day of disability if such Employee was injured while at work and receives pay for the balance of the day on account of such injury.

Benefits payable in accordance with this subsection 4.5 shall not be payable for any disability caused or contributed to by:

- (1) insurrection, rebellion, terrorist act, or war, whether declared or undeclared, or act of war;
- (2) active participation in a riot;
- (3) intentionally self-inflicted injury;
- (4) attempted suicide; or
- (5) commission of or attempt to commit a felony.

SECTION V
MEDICAL EXPENSE BENEFITS

5.1. General. A benefit shall be provided in accordance with this Section only for an Employee while coverage for such benefit is in effect with respect to him, or a Dependent of an Employee while Dependent Coverage for such benefit is in effect with such Employee. Benefits in accordance with this Section will be provided to such Participant for the duration of any Agreement to which this Plan is a part. Each covered Dependent must be registered by the Employee on a form or similar documentation as required by the Company or its designee prior to payment of any claim with respect to such Dependent. Medical expense benefits not specifically provided under this Section are excluded from coverage. No benefit shall be payable in accordance with this Section as a result of an injury or sickness entitling an Employee to benefits under any workers' compensation or occupational disease law. No benefits shall be paid for services deemed Cosmetic or Experimental or Investigational as determined by the Claims Administrator in its discretion. Payment will be made for the most cost effective services under this Plan. Benefits may be paid directly to the provider of the service. A Participant may authorize that benefits (otherwise payable to the Participant) be paid directly to the provider of the service through completion of a claim form or other method approved by the Employer. However, in no event may a Participant transfer or assign to the provider the right of appeal, representation, or any other rights conferred by this Plan. Notwithstanding any other provision hereof to the contrary, no benefits will be payable pursuant to this Section V for services which are or may be obtained without cost to any Participant covered by the Plan. If a charge is made to such Participant which he is legally required to pay, any benefits hereunder will be computed in accordance with the provisions of this Section, taking into account only such charge.

5.2. Employee Contributions and Premium Payment.

- (a) The Employee Only contributions toward coverage in any given month will be equal to one-twelfth of ten percent (10%) of the Total Annual Cost Per Employee for 2006 and each subsequent year. The Total Annual Cost Per Employee will be calculated for each calendar year commencing with 2006 and will be based on the Total Annual Participant Cost Per Employee, which shall equal the quotient of (i) the sum of (A) the total claims and administration costs for covered Employees and covered Dependents in the Group Insurance Plan 2005, (B) the total claims and administration costs for persons who satisfy the definition of covered "Employee" or covered "Dependent" of an "Employee" under the Company's Group Insurance Plan, and (C) the total claims and administration costs for persons who satisfy the definition of covered "Employee" or covered "Dependent" of an "Employee" under the Company's Group Insurance Plan 2004, divided by (ii) the sum of (A) the total number of covered Employees in the Group Insurance Plan 2005, (B) the total number of persons who satisfy the definition of covered "Employee" under the Company's Group Insurance Plan, and (C) the total number of persons who satisfy the definition of covered "Employee" under the Company's Group Insurance Plan 2004, in the second prior year (2004 for 2006 contributions, for example) projected forward two years. Once the Total Annual Participant Cost Per Employee is calculated, it shall be

used to develop the Total Annual Cost Per Employee by multiplying it by a factor determined by the Company's actuary, using commonly applied methodology to take into account the demographics of the Group Insurance Plan 2005, the Company's Group Insurance Plan, and the Company's Group Insurance Plan 2004, and the coverage category relative values. The projection shall be based on an annual inflation factor which will be the unadjusted percent change of the Medical Care Component of the Consumer Price Index for all Urban Consumers, U.S. City Average as compared to the previous year, plus 4%, and adjusted for any changes in benefit provisions. Once the Employee Only contribution is determined, the Company will use methodology similar to the methodology utilized to determine the contribution amounts for other coverage categories. Contribution amounts determined under this paragraph (a) are subject to the adjustments described in (b) and (c) below, if applicable.

- (b) In the event that an Employee's covered spouse (A) is not employed by an Employer and (B) either (i) has other group health coverage available and has not elected such other coverage; or (ii) has elected other group health coverage, but, under the coordination of benefits rules of such other coverage and the Plan, the reimbursements from the Plan are more than they would be if such other coverage were primary and Plan benefits were secondary, the contribution amount for the Employee & Spouse coverage category shall be 3.8 times the amount for the Employee Only coverage category and the amount for the Family coverage category shall be 5.0 times the amount for the Employee Only coverage category.
- (c) The monthly contribution amounts described above reflect the reduced applicable contribution amount if an Employee and/or spouse Dependent is participating in a wellness program approved by the Company. If an Employee and/or spouse Dependent is not participating in a wellness program approved by the Company, the applicable monthly contribution amount described above shall be increased by \$75 for each one of them who is covered by the Plan and not participating in such a program. (For purposes of this paragraph (c), participation in a wellness program sanctioned by the Company means completing two health assessments under such program per year.)

5.3. Maximum Benefits Payable to Participants.

For each Participant, all benefits payable under this Section V shall not exceed a lifetime maximum of \$3,500,000.

5.4. Deductible Amount

Notwithstanding any provision of the Plan to the contrary, a separate calendar year deductible amount of \$500 per person and \$1,000 per family will be applied to Covered Medical Expenses under this Section V, except for medical expense benefits under subsections 5.26 (Prescription Drug Benefits), 5.14 (Dental Expense Benefits), and 5.33 (Vision Care Benefits). The deductible amounts described above shall not include any co-payments paid by a Participant and no co-payments shall be reduced as a result of a

Participant or a Participant and his family having reached the applicable deductible amount.

The deductible amount will apply to each Participant, except that the deductible amount will not apply to Covered Medical Expenses after two or more covered family members have incurred Covered Medical Expenses that, in the aggregate, equal the per family deductible; however, in any event no one covered family member may have more than the per person deductible applied to the per family deductible. If an Employee and his spouse are both Employees or former Employees and are both covered under a group insurance plan sponsored by the Employer, the deductible amount will apply to each spouse separately.

5.5. Co-Insurance.

Notwithstanding any provision of the Plan to the contrary (but subject to subsection 5.6(iv)), the Plan will pay 80% of Covered Medical Expenses under this Section V after the deductible amount under subsection 5.4 is met, except for medical expense benefits under subsections 5.25 (Prescription Drug Benefits), 5.13 (Dental Expense Benefits), and 5.32 (Vision Care Benefits). The Participant is responsible to the provider for the co-insurance amount remaining. The term "co-insurance amount" under this subsection 5.5 means the amount of Covered Medical Expenses which is not payable in a calendar year solely due to the percentage limitation described above.

The co-insurance amount applies to each Participant, except that a Participant will not be responsible for paying a co-insurance amount once the sum of the co-insurance and deductible amounts paid by the Participant for the year equals \$1,500. In addition, if an Employee has one or more covered Dependents, none of them will be responsible for paying a co-insurance amount once the sum of their co-insurance and deductible amounts paid for the year equals \$3,000. Notwithstanding any contrary provision, (i) the 50% co-insurance amount described in subsection 5.6(iv) shall not be included for purposes of calculating the maximum amounts described in this subsection 5.5; and (ii) the 50% co-insurance amount described in subsection 5.6(iv) shall continue to apply after such maximum amount have been met.

5.6. Network Benefits.

Medical expense benefits under Section V shall be modified in the following manner:

- (i) Benefits shall be provided through selected medical providers (including, but not limited to physicians, dentists, hospitals and pharmacies) with whom exclusive contracts shall be executed between the Company and such providers or the Claims Administrator and their providers. As such arrangements become available, the Company will designate the benefits under the Plan.
- (ii) Any such medical provider may also be the Company, a subsidiary of the Company, or be employed by the Company or a subsidiary of the Company.
- (iii) With respect to any particular benefit or groups of benefits, a particular provider may be selected and such selections may differ depending on the location of the

facility where the Employee works and as defined by the Employee's residential zip code.

- (iv) When a provider or providers have been selected for a particular location and benefit and the Participant's residential zip code places him within a defined network service area, the Participant shall have the choice of (a) obtaining service from such provider(s) with benefits payable under the terms of the Plan at the negotiated network charge or (b) obtaining the service from a non-selected provider, in which case the medical expense benefit payable shall be reduced to 50% of the amount that otherwise would be payable pursuant to the provisions of Section V.
- (v) When a provider or providers have not been selected for a particular location and the Participant's residential zip code places him outside of a defined network service area, the Participant shall have the choice of seeking services from any provider or providers without a reduction in benefits pursuant to the provisions of Section V of the Plan.

5.7. Benefits Under Federal Law Including Medicare.

- (a) The provisions of this Section V shall not be applicable to a Participant who is or may become eligible for hospital, surgical or other medical expense benefits under any federal law providing such benefits for the public at large. Compliance by the Company with such laws shall be deemed full compliance with the provisions of this Section V with respect to a Participant eligible for benefits under such laws. If, as a result of such laws, the level of benefits provided for any group of Participants is generally lower than the corresponding level of benefits under this Section V, the Employers may, at their option and to the extent they find it practicable, provide a plan of benefits supplementary to the federal benefits to the extent necessary to make total benefits as nearly comparable as practicable to the benefits provided under Section V.
- (b) In accordance with the right the Company has, pursuant to the preceding paragraph 5.7(a), to provide a plan of benefits supplemental to federal benefits, this Plan shall supplement benefits provided by the Health Insurance for the Aged Act, "Title XVIII", of the Social Security Act (Medicare) in the following manner.

Benefits otherwise provided on account of medical expenses covered under this Section V of the Plan shall be reduced by any "benefits available" on account of such medical expenses under such Act as enacted and thereafter amended. "Benefits available" shall mean (i) all benefits to which a person is entitled under Part A of said Act including, in the case of a person not enrolled under Part A of said Act, any benefits to which he would be entitled under Part A of said Act if he were enrolled for such coverage, and (ii) all benefits for which a person is actually covered under Part B of said Act by reason of enrollment for coverage under Part B of said Act; provided, however, following the first eligibility date for coverage under Part B of said Act of a person described in the following sentence, it shall

be assumed that such person is enrolled for coverage under Part B of said Act, and any benefits to which he would be entitled under Part B of said Act if he were enrolled for such coverage shall be included as “benefits available.”

- (c) If a Participant elects to participate in a Medicare+Choice program, including but not limited to private contracting with a Physician, other practitioner or provider, the Plan will only pay the amount for which it would have been liable had the Participant remained in the traditional Part A and/or B program(s).
- (d) Notwithstanding any other provision to the contrary, in no case will this Plan, under the rules establishing the order of benefit determination, make payment in an amount which, when added to the amount paid in accordance with benefits available, would exceed the amount that would be payable by this Plan if it were the only plan providing such benefits.
- (e) The provisions of paragraph 5.7(a) above to the contrary notwithstanding, the Company may, if federal laws permit, substitute a plan of benefits for the benefits provided by the federal laws referred to above, and modify the provisions of the Plan to the extent and in the respects necessary to secure the approval of such substitution from the appropriate governmental authority.

5.8. Coordination of Benefits. All of the benefits provided under this Section V are subject to this provision.

(a) Definitions

- (i) “Other Plan” means any plan providing benefits for, or services in the form of, or by reason of, hospital care, or treatment, or treatments by Physicians or services or supplies provided by other providers which benefits or services are provided by group, blanket, or franchise insurance coverage, group practice, individual practice and other prepayment coverage on a group basis, including Blue Cross-Blue Shield, coverage under a labor management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan.

The term “Other Plan” shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

- (ii) “Covered Services” means any necessary, reasonable and customary item of expense for service covered in whole or in part under this Plan or any Other Plan in which the individual covered under this Plan is enrolled. When any Other Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be a benefit paid.

(b) Payment of Covered Services

Notwithstanding the provisions of this Plan, in no case will this Plan, under the rules establishing the order of benefit determination, as described in paragraph (c) of this subsection 5.8, make payment of an amount which, when added to the amount paid by the Other Plan, exceeds the amount that would be reimbursed by this Plan if it were the only plan providing such benefits.

(c) Effect on Benefits

(i) For the purposes of this subsection 5.8, the rules establishing the order of benefit determination are:

- (1) The benefits of the Plan or Other Plan which covers the person on whose Covered Services claim is based other than as a dependent shall be determined before the benefit of the Plan or Other Plan which covers such person as a dependent;
- (2) The benefits of the Plan or Other Plan which covers the child as a dependent of the parent whose birthday in any year occurs before the birthday in such year of the other parent will be determined before the benefits of the Plan or Other Plan which covers the child as a dependent of such other parent; except that:
 - when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of the Plan or Other Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the Plan or Other Plan which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of the Plan or Other Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of the Plan or Other Plan which covers that child as a dependent of the stepparent, and the benefits of the Plan or Other Plan which covers that child as a dependent of the stepparent will be determined before the benefits of the Plan or Other Plan which covers that child as a dependent of the parent without custody;

notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child;

- (3) When rules (1) and (2) do not establish an order of benefit determination, the benefits of the Plan or Other Plan which has covered the person on whose Covered Services claim is based for the longer period of time shall be determined before the benefits of the Plan or Other Plan which has covered such person the shorter period of time.
 - (ii) If the individual covered under this Plan is also covered under any Other Plan, which is a group contract underwritten by the Insurance Carrier, other than a contract which provides cash benefits to the individual, the rules set forth in this subsection 5.8 establishing the order of benefit determination shall be applicable whether or not such other group contract contains a provision coordinating its benefits with those of this Plan.
 - (iii) Upon receipt of evidence satisfactory to the Claims Administrator in its discretion that an individual covered under this Plan contributed, with respect to the month in which expense for covered services was incurred, 50% or more of the monthly premium or subscription charge for coverage under any Other Plan, the benefits of such Other Plan will be disregarded for the purposes of determining the benefits under this Plan.
- (d) **Right to Receive and Release Necessary Information.** For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any Other Plan, the Claims Administrator or an Employer may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any individual covered under this Plan, which it deems to be necessary for such purposes. Any individual claiming benefits under this Plan shall furnish to the Claims Administrator or the Employer such information as may be necessary to implement this provision.
- (e) **Facility of Payment.** Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the Claims Administrator shall have the right in its discretion to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for Covered Services the Claims Administrator or the Company shall be fully discharged from liability under this Plan.
- (f) **Right of Recovery**
- (1) Whenever payments have been made by the Claims Administrator or the Employer with respect to Covered Services in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Claims Administrator or the Company, irrespective of to whom paid, shall have the right to recover such payments, to the extent of

such excess, from among one or more of the following as it shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

- (2) The Employee, for him or herself and on behalf of his or her Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Claims Administrator or the Employer.

5.9. Alcoholism and Drug Abuse Benefits.

- (a) Alcoholism and drug abuse benefits will be payable if a Participant becomes and remains necessarily confined as a patient in an Approved Residential Facility or receives treatment in an Approved Outpatient Facility as a result of alcoholism or drug dependency when payment is not otherwise provided by this Plan. Payment will be made for the actual fee or charge for covered services which are received in such a facility to the extent the fee or charge for such services is Usual and Customary.
- (b) Payment will be made for the following covered services in an Approved Residential Facility:
 1. Room and board, including nursing services.
 2. Laboratory examinations related to the treatment received at the facility.
 3. Drugs, biologicals and solutions dispensed by the facility for use during confinement.
 4. Supplies and use of equipment required for detoxification and/or rehabilitation (other than recreational, hobby, or craft) which conform to the treatment plan established by the Physician for the Participant.
 5. Professional and other trained staff and other ancillary services provided in the facility required for the care and treatment of the Participant. Ancillary services include all special institutional services and supplies charged by the facility except services and supplies not related or not necessary to the medical care and treatment of the Participant.
 6. Individual and group therapy for the Participant and individual counseling for the Participant to the extent that such counseling is necessary and related to the treatment of the Participant.
 7. Psychological testing of the Participant by a person legally qualified to administer and interpret such tests. Where there are no applicable licensure laws, such individual must be certified by the appropriate professional body for psychological testing.

- (c) Payment will be made for the following covered services in an approved Outpatient Facility:
1. Professional and other trained staff and other ancillary services provided in the facility required for the care and treatment of the Participant. Ancillary services include all special institutional services and supplies charged by the facility except services and supplies not related or not necessary to the medical care and treatment of the Participant.
 2. Individual and group therapy for the Participant and individual counseling for the Participant to the extent that such counseling is necessary and related to the treatment of the Participant.
 3. Laboratory examinations related to the treatment received at the facility.
 4. Drugs, biologicals, solutions and supplies dispensed at the facility which are related to the treatment received including take home drugs.
 5. Psychological testing of the Participant by a person legally qualified to administer and interpret such tests. Where there are no applicable licensure laws, such individual must be certified by the appropriate professional body for psychological testing.
- (d) Benefits for covered services received in an Approved Residential Facility shall not be payable for more than 45 days during any covered period of treatment; except that one day shall be deducted from such 45 days for each one day that a Participant receives hospital expense benefits and for each two days that a Participant receives nursing home benefits for room and board pursuant to subsection 5.20 (Hospital Expense Benefits) and 5.21 (Nursing Home Benefits) for confinements due to alcoholism, drug dependency, or nervous or mental conditions which are related to the treatment in the Approved Residential Facility and which occurred during the same covered period of treatment. A “covered period of treatment” means a period of treatment in an Approved Residential Facility, hospital and/or nursing home commencing with the date of the first admission therein and ending with the date of last discharge therefrom. Successive periods of treatment in an Approved Residential Facility, hospital or nursing home shall be considered as a part of the same period of treatment unless, in the case of a Participant, he or she returns to active full-time work after the end of the prior period of treatment for at least 60 consecutive days of work with the Company before beginning the succeeding period of treatment. No more than 140 days of confinement shall be payable during the lifetime of a Participant including in such maximum all hospital days primarily due to alcohol or drug abuse for which the Participant receives Hospital Benefits under subsection 5.20.
- Benefits for covered services received during visits to an Approved Outpatient Facility shall not be payable for more than 45 visits in a calendar year and for more than 140 visits during the lifetime of each Participant. For the purpose of

this subsection 5.9 a visit is considered to have occurred only if patient counseling or psychological testing of the patient has been provided and paid for by the Plan.

Benefits will not be paid for treatment in an Approved Residential or Outpatient Facility unless a Participant has been examined by a Physician and has been diagnosed by such Physician to have alcoholism or other drug dependency as classified in categories 303.0 - 305.0 and 305.2 - 305.93 of the Ninth Revision, International Classification of Diseases, Adopted for Use by the United States Department of Health and Human Services and unless treatment in such facility is rendered under the supervision and management of a Physician.

- (e) “Covered services” do not include and no benefits are payable for:
1. Charges for services for which benefits are otherwise provided under this Plan.
 2. Charges for personal and convenience items such as telephone, television, personal care items, and personal services.
 3. Charges for diversional activities such as recreational, hobby or craft equipment or fees.
 4. Charges for dispensing of Methadone and/or taking of urine specimen without individual or group therapy, individual counseling or psychological testing.
 5. Charges for services rendered primarily in connection with disorders other than alcoholism or drug dependence.
- (f) For purposes of this subsection 5.9 an “Approved Residential or Outpatient Facility” means a facility providing detoxification and rehabilitation services approved by the Claims Administrator in its discretion. In no event will the term “Approved Residential or Outpatient Facility” include an institution or a part thereof which is used primarily as a rest home, a home for the aged, a nursing home, a sheltered care facility, or a place for the treatment of mental disease.

5.10. Ambulance Benefits. Expenses for local ambulance services will be paid if medically necessary (as determined by the Claims Administrator in its discretion) and the Participant (a) is transported by ambulance from the place where injured or stricken by illness to the nearest facility where necessary medical treatment can be rendered; or (b) is transported from a hospital where medically required services are not available to the nearest hospital where such services are available; or (c) with respect to air ambulance, is transported to a hospital because of the reason stated in (b) and such method of transportation is medically required by the attending Physician (i.e., because of the individual’s medical condition, land transportation cannot be used) and is in fact an ambulance service and not a charter flight service.

5.11. Anesthesia Benefits. If hospital expense benefits are payable to or for the account of a Participant in accordance with subsection 5.20 (Hospital Expense Benefits), anesthesia

benefits will be payable for services rendered in connection with the administration of general anesthesia in a hospital by a Physician, or by a duly qualified registered nurse, when required by, and rendered in relation to, surgical, obstetrical, or in-hospital services for which benefits are payable under the Plan. Payment will be made for the actual amount charged for such services to the extent such amount is Usual and Customary. No benefits shall be payable under this paragraph for services rendered by the operating Physician or by an employee of a hospital. Payment may be made directly to the person rendering such services.

- 5.12. **Chemotherapy Benefits.** Chemotherapy benefits will be payable if a Participant undergoes treatment of malignancies using Chemotherapy as a result of an injury or sickness when payment for such treatment is not otherwise provided for under this Plan. Payment will be made for Chemotherapy which is administered and charged for by a Physician or administered in the outpatient department of a legally constituted hospital by a Physician and charged for by a hospital for the actual amount charged to the extent such charge is Usual and Customary. Payment may be made directly to the Physician or Hospital.
- 5.13. **Dental Expense Benefits.** Dental expense benefits will be payable, subject to the conditions herein, if a covered Participant, while dental expense coverage is in effect with respect to such Participant, incurs covered Dental Expenses. Covered Dental Expenses shall not include any service received prior to the date coverage takes effect with respect to a Participant.
- (a) The maximum amount payable for all Covered Dental Expenses under this subsection 5.13 in any calendar year (except those expenses for orthodontic treatment) shall be \$1,500 for each Participant. The maximum amount payable under this subsection 5.13 for covered orthodontic treatment under item (c)(iii)(4) below shall be \$1,500 for each Participant for all such expenses incurred during the lifetime of each such Participant.
- (b) A separate calendar year deductible amount of \$50 will be applied to Covered Dental Expenses under this subsection 5.13, except for Covered Dental Expenses as provided under subparagraphs (c)(i)(1), (c)(i)(2), (c)(i)(3), (c)(i)(5), (c)(i)(6), and (c)(iii)(4).
- The deductible amount will apply to each Participant, except that it will not apply to Covered Dental Expenses after: (i) at least two covered family members incur Covered Dental Expenses; and (ii) those expenses when applied to the deductible amount equal two times the deductible amount; however, in any event, no one family member may have more than \$50 applied toward such deductible amount. If an Employee and his spouse both are Employees or former Employees and are both covered under a plan sponsored by the Employer, the deductible amount will apply to each spouse separately.
- (c) “Covered Dental Expenses” are the Usual and Customary charges of a Physician which an Employee is required to pay for the following dental services and supplies received, while coverage is in effect, for the necessary dental treatment.

(The amount of payment for dental expenses shall be governed by professional consideration of the procedures, services or courses of treatment that are customarily provided by the dental profession consistent with sound professional standards for the dental condition concerned.) Only Necessary Dental Services are covered under the Plan. The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is covered under the Plan.

- (i) Payment shall be made for 100% of the fee charged (to the extent Usual and Customary) for the following services:
 - (1) Oral examinations including prophylaxis (scaling and cleaning of teeth), but not more than two examinations or more than two prophylaxes in any calendar year.
 - (2) Topical application of fluoride; except that benefits will not be payable for the application of fluoride to a Participant age 20 or more unless such application is necessary for hypersensitive teeth.
 - (3) Space maintainers that replace prematurely lost teeth for a Dependent Child under 19 years of age.
 - (4) Emergency palliative treatment.
 - (5) Sealants – Limited to covered persons under the age of 16 years and once per first or second permanent molar, every five years.
 - (6) Dental x-rays, but not more than one full mouth x-ray in any period of 60 consecutive months; and supplementary bitewing x-rays but not more than once in any calendar year; and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

- (ii) Payment shall be made for 80% of the fee charged (to the extent Usual and Customary) for the following services:
 - (1) Extractions
 - (2) Oral surgery (except for implant surgery under item (c)(iii)(5) below).
 - (3) Fillings.
 - (4) General anesthetics administered in connection with oral surgery or other covered dental services.
 - (5) Treatment of periodontal and other diseases of the gums and tissues of the mouth. (Payment shall be made for 50% of

bridgework required in connection with such treatment.) Only one of the following procedures will be covered per quadrant or site per 36 month period: crown lengthening, gingivectomy, osseous graft, osseous surgery.

- (6) Endodontic treatment, including root canal therapy.
 - (7) Injection of antibiotic drugs by the attending Physician.
 - (8) Cosmetic bonding of eight (8) front teeth (teeth 5 through 12 on the upper dental arch and teeth 21 to 28 on the lower dental arch) for children 8 through 19 years of age if required because of severe tetracycline staining, severe fluorosis, hereditary opalescent dentin, or amelogenesis imperfecta, but not more frequently than once in any period of 3 consecutive calendar years. Charges for such services shall be payable only if such services have been preauthorized prior to the commencement of such services.
- (iii) Payment shall be made for 50% of the fee charged (to the extent Usual and Customary) for the following services:
- (1) Initial installation of fixed bridgework (including inlays and crowns to form abutments).
 - (2) Initial installation (including adjustments during the six-month period following installation) of partial or full removable dentures.
 - (3) Replacement of existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:
 - (aa) The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
 - (bb) The existing denture or bridgework was installed at least five years prior to its replacement (however, this five-year rule does not apply to dentures or bridgework for which no benefit was paid under the Plan) and the existing denture or bridgework cannot be made serviceable; or
 - (cc) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within twelve months from the date of installation of the immediate temporary denture.

Normally dentures will be replaced by dentures but if achieving a professionally acceptable course of treatment requires bridgework, such bridgework will be a Covered Dental Expense.

- (4) Orthodontic treatment consisting of appliance therapy and functional/myofunctional therapy; except that benefits will not be payable for such treatment for a Participant age 22 or older. Dental x-rays and surgical therapy (including extractions) are covered under separate items as listed above.
- (5) Initial installation of implants.
- (6) Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures (limited to relining done more than 6 months after the initial insertions).
- (7) Inlays; gold fillings; crowns (including precision attachments for dentures) limited to one tooth every 60 months.

Hospital Board and Room Expenses, and the charges of a hospital for necessary hospital services and supplies, in connection with injuries or diseases of a dental nature, are included under hospital expense benefits and not under Dental Expense Benefits.

(d) Pre-Determination of Benefits.

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of more than \$200, a description of the procedures to be performed and an estimate of the Physician's charges must be filed with the Claims Administrator prior to the commencement of the course of treatment. The Claims Administrator will notify the Employee and the Physician of the benefits payable based upon such course of treatment and of the expenses not covered. The expenses to be paid will be certified by the Claims Administrator as payable under this subsection 5.13. The Claims Administrator will determine the amount of benefit payable in its discretion.

If a description of the procedures to be performed and an estimate of the Physician's charges are not submitted in advance, the Claims Administrator shall in its discretion make a determination of benefits payable under this subsection 5.13.

This pre-determination requirement will not apply to courses of treatment under \$200 or to emergency treatment, oral examinations, x-rays, or prophylaxis. A course of treatment is one or more treatments in a planned series resulting from a dental examination.

(e) Limitations

A. Restorative:

- Gold, baked porcelain restorations, crowns and jackets. If a tooth can be restored with a material such as amalgam, appropriate payment for that procedure will be made toward the charge for another type of restoration

selected by the patient and the Physician. The balance of the treatment charge will not be payable under the Plan.

- Reconstruction. Appropriate payment will be made toward the cost of procedures necessary to eliminate oral diseases and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion will be considered optional and their cost will not be payable under the Plan.

B. Prosthodontics:

- Partial Dentures. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, Dental Expense Benefits will cover the applicable percentage of the cost of such procedure toward a more elaborate or precision appliance that the patient and Physician may choose to use, and the balance of the cost will not be payable under the Plan.
- Complete Dentures. If, in the provision of complete denture services, the patient and the Physician decide on personalized restorations or specialized techniques as opposed to standard procedures, Dental Expense Benefits will be allowed for the appropriate amount for the standard denture service toward such treatment, and the balance of the cost will not be payable under the Plan.
- Replacement of Existing Dentures. An existing denture will be replaced only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to render such appliances satisfactory will be provided in accordance with the Plan.

Prosthodontic appliances will be replaced only after five years have elapsed following any prior provision of such appliances under the Plan. (This five-year limitation applies only to appliances provided under the Plan. It does not apply to any such appliances for which no benefit was paid under the Plan.)

C. Orthodontics:

- If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination.
- The monthly benefit payment obligation under the orthodontic benefits provision shall cease on the termination date of the Insurance Plan Agreement, unless renewed or extended.

- (f) Exclusions. Covered Dental Expenses do not include and no benefits are payable for:

- (i) Charges for which benefits are otherwise provided under this Plan.
- (ii) Charges for treatment by other than a Physician except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the Physician.
- (iii) Charges for services and supplies that are solely cosmetic in nature, including charges for personalization or characterization of dentures.
- (iv) Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the individual was not covered for dental expense benefits or which were ordered while the individual was covered for dental expense benefits but are finally installed or delivered to such individual more than sixty days after termination of coverage.
- (v) Charges for the replacement of a lost, missing or stolen prosthetic device.
- (vi) Charges set forth as "exclusions" in any other sections of the Plan.
- (vii) Charges for failure to keep a scheduled visit with the Physician.
- (viii) Charges for replacement or repair of a broken orthodontic appliance.
- (ix) Charges for facility usage. For purposes of this paragraph, the term "Facility" means a health care facility that is not a hospital.
- (g) Definition of Orthodontic Treatment. The term "Orthodontic Treatment" means the preventative and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning of teeth to establish normal occlusion.
- (h) Coordination with other Dental Expense Benefits. The Claims Administrator shall follow the same procedures with respect to dental expense benefits concerning coordination of benefits as are set forth in subsection 5.8.
- (i) Definition of "Physician." For the purposes of this subsection 5.13, the term "Physician" means a legally licensed Dentist or Doctor of Dental Surgery practicing within the scope of his license. For the purposes of this paragraph, the term "Physician" also includes a legally licensed physician authorized by his license to perform the particular dental services he has rendered.
- (j) Claims Review. The Claims Administrator reserves the right to require verification of any alleged fact or assertion pertaining to any claim for Covered Dental Expenses.
- (k) Participating Provider Contracts. The Claims Administrator may attempt to establish direct or indirect participating provider contracts with Physicians as

defined under (i) above, or other providers or facilities, or may enter into agreements with a network administrator in areas where the Employer has Employees.

- 5.14. Diagnostic X-ray and Laboratory Examination Benefits. Diagnostic x-ray and laboratory examination benefits, but not Office Call benefits, will be payable (a) if a Participant undergoes a diagnostic x-ray or laboratory examination (including sonography and fetal monitoring) as a result of any injury or sickness, provided that such examination is upon the order of a Physician, or (b) if a Participant undergoes a diagnostic X-ray or laboratory examination, as part of a non-hospital based preadmission testing program approved by the Claims Administrator in its discretion and which meet the requirements for admission to a hospital or outpatient surgical facility for the performance of a covered surgical procedure. (Criteria for approval of a non-hospital based preadmission testing program shall include utilization of a State licensed laboratory and/or X-ray equipment, agreement by the admitting hospital or surgical facility to accept, without duplication, test results submitted by the physician, and an acceptable price schedule.) Such benefits may be paid directly to the person or organization performing such service. Payment will be made for the actual amount charged to the extent that such charge is Usual and Customary. No benefit shall be payable under this subsection 5.14 for any of the following examinations: examinations in connection with dental work, procedure or treatment; examinations and tests in connection with routine or periodic physical, premarital, or similar examinations or tests not required in and directly related to diagnosis of illness or injury (other than routine papanicolaou test, i.e., pap smears); and examinations for which benefits are payable under subsection 5.20 (Hospital Expense Benefits) of this Section; nor shall benefits be payable for more than the number of examinations which are generally accepted by the Claims Administrator in exercise of its discretion to be sufficient to diagnose the condition involved. Benefits will be payable for routine papanicolaou tests, i.e., laboratory analysis of pap smears. Routine screening mammograms will be covered under the following schedule: one mammogram between the ages of 35 and 39 and one mammogram every year for those age 40 and over.
- 5.15. Durable Medical Equipment Benefits. Durable Medical Equipment benefits will be payable if Durable Medical Equipment is received by a Participant on the order of a Physician for use, when used in an outpatient setting, for the treatment of injury or sickness or to improve the functioning of a malformed body member when payment for such equipment is not otherwise provided for under this Plan. Payment will be made of the actual amounts charged for the rental of such equipment to the extent such charges are Usual and Customary and do not exceed the purchase price. Payment may be made directly to the provider or supplier of the equipment. The Claims Administrator in its discretion may approve the purchase of such equipment if it can reasonably be assumed that the duration of need is such that the rental price would exceed the purchase price, or said item cannot be made available on a rental basis.

“Durable Medical Equipment” means medical equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for medical treatment in the home.

Benefits will not be paid for special features or equipment requested by the patient for personal comfort or convenience unless medically necessary. "Durable Medical Equipment" does not include, for example, dentures; hearing aids; eyeglasses; contact lenses; equipment which is primarily and customarily used for non-medical purposes; devices and equipment used for environmental control or to enhance the environmental setting in which the patient is placed; equipment which basically serves comfort or convenience; equipment which basically is utilized for hygienic purposes; prosthetic devices; and any other item or device which does not stand repeated use or which does not serve a meaningful and necessary therapeutic purpose in the care and treatment of the patient. The Claims Administrator shall have discretion to make the final determination as to whether equipment is medically necessary.

- 5.16. Emergency First-Aid Benefits. Emergency first-aid benefits will be payable if a Participant sustains an accidental injury and receives initial emergency first-aid services rendered by a Physician on account of such injury when payment for such services is not otherwise provided for under this Plan. Payment will be made for the actual fee of the Physician to the extent such fee is Usual and Customary. In addition emergency first-aid benefits will include initial emergency first-aid services rendered by a Physician for a medical emergency when payment for such services is not otherwise provided for under this Plan. Payment will be made for the actual fee of the Physician to the extent such fee is Usual and Customary. Initial emergency first-aid services shall not include any follow-up services. Benefits may be provided to more than one Physician for the initial examination and treatment if the Participant is referred from one Physician to a second Physician because of the patient's condition and the second Physician's specialization, in which case payment will be made for the actual fee of each Physician to the extent such fee is Usual and Customary. Such benefits may be paid directly to the Physician.
- 5.17. Hemodialysis Benefits. Hemodialysis benefits will be payable if a Participant receives the use of an artificial kidney machine for hemodialysis upon the order of a Physician while confined in a hospital; in the hospital outpatient department; or in the Participant's home. Payment will be made for the actual amount charged, to the extent such amount is Usual and Customary.
- 5.18. Home Health Care Benefits
- (a) Home Health Care benefits will be payable for services rendered to a Participant in his home or other non-institutional setting or residence by an authorized Home Health Care Agency (where "authorized" means an agency approved by Medicare and licensed by the state in which care is delivered to provide the full array of covered services; which agency may be affiliated with a hospital or nursing home) in accordance with a planned course of treatment ordered by a Physician which (1) begins immediately following a period of covered hospital confinement for which benefits were payable under subsection 5.20 (Hospital Expense Benefits) or a period of covered nursing home confinement for which benefits were payable under subsection 5.21 (Nursing Home Benefits) and is for the continued treatment of the injury or sickness which caused such confinement; or (2) the treatment of an injury or sickness which the Physician certifies requires the skilled services provided by a Home Health Care Agency and the patient is homebound for

medical reasons and physically unable to obtain the necessary medical services on an outpatient basis and, in either case, the planned course of treatment must be accepted by the patient and immediate care givers and approved by the Claims Administrator in its discretion.

During such period of treatment, the Participant must continue to be under active medical supervision, and the Physician must certify to the Claims Administrator that continuing Home Health Care services are medically necessary for the proper treatment of the Participant's specific condition, and that the lack of such treatment would require covered medically necessary confinement in a hospital or nursing home if not provided by a Home Health Care Agency.

Benefits will only be payable, unless otherwise covered under the Plan, when the treatment plan and level of skill of those providing the treatment and care have been approved by the Claims Administrator in its discretion prior to commencement of the treatment plan in the non-institutional setting. Non-notification to the Claims Administrator prior to the commencement of treatment will reduce the amount of benefits otherwise payable by \$100.

In general, the treatment plan and services will be approved in accordance with the following:

- (i) The medical condition at the time the proposed treatment plan is submitted for approval is such that it would otherwise require a medically necessary covered confinement in a hospital or nursing home, and
 - (ii) the proposed treatment plan's projected costs do not exceed the costs of hospital or nursing home confinement that otherwise would have been covered by the Plan, and
 - (iii) the duration of the Home Health Care services does not exceed the normal period to obtain the desired medical objective, not taking into account complications, and
 - (iv) the therapies ordered are consistent with the planned rehabilitative goals.
- (b) Benefits shall be payable for the Home Health Care services listed below for the actual amount charged for such services, to the extent such charge is Usual and Customary.
- (i) part-time or intermittent nursing care by a Registered Nurse (RN),
 - (ii) part-time or intermittent therapy services by a Registered Physical Therapist (RPT) or "qualified speech therapist" as defined in subsection 5.22 (Outpatient Physical or Speech Therapy Benefits),
 - (iii) part-time or intermittent nursing care by a Licensed Practical Nurse (LPN) under the supervision of an RN,

- (iv) part-time or intermittent home health aide services, occupational therapy and nutritional guidance provided by the Home Health Agency under the supervision of a RN or RPT and in conjunction with approved RN or RPT services and these services are required for the patient to remain non-institutionalized, and
 - (v) medical supplies and solutions related to the skilled need for which the Participant qualifies for coverage.
- (c) Such benefits shall not be payable for more than 100 home care visits per calendar year. A home care visit consists of each visit to the patient's home by any member of the Home Health Care Agency (if two or more visits are made by one member in a day, each visit is counted as a separate visit; if two or more members make a visit in a day each visit by each member is counted as one visit) for the purpose of providing necessary covered Home Health Care services and a Home Health Care visit will be counted even though the patient is not seen if the visit is made in good faith, *i.e.*, the agency is not notified prior to the visit that the patient is not available.
- (d) Expenses are not covered for:
- (i) services of a person who ordinarily resides in the home or non-institutional place of residence of the Participant or is a member of the Participant's family,
 - (ii) services and supplies not related to medical care or treatment (including housekeeping services),
 - (iii) services rendered in any period during which the Participant is not under the active care and treatment of a Physician,
 - (iv) custodial care and transportation services,
 - (v) benefits or services otherwise provided under the Plan,
 - (vi) hyperalimentation nutrients taken orally or by tube or used as a feeding modality to repair or prevent nutritional deficiencies or to boost protein-caloric intake, or nutrients delivered to the Participant's residence but not used
 - (vii) services not approved by the Claims Administrator in its discretion, or
 - (viii) services provided by a non-authorized agency.

5.19. Hospice Benefit.

- (a) Hospice benefits will be payable for service rendered to a Participant in such person's home or other non-institutional place or residence by an authorized Hospice Agency (authorized means an Agency approved by Medicare and

licensed by the state to provide hospice related services) when the Participant has been certified by the Physician as being Hospice appropriate.

Benefits will only be payable, unless otherwise covered under the Plan, when the treatment plan and level of skill of those providing the treatment and care have been approved by the Claims Administrator prior to commencement of the treatment plan in the non-institutional setting. Non-notification to the Claims Administrator prior to the commencement of treatment will result in a non-notification reduction of \$100 for covered expenses under the Plan.

Coverage will be approved in accordance with the guidelines of the Claims Administrator.

- (b) Benefits shall be payable for the Hospice Services provided in the person's home or other non-institutional place of residence listed below for the actual amount charged for such services, to the extent such charge is Usual and Customary. Additionally, benefits are not payable for the services listed below which exceed the costs of room and board in a skilled nursing facility which are payable under (c) below.
 - (i) Part-time or intermittent nursing care by a Hospice Registered Nurse,
 - (ii) part-time or intermittent nursing care by a Hospice Licensed Practical Nurse (LPN) under the supervision of an RN,
 - (iii) intermittent Medical Social Worker visits,
 - (iv) part-time or intermittent home health aide services which are (1) in conjunction with approved RN services, and (2) required for the patient to remain non-institutionalized, and
 - (v) medical supplies and solutions related to the Hospice care.
- (c) In lieu of the services listed in (b) above, the Claims Administrator may determine that the patient would qualify for coverage of room and board in a skilled nursing facility. The Claims Administrator must be contacted prior to hospice placement in the skilled nursing facility. At no time will coverage of room and board in a skilled nursing facility be available simultaneously with the services listed in (b) above.
- (d) Expenses are not covered for:
 - (i) services of a person who ordinarily resides in the home or non-institutional place of residence of the Participant or is a member of the Participant's family,
 - (ii) services and supplies not related to medical care or treatment (including housekeeping services),

- (iii) custodial care (except when rendered in conjunction with approved RN hospice services, and when required for the patient to remain non-institutionalized),
- (iv) transportation services,
- (v) benefits or services otherwise provided under the Plan,
- (vi) hyperalimentation nutrients taken orally or by tube, or used as a feeding modality to repair or prevent nutritional deficiencies or to boost protein-caloric intake, or nutrients delivered to the person's residence but unused,
- (vii) services not approved by the Claims Administrator, or
- (viii) services provided by a non-authorized agency.

5.20. Hospital Expense Benefits. Hospital expense benefits will be payable if a Participant becomes and remains necessarily confined as a patient in a legally constituted hospital upon the order of a Physician as a result of an injury or sickness. In determining whether a confinement which is primarily diagnostic in nature meets the requirement that such confinement be necessary and as a result of injury or sickness, the performance during such confinement of a diagnostic procedure meeting one or more of the criteria set forth below will be considered as meeting such requirement --

- (a) those procedures where confinement is mandatory,
- (b) those procedures where advance preparation of the patient could be done only as an inpatient,
- (c) those procedures that require hospitalization for the safety of the patient or success of the test, or
- (d) those procedures where there is a concurrent medical hazard and as a result the patient could not have the test performed as an outpatient.

No benefits will be payable unless during such confinement the Participant is admitted as a bed patient in accordance with the hospital's rules and regulations regarding admission or undergoes a surgical operation in the hospital, or receives emergency care in the hospital on account of, and not later than the day following, an accidental injury or the onset of a Medical Emergency; or the Participant undergoes x-ray or laboratory examinations, as part of a pre-admission testing program approved by the Claims Administrator in its discretion, for performance of a covered surgical operation. For purposes of this paragraph, in the case of a Child who is born in such hospital, the hospital confinement shall be deemed to commence on the date of birth. If the Participant receives ward or semiprivate room accommodations, payment will be made for the actual amount charged by the hospital for room and board; or if the Participant receives private room accommodations, payment will be made for the actual amount charged up to the hospital's most common semiprivate room rate (or up to the charge for the lowest priced private room accommodation available when initially so confined for

any period of confinement the hospital certifies that the requested semiprivate room accommodations were not available); or if the Participant is confined in an isolation room required by infectious diseases requiring routine or reverse isolation such as infectious hepatitis, or spinal meningitis, or required for the treatment of severe burns where a germ-free environment is mandatory, payment will be made for the actual amount charged by the hospital for the room and board; for each day of confinement. For confinements due to alcoholism and drug abuse, refer to subsection 5.10 (Alcoholism and Drug Abuse Benefits). Payment will also be made for the actual amounts charged for Special Hospital Services received during the days of hospital confinement for which payment for room and board charges will be made in accordance with this paragraph. The term "Special Hospital Services" means anesthetics (and the administration thereof by an employee of the hospital) received during such confinements, chest x-rays (screening), and all other special hospital services and supplies charged for by the hospital except services and supplies not related or not necessary to the medical care and treatment of the person confined and except the services of physicians, surgeons, or special nurses other than nursing services provided by the special nursing units generally referred to as Intensive Care Units operated as a part of the hospital's progressive care program. Hospital expense benefits may be paid directly to the hospital. For emergency room benefits a co-payment of \$75 will be applied; provided that, such emergency room co-payment shall be waived if the Participant is admitted to a hospital from the emergency room.

No more than 140 days of confinement shall be payable during the lifetime of a Participant for confinements primarily due to alcohol or drug abuse including in such maximum all Hospital and Approved Residential Facility days for which the Participant receives benefits under this subsection or subsection 5.10 (Alcoholism and Drug Abuse Benefits).

Benefits under this subsection 5.20 shall be payable when a Covered Organ Transplant is performed in an Approved Organ Transplant Center as provided for in paragraph 5.30(b) (Human Organ Transplants). Benefits under this subsection 5.20 shall be payable for 50% of the charge when a Covered Organ Transplant is performed in a hospital or facility which is not an Approved Organ Transplant Center under subsection 5.30(b) (Human Organ Transplants).

5.21. Nursing Home Benefits.

- (a) Nursing Home benefits will be payable if a Participant becomes and remains necessarily confined in a Nursing Home (as defined herein) for the skilled treatment of an injury or sickness as determined by the Claims Administrator in its discretion. Confinements in the Nursing Home must be ordered by a Physician for the purpose of convalescing from an acute illness or injury that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. For benefits to be available, skilled nursing and/or skilled rehabilitation services must be needed on a daily basis, and the covered person must be expected to improve to a predictable level of recovery, and the Participant must continue to be under active medical supervision during

the confinement in the Nursing Home, and such Physician must certify to the Claims Administrator that continuing Nursing Home care is essential. Notification to the Claims Administrator is required prior to the commencement of treatment. Non-notification to the Claims Administrator prior to the commencement of treatment will result in a non-notification reduction of \$100 for otherwise covered expenses under the Plan.

- (b) Covered Nursing Home services shall include room and board in a semi-private room (a room with two or more beds) and those procedures prescribed by the Physician and employed in caring for the sick which require technical nursing skill beyond that which the ordinary untrained person can adequately administer. Such services may be provided by either professional or practical nursing personnel, so long as they extend beyond routine personal care.
- (c) Benefits shall be payable for the actual amount charged for the services described under the preceding paragraph (b) up to the Usual and Customary amount.
- (d) Benefits under this subsection 5.21 shall not be payable for:
 - (i) Periods of confinement when the Participant is not under the active care and treatment by a Physician.
 - (ii) Care in homes which exist primarily for care of tuberculosis, alcoholics, drug addicts, mental or nervous disorders, the blind, the deaf, or the mentally deficient.
 - (iii) Periods of confinement for which the primary carrier would have paid had the primary carrier's qualifying conditions been met. For example, an Employee has Medicare as the primary carrier. Medicare requires a qualifying hospital stay prior to admission to a skilled nursing facility. If the Employee is admitted to the skilled nursing facility without first having the qualifying hospital stay, the Claims Administrator in its discretion will estimate what Medicare would have paid, and then would pay as secondary.
 - (iv) Care in governmental or public financed or operated homes or institutions, or care in homes financed by charitable funds where no charge is customarily or traditionally made to the patient.
 - (v) Care in homes providing purely custodial care, including Shelter Care Homes and Homes for the Aged.
 - (vi) Care in homes wherein the skilled care is part of an agreement with the patient to provide lifetime care in consideration of a transfer of assets or a similar arrangement with no additional cost to the patient.
 - (vii) When skilled nursing and/or rehabilitation services are required intermittently (such as physical therapy three times a week.)

- (viii) Care which is primarily custodial, domiciliary, maintenance, personal care, or due to senility. For the purpose of this paragraph 5.21(d) “custodial, domiciliary or maintenance care” is care that may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs. For the purpose of this paragraph 5.21(d) “senility” means senile deterioration without a concurrent medical condition which requires confinement in a nursing home.
- (e) For the purposes of this paragraph the term “Nursing Home” means only an institution (or ward or wing thereof) that is operated solely to provide convalescent and long-term illness care and which (i) meets every one of the requirements for registration and continuing recognition as an Extended Care Facility by the Joint Commission on Accreditation of Hospitals, and (ii) is recognized under the Health Insurance for the Aged Act of the United States (Medicare) as an Extended Care Facility.

5.22. Outpatient Physical or Speech Therapy Benefits.

- (a) Outpatient physical therapy, occupational therapy, and cardiac rehabilitation benefits will be payable for services performed for a maximum of \$10,000 per calendar year combined when prescribed by a Physician for Participant for a specified condition resulting from disease or injury or prescribed immediately following surgery related to the condition and when the physical therapy is performed in the outpatient department of a Hospital, in a Nursing Home as defined under subsection 5.21 (Nursing Home Benefits) of the Plan, or other facilities such as Rehabilitation Centers having comprehensive physical therapy facilities and approved by the Claims Administrator in its discretion. Such services must be performed by a Physician or a qualified physical therapist according to prescription from a Physician concerning the nature, frequency and duration of treatment. A “qualified physical therapist” is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association or its equivalent, and, where applicable, is licensed by the state. Payment will be made for the actual charge for such therapy or consultation to the extent such charge is Usual and Customary.
- (b) Outpatient speech therapy benefits will be payable for services performed for a maximum of \$3,000 per calendar year when:
 - (i) prescribed by a Physician for a Participant for a residual speech impairment resulting from (i) a cerebral vascular accident or (ii) accidental injury to the head or neck or (iii) surgery to the head or neck or (iv) for children under age 6 (benefits will be paid after attainment of age 6 for continuous treatment which began before age 6), congenital and severe

developmental speech disorders, and where therapy is not available through public agencies (e.g., state, school), and

- (ii) the speech therapy is performed in the outpatient department of a Hospital, in a Nursing Home as defined under subsection 5.21 (Nursing Home Benefits) of the Plan, or in other facilities (such as speech rehabilitation centers as a part of a university speech program) having comprehensive speech therapy facilities which are approved by the Claims Administrator in its discretion.

No benefits shall be payable for long standing, chronic conditions or inherited speech abnormalities. Such services must be performed by a qualified speech therapist according to a prescription from a Physician concerning the nature, frequency and duration of treatment. A “qualified speech therapist” is an audiologist who (i) possesses a Master’s or Doctorate Degree in Audiology and Speech Pathology from an accredited university, (ii) possesses a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association and (iii) where applicable, is licensed by the state. Payment will be made for the actual charge for such therapy to the extent such charge is Usual and Customary.

- 5.23. Physicians’ Attendance Benefits. Except as otherwise provided below, if hospital expense benefits are payable to or for the account of a Participant in accordance with subsection 5.21 (Hospital Expense Benefits), in-hospital Physicians’ attendance benefits will be payable for professional visits made by the Physician in charge of the case to the Participant on account of whose confinement such hospital expense benefits are payable; provided that in-hospital Physicians’ attendance benefits will be payable only for professional visits made during the period of hospital confinement for which such hospital expense benefits are payable. In-hospital Physicians’ attendance benefits will not be payable for any visits during a hospital confinement of a Participant which is primarily due to surgery except that benefits will be payable for any visit during such confinement for the treatment of a separate condition which is unrelated to such surgery. No payment shall be made for routine care of a newborn child, except for the initial examination of said child, when provided and billed by a Physician other than the delivering Physician or the Physician who administered the anesthesia during the delivery. Payment will be made for the actual fee charged to the extent that such charge is Usual and Customary. Benefits may be paid directly to the Physician.
- 5.24. Physicians Consultation Benefits. If hospital or nursing home expense benefits are payable to or for the account of a Participant in accordance with subsections 5.20 (Hospital Expense Benefits) or 5.21 (Nursing Home Benefits), Physicians’ consultation benefits will be payable for the consultation services (other than staff consultations required by the hospital or nursing home’s rules or regulations) rendered by a Physician, to the Physician in charge of the case, during the hospital or nursing home confinement for which hospital or nursing home expense benefits are payable for a condition requiring the assistance of a consulting Physician with the special skill and experience needed in the treatment of such condition. Payment will be made for the consulting Physician’s

actual charge to the extent Usual and Customary. Such benefits may be paid directly to the Physician rendering the consultation services.

5.25. Prescription Drug Benefits.

- (a) Prescription Drug expense benefits will be payable if a Participant, as a result of an injury or sickness, incurs expenses for covered Prescription Drugs and such Prescription Drugs are provided, upon the written order of a Physician or his/her legally licensed agent, by any pharmacy, Physician or any other person or organization legally licensed to dispense drugs within the United States.
- (b) Payment for such Prescription Drug Products will be made for each prescription and refill of a prescription to the extent it is a Legend Drug. The amount of payment is subject to the formulary classification of the prescription, its corresponding co-payment provisions, and other limitations of this subsection 5.25. Payment may be made directly to the person or organization dispensing the prescription or to the Participant.
- (c) Co-payments for Participating Provider Prescription Drug Products. The Participant is responsible for a co-payment for each prescription drug purchased from a Participating Provider as follows:
 - (i) Generic Drug Prescriptions. The Participant must pay \$5 for up to a one-month supply of a generic prescription drug.
 - (ii) Formulary Preferred and Compounded Medications. The Participant must pay \$20 for up to a one-month supply of a formulary preferred prescription drug or compounded prescription drug.
 - (iii) Formulary Non-Preferred. The Participant must pay \$35 for up to a one-month supply of a formulary non-preferred prescription drug.

A mail-order prescription drug program is available to a Participant covered under this Plan. The Plan will provide up to a 90-day supply of an eligible prescription drug after payment of the following: (i) one \$5 co-payment for a generic prescription drug; (ii) two \$20 co-payments for a formulary preferred prescription drug or a compounded prescription drug; and (iii) three \$35 co-payments for a formulary non-preferred prescription drug or brand-name prescription drug for which a generic drug is available.

One or more of the co-payment amounts described above in this paragraph (c) may be adjusted by the Company to an amount not in excess of (A) as of January 1, 2008, the lesser of (i) \$6, under subparagraph (c)(i) above; \$25, under subparagraph (c)(ii), above; or \$45, under subparagraph (c)(iii), above; or (ii) in each case, the amount that results if the amount in subparagraph (c)(i), (ii), or (iii) is increased by the unadjusted percent change in the Medical Care Component of the Consumer Price Index for all Urban Consumers, U.S. City Average, as compared January 1, 2004; and (B) as of January 1 every three (3) years thereafter, the amounts that result if the amounts in effect are increased by the

unadjusted percent change of the Medical Care Component of the Consumer Price Index for all Urban Consumers, U.S. City Average, as compared to the January 1, three (3) years earlier. Such Consumer Price Index data may relate to an equivalent earlier period (e.g., using the preceding October 1 instead of January 1 for the beginning and end dates), if necessary to administer this subsection. The same adjustment shall be applied to the dollar co-payment amounts for mail-order described in the preceding paragraph, which will continue to be subject to the multiples described in that paragraph.

- (d) Non-participating Provider. The Participant is responsible for co-insurance for each prescription drug purchased from a non-Participating Retail Provider as follows:
 - (i) If the Participant purchases a prescription from a non-Participating Provider in the network service area in which the Participant resides or works, then the Participant shall be responsible for 50% of the actual medication and dispensing charge.
 - (ii) If the Participant is traveling outside the defined network service area in which the Participant resides or works, the co-payment provisions of paragraph (c) above shall apply to prescriptions purchased from any non-Participating Provider.

- (e) Notwithstanding any provision to the contrary, benefits under this subsection 5.25 shall be limited as follows:
 - (i) Prescription drugs must meet approved indications established by the FDA or by the Claims Administrator.
 - (ii) Prescription drugs must be prescribed by a Physician or his or her legally licensed agent covered under the plan who is acting within the scope of his or her license.
 - (iii) The Claims Administrator has the discretion to limit quantities for dosage optimization.
 - (iv) The Claims Administrator has the discretion to limit quantities as determined by the FDA or by the Claims Administrator.
 - (v) Certain Prescription Drug Products require prior authorization to determine benefit coverage.
 - (vi) The Claims Administrator has the discretion to require, as a condition to reimbursement, that a Participant obtain all or a defined group of drugs or services from a single participating provider or pharmaceutical vendor.
 - (vii) Multiple prescription drugs, when packaged as a unit, will require a co-payment (or co-insurance payment, if purchased from a non-Participating Provider in the network service area) for each prescription drug.

- (viii) The following brand name medications will be covered at the applicable formulary co-payment level: Coumadin, Dilantin, Lanoxin, Tegretol, and Synthroid.
 - (ix) Prescription drugs will be limited to a one-month supply except when the mail-order option is utilized.
 - (x) Coverage of Non-Legend drugs is limited to insulin, needles and syringes. Insulin is subject to the formulary co-payment provision in paragraph 5.25(c). Needles and syringes are subject to the generic co-payment provision in subparagraph 5.25(c)(i).
 - (xi) Drugs purchased outside of the United States will be payable only if the Participant's primary residence is outside of the United States; provided that, the Claims Administrator also has the discretion to approve payment of the prescription drugs purchased outside of the United States when a Participant is traveling outside the United States. The formulary co-payment provision in subparagraph 5.25(c)(ii) will apply to approved purchases.
 - (xii) On and after January 1, 2008, (A) if the Pharmacy Payment Rate of a prescription drug purchased from a Participating Provider exceeds \$1,000, the Plan shall only reimburse the amount by which the Pharmacy Payment Rate exceeds \$100; and (B) if a prescription drug that is available by mail-order has a Pharmacy Payment Rate of more than \$3,000 for a 90-day supply, the Plan will only reimburse mail-order prescriptions for the amount by which the Pharmacy Payment Rate exceeds \$300 for a 90-day supply of such prescription drug.
- (f) Benefits under this subsection 5.25 shall not be payable for:
- (i) Any items limited or excluded by the medical plan, except where specifically provided;
 - (ii) Charges for vitamins; dietary drugs; immunizing agents; cosmetics or other health and beauty aids; fertility drugs; therapeutic devices and appliances; bandages, and similar supplies; support garments; and other non-medicinal substances;
 - (iii) Fluoride preparations;
 - (iv) Smoking cessation aids or deterrents;
 - (v) Non-Legend Drugs, Over-the-counter medications and Over-the-counter equivalents;
 - (vi) Drugs purchased as replacement prescriptions resulting from loss, theft, or breakage;

- (vii) Any drugs or items in excess of the specific limits described in this subsection 5.25;
- (viii) Charges for the administration of Prescription Drugs;
- (ix) Charges for Prescription Drugs incurred prior to the date coverage under this subsection became effective;
- (x) Charges for any prescription refill of covered prescription drugs in excess of the number specified by the Physician or any refill dispensed after one year from the date of the Physician's latest order;
- (xi) Charges for any prescription drugs for which the cost of the prescription is less than the co-payment amount; and
- (xii) Charges for which benefits are otherwise provided under this Plan.

For purposes of this paragraph:

- (i) "Brand-Name Drug" means a prescription drug product that is (a) manufactured and marketed under a trademark or name by a specific drug manufacturer, and (b) recognized as a brand-name product by the Claims Administrator in its discretion.
- (ii) "Compounded Drug" means a mixture of two or more medications, one of which must be a prescription drug, to treat a diagnosis. Over-the-counter drugs are not covered by the Plan.
- (iii) "Generic Drug" means a prescription drug product that is (a) chemically equivalent to a Brand-Name Drug, and (b) recognized as a Generic product by the Claims Administrator in its discretion.
- (iv) "Non-Preferred Drug" means any Brand-Name Drug that is not on the Claims Administrator's Preferred Drug List.
- (v) "Over-the-counter" drug means any drug or related medical remedy that is available without a prescription, including a drug which is prescribed in an equal, a lesser, or a higher dosage.
- (vi) "Over-the-counter Equivalent" means a drug or related medical remedy that is substantially equivalent to an over-the-counter drug or remedy.
- (vii) "Participating Provider" means any Physician, pharmacy or other organization legally licensed to dispense drugs which has entered into an agreement to provide Prescription Drugs under this Plan at their Pharmacy Payment Rate to be agreed upon between said Participating Provider and the Claims Administrator or such other organization as shall be responsible for providing the benefit; provided, however, that in no event

will the amount agreed upon exceed the Usual and Customary charge of the Participating Provider.

- (viii) “Pharmacy Payment Rate” means the payment a Participating Provider is entitled to receive, including any dispensing fee and any sales tax, for a particular Prescription Drug product dispensed to a Participant according to the terms of the applicable pharmacy provider contract.
- (ix) “Preferred Drug” means a Brand-Name Drug on the Claims Administrator’s Preferred Drug List.
- (x) “Preferred Drug List” identifies those Brand-Name Drugs preferred by the Claims Administrator in its discretion and is reviewed and modified periodically by the Claims Administrator in its discretion.
- (xi) “Prescription Drugs” and “Legend Drugs” mean any medical substance, the label of which under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: “Caution: Federal Law prohibits dispensing without prescription.”

5.26. **Prosthetic Device Benefits.** Prosthetic Device benefits will be payable if a prosthetic device is received as a result of an injury or sickness by a Participant on the order of a Physician when payment for such device is not otherwise covered under the Plan. Payment will be made for the actual amount charged for such device to the extent such charge is Usual and Customary. Payment may be made directly to the provider or supplier of such device. “Prosthetic Device” means a device which replaces all or part of a body organ (including contiguous tissue) or a diseased, malformed, or injured portion of the body or replaces all or part of the function of a permanently inoperative or malfunctioning body organ, or portion of the body furnished on the order of a Physician. Hearing aid benefits will be payable up to a maximum of \$500 for any such subsequent audiometric examination hearing aid evaluation test or hearing aid only if received more than 36 months after receipt of the most recent previous audiometric examination, hearing aid evaluation test or hearing aid, respectively, for which benefits were payable under the Plan. Replacements of unusable prosthetic devices or repairs or modifications of these devices when furnished on a Physician’s order and supplies and equipment not having any use other than in connection with the use of the prosthetic device and which are necessary for the effective use of the prosthetic device will also be covered. The term “Prosthetic Device” includes post-surgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed, or used to replace a congenitally absent lens of the eye. In addition, combinations of prosthetic lenses are covered when determined to be medically necessary by a Physician to restore essentially the vision provided by the crystallin lens of the eye. Devices such as dentures, other dental appliances (except for Mandibular Advancement Devices used to treat sleep apnea), and glasses and contact lens prescribed to correct visual defects are excluded. Also excluded are duplicates and replacement of stolen prosthetic devices, non-durable items such as support garments, special shoes (unless an integral part of a leg brace), and elastic support bandages.

5.27. Psychiatric Benefits.

- (a) Psychiatric benefits will be payable for psychotherapeutic services rendered to a Participant in connection with the treatment of any nervous or mental disorder (other than mental deficiency or retardation) as a result of an injury or sickness when payment is not otherwise provided by this Plan. Payment may be made directly to the person or institution rendering such services under the following circumstances:
 - (i) by a Physician when performed in such Physician's office, or
 - (ii) in the outpatient department of a legally constituted hospital, or
 - (iii) in the community mental health center facility.
- (b) Payment shall be made for such services under the following conditions for the actual fee or charge, except as otherwise provided herein, to the extent the fee or charge for such services is Usual and Customary:
 - (1) Payment will be made for all hospital, professional and other ancillary services (other than those described in subparagraph (5) below) received by an ambulatory Participant when such treatment is provided through such hospital's outpatient or Day Care Program.
 - (2) Payment will be made for all prescribed drugs and medications dispensed and charged for by such hospital outpatient department or Community Mental Health Center Facility rendering such treatments as a part of regular institutional care programs.
 - (3) Payment will be made for the fee charged for electroshock therapy (including the charge made by a Physician for the rendering of such therapy) and anesthesia for electroshock therapy when received in such hospital outpatient department or Community Mental Health Center Facility.
 - (4) Payment will be made for the fee charged for visits to the Physician's office during any calendar year by the Participant for the professional services rendered by such Physician.
 - (5) If a Participant is receiving treatment for which benefits are payable under the preceding subparagraph (4), payment will be made for the fee charged for visits to a Physician's office for counseling during any calendar year by other members of the family of the Participant undergoing treatment to the extent such visits are deemed necessary and related to the treatment of the Participant and are for the professional services of the Physician.
 - (6) Payment will be made for the fee charged for necessary group psychotherapeutic treatments

- (i) in the Physician's office, or
 - (ii) as a part of an approved outpatient program or Day Care Program of a hospital or Community Mental Health Center Facility if such program is approved by the Claims Administrator in its discretion.
- (7) Payment will be made for 100% of the fee charged for psychological testing by a legally licensed psychologist upon the order of a Physician when deemed necessary and related to the treatment of the mental and nervous disorder for which benefits are otherwise payable under this paragraph; provided, however, that the maximum amount payable under this subparagraph (7) in any calendar year for such psychological testing shall be \$200.
- (c) For the purposes of this paragraph, "Psychotherapeutic Services" means the treatment of mental illness (as defined by the American Psychiatric Association's current publication of the "Diagnostic and Statistical Manual of Mental Disorders, DSM – IV" and identified and treated as such by a Physician. "Community Mental Health Center Facility" means an institution providing treatment for mental illness which is associated with and is a part of a defined statewide community mental health program. "Day Care Program" means an approved therapeutic facility in a legally constituted hospital for patients with mental illness who spend part of a day in a planned treatment program in the facility.
- (d) A maximum of 40 visits per Participant per calendar year will be paid under this subsection 5.27.

5.28. Radiation Therapy Benefits.

Radiation therapy benefits will be payable if a Participant undergoes treatment of malignancies; tumors of bones, brain or spinal cord; hemangiomas; vascular nevi; lymphomas; leukemia; and thyroid disease utilizing generally accepted radiation therapy as defined by the Claims Administrator in its discretion, as a result of any injury or sickness when payment for such treatment is not otherwise provided for under this Plan. Payment will be made for radiation therapy which is administered and charged for by a Physician or administered in the outpatient department of a legally constituted hospital by a Physician and charged for by the hospital for the actual amount charged to the extent such charge is Usual and Customary. Payment may be made directly to the Physician or hospital.

- 5.29. Radiology Benefits. If hospital expense benefits are payable to or for the account of a Participant in accordance with subsection 5.20 (Hospital Expense Benefits), radiology benefits will be payable for services rendered in connection with the use of x-rays and other radioactive substances in a hospital by a Physician specializing in radiology including Magnetic Resonance Imaging, when required by, and rendered in relation to, services for which benefits are payable under the Plan. Payment will be made for the actual amount charged for such services to the extent such amount is Usual and Customary and to the extent not otherwise covered under the Plan. No benefits shall be

payable under this paragraph for services rendered by an employee of a hospital. Payment may be made directly to the Physician rendering such services.

5.30. Surgical Operation Benefits.

- (a) Surgical operation benefits will be payable if a Participant undergoes a covered surgical operation as a result of an injury or sickness, provided that such operation was ordered and performed by a Physician.

Payment will be made for

- (i) the actual surgical fee charged by the operating Physician, and
- (ii) the actual surgical fee charged by an assistant operating Physician if such assistant operating Physician actively assisted the operating Physician in performing a major surgical procedure recognized as a covered surgical operation under the Plan on a hospital in-patient basis, and if such operating Physician certifies that such assistance was necessary and that the services of interns, residents or house Physicians were not available

for those procedures defined by the Claims Administrator in its discretion to the extent that such total fee for such surgery, pre-operative care and post-operative care does not exceed the Usual and Customary charge for the surgical procedure performed. Pre-operative care means care in the hospital prior to surgery; and post-operative care means care in the hospital following surgery and any follow-up office visits, including the replacement of post-surgical casts.

Surgical operation benefits will also be payable for the actual fee charged by another Physician, in lieu of the operating Physician, providing post-operative care following a major surgical procedure for which surgical operation benefits are payable to the extent that the total charge by the operating Physician and Physician providing such post-operative care does not exceed the Usual and Customary charge for the surgical procedure performed.

If a Participant undergoes a covered surgical operation in an ambulatory surgical care facility legally licensed as a surgical center in the state in which such facility is located, special hospital services under subsection 5.20 (Hospital Expense Benefits) will be paid; provided, however, the charges for which such special hospital services are payable shall not exceed the Usual and Customary charge of the legally constituted hospitals in the area for the same or similar services. If a Participant undergoes a covered surgical operation in a Physician's office, surgical operation benefits shall be payable for necessary equipment and supply charges to the extent such charges are Usual and Customary.

Payment for obstetrical procedures shall include pre- and post-natal care. "Pre- and post-natal care" means all pre-natal office calls and generally accepted routine laboratory services as determined by the Claims Administrator in its discretion in connection with maternity care, hospital visits during confinement and the normal post-natal examination.

Surgical expense benefits may be paid directly to the operating or assistant operating Physician.

(b) Human Organ Transplants

Surgical Operation Benefits shall be payable if a Participant undergoes a Covered Organ Transplant in an Approved Organ Transplant Center as described in subsection 5.31 (Transplanted Organ or Tissue Benefits).

“Covered Organ Transplant” means transplantation of only procedures pre-approved by the Claims Administrator in its discretion, and shall not include any transplantation of any non-human organs, or artificial devices.

“Approved Organ Transplant Center” means only those medical centers which have been approved by the Claims Administrator in its discretion for organ transplantation benefits under this Agreement.

5.31. Transplanted Organ or Tissue Benefits. If benefits are payable pursuant to this Section V of the Plan to or for the account of a Participant, the initial medical expenses of a donor providing a transplanted organ or tissue to a Participant will also be considered as expenses for which medical expense benefits will be payable under this Section V of the Plan (subject to appropriate plan limits) to the extent not otherwise covered under this Plan or any other plan providing similar benefits.

5.32. Vision Care Benefits

(a) Vision care benefits will be payable, subject to the conditions herein, if a Participant incurs expenses for covered vision care services of an Ophthalmologist, Optometrist or Optician while vision care benefit coverage is in effect with respect to such Participant. Covered vision care services shall not include any services rendered or materials ordered prior to the date coverage takes effect with respect to a Participant.

(b) Payment will be made for the Usual and Customary charge for necessary covered vision care services to the extent that such charge does not exceed a maximum amount of \$150 payable once every other calendar year:

(i) One lens or set of lenses

(ii) Frames

(iii) Examination

(c) Exclusions -- Payment will not be made for the following:

(i) Lenses not requiring a prescription, except a plano lens when prescribed in conjunction with a prescription corrective lens in the same frame (a single vision lens benefit will be payable for the plano lens); and frames not furnished for covered lenses.

- (ii) Medical or surgical treatment of the eye.
 - (iii) Drugs or any other medication; and eyeglass cases and contact lens solutions.
 - (iv) Procedures or services determined by the Claims Administrator in its discretion to be special or unusual such as but not limited to orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography.
 - (v) Services rendered or materials ordered after the date the Participant ceases to be covered for vision care except for lenses and frames prescribed prior to such cessation of coverage and delivered within 30 days of the date prescribed.
 - (vi) Frames, lenses, or other materials necessitated by, or furnished as a condition of, employment with the Employers or the cost of examinations otherwise paid by the Employers.
 - (vii) Sunglass lenses, photosensitive lenses or anti-reflective lenses.
 - (viii) Charges for services for which benefits are otherwise provided under the Plan.
 - (ix) Charges for failure to keep a scheduled visit with the Ophthalmologist, Optometrist or Optician.
 - (x) Charges for vision testing examinations, lenses or frames which are not necessary, according to accepted standards of ophthalmic practice, or which are not ordered or prescribed by the attending Ophthalmologist or Optometrist.
 - (xi) Charges for vision testing examinations, lenses or frames which do not meet accepted standards of ophthalmic practice including charges for any such services or supplies which are experimental in nature.
 - (xii) Replacement of lenses or frames which are lost or broken.
- (d) Coordination with other Vision Care Benefits. The Claims Administrator shall follow the same procedures with respect to Vision Care Benefits concerning coordination of benefits as set forth in subsection 5.8 (Coordination of Benefits).
- (e) Participating Provider Contracts.

The Claims Administrator may attempt to establish direct or indirect participating provider contracts with suppliers of lenses and frames or other providers or facilities, or may enter into agreements with a network administrator in areas where the Employer has Employees.

5.33. Charges in Excess of Usual and Customary and Professional Review.

- (a) In the event that a Physician's charge for a covered medical or dental expense under this Section V of the Plan exceeds the Usual and Customary charge for the services performed, and it is clearly established that the Employee or Dependent has neither agreed to nor ratified such Physician's charge, the Company or the Insurance Carrier will take every reasonable action to resolve the difference between the actual amount charged and the Usual and Customary charge so that there is no residual payment due by the Employee or Dependent. In the event that legal action is brought by the Physician for such excess amount, the Company or the Insurance Carrier will undertake to provide the defense of such action, will pay the expenses of providing such defense, and will pay any resulting judgment entered against the Employee or Dependent. It is understood that in order to be relieved of his obligation for any amount in excess of the Usual and Customary charge, the person involved in such action will be obligated to testify, submit to examination, release information and to furnish any evidence in his possession upon request.
- (b) If a review committee or medical foundation, with whom the Company or the Insurance Carrier has an agreement for the continuing review of
 - (i) the necessity of services received in a hospital, nursing home or any other facility, and/or
 - (ii) the necessity of confinement in a hospital, nursing home or any other facility,

determines that any such services or any day or days of confinement are not necessary, then the Company or the Insurance Carrier will take every reasonable action to resolve the charges for the unnecessary services or day or days of confinement so that there is no residual payment due by the Employee or Dependent for such services, or any day of confinement, determined to be unnecessary by such review committee or medical foundation. The provisions of this paragraph 5.34(b) will apply if it is clearly established that the Employee or Dependent neither agreed to nor ratified the charges for days of confinement or services determined to be unnecessary. In the event that legal action is brought by the hospital or nursing home or any other facility for such charges, the Company or the Insurance Carrier will undertake to provide the defense of such action, will pay the expenses of providing such defense, and will pay any resulting judgment entered against the Employee or Dependent. It is understood that in order to be relieved of any obligation for any amount of such charges, the person involved in such action will be obligated to testify, submit to examination, release information and to furnish any evidence in his possession upon request.

SECTION VI
TERMINATION OF COVERAGE

6.1. Termination of Coverage.

- (a) An Employee's coverage under Sections IV and V (including Dependent Coverage if any such coverage is in effect with respect to the Employee) shall terminate on the last day of the calendar month in which such Employee ceases to be actively at work unless he returns to active work with his Employer during the same calendar month. Provided that, subject to payment of the applicable premium:
 - (i) such coverage on account of an Employee on layoff will be continued for a period of six months following the last day of the calendar month in which the Employee ceases to be actively at work (or in the case of an Employee reporting for reinstatement to his job with an Employer in accordance with the terms of a military leave of absence who is immediately placed on layoff, the last day in the calendar month in which the Employee is placed on layoff); provided, however, that the Employee had at least one year of Continuous Service on the last day in the calendar month in which the Employee is placed on layoff; and provided, further, that coverage in accordance with Section IV (other than weekly accident and sickness benefits) shall be continued beyond the last day of the calendar month in which such Employee completes thirty days of such layoff only if, during the thirty days preceding such last day of the month, he files a request for continuance of such coverage under Section IV on a form to be obtained from the Company and thereafter contributes monthly for such coverage the applicable rate for life insurance (Basic or Basic and Additional); at the end of six months of coverage, an Employee on layoff as described in this paragraph shall be permitted to continue coverage under Section V for a period of 12 additional months by filing a request therefor and contributing monthly for such coverage 102% of the applicable premium (as defined in and pursuant to subsection 6.3).
 - (ii) such coverage on account of an Employee on disability leave of absence shall be continued (A) in the case of an Employee who becomes disabled prior to his attainment of age 60 years, until the earlier of (1) the last day of the month in which he ceases to be on such disability leave of absence without returning to active work during the same calendar month, or (2) the last day of the month in which he attains age 65 years; provided that in no event shall coverage in accordance with Section IV be terminated prior to the last day of the month in which he attains age 65 years if he is receiving disability pension benefits under the Non-Contributory Pension Plan; and provided, further, that such Employee shall make the required contribution for Additional Life Insurance until the later of (a) the end of the first twelve months of such disability leave of absence, or (b) the date the Employee is eligible to receive benefits pursuant to subsection 4.3 (Long Term Disability Benefits); and (B) in the case of an Employee who

becomes disabled on or after attainment of age 60 years, until the earlier of (1) the last day of the month in which he ceases to be on such disability leave of absence without returning to active work during the same calendar month, or (2) the expiration of the period for which weekly accident and sickness benefits or long term disability benefits are paid to him under the Plan;

- (iii) such coverage (other than weekly accident and sickness benefits) on account of an Employee who loses his seniority through discharge or separation and is appealing such discharge or separation may be continued for up to 12 months if within thirty days following such discharge or separation he files a request for continuance of coverage under Section IV and/or Section V while such appeal is pending on a form to be obtained from the Company and agrees to contribute monthly on and after the date coverage would otherwise terminate:
 - (1) the full cost of such insurance as determined by the Insurance Carrier (Basic or Basic and Additional) for coverage in accordance with Section IV, and/or
 - (2) for coverage in accordance with Section V, the applicable full group rate based upon the coverage in effect, and
 - (3) in accordance with subsection 6.3, an eligible Employee may elect to continue coverage under Section V for an additional 6 months by filing a request therefor and contributing monthly for such coverage 102% of the applicable premium (as defined in and pursuant to subsection 6.3).

If the Employee is reinstated, the Company will reimburse him for all contributions with respect to coverage under Section IV and/or V for up to the first 12 months of coverage which would not have been payable if the Employee had not suffered a break in continuity of service as a result of such discharge.

- (iv) such coverage on account of an Employee on family leave of absence will be continued for a period of up to 12 weeks following the last day of the calendar month in which the Employee ceases to be actively at work; provided, however, that coverage in accordance with Section IV shall be continued beyond the last day of the calendar month in which such Employee completes thirty days of such leave of absence only if, during the thirty days preceding such last day of the month, he files a request for continuance of such coverage under Section IV on a form to be obtained from his Employer and agrees to thereafter contribute monthly for such coverage the sum of -
 - (1) the full cost of such insurance as determined by the Insurance Carrier (Basic or Basic and Additional), and

- (2) \$36 per month for weekly accident and sickness coverage.
- (v) such coverage under Section V on account of an Employee entitled to protection under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") will be continued as follows:
 - (1) If the Employee takes a leave of absence from his employment to perform uniformed service for a period of 30 Days or less, the Employee shall be treated as being actively at work during such leave of absence for all purposes under the Plan.
 - (2) If the Employee takes a leave of absence from his employment to perform uniformed service for a period of 31 Days or more, the Employee shall have the right to elect to continue coverage under the Plan for himself and each of his covered Dependents. The duration of continued coverage under USERRA shall extend from the effective date of the Employee's leave of absence to perform Uniformed Service until the earliest of the following dates:
 - A) the last day of the 18-month period beginning on the effective date of the Employee's leave of absence;
 - B) the date the Employee fails to make a required USERRA premium payment; and
 - C) the date the Employee's reemployment rights under USERRA expire.

"Uniformed service" means the performance of duty on a voluntary or involuntary basis under competent authority and includes active duty, inactive duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period during which an Employee is absent from employment with the Employer for the purpose of an examination to determine the fitness of the Employee to perform any such duty in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of person designated by the President in time of war or emergency.

An Employee who elects continued coverage while on uniformed service leave shall be required to pay the total amount of the cost of the coverage provided under the Plan during the period of such leave for the Employee and his Dependents, as determined by the Company, plus 2%.

Notwithstanding any contrary provision contained herein, coverage on account of an Employee on leave for uniformed service covered under USERRA shall continue and shall be subject to reinstatement only to the extent required under such Act.

Notwithstanding anything above in this subsection 6.1 to the contrary, such coverage will terminate on the day an Employee ceases to be actively at work in the event of discharge, strike or quit.

6.2. Conversion of Life Insurance.

In the event that an Employee's life insurance in accordance with Section IV involuntarily terminates solely by reason of the provisions of subsection 6.1, he shall be entitled to have issued to him by the Insurance Carrier without evidence of insurability an individual policy of life insurance only (without disability benefits or accidental means death benefit) in any of the forms then customarily issued by the Insurance Carrier (except term insurance); provided he makes proper written application to the Insurance Carrier within thirty-one days after the last day of the month in which his Basic Life Insurance and/or Additional Life Insurance is initially terminated, and pays the premium for such individual policy applicable to the class of risk to which he belongs and to the form and amount of the individual policy at his attained age at the effective date of such individual policy.

6.3. Continuation of Medical Benefits under COBRA.

- (a) The requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") apply to the Plan. If coverage under Article V of the Plan is discontinued because of any of the qualifying events described below, eligible Employees and Dependents may elect continuation coverage under the Plan according to the COBRA rules.

An Employee has the right to choose this continuation coverage if such Employee loses group health coverage because of a reduction in such Employee's hours of employment or the termination of such Employee's employment (for reasons other than gross misconduct).

The spouse of an Employee covered by the Plan has the right to choose continuation coverage if such spouse loses group health coverage under the Plan for any of the following reasons:

- (i) The death of the covered Employee;
- (ii) The termination of the covered Employee's employment (for reasons other than gross misconduct) or reduction in the covered Employee's hours of employment;
- (iii) Divorce or legal separation from the covered Employee;
- (iv) The covered Employee becomes entitled to Medicare; or
- (v) A proceeding in a case under Title 11, United States Code, with respect to the Employer from whose employment the covered Employee retired.

In the case of a dependent child of an Employee covered by the Plan, the dependent child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

- (1) The death of the covered Employee;
 - (2) The termination of the covered Employee's employment (for reasons other than gross misconduct) or reduction in the covered Employee's hours of employment with the Employer;
 - (3) The covered Employee's divorce or legal separation;
 - (4) The covered Employee becomes entitled to Medicare;
 - (5) The dependent ceases to be a "dependent child" as defined under the Plan;
or
 - (6) A proceeding in a case under Title 11, United States Code, with respect to the Employer from whose employment the covered Employee retired.
- (b) Notice Requirements. Under the law, the Employee or an eligible Dependent has the responsibility to inform the Company of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date the event occurs. The Employer has the responsibility to notify the Company of the Employee's death, termination, reduction in hours of employment or Medicare entitlement.

When the Company is notified that one of these events has happened, the Company will ensure that the Employee and the Employee's eligible covered Dependents are notified within 14 days of the right to choose continuation coverage. Under the law, the Employee and eligible covered Dependents have 60 days from the later of the date the Employee or his eligible covered Dependent(s) would lose coverage because of one of the events described above or the date the Employee or his eligible covered Dependent(s) are advised by the Company of the right to continue coverage to inform the Company that the Employee and/or the eligible covered Dependents want continuation coverage.

Notice to the Employee's eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any eligible covered Dependent children residing with the Employee's spouse. If the Employee or his eligible covered Dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost.

An eligible Employee may elect COBRA continuation coverage for an eligible child who is born to, adopted by, or placed for adoption with such Employee while the Employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the Employee has notified the Company in writing within 30 Days of the child's birth, adoption or placement for adoption.

- (c) Payment for Continuation Coverage. The Employee and his eligible covered Dependent(s) will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage, plus 2%.

Contribution amounts and benefits for continuation coverage are subject to change. The Employee will be notified of any changes in contribution amounts or benefits available under the Plan.

If the Employee or his eligible covered Dependent(s) elect continuation coverage after the qualifying event, then the Employee or his eligible covered Dependent(s) will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of the payment. There is no grace period for the initial contribution. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

Covered individuals will not be billed for any contribution payments for continuation coverage. If any contribution payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Plan will terminate and will not be reinstated.

- (d) Length of Continuation Coverage. If the Employee and/or his eligible covered Dependents elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment or reduced work hours is 18 months.

If the Employee or his eligible covered Dependent is found by the Social Security Administration ("SSA") to be eligible for Social Security disability benefits because of a disability that existed at any time during the first 60 days of this COBRA continuation coverage, then the disabled person and his family members will be eligible to continue Plan coverage for up to 29 months (an additional 11 months). To be eligible for that additional time to continue Plan coverage, the disabled person must remain disabled and must notify the Company:

- (i) Within 60 days after receiving the disability determination from Social Security, and
- (ii) Before the original 18-month period to continue Plan coverage ends.

An increased cost of up to 150% of the cost of Plan coverage may be required for those 11 extra months of continuation coverage. The disabled person must promptly notify the Company of any SSA finding that he or she is no longer disabled.

If a second qualifying event occurs within the applicable 18- or 29-month period, the period to continue Plan coverage under COBRA may be extended for up to 36 months from the first qualifying event. For all other qualifying events, the maximum period to continue Plan coverage is 36 months.

- (e) Termination of Continuation Coverage. COBRA continuation coverage will end on the date that the first of the following occurs:
 - (i) The Employer no longer provides group health coverage to any of its Employees;
 - (ii) The contribution for this continuation coverage is not paid on time;
 - (iii) The Employee or his eligible covered Dependent(s) become covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition such individuals may have or contains a pre-existing condition exclusion that does not apply to such individuals because of the requirements of the Health Insurance Portability and Accountability Act of 1996;
 - (iv) The Employee or his eligible covered Dependent(s) become entitled to Medicare; or
 - (v) The Employee or his eligible covered Dependent(s) elected to extend coverage for up to 29 months due to disability and there has been a final determination by the SSA that such individual is no longer disabled.

The Employee or his eligible covered Dependent(s) must inform the Company within 30 days of the date of any final determination by the SSA that the person is no longer disabled.

- (f) General Information About Continuation Coverage. Continuation coverage is provided subject to eligibility under the law. The Company reserves the right to terminate continuation coverage retroactively if the Employee or his Dependent(s) are determined to be ineligible for continuation coverage. The Company intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements.

6.4. Life Insurance During Eligibility Period for Conversion.

In the event that an Employee's life insurance in accordance with Section IV involuntarily terminates solely by reason of the provisions of subsection 6.1 (Termination of Coverage) and he dies during the thirty-one day period during which application for an individual policy may be made in accordance with subsection 6.2 (Conversion of Life Insurance), there will be paid to his beneficiary of record the maximum amount of life insurance for which an individual policy could have been issued in accordance with subsection 6.2 (whether or not he shall have applied for such individual policy).

6.5. Discontinuance of Coverage.

In the event that a covered Employee gives written notice on a form provided by the Company that he desires to discontinue all coverage hereunder, or a portion thereof, the coverage specified in such notice shall terminate on the last day of the calendar month in which such notice is received by the Company. If an Employee who has declined

coverage for himself under Section V of this Agreement, elects to re-enroll for such coverage, subsection 3.1 of this Plan in regard to pre-existing conditions shall be applicable for the Employee and his Dependents. Coverage will commence effective the first of the month following acceptance and approval of such re-enrollment application by the Company or its designee.

SECTION VII ENROLLMENT AND CONTRIBUTIONS

7.1. Request for Enrollment.

Each request for enrollment for coverage in accordance with Section IV or V shall be on a form provided by the Claims Administrator or his Employer, shall contain an authorization for the Company to deduct from the Employee's pay the amount of his contributions hereunder, and shall be duly executed by the Employee.

7.2. Employee Contributions.

A covered Participant shall contribute in the applicable amount or amounts as determined by the Company in each calendar month with respect to coverage in force with respect to him on the first day of such month. All contributions required shall be made through automatic payroll deductions or, if applicable, from any pension unless such coverage has been declined on a form provided by the Company or its designee, and except that where necessary by reason of lack of earnings they shall be made by direct payment to the Company or its designee.

7.3. Failure to Make Contributions.

If a person required to make contributions fails to pay the applicable contributions for any month, the appropriate Employer shall notify such person of such failure to pay contributions, such notice to be mailed to such person's last known address as shown by the Company's records. If such person then fails to pay such contributions within thirty days after the mailing of such notice, all coverage (except any for which no contribution is required under the preceding provisions of this Plan) shall automatically terminate on the last day of the last month for which he made contribution.

7.4. Refund of Overpayment.

If it is determined that any benefits paid to a Participant under any Section of the Plan should not have been paid or should have been paid in a lesser amount, written notice thereof shall be given to such Participant and he shall repay the amount of the overpayment to the Company.

If the Participant fails to repay such amount of overpayment promptly, the Claims Administrator shall arrange to recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the Participant under the Plan or the Company may make appropriate deduction or deductions from future compensation payable to the Employee and may also make such deduction or deductions upon the request of the Claims Administrator.

SECTION VIII
GENERAL PROVISIONS

8.1. Insurance Policy.

Except to the extent necessary to produce conformity with the preceding provisions, any policy or policies issued by an Insurance Carrier shall contain the provisions customarily contained in policies of group insurance issued by such Insurance Carrier for similar insurance coverages.

8.2. Subrogation and Reimbursement.

The provisions of this subsection apply in the event that the Plan provides benefits to a Participant relating to an illness, injury, disability or death incurred as a result of the action or omission of a third party who is or may be responsible or liable for all or part of such expenses. Further, the provisions of this subsection extend to benefits the Plan provides to a Participant relating to illness, injury, disability or death to the extent that payment is or may be made under the terms of any "no-fault" type of automobile policy, an uninsured or underinsured motorist coverage under an automobile policy, any homeowner's policy, workers' compensation, or any other insurance coverage.

A Participant's acceptance of any payment of benefits under this Plan automatically (i) subrogates the Plan to the Participant's claims and rights of recovery against a third party with respect to the full amount of benefits paid to or on behalf of a Participant as the result of an illness, injury, disability or death that is or may be the responsibility or liability of a third party, not in excess of the benefits paid by the Plan, and (ii) assigns to the Plan any rights the Participant may have to recover payments from any such third party. This subrogation right allows the Plan to pursue any claim and right of recovery that the Participant has against any such third party, whether or not the Participant chooses to pursue such claim or right of recovery. The Plan's right of subrogation shall apply to the first dollar of any amounts recovered or otherwise received from the third party, without regard to whether the Participant has been or will be made whole.

The Plan also shall have exclusive rights to, and the right of first reimbursement from and priority over, any amounts recovered or otherwise received by or on behalf of the Participant as the result of an illness, injury, disability or death that is or may be the responsibility or liability of a third party. The Participant shall immediately reimburse the Plan for the full amount of any and all benefits paid in connection with such illness, injury, disability or death, up to the amount the Participant recovers or otherwise receives. The Plan's right of reimbursement shall apply to the first dollar of any amounts recovered or otherwise received from the third party, without regard to whether the Participant has been or will be made whole, and without regard to any expressed allocation of the amounts recovered by or on behalf of the Participant. The Plan's right of reimbursement applies regardless of the label assigned to the recovery, and regardless of any purported allocation or itemization of such recovery to specific types of injuries. If the recovery is for damages other than for medical expenses, such as pain and suffering, the Participant will still be required to reimburse the Plan first. The Plan's right, and the amount to be reimbursed to the Plan, shall equal the amount of benefits the

Participant received from the Plan, adjusted by the Participant's reasonable share of attorneys' fees and costs to obtain payment from the third party, but shall not exceed the amount the Participant actually received from the third party.

Any settlement proceeds, assets collected from judgments and recoveries paid by a third party shall be held for the Plan and the Plan's interest therein shall be protected to the same extent as if such proceeds or assets were held in trust for the benefit of the Plan to the extent of the amount paid by the Plan and subject to reimbursement to the Plan. To the extent the Participant has control over such assets, the Participant shall exercise all authorities consistent with the Plan's interest in such assets. To the extent not otherwise paid to the Plan, the amount due to the Plan will reduce any other present or future benefits payable from the Plan to or on behalf of the Participant.

As a condition to participation in the Plan and the Plan's making any payments for medical care expenses, the Participant shall cooperate fully with the Plan's recovery under this subsection, including but not limited to (i) notifying the Company in advance of initiating (or a third party initiating on the Participant's behalf) any action against a third party or in advance of any recovery from a third party; (ii) executing and delivering any documents and instruments required to secure the Plan's right of subrogation and reimbursement, (iii) doing nothing to prejudice the Plan's right of subrogation and reimbursement or the Plan's right to enforce any subrogation and reimbursement agreement; (iv) participating in any other reasonable requirements necessary to secure the Plan's right of subrogation and reimbursement, including cooperating in connection with litigation; (v) consenting to judgment for the Plan; (vi) agreeing not to assert a defense under Section 502 of the Employee Retirement Income Security Act of 1974 (as amended) to a claim made by the Plan; (vii) agreeing that a claim brought by the Plan to enforce its rights under this Subsection is an equitable claim; (viii) recognizing that proceeds or assets recovered by the Participant from a third party are held in trust or constructive trust for the Plan.

8.3. Administration Of The Plan.

Except to the extent otherwise expressly provided in an applicable collective bargaining agreement, the Plan shall be administered by the Company or its designee; provided, however, that the Company by resolution of its Board of Directors may designate any person, committee, board or similar body to act as named fiduciary or fiduciaries under the Plan and allocate any and all of its duties and responsibilities under the Plan to such named fiduciary or fiduciaries. If the Board of Directors allocates any of its duties and responsibilities under the Plan to a named fiduciary other than the Company, such named fiduciary shall be substituted for the Company wherever such term appears under the Plan with respect to any duties and responsibilities so allocated. The Company and such other named fiduciary or its delegates shall have sole discretionary authority to interpret the terms of the Plan, to determine eligibility for and entitlement to Plan benefits and shall have the discretion to take any other action with respect to the Plan, notwithstanding any provision of the Plan to the contrary. Any interpretation, determination or action pursuant to such authority shall be given full force and effect and shall not be given "de novo" review if challenged in any proceeding in any court, agency or other forum. Prior

exercise of such authority shall not create a precedent or obligate such named fiduciary or delegates to exercise their authority in the same or similar fashion thereafter.

8.4. Limitation for Filing Claims.

All claims under Section V of this Plan must be filed no later than one calendar year following the calendar year in which the expenses were incurred. For this purpose, expenses are incurred on the date the related service is rendered. Claims for expenses filed after this deadline will not be paid. Participants shall comply with the requirements governing claims and appeals as set forth in the Department of Labor Regulations Section 2560.503-1.

8.5. Health Information Privacy. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the privacy regulations issued thereunder (“Privacy Rule”) require the Company to ensure that certain health information is adequately protected and used or disclosed only for limited purposes. The Plan is a “hybrid entity” within the meaning of the “Privacy Rule” which means only the Plan’s Health Care Components are covered under HIPAA while the other benefit components are not covered under HIPAA. The Health Care Components of the Plan are identified below and are subject to this provision and must comply with the standards for privacy of individually identifiable health information as set forth in the Privacy Rule.

(a) Definitions. The following words and phrases, with the initial letter of each word capitalized, have the meanings indicated below for purposes of this Article XIV.

- (i) “Health Care Component” means the Plan’s benefit components which provide medical, dental, vision, prescription drug, behavioral health, and health care reimbursement benefits. Such benefit components are covered under HIPAA.
- (ii) “Health Care Operations” means any of the following activities to the extent that they are related to a Health Care Component’s covered functions:
 - (1) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;
 - (2) Reviewing competence or qualifications of health care professionals and evaluating provider and Health Care Component performance;
 - (3) Underwriting and other activities that relate to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance

of risk relating to claims for health care (including stop-loss insurance);

- (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - (5) Business planning and development, such as cost-management and planning-related analysis related to managing and operating a Health Care Component, and development or improvement of coverage policies; and
 - (6) Business management and general administrative activities, including, but not limited to: (A) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (B) customer service, including the provision of data analyses for an Employer, provided that PHI is not disclosed to the Employer; (C) resolution of internal grievances; (D) due diligence related to the sale, transfer, merger, or consolidation of all or part of a Health Care Component with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (E) consistent with applicable requirements of the Privacy Rule, creating de-identified information or a limited data set, both as defined in the Privacy Rule.
- (iii) “Individual” means a Participant who is or was covered under one or more Health Care Components and who is the subject of Protected Health Information.
- (iv) “Payment” means activities undertaken by a Health Care Component to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:
- (1) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - (2) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (3) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

- (4) Review of health care services with respect to medical necessity, coverage under a Health Care Component, appropriateness of care, or justification of charges;
 - (5) Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and
 - (6) Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.
- (v) “Privacy Policy” means the Caterpillar Inc. and Subsidiaries Health Plan HIPAA Privacy Policy.
- (vi) “Protected Health Information” or “PHI” means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of an Individual, provision of health care to an Individual, or payment for such health care; (2) can either identify the Individual, or there is a reasonable basis to believe the information can be used to identify the Individual; and (3) is received or created by or on behalf of a Health Care Component.
- (vii) “Responsible Employee” means an employee (including a contract, temporary, or leased employee) of an Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations, or (2) make it likely that he or she will receive or have access to PHI. Responsible Employee also includes any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Health Care Component, even though his or her duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the Health Care Component’s HIPAA firewall when they perform Health Care Component functions.
- (b) Responsible Employees. Only Responsible Employees are permitted to use, disclose, create, receive, access, maintain, or transmit PHI on behalf of a Health Care Component. The use or disclosure of PHI by Responsible Employees shall be restricted to the Health Care Component administration functions that an Employer performs on behalf of a Health Care Component.

Employees of an Employer who perform the following functions on behalf of one or more Health Care Components are Responsible Employees:

1. claims determination and processing functions;
2. vendor relations functions;
3. benefits education and information functions;
4. legal activities;

5. information systems support activities;
6. internal audit functions; and
7. human resources functions, including payroll.

In addition to those individuals described above, the HIPAA privacy officer, and Company employees to whom the HIPAA privacy officer has delegated any of the following responsibilities shall also be Responsible Employees:

- A. implementation, interpretation, and amendment of the Privacy Policy;
 - B. Privacy Rule training for Responsible Employees;
 - C. investigation of and response to complaints by Individuals and/or employees;
 - D. preparation, maintenance, and distribution of the privacy notice;
 - E. response to requests by Individuals to inspect or copy PHI;
 - F. response to requests by Individuals to restrict the use or disclosure of their PHI;
 - G. response to requests by Individuals to receive communications of their PHI by alternate means or in an alternate manner;
 - H. amendment and response to requests to amend Individuals' PHI;
 - I. response to requests by Individuals for an accounting of disclosures of their PHI;
 - J. response to requests for information by the Department of Health and Human Services;
 - K. approval of disclosures to law enforcement or to the military for government purposes;
 - L. maintenance of records and other documentation required by the Privacy Rule;
 - M. negotiation of Privacy Rule provisions and/or reasonable security provisions into contracts with third party service providers;
 - N. maintenance of Health Care Component PHI security documentation; or
 - O. approval of access to PHI stored in electronic form.
- (c) Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain

permitted and required functions on behalf of Health Care Components, consistent with the Privacy Policy. This includes:

- (i) uses and disclosures for Payment and Health Care Operations functions of a Health Care Component, another HIPAA covered entity, or a health care provider;
- (ii) disclosures to a health care provider for the health care provider's treatment activities;
- (iii) disclosures to an Employer (1) of summary health information for purposes of obtaining health insurance coverage or premium bids for the Health Care Components or for making decisions to modify, amend, or terminate the Health Care Components, or (2) of enrollment or disenrollment information;
- (iv) disclosures of an Individual's PHI to the Individual or his or her personal representative, as defined in the Privacy Rule;
- (v) disclosures to an Individual's family members or friends involved in the Individual's health care or payment for the Individual's health care, or to notify an Individual's family in the event of an emergency or disaster relief situation;
- (vi) uses and disclosures to comply with workers' compensation laws;
- (vii) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;
- (viii) disclosures to the Secretary of Health and Human Services to demonstrate the Health Care Components' compliance with the Privacy Rule;
- (ix) uses and disclosures for other governmental purposes, such as for national security purposes;
- (x) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- (xi) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- (xii) uses and disclosures required by other applicable laws; and
- (xiii) uses and disclosures pursuant to an Individual's authorization that satisfies the requirements of the Privacy Rule.

- (d) **Certification Requirement.** The Company may permit an Employer's Responsible Employees to access PHI only upon receipt of a certification by the Employer that the Employer agrees:
- (i) not to use or further disclose PHI other than as permitted or required by this Section and the Privacy Policy or as required by law;
 - (ii) to take reasonable steps to ensure that any agents, including subcontractors, to whom the Employer provides PHI received from the Health Care Components agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
 - (iii) not to use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Employer other than another Health Care Component or health plan;
 - (iv) to report to the Company any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures described above of which the Employer becomes aware;
 - (v) to make available PHI for the Individual's inspection and copying in accordance with the Privacy Rule;
 - (vi) to make available PHI for the Individual's amendment, and to incorporate any amendments to PHI in accordance with the Privacy Rule;
 - (vii) to make available PHI required to provide the Individual with an accounting of disclosures in accordance with the Privacy Rule;
 - (viii) to make its internal practices, books, and records relating to the use and disclosure of PHI received on behalf of the Health Care Components available to the Secretary of Health and Human Services for purposes of determining compliance with the Privacy Rule;
 - (ix) if feasible, to return or destroy all PHI received from the Health Care Components that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible; and
 - (x) to take reasonable steps to ensure that there is adequate separation between Health Care Component administration functions and the Employer's other activities.
- (e) **Mitigation.** In the event of non-compliance with any of the provisions set forth in this Section, the HIPAA privacy officer shall address any complaint or report of non-compliance promptly and confidentially. The HIPAA privacy officer first will investigate the complaint or report and document his or her investigation

efforts and findings. If PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with this Section, the HIPAA privacy officer shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur. If a Responsible Employee or other employee of the Company is found to have violated the Privacy Policy, such employee shall be subject to disciplinary action up to and including termination of employment.

8.6. Participating Provider Contracts.

Where the Claims Administrator enters into direct or indirect participating provider contracts with Physicians or other providers or facilities, or agreements with a network administrator, in areas where the Employer has Employees, the standard rules of the network administrator shall govern the benefits provided hereunder.

LETTERS OF AGREEMENT

LETTER OF AGREEMENT NO. 1

RE: Health Maintenance Organization Plans

This will confirm our understanding that in the event a Health Maintenance Organization plan were to be developed in one or more communities where our plants are located, it would be desirable to offer the employees and their dependents, who are located in such communities, the option to enroll in such a plan as an alternative to enrollment under the health program outlined in Section V of our current Insurance Plan Agreement. Eligibility for participation will be based on the applicable zip code service area as defined and established by the Company or its designee for such communities.

When employees and their dependents are enrolled in a Health Maintenance Organization plan, their benefits, rights, and obligations shall be governed by the terms, rules, and procedures of the Health Maintenance Organization plan as in effect from time to time, including any changes thereto, and benefits not covered by such plan will not be covered under Section V of the current Group Insurance Plan.

In this regard, please be advised that the undersigned is prepared to investigate any such alternative plan in the event that one or more are formed, and if it is found, by mutual agreement between the undersigned and the Union (regardless of whether the plan is approved by the United States Department of Health and Human Services under the Health Maintenance Organization Act of 1973) that such a plan or plans is of high quality and provides at least the level of benefits specified in Section V of our Insurance Agreement, at a cost to the undersigned that does not exceed its cost at that time to provide these benefits under such Section V, then steps will be taken by the undersigned within a reasonable period of time following such investigation but before the termination of such Insurance Plan Agreement to permit employees and their dependents, an option, annually, to enroll in such a plan.

LETTER OF AGREEMENT NO. 2

RE: Guidelines for A&S Reduction by Social Security Amounts

The following guidelines will be used by the Company for reducing Accident and Sickness Benefits by Social Security Disability Insurance Benefits:

- (a) As early as the thirteenth but no later than the twentieth week of disability, depending upon the initial prognosis on the claim, an Employee will be notified of the eligibility requirements and advised to apply for Social Security Disability Insurance Benefits (DIB). The Employee will be advised that, effective with the payment for the twenty-sixth week of disability, Accident and Sickness (and Long Term Disability) benefit computations will presume eligibility for DIB except that if, prior to such twenty-sixth week, the Employee files for DIB and completes a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Insurance Carrier of its determination, he shall receive unreduced Accident and Sickness (or Long Term Disability) benefit payments while he is otherwise eligible. Further, the Employee will be instructed that, if his Physician anticipates that the Employee's disability will not

extend beyond twelve months, his Physician should complete a statement indicating such a prognosis. Where such a statement is provided, a reduction of Accident and Sickness (or Long Term Disability) benefits, based on presumed eligibility for DIB, will not be instituted in the twenty-sixth week of disability. If during the ensuing period of disability it becomes apparent that either 1) through deterioration of the Employee's condition, or 2) a prolongation of the recovery period, that he will not return to work for a prolonged period, he will be requested to file for DIB and complete reimbursement and authorization forms.

- (b) In the twenty-fourth week of disability, any Employee whose Physician has not completed the statement referenced in (a) above, will be again advised to apply for DIB if he has not done so and instructed to complete a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Insurance Carrier of its determination. Failure to 1) apply for DIB, 2) complete a reimbursement agreement, or 3) complete the authorization form will result in the suspension of an amount of Accident and Sickness (or Long Term Disability) benefits equal to the presumed amount of DIB (commencing at the 26th week) until the Employee provides satisfactory proof that he has applied for DIB, completed a reimbursement agreement and an authorization form. The Employee also will be advised that he may authorize release of information in the Accident and Sickness (and Long Term Disability) benefit claim files to the Social Security Administration. In the event the Company institutes a program to assist Employees in the DIB application process, the Employee is required to cooperate in that process. Failure to comply with the process will result in the suspension of an amount of Accident and Sickness (or Long Term Disability) benefits equal to the presumed amount of DIB until such time as the Employee cooperates with that process.
- (c) Upon receipt of an initial determination of disallowance of DIB, a notice will be sent instructing the Employee to 1) file a request for reconsideration, within two weeks of the date of the notice, and 2) complete an authorization form allowing the Social Security Administration to advise the Company or Insurance Carrier of its determination. Failure to either 1) request such reconsideration within such time period, or 2) complete the authorization form will result in the suspension of an amount of Accident and Sickness (or Long Term Disability) benefit payments equal to the presumed amount of DIB until the Employee provides satisfactory proof that such request has been filed and the authorization form has been completed.
- (d) Upon receipt of a reconsideration determination of disallowance, the Employee will be encouraged to file for a hearing before an administrative law judge of the Social Security Administration. If the Employee files for such a hearing, he will be requested to complete another authorization form as referenced in (c) above.
- (e) In the event of a reconsideration determination denying DIB, and provided any subsequent review does not reverse such decision, the Employee will not be required to repay any Accident and Sickness (or Long Term Disability) benefits otherwise payable, unless such denial of DIB resulted from the Employee's

refusal to accept vocational rehabilitation. Where such denial occurs, the Employee is obligated to repay Accident and Sickness (and Long Term Disability) benefits in an amount equal to the amount of DIB to which he would otherwise have been entitled for the same period or periods of disability.

- (f) Upon receipt of a notice of award of DIB, any overpayment of Accident and Sickness (or Long Term Disability) benefits caused by the retroactive award of DIB is to be repaid. The amount of the overpayment will be based on the actual amount of such award.
- (g) In the event of a DIB award resulting from a reconsideration or hearing before an administrative law judge, the amount of Accident and Sickness (and Long Term Disability) benefits overpayment will be reduced by an amount equal to any attorney fees associated with the award, provided that 1) the Employee makes such repayment within 30 days of the date the Employee is notified of the amount to be repaid, and 2) such reduction applies only to attorney fees associated with a successful appeal of a denial of DIB and includes only that portion of the attorney's fee associated with the period of time the Employee was entitled to receive Accident and Sickness (and Long Term Disability) benefits, and 3) such reduction for such attorney fees may not exceed 25 percent of the overpayment. Attorney fees for services prior to denial of the initial application for DIB will not reduce the amount of overpayment. Failure to repay the full amount of the overpayment within one year of the date of notification of such overpayment shall result in the Employee being separated from the Company unless such one-year period is extended by mutual agreement of the Company and the Union.
- (h) An Employee age 65 or older may be entitled to Old-Age Benefits as early as the first day of total disability. No reduction of Accident and Sickness benefits shall be made until the Employee provides evidence that he is receiving Old-Age Benefits (through authorization of information disclosure by the Social Security Administration or otherwise). If requested, such evidence shall be provided by such an Employee.
- (i) In the event an Employee receives an initial determination of disallowance of DIB, all amounts of Accident and Sickness Benefits withheld will be paid to the Employee unless the Employee was denied DIB for failure to accept vocational rehabilitation or for not filing for DIB within the period of time specified by the Social Security Administration as necessary for DIB to commence at the first of the sixth month of disability.
- (j) When the Company mails the initial notice to the Employee requesting that the Employee apply for DIB, a copy of such initial notice will be mailed to the Union's Local Insurance Representative, if any, of the facility at which the Employee works.
- (k) Upon receipt of the final determination of disallowance of DIB the Employee shall reapply for a new initial determination under the rules as outlined in this

PROPOSAL 3

Letter of Agreement 2 within thirty days of notification by the Company to reapply for DIB.

LETTER OF AGREEMENT NO. 3
RE: Flexible Spending Account Plan

Pursuant to the terms of Caterpillar's Flexible Spending Account Plan, which is qualified under Section 125 of the Internal Revenue Code, active Employees will be eligible to participate in the plan for payment of health care expenses and/or dependent care expenses on a pre-tax basis.

LETTER OF AGREEMENT NO. 4
RE: Medical Premium Payment Plan

Pursuant to the terms of Caterpillar's Medical Premium Plan, which is qualified under Section 125 of the Internal Revenue Code, active employees will be able to pay required premiums under Section 5 of the Plan on a pre-tax basis, provided that, in order to permit the pre-tax treatment of such contributions, the eligibility and coverage provisions of such Medical Premium Payment Plan will be applied to the Group Insurance Plan.

LETTER OF AGREEMENT NO. 5
RE: Health Insurance Legislation

This confirms our understanding that if during the term of our current Insurance Plan Agreement any federal or state law (other than a Workers' Compensation or Occupational Disease law) is enacted or amended (other than a Workers' Compensation or Occupational Disease law) regarding hospital, surgical, medical, dental, vision, or prescription drug benefits for employees, retirees, or their dependents, which may duplicate or be integrated with the benefits under Section V of the Group Insurance Plan 2005, then the Company may modify the benefits described in Section V, but only if, with respect to each modification, (i) the modification increases, or does not reduce, a benefit available under Section V or reduces, or does not increase, the amount payable by a Participant under Section V with respect to a benefit; (ii) the modified benefit is available on an optional basis to Participants; or (iii) the modification eliminates a benefit available under Section V that would duplicate a benefit available as a result of such law.

In the event any such federal or state law is enacted, the Company will meet with the Union to discuss the modification of the benefits under Section V that may be affected by such a law in the manner described above. No such modification shall be made without the Union's agreement.

LETTER OF AGREEMENT NO. 6
Re: Additional Benefits

The Company and the Union agree that during the term of this Agreement, and any extension or amendment thereof, the Company may unilaterally elect to extend to bargaining unit employees, or any sub-groups of such employees, any one or more of the medical, prescription drug or dental benefits, or benefit arrangements, programs or options (hereafter collectively referred to as "Additional Healthcare Benefits"), that the Company makes available to its salaried and management employees upon the same terms as such benefits are made available to salaried and

management employees. During annual open enrollments, or such other open enrollments as may be initiated by the Company from time to time, bargaining unit employees may voluntarily choose or elect to enroll in either the Additional Healthcare Benefits offered to them by the Company or to participate in the benefits, programs or options contained in the Group Insurance Plan. The parties further agree that, should the Company elect to offer any such Additional Healthcare Benefits to employees under the terms of this Letter of Agreement, the Company shall have no duty to negotiate or bargain with the Union with respect to the offering of such Additional Healthcare Benefits, including but not limited to the administration of such Additional Healthcare Benefits, or the voluntary acceptance of such Additional Healthcare Benefits by individual employees, the right to bargain with the Company with respect to all such matters being expressly waived.