HEALTH AND WELFARE

EMPLOYEE BENEFIT PLANS

OF THE

GLAZIERS, ARCHITECTURAL METAL & GLASS WORKERS LOCAL UNION NO. 740 WELFARE FUND

As Amended and Restated July, 2008

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PART I
STATEMENT OF ERISA RIGHTS

As a participant in Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called Afiduciaries@ of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials

and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you pay these costs and fees.

Assistance with Your Questions

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

PART II
MEDICAL, DENTAL AND DISABILITY INCOME PLANS

Article 1
INTRODUCTION AND SPECIFICATIONS

1.01 Establishment of Plan. The Trustees of the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund have established this Plan pursuant to the authority vested in them by the Amended and Restated Trust Agreement of the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund.

1.02 Name of Plan. The name of the Plan is Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Plan.

1.03 Type of Plan. This Plan is a welfare plan that provides hospital, surgical, medical, dental and disability income benefits. As an employee benefit plan, the governing law is contained in the Employee Retirement Income Security Act, as amended.

1.04 Type of Administration. A Board of Trustees administers the Plan with the assistance of the William C. Earhart Company, Inc., a contract administrative organization. The Board of Trustees is the Administrator of the Plan.

1.05 Funding and Source of Payment of Benefits. The Plan is funded by financial contributions required under the terms of collective bargaining agreements between Glaziers, Architectural Metal & Glass Workers Local Union No. 740 and the employers who are represented by Mt. Hood Glass Management Association, Inc. and independent contractors located within all counties in the State of Oregon, except Malheur, and the following counties of the State of Washington: Clark, Cowlitz, Skamania and Klickitat. The Plan permits contributions to be made on behalf of employees of employers who make financial contributions to the Plan, labor organization employees and employees of the Glaziers, Architectural Metal & Glass Workers Joint Apprenticeship and Journeyman Training Trust. Previously eligible employees and their spouses, former spouses and dependents can make self-payments as permitted under continuation of coverage after their eligibility ceases. Retirees are also permitted to make self-payments provided they meet the retiree eligibility requirements. The amount of self-payment is determined by the Board of Trustees and is subject to change at their discretion.

Employer contributions required by a collective bargaining agreement are received and held in trust by the Board of Trustees. Contributions are also received from or on behalf of individuals who are permitted by the Plan to receive Plan benefits. The Plan is self-funded and pays for benefits out of Plan assets. A complete list of the names and addresses of employers and employee organizations sponsoring and contributing to the Plan and information as to whether a particular employer contributed to the Plan may be obtained by a participant upon written request addressed to the Board of Trustees at their address set forth in section 1.06. Participants may also review a copy of any of the collective bargaining agreements requiring payment to fund the Plan or obtain a copy of any such collective bargaining agreement at the office of the Plan's administrative agent identified in Section 1.08.

Any excess loss coverage insurance, life insurance, Kaiser health and dental, and vision care coverage are insured benefits and are outside of the Plan. Union Labor Life Insurance Company (ULLICO) insures the excess loss coverage, life and accidental death and dismemberment benefits. The excess loss coverage reimburses the Fund for benefits paid on individual participants and all participants that exceed certain minimum amounts. No excess loss benefits are payable to participants. ULLICO's address and telephone number are: ULLICO, Inc., 111 Massachusetts Avenue, N.W., Washington, D.C. 20001, (202) 682-6950. Vision care benefits are insured through Vision Service Plan (VSP), 3333 Quality Drive, Rancho Cordova, CA 95670, (800) 877-7105.

1.06 Name, Address and Telephone Number of Board of Trustees. This Plan is administered by a joint labor-management Board of Trustees, the name and address of which is:

Board of Trustees of the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund
3140 N.E. Broadway
Portland, Oregon 97232
(503) 282-5581
Toll Free - North America - 1-800-547-1314

1.07 Identification Number. The employer identification number assigned to the Plan by the Internal Revenue Service is EIN 93-6032243. The Plan Number is 501.

1.08 Name, Address and Telephone Number of Administrative Agent:

The William C. Earhart Co., Inc.
3140 NE Broadway
Portland OR 97232
(503) 282-5581
Toll Free - North America - 1-800-547-1314

1.09 Name and Address of Agent for Service of Process:

Hannah Sutton, President
Catherine Gladstone, Vice President
c/o The William C. Earhart Company, Inc.
3140 N.E. Broadway
Portland, Oregon 97232

Service of legal process may also be made upon a Plan trustee.

1.10 Names, Titles and Addresses of Board of Trustees:

Employer

Michael Worthington
Centennial Glass Co.
7358 SE 92nd Avenue
Portland, OR 97266

James Watts
3434 S W Water
Portland, OR 97201

Peter Potwin
Benson Industries, Inc.
1650 NW Front Ave., Suite 250
Portland, OR 97209

Labor Organization

Cris Baugher
Business Representative
Glaziers Local 740
11105 NE Sandy Blvd
Portland, OR 97220

Bruce Neelands
4030 NE 142nd
Portland OR 97230

Jerry L. Fisher
Glaziers Local 740
11105 NE Sandy Blvd
Portland, OR 97220

1.11 Eligibility, Termination of Eligibility and Benefits. Eligibility requirements are set forth in Article 3. Benefits provided under this Plan are set forth in Articles 4, 5 and 6.

1.12 Fiscal Year and Benefit Year. The Plan's fiscal year is August 1 to July 31. Benefits are determined on a calendar year basis.

Article 2

DEFINITIONS

Definitions of the following terms shall apply uniformly throughout this Plan. Other terms may be defined where they are used in this Plan.

2.01 **Administrative Agent** means the person or organization that contracts with the Trustees to provide services for administering the activities of the Trust and Plan and to whom the Trustees delegate responsibilities of the Plan and Trust.

2.02 **Administrator** means the Board of Trustees of the Welfare Fund.

2.03 **Calendar Year** means the 12 consecutive months that start on January 1st and end on December 31st of any year.

2.04 **Chemical Dependency** means an addictive relationship a person may have with a drug or alcohol agent. The dependency may be characterized by either a physical or psychological relationship, or both, to the extent that it interferes with the person's social, psychological or physical adjustment to common problems on a daily basis. For purposes of this Plan, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

2.05 **COBRA Participant** means any former participant who is eligible to receive benefits under this Plan by electing continuation of coverage as provided in Article 8.

2.06 **Complications of Pregnancy means:**

A. Conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, or which are caused by pregnancy, such as: acute nephritis, nephrosis, cardiac decompensation, miscarriage, and similar medical conditions of comparable severity.

B. Non elective caesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

C. Complications of pregnancy does not include: false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions which are associated with the management of a difficult pregnancy but which do not constitute a nosologically distinct complication of pregnancy.

2.07 **Contribution** means the amount to be paid to the Trust under the terms of a collective bargaining agreement or an amount required by the Trustees to be paid by or on behalf of a person for that person to become and/or continue to be eligible for benefits.

2.08 **Coverage** means eligible for benefits and entitled to benefits under this Plan or, when the context requires otherwise, it means eligible for benefits and/or entitled to benefits under another health plan, insurance policy or health care arrangement.

2.09 **Covered Charges** means the reasonable and customary charges for necessary medical and dental services, supplies and treatments which are:

A. Covered under this Plan; and

B. Are in accordance with accepted standards of medical or dental practice; and

C. Are deemed by the Trustees to be reasonably necessary and reasonably priced, taking into consideration the condition being treated.

2.10 **Covered Person** means an employee, retiree, dependent or other person who is eligible to receive benefits under this Plan. It includes the term "eligible person" or "eligible dependent".

2.11 **Custodial Care** means treatment, services, or confinement, regardless of who recommends, prescribes, or performs them, or where they are provided, which could be rendered safely and reasonably by a person not medically skilled, and are designed mainly to help the patient with daily living activities. Custodial care includes:

A. Personal care such as help in: walking, getting in and out of bed, bathing, eating (including tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema;

B. Homemaking such as preparing meals or special diets;

C. Moving the patient;

D. Acting as companion or sitter;

E. Supervising medication usage which can usually be self-administered.

The Trustees shall determine which services constitute custodial care.

A determination of custodial care does not imply that the care being rendered is not required by the patient. Such a determination only means that it is the kind of care that is not covered under this Plan.

2.12 **Dentist** means an individual who is licensed to practice dentistry by the government authority which has the jurisdiction over the licensing and practice of dentistry.

2.13 **Dental Hygienist** means an individual who is licensed to practice dental hygiene by the government authority which has the jurisdiction over the practice of dental hygiene and works under the supervision of a dentist.

2.14 **Experimental Procedure means:**

Any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that is meant to investigate and is limited to research. This term also means techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies. "Experimental Procedure" also includes procedures that are not proven in an objective manner to have therapeutic value or benefit. Any procedure or treatment whose effectiveness is medically questionable is also deemed experimental.

The Trustees determine "experimental" through studies, opinions and reference to or by the American Medical Association, The Federal Drug Administration, The Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies or any other medical association or Federal program or agency that has the authority to approve medical testing and treatment.

2.15 **Fund or Welfare Fund** means the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund.

2.16 **Home Health Care Agency** means an agency or organization which:

A. Is primarily engaged in providing nursing and other therapeutic services; and

B. Is federally certified and duly licensed, if such licensing is required; and

C. Has policies established by a professional group associated with such agency, including at least one physician and at least one registered nurse, to govern the services provided; and

D. Provides for full-time supervision of such services by a physician or by a registered nurse; and

E. Has its own administrator; and

F. Maintains a complete medical record on each patient.

2.17 **Home Health Care Plan** means a program for continued care and treatment established and approved in writing by the attending physician. The plan must be established within seven days after leaving a hospital. Confinement has to be for the same or a related illness. The physician must certify that the proper treatment of the injury or illness would require continued care as a resident in a hospital in the absence of services and supplies provided as part of the home health plan.

2.18 **Hospital** means an institution that:

A. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick persons by or under the supervision of physicians; and

B. Maintains clinical records on all patients; and

C. Has bylaws in effect with respect to its staff of physicians; and

D. Has a requirement that every patient be under the care of a physician; and

E. Provides 24-hour nursing service rendered or supervised by a registered nurse; and

F. Has in effect a hospital utilization review plan; and

G. Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and

H. Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically herein provided, the term "Hospital" does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, nor does it mean any institution that makes a charge that a covered person is not required to pay.

2.19 **Illness** means a sickness or disease that is not employment related. Pregnancy is treated in the same manner as an illness under this Plan.

2.20 **Injury** means physical damage to a covered person's body caused by an accident, independent of all other causes and not related to employment.

2.21 **Marriage** means only a legal union between one man and one woman as husband and wife.

2.22 **Medically Necessary** means that the services, supplies, treatment and confinement must be generally recognized in the physician's profession as effective and essential for treatment of the injury or illness for which it is ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered "Medically Necessary," the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies or confinement shall not be considered "Medically Necessary" if they are an Experimental Procedure, or if investigational or primarily limited to research in their application to the injury or illness; or if primarily for scholastic, educational, vocational or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker.

The Trustees reserve the right to review medical care and make a determination as to whether the services, treatment, supplies, confinement, or portion of a confinement, is or is not Medically Necessary. The Trustees may rely on their medical reviewer or an independent reviewer for each determination. The fact that a physician or any other health care provider may order or recommend services, treatment, supplies or confinement does not, of itself, make them Medically Necessary.

The definition and determination of Medically Necessary shall not apply to any services which are covered under the Plan as preventive services. Preventive services means those services and supplies used for routine physical examinations and any such other services which are not for the treatment of an injury or illness, but which are for prevention of disease and for maintenance of good health which may otherwise be covered under the Plan.

2.23 **Medicare** means the federal health insurance program set forth in Parts A and B, Title XVIII of the Social Security Act, as amended.

2.24 **Participant** means any bargaining unit employee, non-bargaining unit employee, union employee, training fund employee, retiree or former employee who has elected COBRA continuation coverage and who is eligible to receive benefits under the Plan.

2.25 **Physician** means a person duly licensed as a medical doctor (M.D.), osteopathic doctor (D.O.), optometrist (O.D.), a chiropractic doctor (D.C.) or podiatrist (D.P.M.) by the state where the service is performed and who is performing services within the scope of his or her license.

2.26 **Plan** with a capital "P" means the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Plan.

2.27 **Plan Year** means the 12 consecutive months that start on May 1st and end on April 30th of any year.

2.28 **Reasonable and Customary** means those charges made for medical or dental services and/or supplies essential to the care of a covered person which will be considered reasonable and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any medical or dental complications, degree of professional skill or unusual circumstances which require additional time, skill or experience. One guide, but not necessarily the only guide, to reasonable and customary shall be Percentile Charges as set forth in the Schedule of Benefits from the most recently published Health Insurance Association of America's Book of Prevailing Charges, adjusted to the appropriate geographic area. Another guide shall be eligible charges for purposes of Medicare reimbursement.

The fact that a service or supply is determined to be medically necessary does not, of itself, mean the charges will be determined to be reasonable and customary.

2.29 **Spouse** means only a person of the opposite sex who is a husband or a wife.

2.30 **Trust** means the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund.

2.31 **Trust Agreement** means the amended and restated Declaration of Trust of the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund.

2.32 **Trustees** mean the persons appointed to act as Trustees of the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund. This term also includes and is the same as "Board of Trustees".

Article 3

ELIGIBILITY

3.01 **Classes of Persons Eligible for Benefits.** Persons who are eligible to receive benefits from the Plan are classified as:

A. Bargaining unit employees

B. Non-bargaining unit employees

C. Retirees

D. Employees of the Union or Training Fund

E. Dependents

3.02 **Bargaining Unit Employee Eligibility.** A bargaining unit employee is a person who performs work for one or more participating employers who are subject to a collective bargaining agreement between such employer(s) and Glaziers, Architectural Metal & Glass Workers Local Union No. 740 and whose work is covered by the agreement. Persons in this classification become eligible for benefits as follows:

A. Initial Eligibility. Each employee covered by a collective bargaining agreement who has contributions paid on his or her behalf for 360 hours or more in three (3) consecutive months shall become eligible for benefits as of the first day of the second month following the third consecutive month in which the 360 hours was accumulated.

B. Continued Eligibility. Any employee covered by the collective bargaining agreement shall remain eligible for benefits for all months in which contributions are paid on his or her behalf for 120 hours or more by one or more participating employers in the next preceding month.

C. Continued Eligibility by Use of Reserve Account. An eligible bargaining unit employee who works in excess of 150 hours in a month will be permitted to accumulate excess hours over 480. If in any month an employee works less than the 120 hours required to maintain eligibility, a transfer of a sufficient number of hours may be made from the reserve account to bring the total hours to the required 120 so that eligibility will continue.

D. Termination of Eligibility. If a bargaining unit employee ceases to satisfy the eligibility requirements set forth in sections A and B and does not have enough hours in the reserve

account described in section C. to meet the minimum monthly hours requirement, the bargaining unit employee's eligibility for benefits under this Plan shall terminate.

E. Employees who leave their employment to serve on military duty covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA) shall have their eligibility and reserve account restored upon return to employment with a contributing employer, provided their return to employment is within the return to reemployment time periods prescribed by USERRA.

3.03 Non-bargaining Unit Employees. Non-bargaining unit employees are persons who perform work for an employer who is party to a collective bargaining agreement with Glaziers, Architectural Metal & Glass Workers Local Union No. 740, whose work is not covered by the terms and conditions of the collective bargaining agreement, whose employer has entered into a written agreement to participate in this Plan and who has had the required contributions paid on the person's behalf.

A. Eligibility for non-bargaining unit employees shall begin on the first day of the second month following the month for which contributions and contribution reserve were first paid. Eligibility shall continue thereafter so long as the required contributions are paid on the person's behalf.

B. Termination of Eligibility shall occur when the required contributions cease being paid on the person's behalf, when the employer's written participation agreement is terminated, when the employee ceases to work the monthly hours required by the employer's participation agreement or when eligibility is terminated under any other provision of this Plan or the Trust Agreement.

3.04 Employees of the Union or the Training Trust. Employees of the Union or the Training Trust are persons who are employed by either District Council 5, International Union of Painters and Allied Trades AFL-CIO, Glaziers, Architectural Metal & Glass Workers Local Union No. 740 or Glaziers, Architectural Metal & Glass Workers Joint Apprenticeship & Journeyman Training Trust who do not participate in another welfare plan, whose employer has entered into a written agreement to participate in this Plan and who has the required contributions paid on the person's behalf.

A. Initial Eligibility, Continued Eligibility and Termination of Eligibility. Union and Training Trust employees shall meet the same eligibility requirements that are required for bargaining unit employees as set forth in section 3.02 A, B, and C. Eligibility for benefits for Union and Training Fund employees shall be terminated in the same manner as benefits are terminated for bargaining unit employees as set forth in section 3.02 D.

3.05 Retiree and Retiree Dependent Eligibility. Employees who retire from active employment may apply for continuing benefit eligibility for themselves and their dependents if they meet the requirements and conditions established by the Trustees.

A. Retiree's Minimum Qualifications Required at Time of Application. To be eligible for continuation of benefits through the Plan as a retiree from active employment, a retiree must make application for such benefits within six months following the date of retirement and:

1. Have retired from employment with a participating employer or the International Union of Painters and Allied Trades, AFL-CIO; and

2. Qualify for a retirement benefit under the Western Glaziers Retirement Fund; and

3. Not be eligible as an employee under any other health benefits plan or Medicare; and

4. Have been eligible for benefits under a health and welfare plan sponsored by the International Union of Painters and Allied Trades, AFL-CIO and have previously

been eligible for benefits from Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund; or

5. Meets the requirements of 1, 2, and 3 and have been eligible as an employee for benefits from the Glaziers, Architectural Metal & Glass Workers Local Union No. 740 Welfare Fund in 24 of the 36 months immediately preceding the date application for continuing eligibility is made. If the employee has been unemployed or partially unemployed during the 12-month period immediately preceding the date application for continuing eligibility is made and the employee cannot satisfy the foregoing 24-month requirement because of such unemployment, any time spent by the employee during the 12-month period actually seeking employment with participating employers will be counted toward satisfying the 24-month requirement. It is the obligation of the employee to prove he or she was seeking employment with a participating employer.

B. Initial and Continued Eligibility. A retiree's initial eligibility must immediately follow active employee coverage without a break in benefit entitlement. Eligibility shall continue thereafter so long as the required contributions are paid on the retiree's behalf and the Trustees permit retirees to continue to be eligible for participation for benefits under the Plan.

C. Payment. A retiree who elects to continue eligibility under this Plan for the retiree and/or the retiree's dependents shall have contributions for such eligibility deducted each month from the retiree's benefits paid by the Western Glaziers Retirement Fund. Should the retiree's retirement benefit be inadequate to pay the contribution required for eligibility for benefits, no deduction from the retiree's retirement benefits shall be made and the retiree shall be billed monthly by the Administrative Agent for the full contribution amount. The retiree's payment is due on the first day of the month and must be received by the Administrative Agent not later than the last day of the month in which benefit eligibility is sought. If the last day falls on a Saturday, Sunday or holiday, the next working day will be considered to be the deadline for receipt of such payment. If eligibility for benefits ends because of failure to make the required payment, the retiree may not reapply for eligibility.

D. Cost of Eligibility for Benefits. The Trustees shall determine the amount of the retiree's and their dependent's payment for eligibility for benefits. The Trustees reserve the right to increase or decrease the amount of the payment and also reserve the right to increase, decrease, change or eliminate the benefits.

E. Retiree Dependent Eligibility. A retiree may elect to purchase medical coverage for those dependents defined in Section 3.06. Dependents who are eligible for other health coverage or Medicare are not eligible for coverage under the Plan. The cost for medical coverage under the Plan shall be determined by the Trustees. A dependent must be enrolled on the date when the retiree's medical coverage is commenced.

F. Continuation of Coverage for Dependents of a Deceased Retiree. Dependents of a deceased retiree may elect to continue to remain eligible for benefits after the retiree's death provided the dependents pay the contribution required by the Trustees. Eligibility for benefits for a dependent spouse or child may be continued for at least six months regardless of the occurrence of any of the terminating events set forth in subparagraph G.

G. Termination of Coverage for Dependents of a Deceased Retiree. Eligibility for benefits for a dependent of a deceased retiree will terminate upon the earliest occurrence of any of the following events:

1. The date the spouse remarries; or

2. The date the dependent becomes eligible under another health plan or Medicare; or

3. Five years.

4. With respect to dependent child, the date the dependent child ceases to be a dependent of the deceased retiree's spouse.

5. Nonpayment of the required contribution within or prior to the calendar month in which the dependent seeks benefit eligibility.

H. Termination. Termination of Eligibility for retirees and their dependents shall occur when:

1. The Trustees change the eligibility rules, eliminate retiree participation or eliminate the Plan, or

2. A retiree returns to employment and qualifies for benefits under another health insurance or health benefits plan, or

3. A retiree ceases to be eligible for pension benefits as provided under the terms of the Western Glaziers Retirement Fund, or

4. A retiree returns to employment or self-employment in the glazing industry unless the employment is with an employer who is required to make contributions to this Plan and that employment is insufficient to entitle the retiree to become eligible for benefits as an employee, or

5. The retiree ceases to pay the required monthly contribution. If coverage terminates because of delinquency of contribution payments, the retiree may not reapply for eligibility for benefits, or

6. The retiree and/or their dependent becomes eligible under Medicare.

I. Continuation of Eligibility for Dependents of Retirees after the Retiree Becomes Eligible for Medicare. Eligibility for benefits by a retiree's dependents may continue after the retiree's eligibility ceases as a result of the retiree's eligibility for Medicare. To continue benefit eligibility for retiree's dependents, the dependents must elect to continue eligibility prior to the date when the retiree becomes eligible for Medicare. The amount of contribution required to be paid by the dependents shall be the amount established by the Trustees. Nonpayment of the required contribution within or prior to the calendar month in which the dependents seek eligibility shall terminate the dependents eligibility to participate in the Plan. In the event the retiree dies while his or her dependents continue to be eligible for benefits, the dependent's eligibility will be continued on the same basis as the dependent of a deceased retiree as provided for in Sections F and G of this paragraph.

J. Cancellation of Retiree Eligibility by Trustees. The Trustees, in their sole discretion, may amend, alter or terminate the eligibility and benefits provided to retirees and their dependents at anytime.

3.06 Dependents. Dependents are the lawful spouse and unmarried dependent children of eligible employees, eligible retirees or COBRA participants. Unmarried dependent children are the natural children, legally adopted children, stepchildren and foster children of an eligible employee, eligible retiree or COBRA participant who are less than 19 years of age and who are dependent on the eligible employee, eligible retiree or COBRA participant for support and maintenance. Stepchildren and foster children must be a permanent resident of the eligible employee's, eligible retiree's, deceased retiree's spouse's or COBRA participant's household. If an unmarried dependent child is 19 years of age or older and is attending school as a full-time student, the child shall be eligible for benefits as a dependent until age 23. Any dependent child who is incapable of self-sustaining

employment by reason of a disability caused by mental retardation or physical handicap when the maximum age as defined above is reached will continue to qualify as an eligible dependent until age 23 so long as the child remains disabled, unmarried and is dependent on the employee, retiree, deceased retiree's spouse or COBRA participant for support and maintenance provided proof of such incapacity is submitted to the Trustees. Proof of continued incapacity shall be furnished to the Trustees from time to time upon their request. No unmarried dependent child shall be eligible for benefits under this Plan after his or her 23rd birthday. A person shall not qualify as an eligible dependent if such person qualifies as an eligible employee.

A. Eligibility. Dependents shall be eligible to receive benefits under this Plan when the employee, retiree or COBRA participant becomes eligible. Newborn and adopted children will be covered from birth or date placed for adoption for charges as a result of sickness, injury, congenital defects **or** premature birth. Dependents who are eligible for benefits under another health plan or Medicare are not eligible for benefits under this plan.

B. Termination of Dependent's Eligibility. Unless otherwise provided for in this Article, termination of a dependent's eligibility will take place when the employee's, retiree's, deceased retiree's spouse's or COBRA participant's eligibility ceases **or** when the dependent becomes eligible for benefits under another health plan or Medicare.

C. Qualified Medical Child Support Order (QMED). A court or state agency order may require a participant to continue a dependent child's eligibility for Plan benefits. A copy of the Plan's QMED determination procedures are available from the administrative agent without charge. For a free copy of the Plan's procedures, contact the William C. Earhart Company, Inc. by telephone (503-282-5581) or by mail at P.O. Box 4148, Portland, OR 97208.

Article 4

MEDICAL BENEFITS
GENERAL RULES

The Plan uses the services of Providence Preferred which has a panel of preferred medical providers and a list of preferred medical facilities. Use of a Providence Preferred provider or facility will usually result in a savings in the overall cost of medical services. However, the use of Providence Preferred medical providers or facilities is not required to obtain Plan benefits.

4.01 Eligibility. All classes of persons eligible for benefits as described in Article 3 who have not elected medical benefits under a Kaiser health plan are eligible for the medical benefits contained in this Article.

4.02 Explanation of How Benefits are Paid and the Use of Providence Preferred. The Plan pays benefits under two categories: Base Benefits and Major Medical Benefits. Base Benefits are set forth in the Schedule of Medical Benefits, Section 4.13. The Plan will first pay the amount of Base Benefits. If the amount of Base Benefits is not sufficient to pay all covered charges incurred, then the Plan will pay Major Medical Benefits as follows: if a preferred provider or medical facility is used, the Plan will pay 80% of the first $2,000.00 in charges and 100% of any additional charges in each calendar year; if a non preferred provider of facility is used, the Plan will pay 70% of the first $2,000.00 in charges and 90% of any additional charges in each calendar year. Major Medical Benefits are set forth in Sections 4.14 and 4.15. Base Benefits are not subject to the deductible. Unless otherwise specified, before Major Medical Benefits are paid, the covered person must first pay the deductible set forth in Section 4.03.

4.03 Deductible. The deductible is the amount of covered charges that is the sole responsibility of the covered person and which must be incurred each calendar year before the Plan is obligated to pay any Major Medical benefit expense.

A. Covered Person. The amount of the deductible is $150.00 for each covered person. After the deductible has been satisfied in a calendar year, no further deductible will be applied toward other covered charges incurred during the remainder of that calendar year.

B. Family of Covered Persons. The amount of the deductible for an entire family of covered persons is $300.00. After the family deductible has been satisfied in a calendar year, no further deductible will be applied toward other covered charges incurred by the entire family during the remainder of that calendar year.

C. Carryover of Satisfied Deductible. Any covered charges applied toward the deductible in the last 90 days of a calendar year may be carried over and combined with subsequent covered charges to satisfy the deductible for the following calendar year.

4.04 **Maximum Lifetime Benefit Payment.** The maximum lifetime benefit payment for each participant is $500,000.00. After an amount of Major Medical Benefits equal to or greater than the maximum payment amount has been paid for expenses incurred by any one person, $25,000.00 will automatically be added to the balance of the maximum payment the first of each calendar year until the original maximum is reinstated. In the discretion of the Trustees, the maximum may be restored in its entirety by providing evidence of good health acceptable to the Trustees.

4.05 Hospital Benefits. The following benefits are provided:

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

A. Room Benefits are provided up to a maximum of seventy (70) days for any one period of hospital confinement. Two or more periods of hospital confinement are considered one period of confinement unless between confinements an employee has returned to full time work. In the case of a retiree, dependent, or other covered person, if two hospital confinements are separated by more than three months each confinement shall be considered one confinement period. Confinements due to entirely unrelated causes are also considered as separate confinements.

B. Miscellaneous Hospital Expense Benefits are provided for the hospital's customary charge for operating room, X-rays, laboratory examinations, medicines, dressings, drugs, anesthetic materials and equipment and other necessary items.

C. Private Ambulance Service is provided for local emergency transportation.

D. Hospital Outpatient Expense Benefits. Covered charges include treatment for injuries that require emergency hospital out-patient attention within 48 hours following an accident, or for hospital care, treatment or services at the time of a surgical operation when there is no charge made for room and board. The covered person shall pay the first $100.00 of charges for each hospital out patient visit.

E. Hospital Out Patient Sickness Benefits. Covered charges include treatment for illness which requires emergency hospital out patient attention including regular and customary physician charges provided there is no charge for room and board. The covered person shall pay the first $100.00 of charges for each hospital ou -patient visit.

F. In-Hospital Medical Benefits. Should a covered person need medical attention when confined as a resident patient in a hospital as a result of accidental bodily injuries or sickness, the Plan will pay for covered charges specified in the Hospital Visit schedule; however, benefits shall not exceed the amount for each call nor the maximum benefits shown in the Schedule of Benefits for any one period of hospital confinement.

G. Extension of Benefits. Hospital Benefits will be payable if a covered person is confined in a hospital at any time within 13 weeks after eligibility for benefits has terminated, provided the covered person has been totally and continuously disabled and under the regular care of a legally qualified physician from the date benefit eligibility terminates to the date hospital confinement begins. Benefits will not be paid for charges incurred beyond the date the covered person becomes eligible for benefits under another group plan.

H. Benefits Will Not Be Paid For:

1. More than one doctor call each day, or

2. Care following surgery during the period of time considered follow-up care under the Surgical Benefits provision.

4.06 Surgical, Anesthesia and Assistant Surgeon Benefits. The following benefits are provided:

A. One Operation, Two or More Surgical Procedures. Two or more surgical procedures performed during a single operation through the same incision, or in the same natural body orifice, or in the same operative field will be considered as one procedure and payment will not exceed the benefit specified for the most expensive procedure. In the case of multiple surgical procedures in separate operative fields and separate incisions, 50% of the allowance for the minor procedures will be paid in addition to the amount payable for the major procedure, unless otherwise specified in the Surgical Schedule.

B. Maximum Payment. The aggregate payment for all surgery performed during one period of disability shall not exceed the maximum payment shown in the Schedule of Medical Benefits.

C. Successive Surgical Procedures for Related Causes. Successive surgical procedures due to related causes are considered as having been performed during one period of disability unless an employee has returned to regular work full time between procedures, or, in the case of a retiree, dependent or other covered person, a period of more than three months elapses. Subsequent operations due to causes entirely unrelated to the causes of the previous operation are considered as being performed during one period of disability.

D. Unlisted Cutting Procedures. To determine the value of a cutting procedure not listed in the Surgical Schedule, the Trustees will determine the benefit amount by taking into account the nature and complexity of the procedure involved, and the exceptions, limitations and exclusions of the Plan.

E. Assistant Surgeon Benefits.

1. Benefits payable to an assistant shall be the greater of: (a) 20% of the maximum payment listed for the surgical procedure, or (b) $42.00.

2. Surgical conditions regarding multiple surgical procedures are equally applicable to assistant surgeon procedures.

F. Anesthesia Conditions. Anesthesia services include the customary preoperative and postoperative visits, the administration of the anesthetic and the administration of fluids or blood incident to the anesthesia or surgery.

G. Additional Surgical Expense Benefit. When a covered person undergoes surgery for which benefits are payable under Surgical Benefits and when the surgery is not performed in a hospital, benefits will be payable for the charges incurred for the necessary anesthetics, surgical dressings, drugs or other surgical supplies, but not to exceed the maximum amount shown in the Schedule of Benefits.

H. Extension Of Benefits. Surgical Benefits will be payable if a covered person has a surgical operation performed at any time within 13 weeks after eligibility for benefits terminates, provided the covered person is totally and continuously disabled and under the regular care of a legally qualified doctor of medicine from the date eligibility for benefits terminates to the date the operation is performed.

4.07 Home and Office Doctor Call Benefits.

A. Doctor Calls. If a covered person needs medical attention as a result of accidental bodily injury or sickness, the Plan will pay for the actual charge made by a legally qualified doctor of medicine, for medical attention, but not to exceed the amount per call nor the Maximum Benefit shown in the Schedule of Benefits for any one calendar year. These benefits begin with the first call and are payable for doctor's calls at the covered person's home or at the doctor's office.

B. Hospital Doctor Visits. If disability results in a surgical operation, benefits will be payable under the Home and Office Doctor Call Benefits provision for treatment by a legally qualified doctor of medicine only when such doctor is other than the one who performed the surgical procedure.

C. Benefits will not be paid for more than one call per day.

D. Chiropractic Services. Benefits for non-surgical muscosekletal disorder treatment are payable at 80% to a maximum of $25.00 per visit up to 30 visits per calendar year. Benefits for necessary x-rays and lab services related to non-surgical muscosekletal disorder treatment are payable at 80% to a maximum of $100.00 per calendar year.

4.08 Maternity Benefits.

A. Female Employees and Dependent Wives. Maternity benefits will be payable in the same manner as any sickness under the Base Plan Benefits and Major Medical Benefits.

B. Dependent Children. No maternity benefits are provided for expenses incurred by a dependent child. Benefits are provided for expenses incurred as a result of complications from pregnancy.

4.09 X-Ray And Laboratory Expense Benefits.

A. Covered Charges.

The Plan will pay for actual charges for X-rays or laboratory examinations needed as a result of accidental bodily injuries or sickness, when a covered person is not confined as a resident hospital patient.

B. Benefits Will Not Be Paid For:

1. Examinations not performed by, or under the supervision of, a legally qualified physician, or

2. Dentistry or optometry, or

3. Any examination for which benefits are provided under any other provision of this plan, or

4. Examinations not related to an injury or illness.

4.10 Supplemental Accident Expense Benefits.

A. When a covered person needs additional medical attention as a result of accidental bodily injuries within ninety days from the date of an accident, the Plan will pay reasonable and customary charges in the community in which service is rendered for:

1. Surgery or medical treatment or services performed by a legally qualified physician.

2. Hospital care.

3. Nursing care provided by a registered graduate nurse.

4. X-ray and laboratory examinations that are in excess of any benefits payable under any other provision of this Plan.

5. Ambulance to and from the hospital.

4.11 Hearing Examination and Hearing Aids. One hearing examination and necessary hearing aids every five years from the date of the first examination. Eighty percent (80%) of the cost up to $1,400.00 will be allowed for each ear for each participant during each five-year time period. Hearing aid batteries or repairs are not included in this benefit.

4.12 TMJ and Orthognathic Treatment. The benefit for treatment of the temporomandibular joint (TMJ) and Orthognathic treatment shall be limited to a lifetime total benefit of $4,000.00.

PART A - BASE BENEFITS

4.13 Schedule of Base Medical Benefits Available for Eligible Persons

A. Doctor, Home & Office Medical Benefits

Home & Office Visit
For employees $12.00
For dependents $8.00
For retirees and other covered persons $8.00
Maximum Visits per Calendar Year 70

B. Hospital Visits

1. NEW OR ESTABLISHED PATIENT

90200 Initial hospital care, brief or limited history and examination, including the initiation of diagnostic and treatment program and preparation of hospital records $52.50

90215 Initial hospital care, intermediate history and examination including initiation of diagnostic and treatment program and preparation of hospital records $77.50

90220 Initial hospital care, comprehensive history and examination including initiation of diagnostic and treatment program and preparation of hospital records $111.00

90230 Initial hospital care, usually complex medical problem, necessitating a comprehensive history and examination examination, extensive review of prior medical records, assessment of data and preparation of hospital records ..... By report

2. ESTABLISHED PATIENT, FOLLOW-UP CARE

90240 Brief examination, evaluation, and/or treatment, same illness $19.50

90250 Limited examination, evaluation and/or treatment, same or new illness (characteristic of the usual hospital visit) $26.50

90260 Intermediate examination, evaluation and/or treatment, same or new illness $32.50

90270 Extended re-examination or re-evaluation $43.50

90275 Final hospital care for discharge of a patient including final examination of the patient, discussion of the hospital stay, prognosis, instructions to the patient for continuing care, and preparation of discharge records $43.50

C. Hospital Expense Benefits

Daily Room and Board $60.00
Days Payable 70

Miscellaneous Expenses ..... 100% of Usual and Customary Charges
Ambulance Benefit $25.00
Post Surgery Hospital Outpatient Benefit $25.00

D. Surgical Benefits

Surgical Procedure

1. INTEGUMENTARY SYSTEM

Skin, Mucous Membrane, Subcutaneous, Areolar Tissues

Excision of nail and/or nail matrix, partial or complete, e.g., ingrown or deformed nail for permanent removal $60.0
Wounds, recent, up to two and one-half inches $12.00

Breast

Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duet lesion (including gynecomastia) or nipple lesion (including any other partial mastectomy), male or female

Unilatera $90.00
Bilateral $150.00
Complete (simple) mastectomy $180.00

2. MUSCULOSKELETAL SYSTEM

Fractures

Vertebral body, one or more requiring reduction $180.00
Humerus, shaft, simple, closed reduction $150.00
Radius or ulna, shaft, simple, closed reduction $120.00
Radius or ulna, shaft, simple or compound, open reduction $240.00
Radius and ulna, simple, closed reduction $150.00
Radius and ulna, simple or compound, open reduction $300.00
Metacarpal, one, simple or compound, closed reduction, with uncomplicated soft tissue closure $60.00
More than one, simple or compound closed reduction, with uncomplicated soft tissue closure $75.00
Femur, shaft, including supracondylar, simple, closed reduction .. $240.00
Patella, simple or compound, open reduction $300.00
Tibia and fibula, shafts, simple, closed reduction $180.00
Ankle, bimalleolar (including Pott's), simple, closed reduction $150.00

Joints

Arthrectomy: Excision of joint (see Arthrodesis)
Excision of intervertebral disc $540.00
Meniscectomy: Excision of semilunar cartilage of knee joint $300.00
Arthrodesis: Fusion of joint
Hip $600.00
Ankle $420.00
Hammer toe, operation, one toe $120.00
Dislocations
Clavicle, sternoclavicular, simple, closed reduction, with anesthesia $60.00
Elbow, simple, closed reduction $30.00
Compound with uncomplicated soft tissue closure $150.00
Knee (femoral-tibial joint), simple, closed reduction $120.00
Simple or compound, open reduction $360.00

Tendons

Tenolysis, single $150.00

3. RESPIRATORY SYSTEM

Nose

Classic submucous resection, nasal septum $180.00
Accessory Sinuses Antrotomy, intranasal
Unilateral $90.00
Bilateral $150.00
Radial antrotomy (Caldwell-Lue), unilateral $300.00

Larnyx

Laryngectomy, without neck dissection $600.00
Laryngoscopy, direct, diagnostic (independent procedure) $60.00
With biopsy $90.00

Lungs and Pleura
Total pneumonectomy $600.00
Total, subtotal or segmental lobectomy $600.00
Surgical Collapse Therapy
Pneumothorax: Intrapleural injection of air, initial $30.00

4. CARDIOVASCULAR SYSTEM
Heart and Pericardium
Mitral valve, valvotomy (commissurotomy)
(closed) $840.00
Valvuloplasty for stenosis or insufficiency
(open) $1,200.00
Replacement (open) $1,200.00
Arteries and Veins
Repair of atrial septal defect $1,200.00
Ligation and division and complete stripping of long or short saphenous veins
Unilateral $180.00
Bilateral $300.00
Long and short saphenous veins
Unilateral $240.00
Bilateral $360.00

5. DIGESTIVE SYSTEM
Adenoids and Tonsils
Tonsillectomy, with or without adenoidectomy
Under age 18 years $90.00
Age 18 years or over $120.00
Esophagus
Esophagoscopy, diagnostic $90.00
Stomach
Total gastrectomy $600.00
Subtotal or hernigastrectomy, without vagotomy $480.00
With vagotomy $540.00
Intestines (Except Rectum)
Enterectomy: Resection of small intestine with anastomosis $420.00
Colectomy: Partial resection of large intestine in two stages, including first stage colostomy or cecostomy $600.00
Enterostomy: External fistulization of intestines (independent procedure)
Small bowel (ileostomy or jejunostomy) $300.00
Large bowel (colostomy or cecostomy) $300.00

Revision of colostomy
Simple (release of superficial sear) $30.00
Complicated (reconstruction in depth) $150.00
Appendix
Appendectomy $240.00
Rectum
Complete proctectomy, combined abdominal-perineal, one or two stages $600.00
Fissurectomy, with or without sphincterotomy $120.00
Hemorrhoidectomy, external, complete $120.00
Internal and external $180.00

Biliary Tract
Cholecystotomy or cholecystostomy with exploration, drainage or removal of calculus $300.00
Cholecystectomy $480.00
Abdomen, Peritoneum and Omentum
Exploratory laparotomy; exploratory cellotomy $240.00
Hernioplasty; Herniorrhaphy; Herniotomy
Inguinal, unilateral $210.00
Femoral, unilateral $210.00

6. URINARY SYSTEM
Kidney
Pyelostomy with removal of calculus; pyelolithotomy; pelviolithotomy $420.00
Nephrectomy, including partial ureterectomy $480.00
With total ureterectomy through same or separate incision $600.00
Bladder
Cystotomy or cystostomy with fulguration $360.00
Transurethral resection of large bladder tumors $360.00
Cystoscopy, diagnostic, initial, office $30.00
Cystoscopy with fulguration of small bladder tumors $150.00

7. MALE GENITAL SYSTEM
Penis
Circumcision, clamp procedure, except newborn $30.00
Testis
Orchiectomy, simple, unilateral $120.00
Epididymis
Epididymectomy, unilateral $180.00
Spermatic Cord
Excision of varicocele (independent procedure)
Unilateral $180.00
With hernia repair $240.00
Prostate
Prostatectomy, perineal, subtotal $480.00
Perineal, radical $600.00
Suprapubic, one or two stages $480.00
Transurethral resection of prostate including control of postoperative bleeding, complete $480.00

8. FEMALE GENITAL SYSTEM
Vulva
Vulvectomy, complete $330.00
Partial, less than 80% of vulvar area $240.00
Excision of Bartholin's gland or cyst $120.00
Oviduct
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (independent procedure) $230.00
Uterus and Cervix Uteri
Hysterectomy
Total hysterectomy (corpus and cervix) with or without tubes, and/or ovaries, one or both $360.00
Supracervical hysterectomy; subtotal hysterectomy $330.00
Trachelectomy, cervicectomy: Amputation of cervix (independent procedure) $120.00

Dilation and curettage, diagnostic and/or therapeutic non-obstetrical) $90.00

9. ENDOCRINE SYSTEM

Thyroid Gland

Thyroidectomy, total or complete $420.00
Subtotal or partial $360.00
Total or subtotal, for malignancy, with radical neck dissection $600.00

10. NERVOUS SYSTEM

Skull, Meninges and Brain

Craniotomy following trauma

Evacuation of hematoma, subdural, extradural, or intracerebral by craniotomy, including necessary burr holes $600.00

Craniotomy for nontraumatic causes

Craniotomy for lobotomy, unilateral $240.00

Spine and Spinal Cord

Spinal puncture, lumbar, simple (independent procedure) $12.00
Laminectomy for lesion of spinal cord or meninges $600.00
Laminectomy for removal of intervertebral discs, cervical, lumbar or thoracic $540.00
Myringotomy; tympanotomy; plicotomy; with or without eustachian inflation and/or aspiration $18.00
Mastoidectomy, simple $300.00
Fenestration of semicircular canal $600.00

11. MATERNITY SCHEDULE

Obstetrical procedures under the Surgical Schedule will be:

		Follow Up Days
Total obstetrical care, including antepartum care, obstetrical delivery and postpartum care (with or without low forceps, and/or episiotomy)	$210.00	45
Classic Cesarean Section	$300.00	45
Ectopic pregnancy, tubal, requiring salpingectomy, and/or oophorectomy, abdominal or vaginal approach	$300.00	60
Miscarriage	$120.00	45

E. Laboratory and X-Ray Benefits

Maximum per accident $150.00

F. Supplemental Accident Benefit $500.00

G. Chemical Dependency and Mental and Nervous Disorders Treatment ..... See Part C

H. Well Newborn Baby Care. A well newborn baby shall have benefits paid through the first seven (7) days of life for routine nursery charges, examination fees and circumcision when such services are not required as a result of symptoms of illness or injury.

I. Routine Physical Examinations. The Plan shall pay up to 400.00 for routine physical examinations in any 24-month period for each participant at least eight (8) days or age or older. Routine physical examinations shall include: a physical examination of the heart,

lungs and abdomen, an evaluation of the participant's general health status, diagnostic services as may be required as part of the examination, necessary immunizations and booster shots. Routine physical examinations may also include mammogram, pelvic or prostate examinations and pap smear test. Routine physical examinations shall not include services required as a result of an illness, injury or symptoms of illness.

J. Colonoscopy. For eligible person age 50 or older, the Plan pays 100% of charges up $2,000.00 for a routine colonscopy exam once every five (5) years if performed by a preferred medical provider. If not performed by a preferred provider, the plan will pay as a Major Medical Benefit.

PART B MAJOR MEDICAL BENEFITS

The Plan uses the services of Providence Preferred which has a panel of preferred medical providers and a list of preferred medical facilities. Use of a Providence Preferred provider or facility will usually result in a savings in the overall cost of medical services. However, the use of Providence Preferred medical providers or facilities is not required to obtain Plan benefits.

4.14 When and How Major Medical Benefits are Provided and the Use of Providence Preferred. Major Medical Benefits are provided if a covered person incurs covered charges in excess of the Base Benefits and the deductible. The amount of Base Benefits paid by the Plan is not included in calculating the Major Medical Benefits. The Major Medical Benefit is the percentage payable of covered charges incurred in excess of the deductible and Base Benefits. The percentage of covered charges that a covered person may be required to pay may not be used to satisfy the deductible nor are such charges payable under the Plan. Surgical benefits are not subject to the application of the deductible. As Major Medical Benefits, the Plan will pay as follows: if a preferred provider or facility is used, the Plan will pay 80% of the first $2,000.00 in charges and 100% of any additional charges in each calendar year; in a non preferred provider is used, the Plan will pay 70% of the first $2,000.00 in charges and 90% of any additional charges in each calendar year.

4.15 Covered Charges Under Major Medical Benefits. Covered charges under the Major Medical Benefit are the following charges that are incurred for services and supplies recommended by the attending physician provided they are reasonably necessary for treatment and are reasonable and customary charges:

A. Hospital charges for room and board:

1. Private room - the average semiprivate room charge in the hospital where confined.

2. Semiprivate room - the average semiprivate room charge in the hospital where confined.
3. Ward accommodation - the ward accommodation charge in the hospital where confined.

B. Hospital charges for drugs, medicines and other services and supplies.

C. Hospital charges for outpatient services.

D. Physician's charges for hospital and office calls.

E. Charges of a certified nurse practitioner, registered nurse (R.N.) or qualified physiotherapist, unless such person ordinarily resides in a covered person's household or is a member of a covered person's family.

F. Charges for local professional ambulance service.

G. Extraordinary professional Ambulance service, if the accidental injury or sickness requires special and unique hospital treatment, transportation by a professional ambulance, railroad or commercial airline on a regularly scheduled flight within the United States or Canada to the nearest hospital equipped to furnish treatment not available in a local hospital.

H. Charges for the following services and supplies:

1. Drugs and medicines requiring a physician's written prescription,

2. Diagnostic X-ray and laboratory service,

3. Oxygen and the rental equipment for its administration,

4. Blood or blood plasma and its administration,

5. Radium, radioactive isotopes and X-ray therapy,

6. Casts, splints, braces, trusses and crutches,

7. Rental (up to the purchase price) of hospital type equipment including hospital bed, wheel chair, iron lung or similar durable therapeutic equipment,

8. Artificial limbs and eyes to replace natural limbs and eyes lost while eligible for benefits,

9. Dental services rendered by a physician or dentist for the treatment of an injury to the jaw or to natural teeth, resulting from an accident occurring while eligible for benefits, provided the treatment is rendered within six months of the accident. Dental services include the initial replacement of these teeth and any necessary dental X-rays.

I. Charges for pregnancy and childbirth.

J. Charges for a diabetes self-management education program. This means instruction on an outpatient basis for a person with diabetes to learn the disease and its control. The program must be provided by health care professionals such as physicians, nurses, pharmacists and registered dieticians, who are knowledgeable about the disease process of diabetes and the treatment of a person with diabetes. The Plan will not pay more than the lesser of $120 or 75% of the charges incurred, for the successful completion of a self-management education program. This benefit is available only once during each participant's lifetime.

K. Colonoscopy. For eligible persons age 50 and older, the Plan pays up to $2000.00 for a routine colonoscopy exam performed once every five (5) years by a non preferred provider subject to the Plan Deductible in Section 4.03 and the co-payment requirements of Section 4.14.

L. Prescription Medication and Supplies.

1. Prescription Medication and Supplies are provided as a major medical benefit under Section 4.15 H (1), by either a retail drug card at an approved pharmacy or by mail order at an approved mail order pharmaceutical facility.

2. Medications and Accessories defined. Medications are insulin, drugs or medicines that relate directly to the treatment of an illness or injury and which cannot be legally dispensed without a prescription. The containers that contain medication must bear the legend “Caution--Federal law prohibits dispensing without prescription.”

Accessories include diabetic supplies, insulin syringes, needles, glucose tablets, test strips and lancets.

3. Exclusions: Medications and accessories do not include contraceptive drugs or devices, abortion drugs or devices except where life of the mother would be endangered, drugs available without a prescription, drugs for which there is a non-prescription equivalent available, smoke cessation medications, injectable medications, drugs for cosmetic purposes, drugs to enhance athletic performance, drugs to treat infertility, obesity medications, medical supplies such as dressings and antiseptics, disposable needles and syringes needed to inject medications other than insulin.

4. Retail Drug Card. Medications and accessories may be obtained through the use of a retail drug card. A retail drug card is to be obtained from the Plan Administrative Agent. Medications and supplies must be obtained from a Plan approved pharmacy and will be dispensed for up to a 34-day supply. A participant shall be required to pay a $10.00 co-pay charge for each generic prescription medication filled or refilled and a $40.00 co-pay charge for each brand named medication.

5. Mail Order Medications. Medications may be obtained through the use of a mail service prescription program. Mail order forms can be obtained from the Plan Administrative Agent. Medications and supplies must be obtained from a Plan approved mail order pharmaceutical service. A supply of up to 90 days of medication may be obtained for each prescription or prescription refill. A participant shall be required to pay a $5.00 co-pay charge for any generic prescription medication filled or refilled and shall be required to pay a $30.00 co-pay charge for each brand named medication.

M. Mammoplasty. Persons receiving benefits in connection with mastectomy coverage will be provided, in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prosthesis and treatment of physical complications of the mastectomy, including lymphedema; and, all other benefits required to be provided by the Women's Health and Cancer Rights Act of 1988.

4.16 Extension Of Benefits.

A. Total Disability Requirement. If a covered person is totally disabled on the date the eligibility for benefits terminates, Major Medical Benefits will be payable for covered charges for treatment of the disability which caused the total disability and which are incurred up to one year after the date eligibility for benefits terminates or until the covered person becomes eligible for benefits under another health plan, whichever occurs first.

B. Definition of Totally Disabled. "Totally Disabled" means that because of injury or sickness:

1. A covered person is unable to engage in any occupation for wages or profit for which he or she is qualified by reason of education, training or experience, or

2. A dependent retiree or other eligible person is unable to engage in the normal activities of a person of same sex and age.

4.17 Limitations on Sections 4.02 to 4.16

Third Party Liability Maximum Benefit. Benefits not to exceed $5,000.00 may be paid when charges are incurred for treatment of any injury, illness or disability caused by a third party against whom a

claim of liability could be asserted. No benefits shall be paid under this section until all primary plans have paid the full amount of their benefits, nor shall benefits be payable under this section unless the employee, dependent or covered person asserts and pursues a claim against the third party and signs a reimbursement agreement with the Trust in a form adopted by the Trustees. Benefits paid under this section are subject to the offset provisions of Article 12, Section 12.04.

4.18 Exclusions to Sections 4.02 to 4.17. No benefits are payable under sections 4.02 through 4.17 for:

A. Eye refractions or the fitting or cost of eyeglasses.

B. Cosmetic surgery.

C. Charges that the covered person is not required to pay.

D. Pregnancy charges for dependents, unless they are for complications of pregnancy, as defined in Article 2, Section 2.06.

E. Charges incurred for treatment of any injury or illness that is a result of war, or an act of war, whether declared or undeclared.

F. Any expense that exceeds reasonable and customary charges.

G. Charges incurred for custodial care.

H. Charges incurred for experimental procedures.

I. Charges incurred for treatment of any injury that is a result of self-infliction whether sane or insane or participation in a felony, riot or insurrection.

J. Charges incurred for confinement or services in a hospital owned or operated by the federal government, except reasonable and customary charges otherwise payable under this Plan which were incurred by (a) a covered person at a Veteran's Administration Facility; or (b) a covered person who is an armed service retiree, for services or supplies which are not related to military service.

K. Charges for dental care or treatment or dental x-rays, unless specifically provided.

L. Disability due to an accidental bodily injury arising out of and in the course of the covered person's employment or self-employment.

M. Disability due to occupational disease arising out of and in the course of the covered person's employment or self-employment.

N. Charges for elective abortions, except where the life of the mother would be endangered if the fetus were to be carried to term, or for complications of an abortion.

O. Charges for pregnancy for a dependent child, except for complications of pregnancy, as defined in Section 2.06.

P. Transportation, except as provided in sections 4.15 F and G.

Q. Charges incurred for recreational or leisure therapy.

R. Treatment for obesity or weight control, including surgery or any other treatment provided for obesity or weight control, and any complications arising out of or related to such treatment,

whether or not there is a medical condition related to or caused by obesity or treatment of obesity.

S. Sexual disorders, including services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.

T. Charges incurred for treatment of any injury, illness or disability caused by a third party against whom a claim of liability could be asserted except as provided for in Article 4, Section 4.17.

U. More than one doctor call each day during a period of hospitalization or more than one doctor, home or office call per day.

V. Care following surgery during the period of time considered follow up care under the Surgical Benefits provision contained in Section 4.13 B. 2.

W. Preventive inoculations.

X. Charges of a certified nurse practitioner, registered nurse (R.N.) or qualified physiotherapist when such person ordinarily resides in a covered person's household or is a member of a covered person's family.

Y. Dental services rendered by a physician or dentist for the treatment of an injury to the jaw or to the natural teeth resulting from an accident when occurring while eligible for benefits if the treatment is not rendered within 6 months of the accident.

Z. Addiction to or dependency on tobacco, tobacco products or foods.

AA. Charges of any institution, or part thereof, that is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged.

BB. Chemical dependency educational programs or volunteer mutual support group programs.

PART C CHEMICAL DEPENDENCY AND MENTAL AND NERVOUS DISORDERS TREATMENT EXPENSE BENEFIT

4.19 Definitions to be used exclusively for this section are:

A. Adult means a covered person who is over 17 years of age.

B. Bargaining Unit Employee means a person who performs work for one or more participating employers who are subject to a collective bargaining agreement between such employer(s) and Glaziers, Architectural Metal & Glass Workers Local Union No. 740 and whose work is covered by that agreement.

C. Chemical dependency means the addictive relationship an individual may have with any drug or alcohol agent. The addiction may be physical, psychological, or both. It must interfere with the covered person's adjustment to common problems on a daily basis. Chemical dependency does not include addiction to tobacco products or foods.

D. Child means a covered person who is 17 years of age or less.

E. Educational programs or volunteer mutual support group programs are not considered chemical dependency programs.

F. Health facility means a hospital or other institution approved by the appropriate authority of the jurisdiction in which it is located for the inpatient care and treatment of chemical or mental and nervous disorders. The treatment must be part of a program under which the staff are directly supervised by or the individual's treatment plan is approved by a licensed physician, psychologist, nurse practitioner, or clinical social worker.

G. Outpatient treatment means a program approved by the appropriate authority of the jurisdiction in which it is located for the treatment of chemical dependency or mental and nervous disorders on an outpatient basis. The program must be one under which the staff is directly supervised by or the individual's treatment plan is approved by a legally licensed physician, psychologist, nurse practitioner, or clinical social worker. The program may include part-day treatment at a residential treatment facility on a less intensive schedule than set forth in the definition of residential treatment facility. Educational programs or volunteer mutual support group programs are not considered chemical dependency programs.

H. Residential treatment facility means an institution approved by the appropriate authority of the jurisdiction in which it is located for the treatment of chemical dependency or mental and nervous disorders in a residential setting. The treatment must be part of a program under which the staff are directly supervised by or the individual's treatment plan is approved by a legally licensed physician, psychologist, nurse practitioner, or clinical social worker. Treatment may also be provided on a part-day, organized, formal, regularly scheduled basis. Part-day treatment shall consist of at least four hours of structured treatment per day, for at least four days each week. Educational programs or volunteer mutual support group programs are not considered chemical dependency programs.

4.20 Payment of Benefit. Benefits will be paid upon receipt of due proof that a covered person incurred covered charges for the treatment of chemical dependency (including alcoholism) or mental and nervous disorders.

4.21 Coverage Provided. Covered charges under this benefit will include the reasonable and customary charges described below for treatment of chemical dependency or mental and nervous disorders. Payment will be made as shown in each section. The 24 consecutive month period referred to in this section means the 24 consecutive month period beginning with the first use of services. Benefits will renew in full on the first day of the 25th month of coverage following the first use of services. In addition to the benefits provided under this section, Bargaining Unit Employees who participate in the Joint Labor Management Glazing Industry Drug-Free Workplace Program shall be eligible for a benefit of up to $100 for pre-treatment evaluation and consultation if the employee fails to satisfactorily complete a required drug/alcohol test conducted by that program.

A. Health Facility Treatment. Benefits will be paid for charges incurred for the treatment of substance abuse or mental and nervous disorders while a covered person is confined as an inpatient in a health facility. These benefits are subject to the maximums described below.

1. The benefit for treatment of **chemical dependency** in any 24 consecutive month period will not be more than:
    a. $4,500 for an adult;
    b. $4,000 for a child.
    less any benefits paid for treatment at a residential treatment facility.

2. The benefit for treatment of **mental or nervous conditions** in any 24 consecutive month period will not be more than:
    1. ten (10) days of hospitalization.

B. Residential Treatment Facility. Benefits will be paid for charges incurred for the treatment of chemical dependency and mental or nervous disorders at a residential treatment facility.

1. The total benefit for treatment of **chemical dependency** in any 24 consecutive month period will not be more than:
    a. $3,500 for an adult;
    b. $3,000 for a child.

2. The benefit for treatment of **mental or nervous condition** in any 24 consecutive month period will not be more than:
    1. seventeen (17) days of residential.

C. Outpatient Treatment. Benefits will be paid for charges incurred for outpatient treatment of chemical dependency and mental or nervous disorders. These benefits are subject to the maximums described below.

1. The total benefit for treatment of chemical dependency in any 24 consecutive month period will not be more than:

    a. $1,500 for an adult;
    b. $2,000 for a child.

2. The total benefit for treatment of mental or nervous conditions in any 24 consecutive month period will not be more than thirty-three (33) consultations.

D. The benefits payable for all treatment of chemical dependency during a 24 consecutive month period will not exceed:
    a. $6,000 for an adult;
    b. $6,000 for a child.

Article 5

DENTAL BENEFITS

5.01 Definitions:

A. Covered Dental Charges means the reasonable and customary charges for services rendered or supplies furnished by a dentist in the area where such services or supplies are so recommended or approved.

B. Date of the incurred dental charge means the date the applicable service or care is rendered. The insert date of an appliance is considered the date the charge is incurred.

C. Dentist means an individual who is licensed to practice dentistry by the government authority which has the jurisdiction over the licensing and practice of dentistry.

D. Dental Hygienist means an individual who is licensed to practice dental hygiene by the government authority that has the jurisdiction over the practice of dental hygiene and works under the supervision of a dentist.

E. Reasonable and Customary Covered Charges are those charges which do not exceed the customary fees charged by dentists for the same services performed within the particular geographic area where such services or supplies are recommended or approved.

5.02 Persons Eligible. The following persons are eligible for dental benefits:

A. Class 1. Persons who perform work for one or more employers, whose work is covered by the terms and conditions of a collective bargaining agreement between the person's employer(s) and Glaziers, Architectural Metal & Glass Workers Local Union No. 740, who

has had the required contributions paid on the person's behalf and who are eligible for medical benefits under this Plan.

B. Class 2. Persons who perform work for an employer who is party to a collective bargaining agreement with Glaziers, Architectural Metal and Glass Workers Local Union No. 740, whose work is not covered by the terms and conditions of the collective bargaining agreement, whose employer has entered into a written agreement to participate in this Plan, who has had the required contributions paid on the person's behalf and who are eligible for medical benefits under this Plan.

C. Class 3. Persons who are employed by either Glaziers, Architectural Metal and Glass Workers Local Union No. 740 or Glaziers, Architectural Metal & Glassworkers Joint Apprenticeship & Journeyman Training Trust or IUPAT District Council No. 5 who do not participate in another welfare plan, whose employer has entered into a written agreement to participate in this Plan, who has had the required contributions paid on the person's behalf and who are eligible for medical benefits under this Plan.

D. Class 4. Persons who would otherwise be eligible under this Plan for medical benefits but have elected medical coverage under a Kaiser health care plan.

E. Class 5. Dependents of persons in Classes 1, 2, 3 and 4 provided they meet the dependent eligibility requirements as set forth in Article 3.

F. Class 6. Retirees who have applied for and have been approved to receive medical benefits under Article 4 Medical Benefits.

5.03 Dental Expense Benefit. The Plan will pay for a percentage of the expenses hereafter stated which are actually incurred by a covered person for covered dental charges in an amount not to exceed the "Reasonable and Customary Covered Charges" for the services, supplies and treatments as defined in Section 5.01 when performed by a legally qualified practitioner for oral examination and treatment of accidentally injured or diseased teeth or supporting bone or tissue. The Plan will pay 100% of covered dental charges incurred in each calendar year for oral examinations, topical application of sodium or stannous fluoride and dental x-rays as described under Class A Charges. The Plan will pay 80% of all other Class A Charges and 50% of all Class B and Orthodontia Charges. The Plan will pay a maximum of $1,500.00 per calendar year for each covered person. Before the Plan will pay any covered charges incurred for Class B Charges, each covered person shall be solely responsible for and pay the first $50.00 ($150.00 for family) of covered charges incurred in each calendar year. Benefits payable for orthodontic care during the covered person's lifetime will not exceed $500.00. Benefits payable for all other dental charges will not exceed $1,500.00 during each calendar year. The first $50.00 paid by the covered person, or $150.00 paid by a family, shall be referred to as the "deductible".

When a covered person selects a more expensive course of treatment than is necessary or is customarily provided, the Plan will pay for the least expensive course of treatment in accordance with the terms of this Plan.

Persons eligible for dental benefits may elect to receive dental benefits using Dental Options. Dental Options is a Dental PPO (Preferred Provider Organization). Eligible persons who elect to receive benefits using Dental Options must use a dental service provider from a list of dental offices under contract with Dental Options. For eligible persons selecting Dental Options, the Plan will pay: 100% of covered dental charges incurred in each calendar year for oral examinations, topical application of sodium or stannous fluoride and dental x-rays as described under Class A Charges; 90% of all other Class A Charges; and, 50% of all Class B and Orthodontia charges. Before the Plan will pay any covered charges incurred for Class B charges, each covered person shall be solely responsible for and pay the first $50.00 of covered charges incurred in each calendar year. Benefits payable for orthodontic care during the covered person’s lifetime will not exceed $500.00. Benefits payable for

all other dental charges will not exceed $1,500.00 for each covered person during each calendar year. The first $50.00 paid by the covered person shall be referred to as the “deductible.”

5.04 Payment of Benefits. Benefits will be payable under this provision upon receipt of due proof that a covered person, while covered under this benefit, has incurred covered dental charges. Payment will be made for the covered dental charges incurred in excess of the deductible and multiplied by the benefit payable shown in section 5.03. In no event will the benefit exceed the maximum payment, per covered person, per calendar year, as shown in section 5.03.

5.05 Covered Dental Charges include:

A. Class A Charges.

1. Oral examinations, including scaling and cleaning of teeth, but not more than one examination including scaling and cleaning in any period of six consecutive months.

2. Topical application of sodium or stannous fluoride once in each period of twelve consecutive months but only if the covered person has not yet attained the age of fifteen years.

3. Dental X-rays.

4. Extractions.

5. Oral surgery, including excision of impacted teeth.

6. Fillings.

7. General anesthetics administered in connection with oral surgery or other covered dental service.

8. Injections of antibiotic drugs by the attending dentist.

9. Drugs for treatment of dental disease that can be dispensed by a licensed pharmacist only upon a prescription by a legally qualified dentist or physician operating within the scope of their license.

10. Space maintainers.

11. Treatment of periodontal diseases of the gums and tissues of the mouth.

12. Endodontic treatment, including root canal therapy.

B. Class B Charges.

1. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework, provided that such installation is required as a result of the extraction on or after the effective date of the covered person's eligibility for benefits under this provision, of one or more natural teeth, accidentally injured or diseased, and that such denture or bridgework includes the replacement of teeth so extracted.

2. The replacement or alteration of full or partial dentures, or fixed bridgework that is necessary because of:

a. Oral surgery resulting from an accident or

b. Oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue, but only if this occurs after the covered person has become eligible for benefits under this provision, and the replacement or alteration is completed within twelve months after such surgery.

3. The replacement of a full denture that is necessary because of:

a. Structural change within the mouth, but only if more than five years has elapsed since the initial placement,

b. The initial placement of an opposing full denture, but only after the covered person has been covered under this provision for at least two years, or

c. Replacement of an immediate temporary denture, but only within twelve months of the installation of the temporary.

4. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if:

a. The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while eligible for benefits under this provision and after the existing denture or bridgework was installed, or

b. The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

5. Inlays, gold fillings, crown, tooth implant, including precision attachments, for dentures.

6. Repair or recementing of crowns, inlays, tooth implants, bridgework, or dentures or relining of dentures.

7. The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.

C. Orthodontia Charges. Orthodontic care, treatment, services and supplies (except for missing primary teeth) including correction of malocclusions.

5.06 Exclusions and Limitations

A. No benefits are payable under this provision for:

1. Orthodontic appliances and treatment except as specifically provided for in Section 5.03 and 5.05;

2. Charges incurred after termination of eligibility, except for prosthetic devices which were fitted and ordered prior to termination and which are delivered to a covered person within 30 days after the date of termination;

3. Charges incurred for treatment of an injury or illness that is employment or self employment related or covered under any Workers' Compensation Law, Occupational Disease Law or similar law;

4. Charges incurred for treatment of any injury or illness that is a result of war, declared or undeclared;

5. Any portion of any expense incurred that is paid for or furnished by or at the direction of any government agency, except reasonable and customary charges otherwise covered under this provision which were incurred:

    a. at a Veteran's Administration Facility; or

    b. by an armed service retiree, or such covered person's dependent for services or supplies which are not related to military service.

6. Loss incurred while engaged in military, naval or air service;

7. Any services that are paid or payable under any other benefit of this Plan;

8. Replacement of lost or stolen prosthetics;

9. Replacement of prosthetics less than five years after preceding placement; or

10. Services rendered solely for cosmetic purposes, unless such services are required because of an accidental bodily injury sustained while covered under this benefit.

11. Rebase or reline of a denture in less than six (6) months from the date of initial placement and not more often than once in any two year period.

12. Charges incurred for treatment of any injury, illness or disability caused by a third party against whom a claim of liability could be asserted unless the participant, employee, dependent or covered person signs a reimbursement agreement with the Trust in a form adopted by the Trustees.

Article 6

WEEKLY LOSS OF TIME BENEFITS

6.01 Eligibility. Bargaining unit employees, union employees and Training Fund employees who have met the eligibility requirements set forth in Article 3 are eligible for weekly disability benefits. Bargaining unit, union and Training Fund employees who are receiving medical benefits under the Kaiser plan are also eligible if they would otherwise meet the requirements set forth in Article 3. Dependents, non bargaining unit employees and retirees are not eligible for this benefit.

6.02 Benefits Payable. If an eligible employee is unable to do the major duties of his or her occupation due to an injury or illness, that employee shall be eligible to receive weekly disability benefits for up to 39 weeks for each period of disability. Benefits will be paid beginning on the eighth (8th) day of disability due to an illness and on the first full day of disability due to an injury. The date an injury occurs is considered the first day of a disability due to an injury. If disability due to an illness requires hospitalization, benefits will start on the first day of hospitalization. Periods of disability separated by less than two weeks' active work on a regular basis shall be considered one period of disability unless the subsequent period of disability is due to a different cause and begins after the eligible employee returns to the duties of his or her regular occupation for at least one full day.

6.03 Schedule of Benefits.

1st through 13th week ..... $350 per week
14th through 26th week ..... $400 per week
27th through 39th week ..... $400 per week

6.04 Physician Care Required. During the entire period of disability when benefits are claimed, the eligible employee must be under the regular care of a physician.

6.05 Pregnancy. Benefits are payable for disability of an eligible female employee due to pregnancy, including resulting childbirth, abortion, miscarriage or complications from pregnancy.

6.06 Limitations and Exclusions. Benefits will not be payable for:

A. Disability due to bodily injuries or occupational disease arising from or in the course of any employment or self-employment.

B. Disability due to injury, sickness or disease for which any benefits are provided under Workers' Compensation or similar laws.

C. Disability due to an accident sustained or contracted in consequence of being intoxicated or under the influence of alcohol or any narcotic unless administered on advice of a physician.

D. Intentional self-inflicted injury.

E. Injury or illness resulting from taking part in a riot.

F. Injury or illness resulting from any war or act of war.

G. Injury or illness incurred or received while in military service.

H. Injury or illness resulting from taking part in an assault or felony.

I. Voluntary use of a non-prescribed controlled substance.

J. Charges incurred for treatment of any injury, illness or disability caused by a third party against whom a claim of liability could be asserted unless the participant, employee, dependent or covered person signs a reimbursement agreement with the Trust in a form adopted by the Trustees.

6.07 Termination. Eligibility for benefits will terminate when eligibility under Article 3 terminates.

6.08 Application for Benefits. The initial determination of eligibility for payment of benefits has been delegated to the Administrative Agent by the Trustees. The following procedures have been established by the Trustees for initial payment of benefits and the continuation of benefit payment.

1. Method of Making a Claim. All claims for the payment of benefits shall be in writing and made on a form prescribed by the Trustees. Claim forms can be obtained from the Administrative Agent. Each claim for benefits must be complete and contain or be accompanied by a statement by the employee's doctor that he or she is unable to perform the major duties of his or her occupation due to an injury or illness.

2. When Initial Application for Benefits Must Be Made. Each claim must be presented within 90 days after the employee becomes unable to perform the major duties of his or her occupation. The Trustees may, in their sole discretion, accept a claim after such time has passed if extenuating circumstances prevented the employee from making a claim.

3. Additional Claim Information May Be Required. If an employee fails to submit a properly completed form or additional information is needed, the employee shall be notified that additional information is needed for the claim to be complete. The notice shall be delivered to the employee as soon as possible, but in no event later than 45 days from receipt of the claim. The notice shall inform the employee what additional information is needed. The employee has 45 days after receipt of the notice within which to provide such additional information as may be required.

4. Reexamination of Claims. At any time after a claim has been accepted for payment of benefits, it may be reexamined to determine whether payment of benefits should continue. The Trustees may require the employee to provide additional information they deem necessary to determine whether benefit payments should continue to be made.

6.09 Decision on Benefit Claims.

5. Initial Determination. The Administrative Agent shall make a claim determination within 45 days of receipt of the claim. The determination shall be made sooner than 45 days, if possible.

6. Extension of Time to Make Initial Determination. The Administrative Agent may extend the time for making an initial determination for 30 days due to matters beyond the control of the Plan. The Administrative Agent may extend the time for making an initial determination for a second 30 days due to matters beyond the Plan's control. The employee will be notified before the deadline expires that the deadline has been extended. All extension notices will explain the circumstances requiring delay, the standards for eligibility, unresolved issues, information needed to resolve those issues and the date the Plan expects to decide the claim.

7. Extension of Deadline if Additional Information Is Needed. If an extension of a deadline is necessary because the employee fails to provide necessary information, the extension notice to the employee shall specify the information needed and give the employee at least 45 days to respond. The Plan's deadline for making a determination of the claim shall be suspended until the employee's complete response is received or 45 day, whichever is the earliest.

6.10 Types of Claim Determination. The Administrative Agent shall notify the employee that his or her claim has been accepted, denied or partially denied. If a claim is denial or partially denied, the notice shall contain:

8. The reason for the denial.

9. Specific reference to the Plan language relied upon for the denial.

10. A copy of the Plan language relied upon for the denial.

11. A copy of the Plan's appeal and claim denial review procedure.

6.11 Appeal and Review of Claim Denials.

12. How To Make an Appeal. An employee who is dissatisfied with the claim determination made by the Administrative Agent may request a review of that determination by appealing to the Board of Trustees. The appeal must be in

writing and state the reasons for the appeal. The appeal must be filed at the office of the Plan by mail at: P.O. Box 4148, Portland, OR 97208 or by delivery at 3140 NE Broadway, Portland, OR 97232. The appeal must be made within 180 days from the date the claim determination was received.

13. Review on Appeal. The Trustees shall review all records of the claim and shall issue their decision without deference to the determination made by the Administrative Agent. The review shall be conducted within 45 days from receipt of the appeal. The time for conducting the review may be extended for an additional 45 days. In the event the review period is extended by 45 days, the employee shall be notified of the extension and reasons therefore prior to the end of the initial 45 day period.

14. Appeal Hearing. The employee may request a hearing before the Trustees, during which the employee shall be entitled to present his or her position and any evidence that supports that position. The employee may be represented at the hearing by an attorney or other representative at his or her own expense. The hearing shall be held within 45 days from receipt of the appeal. The Trustees may extend the time for conducting the hearing up to 45 additional days. The employee shall be notified of the extension and reasons therefor prior to the end of the initial 45 day period.

15. Decision of Trustees. The Trustees shall render their decision within 5 days from the close of the appeal review or hearing. The decision shall be in writing and shall state the reasons supporting the decision. It shall be mailed to the employee at his or her last known address.

Article 7

EXTENSION OF BENEFITS

Covered Charges Extension Due to Disability

A. Eligibility. If a covered person is totally disabled at the time eligibility under this Plan terminates, benefits may be extended for covered charges incurred solely and expressly for the care and treatment of the condition that caused the disability, if

1. The expense would have been covered if eligibility under this Plan had continued; and

2. The covered person remains totally disabled to the date each such expense is incurred; and

3. The covered person is not entitled to similar benefits under any other plan when each such expense is incurred.

B. Benefits that are Extended. Benefits under this section are extended and payable only for the treatment of the injury or illness that caused the total disability. The benefit payable will be subject to the same maximums, limitations and exclusions that were in effect under this Plan at the time eligibility under this Plan would have otherwise terminated.

C. The Duration of Extended Benefits. Benefits till continue until the earliest of:

1. The date the covered person is no longer totally disabled, or

2. The date the covered person becomes covered for benefits under Medicare, an insurance plan, policy or self-funded plan, or

3. The end of 12 consecutive calendar months after eligibility under this Plan would otherwise terminate.

D. Definition of Totally Disabled. Totally disabled means:

Totally disabled, with respect to a participant, means that, due solely to injury or illness that is not employment related, the participant is prevented from engaging in the participant's regular or customary occupation.

Totally disabled, with respect to a dependent, means that, due solely to injury or illness that is not employment related, the dependent is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

E. The reserve account provided for in Article 3, Section 3.02 shall not be used to extend benefits for employees who are on a leave covered by the Family Medical Leave Act.

7.02 Employer Non-Payment of Contributions

4. This benefit extension is limited to those situations in which an employer who is obligated to contribute to Fund on behalf of its employees has failed to pay contributions.

5. Employees and their dependents who are included within the employees described in the preceding paragraph may remain eligible for health and welfare benefits from the Fund for up to three months provided they pay a contribution rate set by the Trustees and are otherwise eligible but for their employer's failure to make the required Fund contributions.

6. Each employee who is included in the class of employees described in paragraph 1 shall provide to the Fund's administrative agent proof of employment by that employee during all periods of time when his or her employer did not make the required contributions to the Fund. Proof of employment shall consist of payroll stubs, earnings records or a signed affidavit on a form prepared by the Trustees.

7. Fund shall extend eligibility on behalf of an otherwise eligible employee for no more than the first three consecutive months that that employee should have had contributions paid on his or her behalf.

Article 8

CONTINUATION OF COVERAGE AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

8.01 Eligibility. Covered persons may continue to be eligible for benefits under this Plan, if benefit eligibility would otherwise terminate due to a qualifying event.

8.02 Qualifying Event means one of the following occurrences that would otherwise terminate the covered person's eligibility for benefits in the absence of this Article:

A. Termination of the participant's employment, other than for gross misconduct.

B. A participant's reduced work hours.

C. A participant's retirement.

D. A participant's death.

E. A participant's entitlement to Medicare.

F. A covered person's divorce or legal separation.

G. With respect to a child, if the child ceases to satisfy the Plan's definition of a dependent.

8.03 Election Period. A covered person may elect to continue coverage within 60 days of the later of:

A. The date the covered person would otherwise lose eligibility due to the qualifying event, or

B. The date the covered person is notified of the right to elect the continuation of benefit eligibility.

8.04 Notification of Certain Qualifying Events. It is the participant's or dependent's responsibility to notify the Trustees of any of the following qualifying events: divorce, legal separation, or when a dependent child ceases to be an eligible dependent. The participant or dependent must provide such notification within 60 days after the later of:

A. The date of the qualifying event, or

B. The date the dependent would otherwise lose coverage due to the qualifying event.

8.05 Election to Continue Benefits. An election to continue benefits must be in writing on a form provided by the Trustees. Elected benefits will be continued provided:

A. The election form is duly completed and returned to the Trustees within the 60 day notification required in Section 8.04; and

B. The required premium is paid to the Trustees within 45 days of the participant's or dependent's election.

8.06 Continuation Period. Eligibility for benefits may continue, on a self-pay basis, as follows:

A. Eligibility for a participant and/or the participant's eligible dependents may be continued for up to 18 months if eligibility was terminated due to the participant's:

1. Termination of employment, other than for gross misconduct, or

2. Reduced work hours, except in the case of a bankruptcy proceeding under Title 11 of the United States Bankruptcy Code with respect to the participant's employer, or

3. Retirement.

The 18-month period of continuation may be extended an additional 11 months if within 60 days of the time coverage ceased, a participant or his dependent is determined to be disabled by the Social Security Administration. Proof of disability must be provided to the Trustees within 60 days of the date the Social Security Administration makes this

determination. This extended period of continuation eligibility applies to the participant or dependent who has been determined to be disabled by the Social Security Administration. Dependents of COBRA participants whose eligibility has been extended shall have their eligibility extended for a like period of continued eligibility.

B. Benefit eligibility for an eligible dependent may be continued for up to 36 months, if coverage terminated due to:

1. The participant's death, or

2. Divorce or legal separation, or

3. With respect to a dependent child, if the child ceases to satisfy the Plan's definition of an eligible dependent.

C. If the qualifying event is the participant's entitlement to Medicare, coverage for an eligible dependent may be continued for up to 36 months from the date the participant became entitled to Medicare.

D. If a dependent's eligibility is continued for reasons listed under item A of this section, and, during the initial continuation period, a qualifying event occurs which entitles the dependent to continue eligibility under item B of this section, such dependent may elect to continue coverage up to a combined maximum of 36 months.

8.07 Contributions for Benefits. The participant or dependent who has elected to continue eligibility for benefits shall be solely responsible for the payment of the contributions for such continued eligibility. If an election is made after the qualifying event, contribution payment for continuation eligibility during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the contribution may be paid in monthly installments.

8.08 Termination of Eligibility. The continued eligibility will cease on the first of the following dates:

A. The date this Plan terminates, or

B. The date a required contribution is due and unpaid after any applicable grace period, or

C. The date the participant or dependent becomes insured or eligible for benefits under another health plan, unless the participant or dependent has a pre-existing condition which is not covered under the new plan, or

D. The date the participant or dependent becomes covered by Medicare, or

E. The date the applicable period of continuation is exhausted, or

F. The first day of the month which begins 30 days after a participant or dependent receives a final determination from Social Security that the participant is no longer disabled, in situations where the qualifying event was termination of employment or reduction in hours and where COBRA eligibility was being continued for an additional 11 months for a disabled participant or dependent.

Article 9

CLAIMS PROCEDURES

9.01 Types of Claims Covered. The claim and claim review procedures contained in this Article apply only to medical and self-funded dental claims. Claims and claim review procedure for weekly

disability benefits, vision examination and hardware, life and accidental death and dismemberment benefits are covered elsewhere.

9.02 Prior Authorization for Services Not Required. This Plan does not require preauthorization or precertification of treatment as a condition for payment of covered benefits. Covered benefits are paid on behalf of eligible persons after treatment is provided. The plan does use the services of Providence Preferred and ULLICO Managed Care Service to advise eligible persons in the choice of treatment he or she may desire to receive. The use of Providence Preferred or ULLICO Managed Care Service usually results in a savings in the overall cost of medical services. The Plan urges eligible persons to use Providence Preferred or ULLICO Managed Care Service whenever possible.

9.03 No Preapproval of Services or Treatment. All participants are provided with a copy of the Plan for the use of themselves and their dependents. The Plan contains information necessary to determine the types of services and treatments paid for by the Plan. The Plan's administrators, agents, claims administrative agent or their employees will not authorize or approve any service or treatment before it is administered. The Plan administrators, agents, claim administrative agents and their employees may provide preservice and pretreatment information regarding benefits available to eligible persons. However, any information provided prior to the rendering of services or treatment is not binding on the Plan or Fund and is subject to determination for payment after the services are rendered or treatment is performed.

9.04 Submission of Claims for Payment. It is the eligible person's responsibility to submit claims for payment within 90 days after receiving services or treatment. Claims shall be submitted on a standard medical or dental provider's form or a form provided by the Plan's administrative agent. The claim form must be completed in its entirety and be accompanied by a statement from the service or treatment provider detailing the services provided or treatment rendered. If the claim is presented on behalf of a dependent, the claim must state the name of the dependent's spouse, parent or step parent.

Claims must be submitted to:

The William C. Earhart Company, Inc.
PO Box 4148
Portland, OR 97208

9.05 Claim Acceptance or Denial. Properly filed claims will be processed within 30 days from the date of receipt. The person filing the claim will receive a notice that the claim has been accepted in full or in part, partially denied or denied in its entirety. The initial 30 days processing period may be extended for an additional 15 days due to circumstances beyond the control of the Plan. Notice of this extension shall be provided to the claimant prior to the end of the initial 30 day period.

Additional information may be needed to process a claim. The person making the claim shall be notified that he or she needs to provide additional information. The notice shall specify the nature of the additional information that is needed to complete the claim and allow it to be processed. The time period for making the claim acceptance or denial shall be tolled from the date the request is sent until the requested information is received, or within 45 days, whichever is sooner.

9.06 Denial of Benefits. If payment for benefits is denied, the Plan's administrative agent will issue a partial or entire benefit denial determination. The determination will be in writing and addressed to the person claiming the benefit. It shall contain the following information:

A. The reason for the denial.

B. A reference to the plan provision relied on.

C. A description of any additional material needed to perfect the claim

D. An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that a copy of any such internal guidelines is available on request.

E. A statement that an explanation of medical judgment will be provided upon request if the denial is based on medical necessity or the service or supply is experimental or investigational in nature or an equivalent exclusion.

F. The Plan's appeal procedure and time limitation.

9.07 Appeal Rights, Contents of Notice of Appeal and Time Limitations.

A. A person adversely affected by a claim determination shall have 180 days from the date of the adverse determination to file an appeal with the Trustees or their administrative agent. Failure to file Appeals must be made in writing and by the person who made the claim or his or her authorized representative. Appeals filed by authorized representatives must contain a written statement signed by the claimant authorizing the representative to act on his or behalf.

B. Appeals must be made in writing and by the person who made the claim or his or her authorized representative. Appeals filed by authorized representatives must contain a written statement signed by the claimant authorizing the representative to act on his or her behalf.

C. The notice of appeal shall identify the denial determination which is the subject of the appeal, set forth the reasons why the claimant believes the determination should be reversed and provide any information the claimant believes is relevant to the appeal.

D. Notices of appeal shall be filed with the Trustees of the Plan at:

By Personal Delivery:	or	By Mail:
The William C. Earhart Company, Inc.		The William C. Earhart Company, Inc.
3140 NE Broadway		PO Box 4148
Portland, OR 97232		Portland, OR 97208

9.08 Appeal Procedure. The following procedures shall be used exclusively for reviewing adverse claim determinations. These procedures must be exhausted before a lawsuit may be filed by the person receiving an adverse claim determination.

Information Available to Claimant. Upon request, the claimant, or his or her authorized representative, will be permitted access to all documents relevant to the claim. Relevant documents shall include information relied upon, submitted, considered or generated in making the benefit determination. If a denial is based upon a medical determination, an explanation of the determination and its application to the claimant's medical circumstances will also be made available upon request. The documents made available will also include internal guidelines, procedures or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination. Relevant documents do not include any other person's medical or claim records or information specific to the resolution of another person's claim.

Appeal Hearing. The Board of Trustees shall hear and determine all appeals. All appeals will be heard at the next quarterly Trustee meeting following receipt of the notice of appeal. If a notice of appeal is received within 30 days of the next quarterly Trustee meeting the appeal hearing may be postponed until the second quarterly Trustee meeting following receipt of the notice of appeal.

The Trustees will review the administrative file that will consist of all documents relevant to the claim. They will also review all additional information submitted by or on the claimant's behalf. The review will be de novo and without deference to the initial denial.

The Trustees shall have absolute and unlimited discretion in reviewing benefit claims, interpreting the Plan, determining entitlement or lack of entitlement, and making their decisions.

If the denial is based on medical judgment, the Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. The Trustees may have an individual with a different licensure review a matter if that individual is trained to deal with the condition involved. The health care professional consulted will not be the individual who made the initial benefit determination nor a subordinate of that individual. The Trustees will identify by name any individuals consulted for medical or vocational advice.

The claimant or his or her representative will be allowed to appear before the Trustees and present any evidence or witnesses. If the claimant elects to appear before the Trustees, a copy of the administrative file will be mailed to the claimant in advance of the hearing. If the claimant does not elect to appear, the hearing will be determined based on the administrative file and the comments of any witnesses consulted. If the claimant does appear at the hearing, a stenographic record shall be made of any testimony provided.

In their discretion, the Trustees may set conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters that may occur during a hearing.

C. Issuance of a Decision. The Trustees will provide the claimant written notification of their decision within five days from the close of the hearing. Where appropriate, the Trustees may issue a more detailed explanation of the reasons for their decision within 30 days of the close of the hearing. The decision will set out the specific reasons for an adverse decision, reference the plan procedure involved, inform the claimant that all information relevant to the individual's claim is available upon request and free of charge, notify the claimant of his or her rights under section 502(a) of ERISA, and identify any internal rule or guideline upon which the Trustees rely. If a denial is based on a medical judgment, the decision shall also contain an explanation of the medical judgment relied upon in the claimant's case.

If a decision cannot be reached at the initial meeting at which an appeal is heard, the Trustees may defer a decision on an appeal until the next quarterly scheduled appeals meeting provided that written notice is provided to the claimant.

9.09 Review of Trustees' Decision. The Plan has no voluntary dispute resolution procedures. If the claimant is dissatisfied with the Trustees' decision, he or she may seek redress in court pursuant to 29 USC ' 1132.

Article 10

COORDINATION OF BENEFITS

10.01 Purpose. The benefits that would otherwise be payable under this Plan in the absence of this provision shall be reduced by the amount, if any, necessary so that the sum of the benefits payable under this Plan and other plans do not exceed the total of the covered person's allowable expenses. For purposes hereof, if the manner in which an expense is incurred is such that none of such plans would consider such expense a necessary, reasonable and customary charge, such expense shall not be considered an allowable expense.

10.02 Definitions.

A. Allowable Expenses means any necessary, reasonable and customary item of expense for services, supplies or treatment covered, in whole or in part, by any medical or dental plan. When a plan provides service instead of cash payment, the Trustees will view the reasonable cash value of each service as an allowable expense and as a benefit paid. The Trustees will also view benefits payable by another plan as an allowable expense and as a benefit paid, whether or not a claim is filed under that plan.

B. Plan means any of the following that provide full or partial medical or dental benefits or services, on an insured or uninsured basis:

1. Group, blanket, franchise or health maintenance organization insurance;

2. Group Blue Cross, group Blue Shield, group practice, group self-funded or other group prepayment plans;

3. Union welfare plans, employer organization plans, employee organization plans or labor-management trusteed plans;

4. Governmental programs or coverage required or provided by law;

5. Personal injury protection benefits which applicable state or federal law requires to be afforded without regard to fault under motor vehicle insurance policies;

6. Group automobile "fault" policy, but only the medical benefits included therein;

7. School or other educational institution plans which provide coverage for students.

Plan does not include Medicaid or any government program coverage with which the Trustees are not allowed, by law, to coordinate.

C. Claims Determination Period means January 1st to December 31st, or that portion of a calendar year during which the covered person is eligible for benefits under this Plan.

10.03 Plans Shall Be Applied Separately. Each Plan, as defined in 10.02 B, shall apply separately:

A. To each policy, contract, agreement or other plan for benefits or services; and

B. To that part of such policy, contract, agreement or plan which reserves the right to consider the benefits or services of other plans in determining its benefits and to that part which does not.

10.04 Effect on Benefits.

A. This Article applies in determining the benefits payable under this Plan for allowable expenses a covered person incurs during a claims determination period when the total benefits payable under this Plan without this provision, and under all other plans, without a provision similar to this provision, exceed the allowable expenses incurred.

B. The amount payable under this Plan will be reduced to the extent necessary so that the total amount payable under all plans will not be greater than 100% of the allowable expenses.

C. If one of the other plans contains a coordination of benefits provision, and its rules require the benefits of this Plan to be determined first, the benefits payable under this Plan will be provided without reduction.

10.05 Which Plan Pays First.

A. In coordinating benefits, one of the two or more Plans involved shall be designated the primary plan and the other(s) shall be designated the secondary plan(s) as provided in the following paragraph. The primary plan shall pay without regard to the other plans all allowable expenses and benefits provided for in the primary plan. The secondary plans shall coordinate their payments so that the total of the payments from all plans shall not exceed the allowable expenses. The allowable expenses for purposes of this section means any necessary, reasonable and customary item of expense for medical or dental services, treatment or supplies, at least a portion of which is covered under this Plan or another Plan when incurred. Notwithstanding the above, no plan shall pay more than it would have without this provision.

B. A plan is primary if it:

1. Does not have a coordination of benefits provision;

2. Covers the claimant as an employee;

3. Covers the claimant as an employee longer than the other plan;

4. Covers the claimant as other than a laid-off employee or as a retiree.

5. Provides personal injury protection benefits which applicable state or federal law requires to be afforded without regard to fault under motor vehicle insurance policies.

6. Provides benefits under a group automobile "fault" plan or policy.

C. In the event a dependent child is the claimant and is covered by more than one plan:

1. If such dependent child's parents are not divorced or separated, a plan is primary if:

a. It covers the parent whose date of birth occurs earlier in the calendar year, excluding year of birth, or

b. It covers the parent for the longer period of time, when both parents have the same date of birth, or

c. If a plan does not utilize 1(a) or (b) above, the rules of that other plan will be used to determine which plan pays first.

2. If such dependent child's parents are divorced or separated, a plan is primary if:

a. It is the plan of the natural parent with custody,

b. It is the plan of the spouse of the parent with custody (i.e. such plan will pay before the plan of the natural parent without custody), or

c. A court order makes one parent financially responsible for the health care expenses of the child, or

d. It covers the dependent child as other than a dependent of a laid-off employee or of a retiree.

3. In any situation where items 1 or 2 above cannot determine which plan is primary, the plan which has covered the employee for the longer period of time will be primary.

D. This Plan will pay as either primary or secondary according to method of coordinating benefits as set forth in this Article.

10.06 Failure of Covered Person to Obtain Benefits from Primary Plan. Whenever a person who has coverage under this Plan fails to obtain available benefits under another plan which is primary, this Plan shall not assume the primary plan position and will pay benefits only as a secondary plan.

10.07 Right to Receive and Release Necessary Information. In order to apply this provision, the Plan may, without the consent of or notice to any covered person, release to or obtain from any insurance company, health plan, organization or person any information it deems necessary.

10.08 Facility of Payment. Whenever payments that should have been made under this Plan have been made under any other plan, the Trustees will have the right to repay that plan the amount it determines will satisfy the intent of this provision. Any amount so paid will be considered to fully satisfy the Plan's liability under this Article.

10.09 Right of Recovery. Whenever the Plan pays out more than is necessary to satisfy the intent of this Article, it has the right to recover the excess payment from: (a) any person to or for whom such payments were made; (b) any other insurance company; or (c) any other health plan, or (d) any other organization or person.

Article 11

SUBROGATION AND REIMBURSEMENT

11.01 To the extent that the Plan has paid benefits for an employee, retiree, dependent or other eligible person, when the person for whom benefits have been paid may have a claim or right of recovery against another person, organization or insurance company which may include a claim or right of recovery for the benefits paid:

A. The Plan shall be reimbursed from any recovery received from the person, organization or insurance company in the amount of benefits paid on a covered person's behalf, regardless of whether the covered person makes a claim for recovery of those benefits.

B. The Plan shall be subrogated to all rights of recovery which the employee, retiree, dependent or other person may have against any other person, organization or insurance company, and the Plan shall be entitled to the proceeds of any settlement or judgment that may result from the exercise of such rights to the extent of the amount of benefits paid by the Plan.

C. The Plan has a lien against any claim or legal action the employee, retiree, dependent or other eligible person may have against any other person, organization or insurance company based upon all rights of recovery to the extent of the amount of benefits paid by the Plan.

D. The employee, retiree, dependent or other eligible person shall hold in trust any money received as a result of any rights of recovery against any other person, organization or insurance company and such monies shall be used to reimburse the Plan.

E. At the request of the Plan, the employee, retiree, dependent or other eligible person shall execute and deliver all documents, instruments and papers and perform any other acts necessary to protect the Plan's subrogation and reimbursement rights.

F. The employee, retiree, dependent or other eligible person shall cooperate with the plan to protect its rights and shall do nothing to prejudice those rights.

11.02 If the Plan is not reimbursed pursuant to this Article, the Plan may offset any unreimbursed benefit payments from future benefit payments pursuant to Article 12, Section 12.04.

Article 12

MISCELLANEOUS PROVISIONS

12.01 **General.** Any and all rights or benefits accruing to any covered person under this Plan shall be subject to all terms and conditions of this Plan. The adoption and maintenance of this Plan shall not constitute a contract between the Trust and any employee, retiree, dependent or other person or be a consideration for, or an inducement or condition of employment of any employee. Neither participation nor anything contained in this Plan shall give any employee the right to be retained in the employ of the employer, nor shall it interfere with the right of any employer to discharge any employee at any time.

12.02 **Filing of Information.** Each eligible employee, retiree, dependent or other interested person shall file with the Trustees such pertinent information concerning the covered person as the Trustees may specify, including proof of dependency or eligibility, and in such manner and form as the Trustees or Plan Administrator may specify or provide. No eligible employee, retiree, dependent or other interested person shall have rights or be entitled to any benefits hereunder unless such information is filed with the Trustees.

12.03 **Payment to Other Than Covered Persons.** If the Trustees shall find that any person to whom any benefits are payable under this Plan is unable to care for personal affairs, is a minor or has died, then any payment due the person or the estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to the spouse, a child, a relative or an institution maintaining or having custody of such person. The Trustees may, in their discretion, hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this Plan.

12.04 **Offsets from Future Benefit Payment.** If a covered person is paid benefits under this Plan that are in excess of the benefits that should have been paid, or which should not have been paid, or are not repaid pursuant to a reimbursement agreement, the Trustees may cause the deduction of the amount of such payments from any subsequent benefits payable to such covered person. The Trustees may recover such amount by any other appropriate method that they, in their sole discretion, shall determine.

12.05 **Construction.** This Plan shall be construed according to the Employee Retirement Income Security Act. To the extent any state law must be used in construing this Plan, the laws of the State of Oregon shall be used for such construction.

12.06 **No Waiver or Estoppel.** No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

12.07 **Cancellation of Health Care Benefits.** If the Trustees are unable to ascertain the whereabouts of any covered person to whom benefits are payable under this Plan within one year from the date such payment is due, and a notice of such payment due is mailed to the last known address of such person as shown on the records of the Trust, and within three (3) months after such mailing such person has not filed with the Trustees written claim therefore, the Trustees may direct that such payment be canceled and forfeited and, upon such cancellation, this Plan shall have no further liability therefore.

12.08 Agent for Service of Legal Process. The agent for the service of legal process under the Plan is the Administrative Agent identified in Article 1. The Administrative Agent shall promptly furnish the Trustees a copy of any complaint, summons or similar documents relating to the Plan and, if so directed by the Trustees, shall coordinate any applicable defense as directed by counsel for the Trust.

12.09 Assignment. Amounts payable at any time may be used to make direct payments to physicians and hospitals. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof. If by reason of bankruptcy or other event happening at any time so that the amount payable will not be enjoyed by the covered person, then the Trustees, in their sole discretion may terminate such covered person's interest in any such amount.

12.10 Right to Receive and Release Information. For the purpose of determining the applicability of and implementing the terms of these benefits, the Trustees may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in this Plan. In so acting, the Trustees shall be free from any liability that may arise with regard to such action. Any covered person claiming benefits under this Plan shall furnish to the Trustees such information as may be necessary to implement this provision.

12.11 Notices. Any notice, application, instruction, designation or other form of communication required to be given or submitted by any covered person shall be in such form prescribed by the Trustees and sent by first class mail or delivered in person to the Administrative Agent. Any notice, statement, report or other communication from the Trustees to any covered person shall be deemed to have been duly delivered when given to such person or mailed by first class mail to such person at the person's address last appearing on the records of the Fund. Each person eligible to receive benefits under the Plan shall file with the Trustees the person's complete mailing address. If the Trustees shall be in doubt as to whether payments are being received by the person entitled thereto, the Trustees shall notify such person by certified mail addressed to such person's last known address, that all future payments will be withheld until such person submits to the Trustees the proper mailing address and such other information the Trustees may reasonably request. If the certified mail is returned to the Fund because it was refused or the addressee was unknown, the Fund may withhold future payments until it has a correct mailing address.

12.12 Workers' Compensation Not Affected. This Plan is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

12.13 Free Choice of Physician. A covered person shall have free choice of any physician or surgeon. The physician-patient relationship shall be maintained except that the Trustees may require such information from the physician as is necessary to process claims.

12.14 Misstatements. In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits thereunder.

12.15 HIPAA Privacy Provision. The following rules will be followed as regards privacy of information:

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Administrative Agent.

This Plan, and the Plan Sponsor, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or a permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact Catherine Gladstone. If you have questions about the privacy of your health information please contact Ryan Stephens If you have questions about the electronic security of your health care information, please contact Nahan Hartman. If you wish to file a complaint under HIPAA, please contact Catherine Gladstone. Nathan Hartman, Ryan Stephens and Catherine Gladstone can be contacted at the office of the Administrative Agent identified in Article 1, Section 1.08.

12.16 Use of Protected Health Information (PHI) by Trustees

A. Trustee Access to Protected Health Information. The trustees are permitted access to PHI to the extent necessary to allow them to carry out Plan administrative functions permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the rules and regulations promulgated thereunder**.**

8. **Trustees' Responsibilities Regarding the Use of PHI.** The Trustees shall:

9. Neither use nor disclose PHI except as permitted by HIPAA.

10. Require any subcontractor or agent to whom the Trustees or their Administrative Agent provide PHI to agree to the restrictions and conditions in the Plan and HIPAA's rules and regulations.

11. Neither use nor disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan administered by the Trustees.

12. Promptly report any use of disclosure of PHI that is inconsistent with the uses and disclosures allowed under the Plan or HIPAA.

13. Make PHI available to the eligible person(s) in accordance with law requirements.

14. Make PHI available for amendment and amend an individual's PHI upon request.

15. Track disclosures of PHI so that an accounting of disclosures can be made to an individual in accordance with HIPAA and its regulations.

16. Make the Fund's and Plan's internal practices, books and records relating to the use and disclosure of PHI available to the United States Department of Health and Human Services for compliance with HIPAA and its regulations.

17. When a PHI is no longer needed for the purpose for which use or disclosure was made, each Trustee must return to the Plan all PHI that was received from or on behalf of the Plan.

18. **Electronic Personal Health Information (ePHI) Obligations.** If the Trustees create, receive, maintain or transmit any electronic PHI (except health information which is not subject to these restrictions) on behalf of the Fund and/or Plan, they will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI.

The Trustees will require any subcontractor or agent to whom they provide such ePHI to agree to implement reasonable and appropriate security measures.

Within a reasonable period of time the Trustees will report to the Fund any security incident that results in unauthorized access, use, disclosure, modification or destruction of the Fund's ePHI of which they become aware. The Trustees will report to the Fund and Plan all security incidents on an aggregate basis upon the Fund's or Plan's written request.

19. **Separation Between the Trustees, the Fund and Plan.** The Trustees represent that adequate separation exists between the Fund and the Plan and the Trustees so that PHI will be used only for plan administration purposes.

20. **To Whom PHI and ePHI May Be Provided.** The following persons or organizations that have a contractual arrangement with the Fund may receive PHI and ePHI relating to payment, health care operations or other matters pertaining to the Fund and its Plan.

Employees of The William C. Earhart Company, Inc.; and
Business associates of the Fund and Plan who have signed a business associate agreement and the employees, officers, directors, agents and subcontractors of those business associates.

The persons and organizations identified above will have access to PHI and ePHI only to perform plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of their contracts, for any use or disclosure of PHI the violates the business association agreement.

The Trustees will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the persons or organizations identified above have access to ePHI.

21. **To Whom Reports of Non-Compliance May Be Made.** Anyone who suspects an improper use or disclosure of PHI or ePHI may report the occurrence to the Plan's representative at the following address and telephone number:

Catherine Gladstone, Vice President
William C. Earhart Company, Inc.
PO Box 4148
Portland OR 97208
503-282-5581

22. **Copying, Correction, Inspection and Accounting Requests.** Requests to inspect and copy, to correct or amend, and for an accounting of PHI should be made in writing to:

Catherine Gladstone, Vice President
William C. Earhart Company, Inc.
PO Box 4148
Portland OR 97208
503-282-5581

23. **Certification of the Trustees.** The Fund, Plan any health insurance issuer and HMO shall disclose PHI to the Trustees only upon the receipt of a certificate by the Trustees that the Plan has been amended to incorporate the provisions of 45 C.F.R.§ 164.504(f)(2)(ii) and that the Trustees agree to the conditions of disclosure as set forth above.

12.17 Interpretation of Plan. The Trustees shall have the full, absolute and unlimited power to construe or interpret this Plan, including but not limited to, benefit eligibility or entitlement.

12.18 Amount of Contribution. The Trustees shall have the full, absolute and unlimited power to establish and increase or decrease the contribution rate required to be paid on behalf of non-bargaining unit persons, employees of the Union or Training Fund, employees entitled to an extension of benefits pursuant to Article 7, Section 7.02, retirees and all dependents except for dependents of bargaining unit employees.

12.19 Subject to Trust Agreement. This Plan is subject to all of the terms and conditions set forth in the Trust Agreement of the Fund, all amendments thereto and all past and future lawful acts of the Trustees.

12.20 Delegation of Duties to Administrative Agent. The Trustees have the right to delegate to their Administrative Agent activities involving the administration of this Plan.

Article 13

AMENDMENT AND TERMINATION

13.01 Plan Amendments. This Plan contains all the terms of the Plan and may be amended from time to time by the Trustees. The Trustees may, in their sole discretion, change the eligibility requirements or benefits, eliminate any of the classes of persons eligible for benefits, eliminate any benefit(s), or increase or decrease the amount of contribution required by any or all classes of persons other than bargaining unit employees. Any changes so made shall be binding on each Participant and on any other covered person referred to in this Plan.

13.02 Termination of Plan. The Trustees reserve the right at any time to terminate the Plan by a written instrument to that effect. All previous payments and contributions received by the Trustees shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered persons under this Plan until all contribution are exhausted.