MICHAEL J. DAY MACHINISTS
RETIREE HEALTH INVESTMENT PLAN

SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT

(Effective January 1, 2003)

MICHAEL J. DAY MACHINISTS RETIREE HEALTH INVESTMENT PLAN

Dear Eligible Participant:

This document describes your Michael J. Day Machinists Retiree Health Investment Plan. The purpose of the plan is to assist participants in providing some measure of financial security for themselves and family members upon retirement by accumulating and holding in trust funds to help pay for permissible health care expenses after retirement.

We recommend that you read this booklet carefully so that you will be fully informed as to the plan's eligibility requirements and the available benefits. If you have questions which the booklet does not answer or if you need clarification, please contact the Board of Trustees directly. Only the Board of Trustees is authorized to administer the plan and to provide information relating to eligibility, benefits, and other provisions of the plan. Statements by other persons, including union officers, your employer or individual Trustees, are not authorized and will not bind the Board of Trustees of the Plan.

Sincerely,

Board of Trustees of the Michael J. Day Machinists Retiree Health Investment Plan

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MICHAEL J. DAY MACHINISTS RETIREE HEALTH INVESTMENT PLAN

I. SUMMARY PLAN DESCRIPTION

A. Name of Plan: This Plan is known as the Michael J. Day Machinists Retiree Health Investment Plan.

B. Name of Trust: The assets of the Plan are held in the Michael J. Day Machinists Retiree Investment Trust ("Trust").

C. Plan Sponsors: This Plan is sponsored by the Board of Trustees of the Trust ("Board of Trustees").

D. Identification Number: The employer identification number of the Plan is 41-2061777.

E. Type of Plan: This Plan is a welfare plan which will consist of individual accounts to be used to provide financial assistance to eligible retirees and their eligible dependents by paying for qualifying health care expenses.

F. Type of Administration: The Plan is administered by the Board of Trustees.

G. Name, Address and Telephone Number of Plan Administrator:

Board of Trustees of the
Michael J. Day Machinists Retiree Investment Trust
c/o Associated Third Party Administrators
1640 South Loop Road
Alameda, California 94502
Phone: 510-337-3050

H. Name and Address for Service of Process: The agent, for the purpose of accepting service of legal process on behalf of the Trust is:

Saltzman & Johnson Law Corporation
120 Howard Street, Suite 520
San Francisco, California 94105

I. Names, Titles, and Addresses of Initial Trustees:

UNION TRUSTEES

James H. Beno, Directing
Business Representative
Machinists Automotive
Trades District,
Lodge No.190
7717 Oakport Blvd., #1
Oakland, California 94621

Don Crosatto

East Bay Automotive
Machinists Local
Lodge No. 1546
10260 MacArthur Blvd.
Oakland, California 94650

EMPLOYER TRUSTEES

Frank Mellon
Human Relations Manager
Central Concrete Supply
610 McKendrie Street
San Jose, California 95110

J. Participation: You become a participant in this Plan on the last day of the month in which an employer first contributes to the Trust on your behalf pursuant to the terms of a collective bargaining agreement or other contribution agreement which has been approved by the Board of Trustees. Participation ends (1) when your account balance returns to zero after you retire, (2) you die or (3) the Plan terminates.

K. General Eligibility: You are eligible for benefits if:

(1) you are receiving retirement benefits from the Automotive Industries Pension Plan, the I.A.M. National Pension Fund or such other retirement plan approved by the Board of Trustees,

(2) you have submitted a full and complete approved written application for benefits, and

(3) you have a positive Account Balance.

L. Eligibility For Death Benefits: If you die and have a positive Account Balance after the payment of all benefit claims incurred before your death, the following will be eligible to receive the Account Balance as a death benefit:

(1) Your spouse, or if none,

(2) Your children in equal shares, or if none,

(3) Your estate.

M. **Circumstances Which May Result in Ineligibility or Denial of Benefits:** A participant who has not satisfied all of the eligibility requirements will not receive a benefit under the Plan.

N. **Entities Used For Accumulation of Assets and Payment of Benefits:** The contributions are received and held by the Board of Trustees in trust pending the payment of benefits and administrative expenses.

O. **Plan Year:** The Plan Year runs from January 1 through December 31 of each year.

P. **Use of Assets upon Termination of Plan:** The Board of Trustees possesses the authority to terminate any of the trust's plans. In the event this Plan is terminated, any and all remaining Trust monies and assets, after payment of expenses, shall be used for the continuation of the benefits provided by the then existing plan or similar benefits, until such monies and assets have been exhausted.

Q. **Procedures To Be Followed in Presenting Claims for Benefits (See page 12 for complete procedures):**

(1) In general, to present a claim for benefits under the Plan, it is necessary to fill out an approved application form and to send that application form with required supporting information to the office of the Plan; which is at Associated Third Party Administrators, 1640 South Loop Road, Alameda, California 94502. Urgent care claims may be made orally.

(2) If the Plan provides as a benefit the reimbursement of out-of-pocket health care expenses, the following procedures apply. The office of the Plan will make initial claims determinations after application therefor has been received. Urgent care claims generally will be decided within 72 hours. Claims made before or during the course of treatment, including pre-authorization requests, normally will be decided within 15 days. Claims made after the services have been provided, or premiums have been paid, generally will be decided within 30 days.

These periods are extended if there are special circumstances, including a need for additional information. If the office of the Plan needs additional information from you, you will be notified with an explanation of the information needed.

(3) If your claim is denied in whole or part you will receive a statement why, including the plan rule which applies. In such circumstances, you have a right to appeal to the Board of Trustees in writing within 180 days. You may appoint in writing a representative to act on your behalf, including your medical care professional. As part of your appeal you may submit written comments, records and other relevant information whether or not submitted during the initial claim determination. Upon your written request, you are entitled to free of charge copies of all documents generated or reviewed during the benefit determination including policies or guidelines, whether or not relied upon. You have a right to have your claim independently reviewed by the Board of Trustees or an authorized sub-committee of the Board. If the appeal requires a medical judgment the Board of Trustees should consult with an appropriate health care professional who was not involved in the initial claim decision and you will receive the name of the professional whose advice was obtained.

(4) Generally, appeals of urgent care claims and claims arising during the course of treatment will be decided within 72 hours of receipt. Appeals concerning other claims, submitted before services are provided, will be decided within 30 days of receipt. Appeals of other claims, submitted after services are provided, or premiums have been paid, will be decided within 60 days of receipt. If special circumstances exist, including the need for additional information, these time periods may be extended.

(5) Decisions on your appeal will be sent to you in writing, except in the case of an urgent care claim, for which the decision may be made orally. The decision on appeal will explain to you the reasons for the decision and the Plan provisions on which the decision is based. You are entitled to receive upon request and free of charge copies of all document and

information relevant to your claim, and rules or other similar criteria relied upon. Only after exhausting these procedures, you may pursue your claim for benefits in court.

(6) The Board of Trustees or any Named Fiduciary for Appeals deciding your appeal have full discretion to determine facts and to interpret the terms of the Plan, including the benefits payable. Their decision is binding to the fullest extent permitted by law.

R. **Statement of ERISA Rights**: As a participant in the Plan 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:

(1) Receive Information About Your Plan and Benefits: Examine, without charge, at the plan administrator's office and at other specified locations such as work-sites 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 Pension and Welfare Benefit Administration.

(2) 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.

(3) 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.

(4) 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.

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control

of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(8) Assistance with Your Questions: If you have any questions about the 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20201. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Administration.

II. DEFINITIONS

Where the following words and phrases appear in this Plan, they shall have the meaning set forth below, unless the context clearly indicates otherwise. Other words and phrases with special meanings are defined where they first appear unless their meanings are apparent from the context.

A. **"Account Balance"** refers to the value of the account established for you under the Plan to receive contributions and to be credited or debited with its share of Plan earnings, losses and expenses.

B. **"Board of Trustees"** refers to the Board of Trustees of the Michael J. Day Machinists Retiree Investment Trust.

C. **"Dependent"** refers to:

(1) Domestic partners registered with a governmental agency.

(2) Unmarried children (including adopted children, step-children and children of domestic partners) who are:

(a) less than 19 years old, or

(b) less than 23 years old if enrolled as a full-time student at an accredited educational institution, or

(c) 19 years old or older but dependent upon the Participant because of mental or physical handicap and prevented from earning a living.

D. **"Domestic Partner"** is an adult person who has registered as a domestic partner of an unmarried Participant on a governmental agency registry for that purpose and who satisfies the requirements of that agency for being a domestic partner.

E. **"Participant"** refers to a person on whose behalf a contribution has been received.

F. **"Plan"** refers to the Trust's Plan, entitled Michael J. Day Machinists Retiree Health Investment Plan.

G. **"Surviving Spouse"** refers to an individual lawfully married to a Participant at the time of the Participant's death.

H. **"Trust"** refers to the Michael J. Day Machinists Retiree Investment Trust.

I. **"Valuation Date"** refers to the last day of each calendar quarter following the inception of the Trust.

III. ELIGIBILITY

A. **Eligibility Requirements:** A Participant shall be entitled to benefits under the Plan, only on the date that all of the following conditions have been satisfied:

1. The Participant is receiving retirement benefits from the Automotive Industries Pension Plan, the I.A.M. National Pension Fund or such other retirement plans approved by the Board of Trustees;

2. The Participant has a positive Account Balance; and

3. The Participant has submitted a full and complete approved written application for benefits under the Plan.

B. Termination of Participation: An individual, whether a Participant or a Surviving Spouse, shall cease to be a Participant in the Plan when:

1. After the Participant has retired, the Account Balance of the Participant becomes zero;

2. the Plan is terminated; or

3. the death of the individual.

IV. INDIVIDUAL RETIREE SPENDING ACCOUNTS

A. Establishment of Individual Retiree Spending Accounts: Individual Retiree Spending Accounts ("Accounts") shall be established for each eligible Participant on the first Valuation Date after the date contributions are made by a contributing employer on behalf of a Participant under the terms of a collective bargaining agreement or contribution agreement accepted by the Board of Trustees. Accounts shall be valued on a quarterly basis.

B. Account Expense Charge: The Account Expense Charge shall be determined as follows:

1. Determine the total of all operating expenses (net of forfeitures and liquidated damages) incurred by the Plan during the current valuation period. It excludes all investment manager and brokerage fees.

2. For the first Valuation Date after the inception of the Plan, determine the number of Accounts for which contributions were received during the valuation period.

3. For the second and subsequent Valuation Dates, determine the number of Accounts that are in existence on the current Valuation Date.

4. For the first Valuation Date, divide no. 1 by no. 2. For the second and subsequent Valuation Dates, divide no. 1 by no. 3. The result is the Account Expense Charge for the valuation period.

C. **Investment Income Factor:** The Investment Income Factor shall be determined as follows:

1. Determine the total net investment income, including gains and losses, for the valuation period, including all realized and unrealized capital gains or losses, net of any investment manager or brokerage fees. Should the forfeitures and liquidated damages for a year exceed the Plan's operating expenses for that year, the excess shall be included in total investment income.

2. For the first Valuation Date after the inception of the Plan, determine the total Contributions made to Accounts for the current valuation period.

3. For the second and subsequent Valuation Dates, determine the sum of the Account balances on the preceding Valuation Date, add total Contributions to Individual Accounts for the current valuation period, and subtract total Plan payments made since the last Valuation Date.

4. For the first Valuation Date, divide no. 1 by no. 2. For the second and subsequent Valuation Dates, divide no. 1 by no. 3. The result is the Investment Income Factor.

D. **Allocation of Investment Income to Accounts:** The net investment income, including gains and losses, to be allocated to the Participant's Account for the valuation period is obtained by multiplying the Investment Income Factor by no. 1 or no. 2 below.

1. For the first Valuation Date after an Employee becomes a Participant, the contributions credited to the Participant's Account during the valuation period.

2. For the second and subsequent Valuation Dates, determine the Account Balance on the preceding Valuation Date, add total contributions made to the Participant's Account since the last Valuation Date, and subtract payments made from the Participant's Account since the last Valuation Date.

E. **Account Balance:** The Account Balance as of a Valuation Date is determined as follows:

1. Take the Account Balance on the preceding Valuation Date;

2. Add the contributions received by the Participant's Account for the valuation period;

3. Add the investment income allocated to the Participant's Account for the valuation period (as determined under Section V, D);

4. Subtract the Account Expense Charge (as determined under Section IV, D) for the valuation period;

5. Subtract benefit payments from the Participant's Account since the last Valuation Date.

F. **Termination of Account:** After the Participant retires or dies, an Account shall be considered terminated on the last day of in the month in which the Account Balance equals zero.

G. **Interim Valuation:** The fact that Accounts are established and valued as of each Valuation Date shall not give any Employee or others any right, title or interest in the Trust or its assets, or in the Account, except at the time or times and upon the terms and conditions herein provided.

H. **Annual Statements:** After the close of each Plan Year, each Participant who has an Account shall receive a statement reflecting the balance of his Account as of the most recent Valuation Date.

V. BENEFITS:

A. Eligible Participants may utilize some or all of the amount of an Account to be reimbursed for actual out-of-pocket expenses incurred for themselves, their spouses,

Dependents, as defined in Part II, a Qualified Beneficiary for continuation coverage purposes, or an Alternate Recipient under a Qualified Medical Child Support Order for health care premiums paid to provide for the following coverages to the extent that they are classified for purposes of I.R.C. Section 501(c)(9) as life, sick, accident or another similar benefit:

1. medical, including acupuncture and physical therapy;

2. dental;

3. vision;

4. prescription drugs;

5. orthodontia; and

6. life insurance, not to exceed Fifty Thousand Dollars ($50,000) in coverage.

B. Benefits shall be paid on a monthly basis, subject to the following:

1. No benefit is payable for an expense which is not a life, sick, accident or other similar benefit for purposes of Internal Revenue Code Section 501(c)(9);

2. During the period between Valuation Dates the Plan will pay a total of up to 80% of the Account Balance as of the last Valuation Date. Any additional amount payable will be determined and paid in accordance with the next following Valuation; and

3. The Board of Trustees has full authority and discretion to interpret these benefit provisions of the Plan.

C. **Death Benefit**: after notice and satisfactory proof of the death of a Participant and after the payment of all benefit claims incurred before the death of the Participant, the Account Balance shall be distributed to the following person or persons listed on file with the Plan:

1. to the Surviving Spouse, or if none,

2. to the Domestic Partner of the Partner, or if none,

3. to the surviving children of the Participant in equal shares.

If, upon reasonable effort and the passage of at least 180 days, none of the above can be identified and located, the Account shall be terminated, a forfeiture of the Account Balance shall occur and the Account Balance shall become zero (0).

VI. ADDITIONAL ELIGIBILITY REQUIREMENTS

A. Application Forms

1. Initial Application Forms. As a condition for payment of any benefit under this Plan, an individual must submit a written application for the benefit in a form and at times prescribed by the Board of Trustees.

2. Verification Forms. As a condition of continued payment of benefits under this Plan, an individual must submit verification of continued eligibility in a form and at times prescribed by the Board of Trustees.

B. Effective Date of First Payment: Benefits under the Plan shall not be due and owing and shall not begin to be paid until the first month following the date the Plan administrator approves an application for benefits.

C. Submission of Initial Application Form: An individual need not apply for benefits at the earliest time the individual is eligible for benefits. An individual is not eligible for any benefits prior to the first month following the trust's approval of the individual's application for benefits.

D. Individual's Obligation To Furnish Information To The Board of Trustees: An individual shall be obligated to cooperate with the Board of Trustees and to provide any information requested by the Trustees within a reasonable period of time which shall not exceed thirty (30) days, (unless special circumstances as determined by the Board of Trustees exist to justify an extension of time). If an individual fails to cooperate fully with the Board of Trustees, the Board shall have the authority not to pay benefits under this Plan otherwise payable.

The Trustees may request from an individual information including but not limited to: an individual's retirement status, individual tax forms and records from the Social Security Administration concerning employment; an individual's marriage certificate; an individual's death certificate and such other information as the Board of Trustees determines is necessary for the proper administration of the Trust and this Plan.

VII. GENERAL PROVISIONS

A. Interpretation of the Trust Agreement and The Plan: The Board of Trustees shall possess full authority and discretion to interpret the terms of the Trust Agreement and this Plan document. The Board of Trustees also possesses full authority to determine whether any claim for benefits is to be granted or denied.

B. Status of Benefits and Eligibility Requirements: The Board of Trustees expressly reserves the right in its sole discretion at any time and from time to time (1) to increase, decrease, or modify the conditions that have to be met before a benefit is payable and such changes may be made applicable to claims in process or which are made in the future, (2) to amend, alter, or modify any eligibility requirement for benefits under this Plan, (3) to amend any provision of the Plan document, or (4) to terminate the Plan in full.

C. Limitations of Liability: Neither the establishment of the Plan or the Trust nor any modifications thereto, nor the payment of any benefits shall be construed as giving any person any legal or equitable right of action or recourse against the Board of Trustees or its agents or employees, except as provided in the Plan and in the Trust Agreement.

D. Non-Affiliation: The health insurer or health plans to which the Trust makes payments are separate and distinct from the Trust and are not agents of the Trust.

E. Non-Assignment of Benefits: An eligible individual shall not have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment hereunder, except in the case of a Qualified Domestic Relations Order or Qualified Child Medical Support Order. Benefits hereunder shall not be subject to levy or execution or attachment or

garnishment.

F. **Participant Remedies:** An individual shall not have any right or claim to benefits from the Trust, except as specified in this Plan. Any dispute as to eligibility, type, amount or duration of benefit under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees under and pursuant to this Plan and the Trust Agreement, and its decision concerning the dispute shall be final and binding upon all parties to the dispute. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder until the claims appeal procedures of the Plan are exhausted.

G. **Extent of Liability:** The benefits provided by this Plan are not insured by any contract of insurance, and there is no liability on the Board of Trustees or other individual or entity to provide payment over and beyond the amount in the Trust collected and available for such purpose.

H. **Standard of Review:** No action of the Board of Trustees may be revised, changed, or modified by any arbitrator, court, or other entity unless the party seeking such action has exhausted all of its administrative remedies under the Trust and this Plan Document and is able to show by clear and convincing evidence that the Board of Trustees' decision was arbitrary and capricious in light of the information actually available to it, and considered by it, at the time of its decision.

VIII. CLAIMS AND APPEAL PROCEDURE

A. General Rules

1. **Applicability:** This Claims and Appeal Procedures applies to eligibility and benefit determinations relating to benefits available through this Plan only and do not apply to benefits concurrently available to Participants from another plan.

2. **Claimant:** For the purposes of this Claims and Appeal Procedure "Claimant" means a participant or beneficiary under the Plan with a claim for benefits.

3. **Named Fiduciary For Appeals:** The initial Fiduciaries to resolve appeals between meetings are Trustees James Beno and Frank Mellon. They can be contacted in the same manner as the Board. They may make

decisions by telephone conference call or other similar convenient method. The Fiduciaries to resolve appeals between meetings will serve until a written resignation is served on the Board, or until the Board replaces the Fiduciaries. Appeals resolved at meetings of the Board shall be resolved by the full Board.

B. Filing Initial Claim Forms

1. **Initial Claims:** Initial urgent care claims may be made orally. All other initial claims must be filed in written form or electronically using such forms or standards as the Plan may specify from time to time. If an urgent care claim or a pre-service claim does not contain all the necessary information, the Plan Manager shall notify Claimant or the Claimant's authorized representative as soon as possible but not later than (a) 24 hours in the case of urgent care, or (b) 5 days in the case of pre-service claims. The Plan Manager's notice of incomplete claims may be oral unless written notification is requested by the Claimant or the Claimant's authorized representative.

2. **Written Urgent Care Claims:** Any initial urgent care claim filed in written or electronic form should prominently designate on its cover that it is an urgent claim requiring immediate attention.

3. **Calculating Time Periods:** The time period within which a benefit determination is to be made begins at the time a claim is filed without regard to whether all the information necessary to make a benefit determination accompanies the filing. If the period of time is extended as hereafter provided, the period for providing the benefit determination shall be tolled from the date on which the notification of extension is sent to Claimant until the date on which the Claimant responds to the request for additional information.

C. Time of Initial Claims Determinations

1. **Urgent Care Claims:**

(a) An urgent care claim is any claim for medical care or treatment with respect to which the time periods for making non-urgent care determination

could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) Any claim that a physician with knowledge of the Claimant's medical condition determines is an urgent care claim shall be treated as one provided that the Plan Manager is notified of the physician's determination.

(c) If paragraph (b) above does not apply, whether a claim is an urgent care claim will be determined by the Plan Manager or other entity to which the Board has delegated this function applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(d) If an urgent care claim is incomplete, the Plan Manager will notify the Claimant within 24 hours after receipt of the specific information necessary to complete the claim. The Claimant will be given at least 48 hours to provide the specified information.

(e) The Plan Manager shall notify the Claimant of the Plan's initial determination as soon as possible, taking into account the medical urgency, but within the following time periods:

(i) If the claim was complete when filed, within 72 hours after receipt by the Plan.

(ii) If the claim was incomplete, within 48 hours after the earlier of the provision of specified information referred to in paragraph (d) or the end of the period afforded to the Claimant to provide such information.

(f) The Plan's initial notice of an adverse determination shall contain the information listed in Article D.

2. Concurrent Care Decisions

(a) Concurrent care decisions can occur when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(b) Any decision by the Plan to reduce or terminate such a course of treatment before the end of such period of time or course of treatment must be given to the Claimant sufficiently in advance to allow the claimant to appeal and obtain a decision on review before the benefit is reduced or terminated.

(c) Any request by a Claimant to extend the course of treatment that is a claim involving urgent care shall be decided as soon as possible, but within 24 hours, provided the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed treatment.

(d) An adverse determination under this provision shall contain the information listed in Article D.

3. Pre-Service Claims

(a) A pre-service claim is any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(b) The Plan Manager or other entity to which the Board has delegated this function shall notify the Claimant of the Plan's initial determination of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

(c) If the Plan Manager or other entity to which the Board has delegated this function determines that there is not sufficient information to determine the claim within the time limit in paragraph (b) and notifies the Claimant prior to the expiration of that time limit of the

circumstances requiring an extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(d) If the extension described in paragraph (c) is necessary due to failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given at least 45 days from receipt of the notice to provide the information.

(e) Notification of initial pre-service adverse benefit determinations shall contain the information listed in Article D.

4. Post-Service Claims

(a) A post-service health care claim is any health care claim for a benefit under the Plan that is not a pre-service claim, a concurrent claim, or an urgent care claim.

(b) The Plan Manager shall notify a Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

(c) If the Plan Manager determines that there is not sufficient information to determine the claim within the time limit in paragraph (b) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring the extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(d) If the extension described in paragraph (c) is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given 45 days from receipt of the notice to provide the information.

(e) Notification of initial post-service adverse benefit determinations shall contain the information listed in Article D.

5. **Expiration of Time Periods:** If a claim is not acted upon within the time periods prescribed by this Article C, the Claimant may proceed to the appeal procedure as if the claim were denied.

D. Notification of Initial Claims Denials

1. **Contents of Notification:** The Plan's notification of an adverse benefit determination on an initial claim shall set forth, in a manner calculated to be understood by the Claimant, the following matters:

(a) The specific reason or reasons for the decision.

(b) Reference to the specific Plan provision on which the decision is based.

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures.

(e) If an internal rule, guideline, protocol or other similar criteria was relied upon, a statement that such document will be provided free of charge upon request.

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

(g) A statement of the Claimant's right to bring a court action under ERISA §502(a) following an adverse decision on review.

2. **Manner of Notification:** The notification shall be in written or electronic form, except that the following special rules will apply to urgent care decisions:

(a) The information described in paragraph 1 may be provided to the Claimant orally within the time frame described in C-1, provided that written or electronic notification is furnished not later than 3 days thereafter.

(b) Any notification of an adverse determination concerning urgent care shall contain a description of the expedited review process available under E-2.

E. Appeals of Adverse Initial Claims Determinations

1. **General Rules:** All adverse decisions of initial claims, other than urgent care claims, may be appealed by Claimants pursuant to the following rules:

(a) Claimants must file an appeal in writing within 180 days following receipt of the Plan notification of an adverse initial determination. There is no specific form for this purpose. Late applications may be considered by the Named Fiduciary for Appeals in its sole discretion if it finds that the delay in filing was reasonable under the circumstances. Failure to file an appeal within the 180 day period will constitute a waiver of the Claimant's right to review the denial of his claim whether or not the Plan is prejudiced by the failure.

(b) Claimants may submit written comments, documents, records or other information relating to the claim.

(c) Upon written request, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (i) were relied upon in making the initial determination, (ii) were submitted, considered or generated in the course of making the benefit determination even if not relied upon, (iii) demonstrate that the Plan provisions

have been followed and applied consistently with respect to similarly situated individuals, or (iv) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

(d) The appeal will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

(e) The appeal will not afford deference to the initial determination.

(f) The appeal will not be conducted by a person who is either the individual who made the initial adverse determination, nor the subordinate of such individual.

(g) In deciding an appeal based in whole or in part on a medical judgment, the Named Fiduciary for Appeals shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination nor the subordinate of any such person.

(h) Upon request, Plan Manager will identify the medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

(i) The Claimant shall have no right to personally appear before the Named Fiduciary for Appeals unless the Named Fiduciary for Appeals in its sole discretion concludes than such an appearance would be of value in enabling it to review the adverse initial determination.

2. Urgent Care Claims: The following expedited procedures will apply to urgent care appeals:

(a) A request for an expedited appeal of a denied urgent care claim may be made orally or in writing by the Claimant or his authorized representative. A written appeal should prominently designate on the cover that it is an urgent care claim requiring immediate attention.

(b) All necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, e-mail or other available similarly expeditious method.

F. Time of Claims Appeal Determinations

1. **Urgent Care and Concurrent Care Claims:** The Named Fiduciary for Appeals shall notify the Claimant of the decision on review as soon as possible taking into account the medical condition of Claimant, but not later than 72 hours after receipt of Claimant's appeal showing that it is an urgent care appeal.

2. **Pre-Service Claims:** The Named Fiduciary for Appeals shall notify the Claimant of the decision on review within a reasonable period of time applicable to the medical circumstances, but not later than 30 days after receipt of Claimant's appeal.

3. **Post-Service Claims:**

   (a) The Named Fiduciary for Appeals shall decide appeals and the Plan Manager shall notify the Claimant of the decision on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's appeal. However, if the Plan Manager determines that special circumstances require an extension of time for processing the claim, written notice must be furnished to the Claimant.

   (b) If special circumstances require a further extension, the appeal will be decided not later than 120 days after receipt of the Claimant's appeal. Before the start of the extension the Plan Manager shall notify the Claimant in writing of the extension describing the special

circumstances and the date as of which the benefit determination is expected to be made.

(c) If the extension described in paragraphs (a) or (b) is due to failure of the Claimant to submit information necessary to decide the appeal, the notice of extension shall specify the required information and the Claimant will be given at least 45 days from receipt of the notice to provide the information.

4. Calculating Time Periods on Appeal: The time period within which decision on review is to be made begins at the time an appeal is received without regard to whether all the information necessary to decide the appeal accompanies the appeal. If the period of time is extended under this procedure due to the Claimant's failure to submit necessary information, the period for making a decision on review is tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

5. Contents of Notification: Adverse decisions on appeal shall be made in accordance with and contain the information listed in Article G.

G. Notification of Appeals Decisions

1. Manner of Notification: Except in the case of urgent care decisions which may be made orally, decisions on appeals will be communicated to Claimants by written or electronic notification.

2. Contents of Notification: Appeals decisions shall set forth in a manner calculated to be understood by the Claimant the following information:

(a) The specific reason or reasons for the decision.

(b) Reference to the specific Plan provisions on which the appeal is based.

(c) A statement that the Claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim as described in E-1(a).

(d) If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon request.

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

3. **No Further Appeals:** Following issuance of the decision on appeal, there is no further right under these procedures to appeal or arbitrate the decision.

H. Legal Proceedings

1. **Legal Actions:** Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their administrative remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her administrative remedies will preclude further judicial review.

2. **Legal Standards:**

(a) The Named Fiduciary for Appeals is given full discretionary authority (i) to finally determine all facts relevant to any claim, (ii) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (iii) to finally determine what benefits are payable from the Plan.

(b) Any decision made by any Named Fiduciary for Appeals shall be binding on all persons affected to the fullest extent permitted by law.

(c) No decision of a Named Fiduciary for Appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the Named Fiduciary for Appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.

I. Miscellaneous Provisions

1. **Authorized Representatives:** A Claimant may appoint in writing an authorized representative to act on his behalf in pursuing a claim or appeal under these claim procedures, including a health care professional with knowledge of the Claimant's medical condition. There is no required form for this purpose. In the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as an authorized representative of Claimant even without written authorization by Claimant.

2. **Plan Records:** The Plan Manager shall maintain records designed to ensure and verify that determinations are made in accordance with Plan documents and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated Claimants. Plan participants' privacy will be protected at all times.

3. **Appeal of Adverse Determinations:** Any decisions affecting a Claimant's benefits under the Plan may be appealed under these claims procedures, including:

   (a) A denial, reduction or termination of any Plan benefit.

   (b) A failure to provide or make payment in whole or in part for any Plan benefit.

   (c) A refusal to provide a Plan benefit based on a determination that the Claimant is not eligible under the terms of the Plan.

   (d) A denial, reduction or termination of or failure to provide or make payment for a benefit

resulting from the application of any utilization review.

(e) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

J. **Rights of Board:** The Board retains the right to interpret and amend these Claims Procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Board is authorized to adopt such rules as it in its discretion deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

IX. AMENDMENT AND TERMINATION OF THE PLAN

The Board of Trustees may at any time amend or modify the Plan or the Trust Agreement. The Board of Trustees retains the discretion to change the form, manner, and duration of any benefit. Upon termination of the Plan, the Board of Trustees shall use any remaining Trust assets, after first satisfying Trust obligations, to provide Plan benefits or similar qualified benefits for so long as Trust assets permit.

THIS PLAN IS ADOPTED BY THE UNDERSIGNED MEMBERS OF THE BOARD OF TRUSTEES ON October __, 2002, TO BE EFFECTIVE January 1, 2003.

_____	_____
TRUSTEE	**TRUSTEE**
_____	_____
TRUSTEE	**TRUSTEE**