UNITARIAN UNIVERSALIST ORGANIZATIONS HEALTH PLAN

(Updated with all Amendments through July 1, 2012)

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ARTICLE 1
INTRODUCTION

Section 1.1 Purpose

The Unitarian Universalist Organizations Health Plan (the "Plan") was established and is maintained by the Unitarian Universalist Association Employee Benefits Trust (the "Trust"), to provide comprehensive health benefits to Eligible Employees (and their eligible Dependents) of Subscribing Employers and to Subscribing Individuals. The Plan, as set forth herein, is intended to constitute an employee welfare benefit plan under Section 3(1) of ERISA and an "accident or health plan" under Section 105(e) of the Code.

Section 1.2 Effective Date

The original effective date of the Plan is January 1, 2007.

Section 1.3 Plan Administration

The Plan is administered by the Administrator. Any notice or document required to be given to or filed with the Plan will be properly given or filed if delivered or mailed by registered mail, postage prepaid, to the Administrator at UUA Health Plan, 25 Beacon Street, Boston, MA 02108.

Section 1.4 Coverage and Benefits

Subscribing Employers, Subscribing Individuals and Covered Persons share the cost of coverage under the Plan in such amounts as shall be determined by the Trust and by Subscribing Employers. The Trust or a Subscribing Employer may change and/or impose Employee contribution requirements under the Plan at any time in their discretion. Benefits under the Plan may be provided on either an insured or self-insured basis, or combination thereof, as shall be determined by the Trust in its sole discretion.

Section 1.5 Plan Supplements

Supplements are attached to and form a part of the Plan for purposes of incorporating by reference the terms and provisions of the Coverage Booklets, identifying Subscribing Employers and identifying Claims Administrators and Appeals Fiduciaries under the Coverage Booklets. From time to time, Supplements may be added to the Plan for purposes of modifying provisions of the Plan or for adding or terminating Coverage Booklets under the Plan.

ARTICLE 2
DEFINITIONS

Section 2.1 Administrator

The term "Administrator" shall refer to the person or persons as may be appointed by the Trust to administer the Plan.

Section 2.2 Appeals Fiduciary

The term "Appeals Fiduciary" means the person(s) or administrators appointed by the Trust under the Plan to whom the Trust has delegated the fiduciary duty and discretion to review and decide benefit claims on appeal. The Appeals Fiduciary is the Trust Committee.

Section 2.3 Claims Administrator

The term "Claims Administrator" means the administrator appointed by the Trust under the Plan, to whom the Trust has delegated the fiduciary duty and discretionary authority to decide claims for benefits under the Plan. Unless otherwise provided in a Coverage Booklet, the Trust has discretionary authority to make all final decisions regarding claims. Further, unless otherwise provided in a Coverage Booklet, the Trust, or the Administrator or Claims Administrator acting for the Trust, has full discretionary authority to determine benefit eligibility, to interpret the Plan, or to make all factual determinations regarding the adjudication of claims and eligibility for benefits of beneficiaries under the Plan.

Section 2.4 COBRA

The term "COBRA" means the health care coverage continuation provisions under the terms of the Consolidated Omnibus Budget Reconciliation Act of 1985, amendments thereto, and the regulations issued thereunder.

Section 2.5 Code

The term "Code" means the Internal Revenue Code of 1986, as amended, and the regulations thereunder.

Section 2.6 Congregation

The term "Congregation" means a congregation that is a member of the Unitarian Universalist Association.

Section 2.7 Coverage Booklet

The term "Coverage Booklet" means a schedule of benefit specifications (which may be in the form of a Summary Plan Description, summary of benefits, insurance contracts, health maintenance organization agreements, administrative services agreements, etc.) listed in Supplement A and incorporated by reference as part of this Plan. Each Coverage Booklet sets

forth the level and types of benefits payable to or on account of such Covered Persons, any contributions required from Covered Persons and other sources of funding (if applicable).

Section 2.8 Covered Person

The term "Covered Person" means any Eligible Employee, Eligible Retiree or Subscribing Individual who has enrolled in the Plan and any eligible Dependent for whom the Eligible Employee, Eligible Retiree or Subscribing Individual has elected to provide coverage and whom the Eligible Employee, Eligible Retiree or Subscribing Individual has properly enrolled under the Plan. The term "Covered Person" shall also refer to any qualified beneficiary electing coverage under COBRA.

Section 2.9 Dependent

The term "Dependent" means the Employee's spouse, domestic Partner, or child, defined as follows: [1]

(a) Spouse. The term "spouse" means the Employee's spouse under a legally valid marriage. In the event a particular state has adopted a definition of marriage that includes same sex marriages, the Plan will recognize such state law with respect to individuals residing in such state or residing in another state recognizing that state's law. At its discretion, the Administrator may, from time to time, request documentation from any Employee regarding his or her marital relationship, including but not limited to a marriage certificate, other documentation issued by a state agency or a decree, order or stipulation entered by a court of law of competent jurisdiction.

(b) Domestic Partner. The term "domestic partner" means an individual who meets the requirements of a domestic partner as established by the Trust and (if applicable) an insurer, which requirements may include but are not limited to the following: that the Employee and the domestic partner not be married to nor be involved in a domestic relationship with any other individual; that the Employee and domestic partner not be related by blood closer than what would bar marriage under the law; that the Employee and the domestic partner share the same permanent residence; that the Employee and the domestic partner have joint responsibility over each other's welfare and other common expenses; and, that the Employee and the domestic partner register their domestic partnership with their state of domicile in accordance with state law (if any).

(c) Child. The term "child" means the Employee's or spouse's or domestic partner's unmarried natural child, stepchild or legally adopted child, who satisfies the following conditions:

(i) The child depends on the employee, spouse or domestic partner for more than half of his or her financial support or the employee, spouse or domestic partner is legally required to provide group health coverage for the child pursuant to a court or administrative order. A child is considered financially dependent if he or she qualifies as a dependent for

[1] 2.9 (c) amended May 1, 2010. See Amendment #3.

federal income tax purposes. The Administrator may require proof of dependent status from time to time.

(ii) The child is under 19 years of age, or the child is under 25 years of age and enrolled as a full-time student (for 12 or more credit hours) in a properly accredited two year community college, four year college or university, or an accredited post-high school trade or technical school. A child age 19 or older who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on his or her behalf. The Administrator may require proof of age and proof of full-time student status from time to time.

(iii) The child is age 19 or older and is physically or mentally incapable of caring for himself or herself due to a physical, mental or developmental disability. The Administrator may require proof of the child's disability from time to time.

A child who is in the process of being adopted is considered a legally adopted child if the Claims Administrator receives from the Administrator legal evidence of both: (i) the intent to adopt; and (ii) that the Employee, spouse or domestic partner have either (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee's, spouse's or domestic partner's right to control the health care of the child.

The term "child" includes a child designated under a Medical Child Support Order (MCSO) which is determined by the Administrator in accordance with the Plan's written procedures (which are incorporated herein by reference) and ERISA to be a qualified Medical Child Support Order. Upon receipt of a MCSO, the Administrator will promptly inform the Employee and each child who is the subject of the MCSO of its receipt of the MCSO and will explain (in writing) the Plan's procedures for determining if the MCSO is qualified. Within a reasonable time, the Administrator will decide whether the MCSO is qualified and will notify the Employee and the child(ren) of its determination. Coverage cannot be discontinued for any child who is enrolled to comply with a qualified MCSO unless the Employee submits written evidence that the MCSO is no longer in effect.

Section 2.10 Effective Date

The "Effective Date" of the Plan is January 1, 2007.

Section 2.11 Eligible Employee or Employee

The term "Eligible Employee" means a person who is employed by a Subscribing Employer, who works at least 1,000[2] hours per calendar year, and who satisfies any eligibility

[2] 2.11 amended January 1, 2008 and July 1, 2010. See Amendments #1 & #3. Amendment #3 is the current controlling definition.

requirements established by the Subscribing Employer in the subscription agreement. When used in this Plan, the term "Employee" shall refer to an Eligible Employee unless indicated otherwise.

Section 2.12 Eligible Retiree or Retiree

The term "Eligible Retiree" means a person who is under age 65 if the person retired from a Subscribing Employer after performing services as a minister. The term "Eligible Retiree" also includes a person who is age 65 or older, who is enrolled in Medicare Parts A and B, who retired from a Subscribing Employer after performing services in any capacity and who worked at least 1,000[3] hours for a Subscribing Employer in five of the ten calendar years preceding the year of retirement. When used in this Plan, the term "Retiree" shall refer to an Eligible Retiree unless indicated otherwise.

Section 2.13 Employer

The term "Employer" means a Congregation or other entity that is an affiliated member of the Unitarian Universalist Association.

Section 2.14 ERISA

The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder.

Section 2.15 HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder.

Section 2.16 Plan

The term "Plan" means the Unitarian Universalist Organizations Health Plan, as adopted effective as of January 1, 2007.

Section 2.17 Plan Year

The term "Plan Year" means, for the initial term, January 1, 2007 to June 30, 2007[4], and for each subsequent year, means the twelve (12) consecutive month period commencing each July 1 and ending the next following June 30.

Section 2.18 Special Enrollment

The term "Special Enrollment" means enrollment in the Plan pursuant to Sections 3.4 or 3.5.

[3] 2.12 amended January 1, 2008 and July 1, 2010. See Amendments #1 & #3. Amendment #3 is the current controlling definition.
[4] 2.17 amended January 1, 2007. See Amendment #2.

Section 2.19 Subscribing Employer

The term "Subscribing Employer" means an Employer that subscribes to the Plan in the manner provided in Section 11.2.

Section 2.20 Subscribing Individual

The term "Subscribing Individual" means a self-employed Unitarian Universalist community minister and a Unitarian Universalist community minister working in a ministerial capacity for an Employer that does not offer a health insurance plan, who subscribes to the Plan in the manner provided in Section 11.3.

Section 2.21 Summary Plan Description

The term "Summary Plan Description" means the summary plan description prepared and issued as, or in conjunction, with a Coverage Booklet under the Plan. From time to time, a Summary Plan Description may be updated with a summary of material modifications explaining any material changes to the terms of one or more of the Coverage Booklets. Summaries of material modifications are incorporated into and form a part of the Summary Plan Description for the Plan.

Section 2.22 Trust

The term "Trust" means the Unitarian Universalist Association Employee Benefits Trust, as amended from time to time.

Section 2.23 Trust Committee

The term "Trust Committee" means the persons designated by the Trustees in accordance with Article 8 of the Trust who from time to time serve as the Trust Committee.

Section 2.24 Trustees

The term "Trustees" means the Trustees designated under the Trust and their successors.

Section 2.25 Trust Fund

The term "Trust Fund" means the trust fund created to hold the assets of the Plan.

ARTICLE 3
ELIGIBILITY AND ENROLLMENT

Section 3.1 Eligibility

The following categories of individuals are eligible to participate in the Plan:

(a) Eligible Employees of Subscribing Employers;

(b) Retired Employees of Subscribing Employers; and

(c) Subscribing Individuals.

These individuals may enroll in the Plan, and may enroll their Dependents, in accordance with Section 3.2. Upon enrollment in the Plan, these individuals and their Dependents become Covered Persons.

Section 3.2 Enrollment Periods and Coverage Effective Dates

(a) Initial Open Enrollment Period. The initial open enrollment period for the Plan began May 1, 2006 and ended November 27, 2006. Coverage for individuals (and their Dependents) who enroll during this period is effective January 1, 2007. If an individual does not enroll in the Plan during this initial open enrollment period, the individual may not enroll until the annual open enrollment period described in Section 3.2(c).

(b) Initial Enrollment Period for New Hires. The initial enrollment period for individuals hired after November 27, 2006 is the 30-day period beginning on the eligibility date specified by a Subscribing Employer in its subscription agreement. Coverage for individuals (and their Dependents) who enroll during this period is effective retroactive to that eligibility date. If a newly hired individual does not enroll in the Plan within 30 days of commencement of employment, the individual may not enroll until the annual open enrollment period described in Section 3.2(c).

(c) Annual Open Enrollment Period. The annual open enrollment period begins and ends on the dates specified by the Trust Committee. Coverage for individuals (and their Dependents) who enroll during this period is effective on January 1st of the following Plan Year.

(d) Enrollment Procedures. To enroll in the Plan, an Eligible Employee, Eligible Retiree or Subscribing Individual must provide information about themselves and their Dependents on an enrollment form and provide any supporting documents as may be required by the Administrator.

Section 3.3 Leaves of Absence

If an unpaid leave qualifies as a leave under the Family and Medical Leave Act of 1993 ("FMLA"), the Trust may select one of the payment options available under Treasury Regulations Section 1.125-3, Q&A-3, or any subsequent regulation, provided the payment options are made available to all Covered Persons taking unpaid FMLA leave in accordance with

such regulations. Military leaves qualifying under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") shall be administered in accordance with the terms of USERRA's benefit requirements.

Section 3.4 Special Enrollment Period for Loss of Other Creditable Coverage

If an Eligible Employee, an Eligible Retiree or Subscribing Individual originally declined medical coverage for themselves or their Dependents under the Plan due to the availability of other health coverage and such other health coverage is subsequently terminated due to (a) loss of eligibility for such coverage, or (b) the termination of any company contributions for such coverage, then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may enroll in the Plan, provided a properly completed enrollment form is received by the Administrator within 31 days of the loss of eligibility for the other coverage or termination of contributions. For this purpose, a "loss of eligibility" for other coverage includes a loss of coverage due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

However, loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or misrepresentation. If the Eligible Employee, Eligible Retiree or Subscribing Individual initially waived coverage for themselves and/or their Dependents under the Plan because COBRA continuation coverage was in effect, the Employee and/or Dependent must exhaust such COBRA coverage before becoming eligible to elect Special Enrollment under the Plan. The effective date of coverage for Special Enrollment under this Section 3.4 will be retroactive to the date the other coverage is lost. If a properly completed enrollment form is not received by the Administrator within 31 days, then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may not enroll until the next annual open enrollment period. Notwithstanding anything to the contrary herein, if a special enrollment opportunity arises under this Section 3.4 and the Eligible Employee, Eligible Retiree or Subscribing Individual is not otherwise enrolled, no Dependents may be enrolled unless the Eligible Employee, Eligible Retiree or Subscribing Individual is also enrolled.

Section 3.5 Special Enrollment Period for Newly Acquired Dependents

(a) HIPAA Special Enrollment. Subject to Section 3.5(b), if an Eligible Employee, Eligible Retiree or Subscribing Individual acquires a new Dependent through birth, adoption, placement for adoption or marriage and requests enrollment in the Plan for the Dependent within 31 days of the birth, adoption, placement for adoption or marriage, medical coverage for the Dependent will become effective retroactive to the date of the birth, adoption, placement for adoption or marriage. The Eligible Employee, Eligible Retiree or Subscribing Individual and his or her spouse or domestic partner may also enroll for coverage during this special enrollment period for newly acquired Dependents if they are not otherwise already enrolled, provided, however, that no Dependents (including the Employee's spouse or domestic partner) may be enrolled under the Plan unless the Eligible Employee, Eligible Retiree or Subscribing Individual is also enrolled. If a properly completed enrollment form is not received by the Administrator within the 31-day period commencing on the date of the birth, adoption, placement for adoption

or marriage, then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may not enroll until the next annual open enrollment period.

(b) Special Rule for Newborn and Newly Adopted Children. If an Eligible Employee, Eligible Retiree or Subscribing Individual and their spouses or domestic partners, if enrolled, are covered under the Plan: (1) coverage for any newborn child will commence on the date of birth and continue for 31 days; and (2) coverage for any newly adopted child will commence on the date on which either: (a) the adoptive child's birth parent, or other appropriate legal authority, signs a written document granting the Eligible Employee, Eligible Retiree or Subscribing Individual or their spouses or domestic partners the right to control the health care of the child; or (b) the Eligible Employee, Eligible Retiree or Subscribing Individual or their spouses or domestic partners assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption, and in either case will continue for 31 days. The written document referred to above includes, but it is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, or in the absence of a written document, other evidence of the right to control the health care of the child. For coverage to continue beyond this initial 31-day period, the Eligible Employee, Eligible Retiree or Subscribing Individual must enroll the child within the 31-day period by submitting an enrollment change form to the Administrator. The Administrator will determine, in its sole discretion, whether the requirements of this Section 3.5(b) have been met and whether a child is entitled to coverage under this Section 3.5(b).

Section 3.6 Other Election Changes[5]

In addition to any other election changes permitted under the Plan, an Eligible Employee, Eligible Retiree or Subscribing Individual may change his or her election of coverage during the Plan Year under the following circumstances:

(a) If the Eligible Employee, Eligible Retiree or Subscribing Individual is subject to a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order under Section 609 of ERISA) that requires coverage under the Plan for a child, the Eligible Employee, Eligible Retiree or Subscribing Individual shall be required to change his or her election to provide coverage for such child (and to provide coverage for the Eligible Employee, Eligible Retiree or Subscribing Individual if he or she is not enrolled in the Plan), or in the event of the expiration of such order, to revoke coverage for such child.

(b) If an Eligible Employee, Eligible Retiree or Subscribing Individual and/or his or her Dependents become entitled to coverage (i.e., enrolled) under Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act), the Eligible Employee, Eligible Retiree or Subscribing Individual may revoke his or her coverage under the Plan and that of his or her Dependents.

[5] 3.6 renumbered to 3.7 July 1, 2010. New 3.6 added July 1, 2010. See Amendment #3.

(c) An Eligible Employee, Eligible Retiree or Subscribing Individual may change his or her election from standard PPO coverage to high deductible PPO coverage at any time during the Plan Year. However, an Eligible Employee, Eligible Retiree or Subscribing Individual may change his or her election from high deductible PPO coverage to standard PPO coverage only during the annual open enrollment period described in Section 3.2(c).

ARTICLE 4
CONTRIBUTIONS

Section 4.1 Contributions by Covered Persons

Covered Persons shall contribute to the Trust in such amounts, at such times, and according to such procedures as the Trustees or Trust Committee may determine from time to time. Contributions of Covered Persons who are Employees of a Subscribing Employer shall be included in the contributions forwarded by the Subscribing Employer to the Trust. Contributions by Covered Persons shall be transmitted to the Trust Fund as soon as administratively practicable after such amounts have been deducted from the Covered Person's compensation or otherwise received.

Section 4.2 Contributions by Subscribing Employers and Subscribing Individuals

Each Subscribing Employer and Subscribing Individual electing to participate in the Trust and the Plan shall contribute to the Trust in such amounts, at such times, and according to such procedures as the Trustees or Trust Committee may determine from time to time. Contributions by Subscribing Employers and Subscribing Individuals will be specified in the subscription agreement.

Section 4.3 Establishment of Funding Policy

The Trust shall, under the Plan, establish and carry out a funding policy consistent with the purposes of the Plan and the requirements of applicable law. The funding policy may be changed by the Trust as appropriate. As part of the funding policy, the Trustees shall exercise their investment discretion to provide sufficient cash assets in the Trust Fund in an amount determined by the Trustees, under the funding policy then in effect, to be necessary to meet the liquidity requirements for the administration of the Plan.

ARTICLE 5
BENEFITS AND LIMITATIONS

The benefits provided under the Plan for each group or classification of Covered Persons are those set forth in the Coverage Booklet(s) applicable to such group or classification of Covered Persons. The benefits and limitations specified in the Coverage Booklets which form a part of this Plan are hereby incorporated by reference in this Plan document. The terms and conditions of the Coverage Booklets shall control in determining benefits payable under the Plan.

ARTICLE 6
TERMINATION OF COVERAGE

Section 6.1 Termination of Coverage

Coverage under the Plan for Covered Persons will terminate on the earliest of the following dates:

(a) the last day of the month in which the Plan or Trust terminates;

(b) the last day of the month in which the Covered Person waives coverage under the Plan or revokes all coverage elections under the Plan;

(c) the last day of the month for which the Covered Person fails to pay the required contribution when due;

(d) the last day of the month in which the Covered Person is no longer an Eligible Employee, an Eligible Retiree, a Subscribing Individual or a Dependent for any reason;

(e) in the case of an Eligible Employee or Eligible Retiree, the last day of the month in which a Subscribing Employer's participation in the Trust is terminated either voluntarily or involuntarily;

(e) in the case of a Dependent, the date of the Dependent's marriage;

(f) the date a Covered Person's coverage is terminated for fraud, misrepresentation or deceit in accordance with Section 11.20; or

(g) the last day of a Covered Person's employment, if the Subscribing Employer elects date of hire/date of termination eligibility on its subscription agreement.

Section 6.2 Federal Laws Regarding Continuation Coverage

Notwithstanding the provisions of Section 6.1, Covered Persons who otherwise meet the requirements for continuation and reinstatement of coverage under the Family and Medical Leave Act of 1993 (FMLA); the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); and Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall be offered the right to continue coverage pursuant to the terms and provisions of the applicable statute, the regulations thereunder and the administrative rules established by the Administrator, in its discretion.

ARTICLE 7
COORDINATION OF BENEFITS

Section 7.1 Purpose

The Coordination of Benefits (COB) provisions in this Article 7 are intended to ensure that, when a Covered Person is covered both by this Plan and by another group health plan or Medicare, the Covered Person shall receive appropriate reimbursement without receiving duplicative payments. The Administrator shall administer these provisions in accordance with this intended purpose. Unless specifically provided otherwise in a Coverage Booklet, the provisions of this Article 7 shall apply in Coordination of Benefits determinations.

Section 7.2 Definitions

The meaning of key terms used in this Article 7 are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters.

(a) Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount This Plan would determine to be eligible expense, if the person were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

(b) Other Plan is any of the following:

(i) Group, blanket or franchise insurance coverage;

(ii) Group service plan contract, group practice, group individual practice and other group prepayment coverages;

(iii) Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

(c) Principal Plan is the plan which will have its benefits determined first.

(d) This Plan is that portion of this Plan which provides benefits subject to this Article 7.

Section 7.3 Effect on Benefits

(a) If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

(b) If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

(c) The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if the person were covered under This Plan only.

Section 7.4 Order of Benefits Determination

The following rules determine the order in which benefits are payable:

(a) A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

(b) A plan which covers the person as an employee pays before a plan which covers the person as a dependent. However, if the person is eligible for Medicare, and Medicare pays (a) after the plan which covers the person as a dependent, but (b) before the plan which covers the person as an employee, then the plan which covers the person as a dependent pays before the plan which covers the person as an employee.

(c) For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits. For a dependent child of parents who are divorced or separated, the following rules will be used in lieu of the birthday rule:

(i) If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

(ii) If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

(A) The plan which covers that child as a dependent of the parent with custody.

(B) The plan which covers that child as a dependent of the stepparent (married to the parent with custody).

(C) The plan which covers that child as a dependent of the parent without custody.

(D) The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

(iii) Regardless of (i) and (ii) above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.

(d) The plan covering the person as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering the person as other than a laid-off or retired employee or the dependent of such a person. However, if either plan does not have a provision regarding laid-off or retired employees, Section 7.4 (f) applies.

(e) The plan covering the person under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the person as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

(f) When the above rules do not establish the order of payment, the plan under which the person has been enrolled the longest pays first unless the person's effective date of coverage under both plans is the same. In this case, Allowable Expense is split equally between the two plans.

Section 7.5 Rights of Claims Administrators

(a) Responsibility for Timely Notice. The Plan is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this Article 7.

(b) Reasonable Cash Value. If any Other Plan provides the benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and This Plan's liability will be reduced accordingly.

(c) Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, the Claims Administrator has the right to pay that Other Plan any amount it determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the requirements of this Article 7.

(d) Right of Recovery. If payments made under This Plan exceed the maximum payment necessary under this Article 7, This Plan has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

ARTICLE 8
COBRA CONTINUATION COVERAGE

Section 8.1 Purpose

This Article 8 includes the provisions relating to the rights of certain Covered Persons to elect to continue group health coverage under the Plan if, but for such election, a qualifying event described in Sections 8.2 or 8.3, and certain other events described in Section 8.4, would result in a Covered Person's loss of coverage under the Plan. As described below, any individual continuing coverage under this Article 8 must pay the full cost of coverage plus an applicable administrative surcharge.

Section 8.2 Eligibility for COBRA Coverage

COBRA continuation coverage is available for Qualified Beneficiaries who experience a qualifying event.

Section 8.3 Qualifying Events

A qualifying event is any of the events listed in this Section 8.3 that, but for the COBRA continuation provided under the Plan, would result in the loss of group health coverage of a Covered Person.

(a) Death. The death of an Eligible Employee, Eligible Retiree or Subscribing Individual.

(b) Termination or Reduction in Hours. The termination or retirement (including disability retirement) of an Eligible Employee (for a reason other than gross misconduct) or a change in employment status that results in a reduction in hours of employment.

(c) Divorce or Legal Separation. The divorce or legal separation of an Eligible Employee, Eligible Retiree or Subscribing Individual and his or her spouse.

(d) Medicare Entitlement. The date the covered Employee becomes entitled to benefits under Medicare or notifies the Administrator that he or she does not want coverage under this Plan to continue and selects Medicare for health insurance coverage. For purposes of this Article 8, a covered Employee shall be considered to be entitled to benefits under Medicare if he or she has enrolled in and is covered under Medicare.

(e) Loss of Dependent Status. The date coverage of a Dependent terminates in accordance with the terms of the Plan.

Section 8.4 Qualified Beneficiaries

Any Covered Person who loses coverage due to a qualifying event is referred to as a qualified beneficiary. Also, a child born to or placed for adoption with a qualified beneficiary during a period of COBRA continuation coverage is a qualified beneficiary.

Section 8.5 Notification Responsibilities

(a) Notification Responsibilities of Subscribing Employers. The Subscribing Employer must notify the Administrator within 30 days of an Eligible Employee's termination of employment, reduction in hours worked, death, or Medicare entitlement.

(b) Notification Responsibilities of Qualified Beneficiaries. Qualified beneficiaries must notify the Administrator of the following events:

(i) In the case of (A) divorce or legal separation from an Eligible Employee, Eligible Retiree or Subscribing Individual; (B) a Dependent ceases to be eligible as a Dependent under the Plan; or (C) the date of the occurrence of a second qualifying event after a qualified beneficiary has elected COBRA, the qualified beneficiary must notify the Administrator on the form prescribed by the Administrator within 60 days of the later of the date of the qualifying event or the date the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event.

(ii) In the case of a disability determination by the Social Security Administration, the qualified beneficiary must notify the Administrator on the form prescribed by the Administrator before the end of the 18-month COBRA continuation coverage period and within 60 days of the later of the date of the qualifying event, the date of the disability determination, or the date the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event.

(iii) In the case of a change in a disability determination by the Social Security Administration, the qualified beneficiary must notify the Administrator on the form prescribed by the Administrator within 30 days of the date of the disability determination.

(c) Notification Responsibilities of Administrator. The Administrator must provide a COBRA election notice to a qualified beneficiary within 14 days after receiving a notification from a Subscribing Employer under Section 8.5(a) or a notification from a qualified beneficiary under Section 8.5(b). a qualifying event occurs, a qualified beneficiary may continue Federal COBRA coverage only if a written request for coverage is received on a timely basis by the Administrator and the required monthly payments are paid on time to the Administrator.

Section 8.6 Electing COBRA Continuation Coverage

Qualified beneficiaries must elect COBRA continuation coverage not later than 60 days after the date of the COBRA election notice The election must be submitted on the form prescribed by the Administrator. Each qualified beneficiary entitled to COBRA coverage may make a separate election. However, a request for COBRA continuation coverage will be deemed to include all qualified beneficiaries unless the Eligible Employee, Eligible Retiree or Subscribing Individual asks that it not include them. A request by a Spouse may include qualified beneficiaries who live with the Spouse.

Section 8.7 Paying for COBRA Continuation Coverage

Qualified beneficiaries are responsible for paying the full monthly cost to the Administrator in advance for COBRA continuation coverage. For the initial period of COBRA continuation coverage (the period from the date of the qualifying event until the date of the qualified beneficiary's COBRA election), the payment must be received by the Administrator within 45 days after the date of the qualified beneficiary's COBRA election. For subsequent months of COBRA continuation coverage, the payment must be received by the Administrator by the first day of each such month; provided, however, that there is a 30-day grace period for making payments. Except for coverage during a disability extension described in Section 8.8, required premium payments for COBRA continuation coverage will be no more than 102% of the Plan cost for the benefits that the Subscribing Employer provides to its similarly situated non-COBRA beneficiaries.

Section 8.8 Duration of COBRA Continuation Coverage

(a) General Rules. COBRA continuation coverage under the Plan will end on the earliest of the following dates:

(i) the end of the 18 month period that follows the date of the qualifying event, if the qualifying event is the termination of a employment or reduction of work hours; or the end of the 36-month period that follows the date of any other qualifying event;

(ii) the end of the last month for which the Covered Person has properly paid the premiums for COBRA continuation coverage. Payments made after the applicable grace period will not be accepted;

(iii) the end of the month in which the Subscribing Employer's participation in the Plan or Trust is terminated, either voluntarily or involuntarily;

(iv) the date that the qualified beneficiary, after electing COBRA continuation coverage, first becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing conditions he or she may have. If the exclusion or limitation for pre-existing conditions in the other group health plan would not apply to the qualified beneficiary (or would be satisfied by the qualified beneficiary) due to the requirements enacted by the HIPAA, then continuation coverage may be terminated under this provision; or

(v) the date that the qualified beneficiary, after electing COBRA continuation coverage, first becomes entitled to (that is, covered by) Medicare;

(b) Extension for Multiple Qualifying Events. If a second qualifying event (referred to herein as a "multiple qualifying event") occurs during the first 18 months of COBRA continuation coverage that arises due to a termination (or reduction of hours) of employment, and the affected qualified beneficiaries provide notice of that multiple qualifying event as required under Section 8.5(b)(i), the 18-month COBRA continuation coverage period for affected qualified beneficiaries may be extended for up to 36 months from the date of the first qualifying event. (If the Extension for Social Security Disability described below applies, the foregoing multiple qualifying event rule will be applied to the first 29 months of COBRA continuation coverage.) To qualify for this multiple qualifying event extension, the following

three conditions must be satisfied: (1) The affected Dependent must be a qualified beneficiary in connection with a termination (or reduction of hours) of employment; (2) The Dependent must still be a qualified beneficiary at the time that the second qualifying event occurs; and (3) The second event must – but for the required COBRA continuation coverage – result in a loss of coverage for the qualified beneficiary under the Plan within the otherwise applicable maximum coverage period. To meet the third requirement, the Administrator will determine whether, in the absence of the first qualifying event, the second event would result in a loss of coverage for the qualified beneficiary under the Plan within the maximum coverage period. This determination will be made by applying the Plan terms to the qualified beneficiary as if the Eligible Employee had not experienced the first qualifying event and determining if the occurrence of the second event in this hypothetical scenario would result in a loss of coverage for the qualified beneficiary under the Plan within 36 months after the covered employee's actual termination (or reduction of hours) of employment.

(c) Extension for Social Security Disability. If any qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security purposes) at any time during the first 60 days of COBRA continuation coverage, the 18-month COBRA continuation coverage period is extended for the disabled qualified beneficiary and all related qualified beneficiaries to up to 29 months from the date of the original termination of employment or reduced work hours. This extension applies only if the qualified beneficiary notifies the Administrator as required in Section 8.5(b)(ii). The premium for the period of coverage beyond the first 18 months can be up to 150% of the applicable premium. If coverage is extended beyond 18 months under this rule and a final Social Security determination is made that the individual is no longer disabled, COBRA continuation coverage will be terminated.

Section 8.9 Type of Coverage

COBRA continuation coverage consists of health coverage under the Plan which, as of the time coverage is being provided, is identical to the health coverage provided under the Plan to similarly situated individuals with respect to whom a qualifying event has not occurred. A qualified beneficiary does not have to show that he or she is insurable to elect COBRA continuation coverage. However, the Plan's obligation to provide COBRA continuation coverage is subject to each qualified beneficiary's eligibility for coverage under the terms of the Plan. The Administrator reserves the right to terminate COBRA continuation coverage (including retroactively) if a qualified beneficiary is determined to be ineligible for coverage under the Plan.

Section 8.10 Annual Enrollment Changes

Qualified beneficiaries entitled to COBRA continuation coverage pursuant to this Article 8 shall be eligible to make enrollment changes during the annual open enrollment period on the same basis as similarly situated covered individuals with respect to whom a qualifying event has not occurred. All such enrollment changes shall be made in accordance with the procedures of Section 3.2 and such other procedures as the Administrator may establish.

Section 8.11 Liability of Subscribing Employer For Notice Failures

If a Subscribing Employer fails to provide the notices required by Section 8.5(a) within the time limits established by the Plan, then the Plan will not be responsible for providing COBRA continuation coverage to the affected qualified beneficiaries. Notwithstanding the foregoing, if the Trust agrees to provide such coverage to a qualified beneficiary (or group of qualified beneficiaries) with respect to a Subscribing Employer, despite the Subscribing Employer's failure to provide the required notice, then that Subscribing Employer will be required to fully indemnify all costs and expenses incurred by the Trust with respect to all affected qualified beneficiaries of the Subscribing Employer.

ARTICLE 9
ADMINISTRATION OF THE PLAN

Section 9.1 Plan Sponsor, Administrator, and Named Fiduciaries

The Trust is the Plan Sponsor and the Administrator will be specified by the Trust or the Trust Committee. The Trust, the Trustees, the Trust Committee and the Administrator are Named Fiduciaries of the Plan. Any Named Fiduciary may delegate any of its responsibilities hereunder, subject to the approval of the Trust, by designating in writing other persons to carry out its responsibilities under the Plan, and may retain other persons to advise it with regard to any of such responsibilities. Any Named Fiduciary of the Plan may serve in more than one fiduciary capacity. Named Fiduciaries of the Plan may allocate fiduciary responsibilities among themselves in any reasonable and appropriate fashion, subject to the approval of the Trust.

Section 9.2 Plan Administration

The Trust Committee, acting on behalf of the Trust, shall have the authority and responsibility to supervise the administration of the Plan. It shall be a principal duty of the Trust Committee to see that the terms of the Plan are carried out for the exclusive benefit of persons entitled to participate in the Plan. To the extent not delegated to a Claims Administrator or Appeals Fiduciary, the Trust Committee shall have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Trust Committee's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by the Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper, in its discretion, for the efficient administration of the Plan.

(b) To appoint Claims Administrators under the Plan to be responsible for daily administration of the respective portions of the Plan and the payment of claims under the respective portions of the Plan.

(c) To appoint Appeals Fiduciaries to review and decide benefit claims on appeal.

(d) To appoint a person or entity to administer the provisions of COBRA continuation coverage.

(e) To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan.

(f) To allocate and delegate any or all of its responsibilities under the Plan, and to designate other persons to carry out any of its responsibilities under the Plan, provided that any such allocation, delegation, or designation is in writing.

(g) To construe and interpret the provisions of the Plan (including all eligibility requirements) and to make factual determinations thereunder, and to remedy ambiguities, inconsistencies or omissions, with all such determinations to be binding on all parties.

(h) To adopt such rules of procedure and regulations as in its opinion may be necessary for the proper and efficient administration of the Plan.

(i) To adopt such rules and procedures as in its opinion may be necessary or appropriate for the proper and efficient administration of medical child support orders (MCSOs), which rules are hereby incorporated by reference. In this connection, upon receipt of a MCSO, the Administrator will promptly inform an Eligible Employee, Eligible Retiree, Subscribing Individual and each child who is the subject of the MCSO of its receipt of the MCSO and will explain (in writing) the Plan's procedures for determining if the MCSO is qualified. Within a reasonable time, the Administrator will decide whether the MCSO is qualified and will notify the Eligible Employee, Eligible Retiree, Subscribing Individual and the child(ren) of its determination. Coverage cannot be discontinued for any child who is enrolled to comply with a qualified MCSO unless the Administrator has received written evidence that the child support order is no longer in effect or the child is no longer otherwise eligible for coverage under the terms of the Plan.

(j) To enforce the Plan in accordance with the terms of the Plan and the rules and regulations adopted by the Trust Committee as described above.

(k) To furnish the Subscribing Employers with such information as may be required by them for tax or other purposes in connection with the Plan.

The Trust shall have discretionary and final authority to interpret the terms of the Plan regarding matters for which it is responsible as set forth in this Article 9 and its decisions shall be final and binding on all parties.

ARTICLE 10
CLAIMS PROCEDURE

Section 10.1 General Rules

Claims for health benefits shall be made in accordance with the terms of the Plan, and in accordance with such procedures and at such times as the respective Claims Administrator (or, if the claim relates to COBRA continuation coverage, the Administrator) shall prescribe. In all events, initial claims for health benefits must be submitted to the Plan in accordance with the foregoing procedures no later than the date that is twenty-four (24) months after the date the claim was incurred, unless a specific time period is otherwise specified in a Coverage Booklet in which case the time period in the Coverage Booklet will control (such time period is referred to herein as the "applicable time period"). Notwithstanding anything in the Plan or a Coverage Booklet to the contrary, if an initial claim is not submitted by or on behalf of a Covered Person within the applicable time period, the claim is not eligible for any payment under the Plan. Claims and appeals may be filed by a Covered Person or a Covered Person's beneficiary or authorized representative. An "authorized representative" means a person authorized, in writing, to act on the behalf of the Covered Person. All communications from the Plan will be directed to the authorized representative unless the written designation provides otherwise. All claims are treated as filed on the date they are received. The claim and first level appeal procedures described in Sections 10.2 and 10.3(b) are mandatory and must be exhausted before pursuing any other legal remedy with respect to any claim. The second level and third level appeal procedures described in Sections 10.3(c) and 10.4 are voluntary and need not be exhausted before pursuing any other legal remedy with respect to any claim. Any fraud, misrepresentation or deceit in the claim or appeal process may result in termination of the claimant's coverage, as described in Section 11.20.

Section 10.2 Procedure for Initial Claims

(a) Filing the Initial Claim. The initial claim for benefits must be filed with the Claims Administrator in such manner as the Claims Administrator may prescribe.

(b) Determination on Initial Claim. If an initial claim is denied in whole or in part, the claimant will receive a written or electronic notice of the denial. The notice will include the following: (1) the specific reason or reasons for the denial; (2) reference to the specific Plan provisions on which the decision was based; (3) a description of any additional material or information necessary for the claimant to complete the claim and an explanation of why such material or information is necessary; (4) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement describing the claimant's right to seek binding arbitration or to file the claim in court after completing the appeal procedures; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if the claimant requests it; (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation shall be

provided free of charge if the claimant requests it; and (7) if the claim is an urgent care claim, a description of the expedited review process used.

(c) Response Times for Initial Claim Determinations. The Claims Administrator will make a determination on the initial claim in accordance with the response times for each different type of claim, as follows:

(i) Urgent Care. An urgent care claim is one in which a delay in the claims decision could seriously jeopardize the claimant's life or health or his or her ability to regain maximum function. Generally, the Claims Administrator will determine whether a claim is urgent. If a request for benefits involves urgent care, the Claims Administrator must notify the claimant of its decision within 72 hours after it receives the request for benefits. This notice may be written, electronic, or oral. However, if oral notice is provided, then written or electronic notification will also be furnished within 3 days of the oral notice. If a request for benefits does not contain all of the necessary information, the Claims Administrator must notify the claimant of the missing information and specifically describe the information necessary to complete its determination. The claimant will have at least 48 hours from the date he or she receives the notice to provide the specified information. If the claimant fails to supply the requested information within the 48-hour period, the claim will be denied. If a notice of missing information is supplied to the claimant, then the Claims Administrator will notify the claimant of its decision (1) within 48 hours after it receives all of the information needed to process the request, or (2) if the claimant does not supply the requested information within the required time frame, within 48 hours of the end of the period he or she was given to supply the additional information. At any point in the claim or appeal process, if the request for benefits is no longer considered urgent, it will be handled in the same manner as a pre-service care or post-service care appeal, depending on the circumstances.

(ii) Pre-Service Care. A pre-service care claim is a claim for which care has not yet been received and which is not urgent. If a request for benefits involves pre-service care, the Claims Administrator must notify the claimant of its decision within 15 days after it receives the request for benefits. If the Claims Administrator needs more than 15 days to determine the benefits due to reasons beyond its control, it must notify the claimant within that 15 day period that it needs more time to determine the benefits. In any case, even with an extension, it cannot take more than 30 days to determine the claimant's benefits. If a request for benefits does not contain all of the necessary information, the Claims Administrator must notify the claimant, within 5 days of its receipt of the request, of the missing information and specifically describe the information necessary to complete its determination. The claimant will have 45 days to provide the specified information to the Claims Administrator. If the claimant fails to supply the requested information within 45 days, the claim will be denied. The time period during which the Claims Administrator is waiting to receive the necessary information is not counted toward the 15-day period in which the Claims Administrator must make the benefit determination.

(iii) Concurrent Care Decisions. There are two types of concurrent care decisions:

(A) Reduction of Benefits. If, after approving a request for ongoing benefits in connection with an illness or injury, the Claims Administrator decides to reduce or

end the benefits they have approved for a claimant, the Claims Administrator will notify the claimant sufficiently in advance of the reduction or termination of benefits to allow the claimant the opportunity to appeal the decision and obtain a decision on appeal of the decision before the benefit is reduced or terminated.

(B) Extension of Benefits. If, while a claimant is undergoing a course of treatment in connection with an illness or injury for which benefits have been approved, the claimant may request an extension of benefits for additional treatments. The Claims Administrator will make a decision as soon as possible. If a claimant submits his or her request at least 24 hours before treatments are scheduled to end, then the Claims Administrator will decide the claim within 24 hours of its receipt of the request. If a claimant submits his or her request less than 24 hours before treatments are scheduled to end, then the request will be handled as if it were a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an urgent care claim, a pre-service care claim, or a post-service care claim**.**

(iv) Post-Service Care. A post-service care claim is a claim for which care has already been received and which is not urgent. If a request for benefits involves post-service care, the Claims Administrator must notify the claimant of its decision within 30 days after it receives the claim for benefits**.** If it needs more than 30 days to determine the claimant's benefits due to reasons beyond its control, it must notify the claimant within that 30-day period that it needs more time to determine the claimant's benefits. In any case, even with an extension, it cannot take more than 45 days to make its determination. If a request for benefits does not contain all of the necessary information**,** the Claims Administrator must notify the claimant of the missing information and specifically describe the information necessary to complete its determination. The claimant will have 45 days to provide the specified information. If the claimant fails to supply the requested information within the 45-day period, the claim will be denied. The time period during which the Claims Administrator is waiting to receive the necessary information is not counted toward the 30-day period in which the Claims Administrator must make the benefit determination.

Section 10.3 Appeals Procedure with Claims Administrator

(a) Overview of Appeals Procedure with Claims Administrator. If a request for benefits is denied, in whole or in part, the claimant may file an appeal with the Claims Administrator. The Claims Administrator uses a two-level appeal process to review appeals of denied claims, except for urgent care claims where the Claims Administrator uses a single level appeal process. The first level appeal process with the Claims Administrator is mandatory, and must be followed before the claimant may file a lawsuit. The second level appeal process with the Claims Administrator is voluntary.

(b) First Level Appeal Process. The claimant must file the initial appeal no later than 180 days from the date he or she receives notice from the Claims Administrator denying the initial claim. Upon request to the Claims Administrator, the claimant may review all documents, records and other information relevant to the claim being appealed. The claimant will have the right to submit any written comments, documents, records, information, data or other material in support of the appeal.

The initial appeal will be reviewed by a representative of the Claims Administrator's appeal review department. The representative will not be a person who was involved in any previous adverse determination regarding the claim that is the subject of the appeal and the representative will not be the subordinate of any individual that was involved in any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on the initial appeal, the Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant without regard to whether the information was previously submitted to or considered by the Claims Administrator. The Claims Administrator will afford no deference to any previous adverse determination on the claim that is the subject of the appeal.

In rendering a decision on an initial appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse determination regarding the claim that is the subject of the appeal and will not be the subordinate of any person involved in a previous adverse determination regarding the claim that is the subject of the appeal.

The Claims Administrator will provide the claimant with written notification of its decision on the initial appeal within the following time frames:

(i) When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;

(ii) When the appeal involves an urgent care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or

(iii) When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

If the initial appeal is denied, the Claims Administrator will notify the claimant and the notice will include: (1) the specific reason or reasons for the decision; (2) reference to the specific Plan provisions on which the decision was based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of any relevant document; (4) a statement describing the claimant's right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if the claimant requests it; and (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of

the Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge if the claimant requests it.

(c) Second Level Appeal Process. If the initial appeal is denied, in whole or in part, the claimant may submit a second level appeal requesting that the decision be reviewed by the Claims Administrator. The second level appeal must be submitted to the Claims Administrator in writing (or communicated orally under special circumstances) within 45 days from the date the claimant received the notice denying the initial appeal. Upon request to the Claims Administrator, the claimant may review all documents, records and other information relevant to the claim which is the subject of the appeal. The claimant will have the right to submit any written comments, documents, records, information, data or other material in support of the second-level appeal.

The second level appeal will be reviewed by a representative of the Claim Administrator's appeal review department. The representative will not be a person who was involved in any previous adverse determination regarding the claim that is the subject of the appeal and the representative will not be the subordinate of any individual that was involved in any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on the second level appeal, the Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant without regard to whether the information was previously submitted to or considered by the Claims Administrator. The Claims Administrator will afford no deference to any previous adverse determination regarding the claim that is the subject of the appeal.

In rendering a decision on an initial appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse determination regarding the claim that is the subject of the appeal and will not be the subordinate of any person involved in a previous adverse determination regarding the claim that is the subject of the appeal.

The Claims Administrator will provide the claimant with written notification of its decision on the second level appeal within the following time frames:

(i) When the appeal involves a pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the second level appeal; or

(ii) When the appeal involves a post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the second level appeal.

If the second level appeal is denied, the Claims Administrator will notify the claimant and the notice will include: (1) the specific reason or reasons for the decision; (2) reference to the

specific Plan provisions on which the decision was based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of any relevant document; (4) a statement describing the claimant's right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if the claimant requests it; and (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge if the claimant requests it.

Section 10.4 Appeals Procedure with Trust Committee

(a) Filing the Appeal. If a second level appeal is denied by the Claims Administrator, a claimant may file a third level appeal with the Trust Committee. The appeal must be in writing (unless it involves an urgent care claim), and the claimant must file the appeal within 45 days from the date he or she receives the notice from the Claims Administrator denying the second level appeal. If the appeal involves an urgent care claim, all information will be communicated between the Trust Committee and the claimant by telephone, facsimile, or other available similarly expeditious method throughout the appeal process. The claimant may submit written comments, documents, records and other information related to the claim, whether or not such information was submitted in connection with the initial claim request or any previous appeal. The claimant also may request that the Plan provide him or her, free of charge, copies of all documents, records, and other information relevant to the claim.

(b) Determination on Appeal. The third level appeal will be reviewed by a person different from the person who made any previous adverse determination regarding the claim that is the subject of the appeal, and the individual making the appeal determination will not be a subordinate of an individual who made any previous adverse determination regarding the claim that is the subject of the appeal. The Trust Committee will afford no deference to any previous adverse determination regarding the claim that is the subject of the appeal.

If the claim is denied on appeal, the notice to the claimant will include: (1) the specific reason or reasons for the decision; (2) reference to the specific Plan provisions on which the decision was based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of any Relevant document; (4) a statement describing the claimant's right to seek binding arbitration or to file the claim in court; (5) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, then that information will be provided along with a free copy of the rule, guideline, protocol, or other criterion if the claimant requests it; and (6) if the decision is based on whether the treatment or service is experimental and/or investigational or not medically necessary, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation shall be provided free of charge if the claimant requests it.

ARTICLE 11
GENERAL PROVISIONS

Section 11.1 Action by Employer

Any action required or permitted to be taken under the Plan by the Trust shall be in accordance with procedures adopted by the Trust for that purpose.

Section 11.2 Additional Subscribing Employers

Any Employer that is not a Subscribing Employer may become one by adopting the Plan and Trust and completing a subscription agreement in the form and manner directed by the Administrator. The Trust must approve any additional Subscribing Employers. A Subscribing Employer who adopts the Plan pursuant to this Section 11.2 and who ceases to be a member of the Association shall cease to be a Subscribing Employer under the Plan subject to the payment by the Employer of any outstanding financial obligations to the Plan.

Section 11.3 Additional Subscribing Individuals

Any person that is not a Subscribing Individual may become one by adopting the Plan and Trust and completing a subscription agreement in the form and manner directed by the Administrator. The Trust must approve any additional Subscribing Individuals. A Subscribing Individual who adopts the Plan pursuant to this Section 11.3 and who ceases to be a member of the Association shall cease to be a Subscribing Individual under the Plan subject to the payment by the Subscribing Individual of any outstanding financial obligations to the Plan.

Section 11.4 Interests Not Transferable

Except as otherwise permitted (a) by the Administrator or the Claims Administrator solely to assign benefits as payment to health care providers pursuant to the terms of a Coverage Booklet; (b) as may be allowed under the terms of a group insurance policy; or (c) as required by the tax withholding provisions of any applicable law, benefits payable to a Covered Person under the Plan are not in any way subject to the Covered Person's debts or other obligations and may not be voluntarily sold, transferred, alienated or assigned.

Section 11.5 Facility of Payment

When a Covered Person is under legal disability, or in the opinion of a Subscribing Employer is in any way incapacitated so as to be unable to manage his or her financial affairs, the Subscribing Employer, the Administrator, or the Claims Administrator may make payments or distributions to the Covered Person's legal representative or until a claim is made by a conservator or other person legally charged with the care of such person, to a relative or friend of such Covered Person for such person's benefit; or the Administrator may direct payments or distributions for the benefit of the Covered Person in any manner which is consistent with the provisions of the Plan. Any payments made in accordance with the foregoing provisions of this subsection 11.5 shall be a full and complete discharge of any liability for such payment under the Plan.

Section 11.6 Employment Rights

Coverage under the Plan does not constitute a contract of employment and participation will not give any Covered Person the right to be employed in the service of the Trust or any Subscribing Employer, nor any right or claim to any benefit under the Plan, unless such right or claim has specifically accrued under the terms of the Plan.

Section 11.7 Litigation by Covered Persons or Other Persons

To the extent permitted by law, and subject to Section 10.4, if a legal action begun by or on behalf of any person against the Trust, the Trust Committee or any Subscribing Employer (or any employee, officer or Trustee of the Trust or a Subscribing Employer) with respect to benefits payable under the Plan results adversely to that person, or if a legal action arises because of conflicting claims to a Covered Person's benefits, the cost to the Trust, the Trust Committee or the Employer (or employee or Trustee of the Trust or a Subscribing Employer) of defending the action may be charged to the sums, if any, that were involved in the action or were payable to or on behalf of the Covered Persons concerned.

Section 11.8 Evidence

Evidence required of anyone under the Plan may be by certificate, affidavit, document or other information which the person acting on it considers pertinent and reliable, and signed, made or presented by the proper party or parties.

Section 11.9 Gender and Number

Where the context admits, words in the masculine gender shall include the feminine and neuter genders, the singular shall include the plural, and the plural shall include the singular.

Section 11.10 Waiver of Notice

Any notice required under the Plan may be waived by the person entitled to such notice.

Section 11.11 Severability

In case any provisions of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan.

Section 11.12 Controlling Law

To the extent not superseded by laws of the United States, the laws of the Commonwealth of Massachusetts shall be controlling in all matters relating to the Plan.

Section 11.13 Recovery of Benefits

If a Covered Person receives a benefit payment under the Plan which is in excess of the benefit payment which should have been made, the Trust shall have the right to recover the amount of such excess from such Covered Person. The Trust may, however, at its option, direct the Claims Administrator to deduct the amount of such excess from any subsequent benefits payable under the Plan to or for the benefit of the Covered Person as allowed under any applicable law. Overpayments made under an insured Coverage Booklet shall be recoverable under the terms of the applicable insurance policy.

Section 11.14 Information to be Furnished by Covered Persons[6]

Covered Persons under the Plan must furnish the Administrator and the Claims Administrator, as applicable, with such evidence, data or information as they consider necessary or desirable for administrative purposes. A fraudulent misstatement or omission of fact made by a Covered Person on an enrollment form or a claim for benefits may be used to cancel coverage and/or to deny claims for benefits under the Plan.

Section 11.15 Finality of Decisions

The Trust shall have the discretionary authority to determine eligibility for benefits, including factual determinations related thereto. Benefits under this Plan will be paid only if the Trust determines, in its discretion, that the applicant is entitled to them. The Claims Administrator shall have the discretionary authority to interpret the respective Coverage Booklets, to make factual determinations under the Plan, and to decide initial claims under the terms of the respective Coverage Booklets. The Appeals Fiduciary shall have the discretionary authority to interpret the terms of the respective Coverage Booklets, to make factual determinations thereunder, and to decide and review appeals of denied claims under any Coverage Booklet. Subject to applicable law, any interpretation of the provisions of the Plan and the Coverage Booklets and any decision on any matter within the discretion of the Trust or a Claims Administrator or Appeals Fiduciary, as the case may be, made in good faith shall be final and conclusive on all persons making any claim under the Plan. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Trust or the applicable Claims Administrator or Appeals Fiduciary shall make such adjustment on account thereof as it considers equitable and practicable. Neither the Trust, the Claims Administrator nor the Appeals Fiduciary shall be liable in any manner for any determination of fact made in good faith.

Section 11.16 Third-Party Reimbursement and Subrogation

(a) Scope. The provisions of this Section 11.16 shall apply to any self-insured benefit provided under the Plan, if a person or persons other than the Covered Person on whose behalf a claim for benefits is made is considered responsible for the sickness or injury causing the Covered Person to incur health care expense charges covered under the participating Plan.

(b) Definitions. For purposes of this Section 11.16:

[6] 11.14 amended July 1, 2010. See Amendment #3.

(i) Covered Person. The term "Covered Person" shall mean a Covered Person, the beneficiary of such person, the legal representative of such person and the estate of such person;

(ii) Responsible Party. The term "Responsible Party" shall mean a person or entity whose alleged act or omission proximately caused the sickness or injury of a Covered Person, including but not limited to the Covered Person or their beneficiaries or agents; and

(iii) Third Party. The term "Third Party" shall mean any person or entity from whom a Covered Person can seek compensation for a sickness or injury because he believes that an act or omission of a Responsible Party caused the sickness or injury that gave rise to the charges that the Covered Person seeks to have paid or reimbursed by the Plan, and includes any insurance company that issues an automobile-medical policy, an underinsured or uninsured motorist policy, a no-fault motorist policy, any other insurance liability coverage to the Covered Person or Responsible Party, including but not limited to a homeowner's, excess or umbrella insurance policy under which the Covered Person or the Responsible Party is an insured. The Plan's right of 100%, first-dollar reimbursement under this Section 11.16 applies to the payment of insurance proceeds to the Covered Person by any such insurance company pursuant to any such policy.

(b) Right of Reimbursement.

(i) In General. The claim of, or with respect to, a Covered Person for benefits under the Plan does not affect the Covered Person's claim or right to action for all damages against a Responsible Party. Notwithstanding any provisions of the Plan to the contrary, this subsection 11.16 shall apply if the sickness or injury causing a Covered Person to incur health expense charges arose, or is believed to arise, from any act or omission of a Responsible Party other than the Covered Person. To the extent that a payment relating to such sickness or injury was or is made, or may be made in the future, by or on behalf of such Responsible Party or by a Third Party, whether by settlement, judgment, insurance proceeds or in any other manner, any health expense charges incurred in connection with such sickness or injury shall be considered a general exclusion and shall not be payable under the Plan. If benefits would be payable to a Covered Person but for the exclusion of this subsection, however, such benefits may be paid if the Administrator determines that all of the following terms and conditions are met:

(A) A properly filed claim for benefits under the Plan is filed with the Claims Administrator for the self-insured participating Plan;

(B) Payment for such health expense charges by or on behalf of the Responsible Party or by a Third Party has not been made to or on behalf of the Covered Person; and

(C) The Covered Person (or in the event of incapacity, that person's legal representative): (i) provides written notice to the Administrator that a claim against the Responsible Party or a Third Party has been made for damages or insurance proceeds as a result of the subject sickness or injury, and furnishes all relevant information, (ii) fully cooperates with the Plan, so as not to prejudice the Plan's right of 100%, first-dollar reimbursement for benefits

paid, and (iii) executes and delivers such instruments as the Administrator may require, including the appointment, by a court of competent jurisdiction, of a legal representative for and on behalf of any minor or minor's estate to take such actions on behalf of a minor, and appearing at depositions and in court in furtherance of the Plan's right of 100%, first-dollar reimbursement.

(ii) Right to Equitable Lien. The payment of benefits under this subsection 11.16 is conditioned upon the Plan's right of 100%, first-dollar reimbursement from the proceeds of any recovery received by or payable to the Covered Person, whether by settlement, judgment, insurance proceeds, or otherwise. The Plan may place a first priority equitable lien in the amount of 100% of benefits paid by the Plan against any Responsible Party or other Third Party recovery for the subject sickness or injury. If the Covered Person should directly receive payment from or on behalf of any Responsible Party or from a Third Party, the Covered Person is required to immediately reimburse the Plan on a first-dollar basis in the amount of 100% of the benefits paid by the Plan, up to the aggregate amount recovered from or on behalf of each Responsible Party and any Third Party. The Plan's right of 100% first-dollar reimbursement shall be a priority lien against any proceeds recovered by the Covered Person, which right shall not be defeated or reduced by the application of any so-called "Made Whole Doctrine," "Rimes Doctrine," "Common Fund Doctrine," "Attorneys' Fund Doctrine," contributory or comparative negligence rules or statutes, uninsured motorist rules or statutes or any doctrine purporting to defeat the Plan's right to 100% first-dollar reimbursement by allocating the proceeds exclusively to non-medical expense damages or to reduce the Plan's right of 100% first-dollar reimbursement for the Covered Person's attorneys' fees and court costs in recovering the proceeds from the Third Party. The Covered Person shall serve as a constructive trustee over the proceeds recovered from any Third Party and the failure to hold such proceeds as such will be deemed a breach of the Covered Person's duties under the Plan.

(iii) Covered Person Responsible for Attorneys' Fees. Except to the extent permitted by the Administrator pursuant to nondiscriminatory rules established by the Administrator in its discretion, the Covered Person is solely responsible for all attorneys' fees and court costs incurred in recovering any settlement, judgment, insurance proceeds, or otherwise, from a Responsible Party or Third Party.

(iv) Duty of Cooperation. The Covered Person has a duty to cooperate fully with the Plan and the Administrator if the Plan asserts its right of reimbursement under this subsection 11.16. A Covered Person's failure to cooperate with the Plan, the Administrator or any entity designated by the Administrator related to the 100% reimbursement right set forth under this subsection 11.16 may result in the Administrator withholding payment of future medical and/or dental benefits payable to or on behalf of the Covered Person or such person's Dependents or Beneficiaries.

(v) Set-Off Against Future Benefits. To the extent permitted by law, amounts due the Plan under this subsection 11.16 may be applied in the discretion of the Administrator or any entity designated by the Administrator against any other present or future medical and/or dental expense benefits (and thereby reduce such benefits) payable to or on behalf of the Covered Person or a related Covered Person.

(vi) Right Not Impacted by Contributory or Comparative Negligence. The Covered Person's obligation to reimburse the Plan for 100% of benefits paid under this subsection 11.16 shall apply whether or not liability is admitted by the Responsible Party, and whether or not a portion of the settlement, judgment or insurance proceeds is expressly apportioned to health expense charges. Reimbursement due the Plan shall not be subject to or limited by any pro-ration formula that takes into account the relationship between the amount of damages claimed by the Covered Person and the amount of recovery received by the Covered Person, whether by settlement, judgment, insurance proceeds or in any other manner, nor shall it be subject to or limited by any reduction of any recovery of payment due to the Covered Person's or any Responsible Party's or Third Party's fault or negligence.

(vii) Right to Recovery of Benefits Paid. The Plan grants to the Administrator, and/or any entity designated by the Administrator, the right to file suit or file liens to recover its 100% right of reimbursement set forth in this subsection 11.16 through any means necessary, including the imposition of a constructive trust or equitable lien over the proceeds received from a Responsible Party or Third Party, equitable restitution or any other equitable remedy available. Failure by the Plan, the Administrator or any designee at any time to exercise said rights shall not constitute a waiver of the Plan's authority to exercise its reimbursement right at a later date. The Plan and/or the Administrator shall be entitled to recover reasonable attorneys' fees from the Covered Person incurred in collecting from the Covered Person any proceeds recoverable under the Plan's right of 100% first-dollar reimbursement. The Plan grants the Administrator and/or its designee, in addition to all other powers provided by the Plan, full discretionary authority to administer, interpret, apply and enforce its reimbursement right in accordance with this subsection 11.16.

(viii) Interest Due. In the event the Covered Person fails to reimburse the Plan for 100% of all benefits paid under this subsection 11.16 within seven days of receipt of payment from or on behalf of a Responsible Party or from a Third Party, interest at the rate of 1½% per month shall be charged on the unreimbursed amount due the Plan.

(ix) Consent of Liens. The Plan's right of 100% first-dollar reimbursement is cumulative with and not exclusive of its right of subrogation, but only to the extent of benefits provided by the Plan. By accepting benefits under this subsection 11.16, the Covered Person consents to the placement of any liens by the Plan, and assigns to the Plan an amount equal to 100% of the benefits paid against any recovery made by or on behalf of the Covered Person, which assignment shall be binding on any attorney representing the Covered Person, insurer or other Responsible Party.

(c) Right of Subrogation.

(i) In General. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. In addition to the Plan's right of 100% first-dollar reimbursement described in subsection 11.16(b), in the event of any payment of benefits under the Plan to any Covered Person, the Plan also shall, to the extent of such payment, be subrogated to all the rights of recovery of the Covered Person arising or believed to arise out of any claim or cause of action that may accrue because of any act or omission of a Responsible Party.

(ii) Obligations of Covered Person. Any Covered Person has the following obligations under this subsection 11.16(c):

(A) To immediately notify the Plan of any and all Responsible Parties and of any Third Party which the Covered Employee or his eligible Dependents may have a claim against as a result of the sickness or injury;

(B) To immediately notify the Plan of any and all claims for damages (including insurance proceeds) made on behalf of the Covered Employee or his Dependents in connection with the sickness or injury; and

(C) To fully cooperate with the Plan, the Administrator or any entity designated by the Administrator in obtaining information about the sickness or injury, furnish all relevant information and assistance and to execute and deliver such instruments as the Administrator or its designee may require to facilitate the enforcement of the Plan's rights under this subsection and not to prejudice such rights including the appointment, by a court of competent jurisdiction, of a legal representative for and on behalf of any minor or minor's estate to take such actions on behalf of a minor and appearing at depositions and in court in furtherance of the Plan's right of 100% reimbursement.

(iii) Plan's Rights. The Plan, the Administrator and any entity designated by the Administrator have the following rights under this subsection 11.16(c):

(A) To place a lien against any Responsible Party or other Third Party recovery for 100% recovery of the benefits paid by the Plan for the subject sickness or injury;

(B) To bring an action on the Plan's behalf, or on behalf of the Covered Person, against any Responsible Party or other Third Party involved in the subject sickness or injury; and

(C) To suspend the payment of any benefits under the Plan pending receipt from the Covered Person of any acknowledgement, agreement, authorization, waiver or release it deems necessary to exercise its rights and privileges under this subsection.

(iv) Proceeds Held Subject to Constructive Trust. Any proceeds collected, held or received by the Covered Person, legal representative, or any other party to whom such proceeds may be paid by virtue of a settlement of, or judgment relating to, any claim of the Covered Person that arises from the same event to which payment by the Plan is related, are constructively held in trust for the benefit of the Plan and for satisfaction of the Plan's subrogation right and/or reimbursement right.

(v) Notice of Litigation. If any of the Plan, the Administrator, any entity designated by the Administrator, the Company or the Covered Person brings an action or litigation against a Responsible Party or other Third Party, the party bringing the action or litigation shall give written notice of such action or litigation to the other parties and of the court in which the action or litigation is brought by personal service or registered or certified mail. Proof of such service shall be filed in such action. If any of the Plan, the Administrator, the Company or the Covered Person brings an action or litigation, the other parties may at any time

before the trial on the facts, join as party plaintiff or consolidate the action, if brought independently.

Section 11.17 Physical Examination and Autopsy

The Administrator, a Claims Administrator, or an Appeals Fiduciary shall have the right and opportunity to have the Covered Person whose injury or sickness is the basis of claim, examined by a physician designated by it, when and as often as it may reasonably require during the pendency of a claim under the Plan and to make an autopsy in case of death, provided it is not otherwise prohibited by law.

Section 11.18 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Claims Administrator for a self-insured benefit under the Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to the Plan and applied to the payment of current benefits and administrative fees under the Plan. Unclaimed Plan funds may be applied only to the delivery of benefits (including administrative fees) under the Plan pursuant to ERISA.

Section 11.19 Certificates of Coverage

The Administrator (or any entity to whom the Administrator delegates responsibility under this subsection 11.19) shall provide a certificate of creditable coverage in accordance with HIPAA to any Covered Person or former Covered Person who (i) terminates coverage under the Plan; (ii) terminates COBRA continuation coverage under the Plan; or (iii) requests a certificate of creditable coverage from the Administrator at any time within 24 months of the loss of coverage under the Plan.

Section 11.20 Persons Eligible for Medicaid

In accordance with Section 609(b) of ERISA, the following provisions shall apply in connection with any state plan for medical assistance approved under Title XIX of the Social Security Act (otherwise known as Medicaid):

(a) Payment for benefits under the Plan shall be made in accordance with any assignment of rights made by or on behalf of a Covered Person as required by Medicaid pursuant to Section 1912(a)(1)(A) of the Social Security Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) When enrolling any Covered Person or in determining or making any payments for benefits of a Covered Person, the Plan shall not take into account the fact that the Covered Person is eligible for or is covered under Medicaid.

(c) To the extent that payment has been made under Medicaid in any case in which the Plan has a legal liability to make payment for items or services covered by Medicaid, payment of benefits under the Plan shall be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person to payment for such items or services.

Section 11.21 Termination of Coverage for Fraud, Misrepresentation or Deceit[7]

If any Covered Person commits fraud, misrepresentation or deceit or omits a material fact in his or her application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Administrator, a Claims Administrator, an Appeal Fiduciary, or a Subscribing Employer, the Administrator may terminate his or her coverage retroactively.

Section 11.22 Execution of Plan Document

This Plan document may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument.

Section 11.23 HIPAA Privacy Rules

(a) Privacy of Health Information. In accordance with the Privacy Rule standard at 45 C.F.R. §164.504(f) and related and successor provisions of federal or state law, the Plan will disclose and will permit its Business Associate or a Health Insurance Issuer with respect to the Plan to disclose health information, including Protected Health Information ("PHI"), to the Plan Sponsor only as provided in this subsection 11.23.

(b) Disclosure to the Plan Sponsor Without Individual Authorization.

(i) Summary Health Information may be disclosed to the Plan Sponsor if the Plan Sponsor requests such information for the following purposes:

(A) Obtaining premium bids from Health Insurance Issuers for purposes of providing health insurance coverage under the Plan; or

(B) Modifying, amending or terminating the Plan.

(ii) Information as to whether an Individual is participating in the Plan or is enrolled in or has disenrolled from a fully-insured or HMO option offered under the Plan may be disclosed to the Plan Sponsor.

(iii) Provided the requirements of subsection (c) have been met, PHI may be disclosed to the Plan Sponsor for the following Payment and Health Care Operations of the Plan:

(A) Activities undertaken to obtain premiums, determine responsibility for coverage and provide benefits, or to provide or obtain reimbursement; utilization review, precertification, preauthorization, concurrent and retrospective review, eligibility, coordination of benefits, subrogation, billing, claims management, obtaining payment under contracts for reinsurance and related data processing, review of health care services with respect to medical necessity, coverage under a plan, appropriateness of care or justification of charges;

[7] 11.21 amended July 1, 2010. See Amendment #3.

(B) Business planning, management and administration - including, cost management, coverage development and administration, development and improvement of methods of payment and coverage policies, customer service, management activities related to HIPAA compliance and implementation, data analysis for internal Plan use, resolution of grievances, due diligence in connection with sale or transfer of assets, permitted fundraising and marketing;

(C) Quality assessment and improvement activities, including outcomes evaluation and the development of clinical guidelines, case management population-based activities related to improvement of health or reducing cost, development of protocols, case management, care coordination, contacting health care providers and patients with information about treatment alternatives.

(D) Professional and performance review, including peer review, health plan and provider performance, training, accreditation, certification, licensing and credentialing;

(E) Health insurance contracting, including underwriting, premium rating, reinsurance, stop loss insurance;

(F) Reviews & audits, including medical review, legal services, auditing functions, fraud and abuse detection and compliance programs.

(iv) PHI may be disclosed to the Plan Sponsor if required by law.

(c) Certification Requirement. The Plan will disclose PHI to the Plan Sponsor without Individual authorization only upon receipt of the Plan Sponsor's written certification that the Plan has been amended to include this subsection 11.23 and the Plan Sponsor also agrees to:

(i) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(ii) Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(iii) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(iv) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Individual who is the subject of the PHI;

(v) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures provided for of which it becomes aware;

(vi) Make PHI available to a Participant in accordance with the Privacy Rule at 45 C.F.R. §164.524;

(vii) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Rule at 45 C.F.R. §164.526;

(viii) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule at 45 C.F. R. §164.528;

(ix) Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the US. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Rule;

(x) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

(xi) Ensure that the requirements of subsection (d) have been met.

(d) Adequate Separation Between the Plan and the Plan Sponsor. In accordance with the Privacy Rule, only the following employees or classes of employees and other persons under the control of the Plan Sponsor may be given access to PHI:

The Trustees of the Trust, members of the Trust Committee, the Administrator and the Plan's Business Associates.

The persons described in this subsection (d) may only have access to and Use and Disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

Persons described in this subsection (d) who do not comply with the provisions of this subsection 11.23 shall be subject to the Plan's Policy on Sanctions for the Improper Use and Disclosure of PHI.

(e) Disclosure to the Plan Sponsor With Individual Authorization. PHI may be disclosed to the Plan Sponsor pursuant to the valid authorization of the Individual who is the subject of the PHI in accordance with the Plan's policy and procedures for disclosure upon such authorization.

(f) Definitions. For purposes of this subsection 11.21, the following terms shall have the following meanings:

(i) "Business Associate" means a natural person or organization that:

(A) On behalf of the Plan, performs or assists in the performance of a Plan function or activity involving the use or disclosure of Protected Health Information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and repricing, or any other Plan function or activity regulated by 45 C.F.R. Subtitle A, Subchapter C; or

(B) Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the Plan, where the provision of the services involves the disclosure to the person of Protected Health Information from the Plan or from another business associate of the Plan.

(ii) "Disclose" means to release, transfer, provide access to, or divulge information in any other manner outside the entity that holds the information.

(iii) "Health Care Operations" means any of the following activities of the Plan:

(A) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(B) Reviewing the competence or qualifications of health care professionals, evaluating practitioner, provider or Plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(C) Securing a contract of stop-loss insurance or excess of loss insurance, provided that the requirements of 45 C.F.R. § 164.514(g) are met, if applicable;

(D) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(E) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of Payment or coverage policies; and

(F) Business management and general administrative activities of the Plan, including, but not limited to:

(1) Management activities relating to implementation of and compliance with the requirements of the HIPAA rules at 45 C.F.R. Subtitle A, Subchapter C;

(2) The provision of data analyses for the Plan Sponsor, provided that Protected Health Information is not disclosed to such Plan Sponsor;

(3) Resolution of internal grievances;

(4) The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity;

(5) Consistent with the applicable requirements of 45 C.F.R. §164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Plan.

(iv) "Health Insurance Issuer" means an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance.

(v) "Individual" means the person who is the subject of PHI.

(vi) "Payment" means:

(A) The activities undertaken by the Plan:

(1) To obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan; or

(2) To obtain or provide reimbursement for the provision of health care.

(B) The activities in paragraph (A) of this definition relate to the Individual to whom health care is provided and include, but are not limited to:

(1) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(2) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(3) Billing, claims management, collection activities, obtaining payment under a contract of stop-loss insurance or excess of loss insurance, and related health care data processing;

(4) Review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, or justification of charges;

(5) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(6) Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:

(I) Name and address;

(II) Date of birth;

(III) Social security number;

(IV) Payment history;

(V) Account number; and

(VI) Name and address of the health care provider and/or Plan.

(vii) "**Plan Sponsor**" means the Trust.

(viii) "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, which was promulgated pursuant to HIPAA.

(ix) "Protected Health Information" means any information, including demographic information collected from an Individual, whether oral or recorded, maintained or transmitted in any other form or medium, that:

(A) Is created or received by a health plan, health care provider, health care clearinghouse or employer;

(B) Relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present or future Payment for the provision of health care to an Individual; and

(C) Identifies the Individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

"Protected Health Information" does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g, records described in 20 US.C. §1232g(a)(4)(B)(iv) and employment records held by a covered entity in its role as employer.

(x) "Summary Health Information" means information, that may be individually identifiable health information and that summarizes claims history, claims expenses, or types of claims experienced by Individuals for whom the Plan Sponsor has provided health benefits under the Plan, provided that the information described at Section 164.514(b)(2)(i) has been deleted, except that information described in Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

(xi) "Use" means the sharing, employment, application, utilization, examination or analysis of information within an entity that holds the information.

Sestion 11.24 **No Liability for Post-Retirement Benefit Obligations**

(Added by Amendment #3, July 1, 2010)

ARTICLE 12
AMENDMENT AND TERMINATION

Section 12.1 Amendment

Any part or all of the Plan and any Coverage Booklets may be amended by the Trust at any time, by a resolution adopted by the Trustees.

Section 12.2 Right to Terminate

No provision in this Plan document, including any provision in the Supplements hereto or Summary Plan Descriptions incorporated by reference in said Supplements, is intended to commit the Trust or any Subscribing Employer to provide benefits of any type to any class of Covered Persons, or to the maintenance of the Plan. The Trust shall have the sole authority to terminate part or all of the Plan as to some or all classes of Covered Persons and/or any Coverage Booklet at any time. A Subscribing Employer may terminate participation in the Plan at any time with the written consent of the Trust subject to the Subscribing Employer satisfying any remaining funding obligations for the Plan. In the event of the dissolution, merger, consolidation or reorganization of a Subscribing Employer, participation in the Plan shall terminate as to such Subscribing Employer, unless the participation in the Plans is continued by a successor to such Subscribing Employer with the consent of the Trust. Such consent will be given only if the successor employer is an Employer In the event of the dissolution, merger, consolidation or reorganization of the Trust, the Plan shall also be terminated.

Section 12.3 Notice of Amendment or Termination

Covered Persons will be notified of any amendment or termination of the Plan within a reasonable time. Upon the termination of the Plan, any benefit rights of Covered Persons affected thereby shall become payable as the Administrator may direct.

IN WITNESS WHEREOF, the Trustees hereby adopt this Plan effective as of January 1, 2007.

On file
Tim Brennan

Date:

On file
Mindy Scharlin

Date:

On file
Dan Brody

Date:

On file
David Tedesco

Date:

On file
Paul Alan Bluestein

Date:

On file
Brent Wilkes

Date:

On file
Kathleen Burek

Date:

SUPPLEMENT A

COVERAGE BOOKLETS

A-1. **Purpose**. The purpose of this Supplement A is to incorporate by reference the terms and provisions of the documents governing eligibility and benefits under the Plan made available to Eligible Employees, Eligible Retirees, Subscribing Individuals and their Dependents. Unless otherwise defined herein, capitalized terms in this Supplement A shall have the same meaning given them in Section 2 of the Plan.

A-2. **Coverage Booklets Incorporated By Reference**. Effective January 1, 2007, the terms and provisions of the following are incorporated by reference and, subject to the terms of paragraph A-3, constitute the controlling terms and provisions of the applicable Coverage Booklet.

- Standard PPO Benefit Booklet
- High Deductible PPO Benefit Booklet (HSA eligible)
- High Deductible PPO Benefit Booklet (non-HSA eligible)
- Medicare Supplement Booklet

A-3. **Resolution of Conflicts**. In the event there is a conflict between the Plan document and the Coverage Booklets incorporated herein by reference, the terms of the Plan document shall control first, and the Coverage Booklets incorporated herein by reference last.

AMENDMENTS

AMENDMENT #1
TO THE
UNITARIAN UNIVERSALIST ORGANIZATIONS HEALTH PLAN

The Unitarian Universalist Organizations Health Plan is hereby amended, effective as of January 1, 2008 as follows:

1. Section 2.11 is amended to read as follows:

Section 2.11 Eligible Employee or Employee

The term "Eligible Employee" means a person who is employed by a Subscribing Employer, who works at least 750 hours per calendar year, and who satisfies any eligibility requirements established by the Subscribing Employer in the subscription agreement. When used in this Plan, the term "Employee" shall refer to an Eligible Employee unless indicated otherwise.

2. Section 2.12 is amended to read as follows:

Section 2.12 Eligible Retiree or Retiree

The term "Eligible Retiree" means a person who is under age 65 if the person retired from a Subscribing Employer after performing services as a minister. The term "Eligible Retiree" also includes a person who is age 65 or older, who is enrolled in Medicare Parts A and B, who retired from a Subscribing Employer after performing services in any capacity and who worked at least 750 hours for a Subscribing Employer in five of the ten calendar years preceding the year of retirement. When used in this Plan, the term "Retiree" shall refer to an Eligible Retiree unless indicated otherwise.

AMENDMENT #2
TO THE
UNITARIAN UNIVERSALIST ORGANIZATIONS HEALTH PLAN

The Unitarian Universalist Organizations Health Plan is hereby amended, effective as of the date indicated below:

1. Effective January 1, 2007, Section 2.17 is amended to read as follows:

The term "Plan Year" means for the initial term, January 1, 2007 to June 30, 2007, and for each subsequent year, means the twelve (12) consecutive month period commencing each July 1 and ending the next following June 30.

AMENDMENT #3
TO THE
UNITARIAN UNIVERSALIST ORGANIZATIONS HEALTH PLAN

The Unitarian Universalist Organizations Health Plan is hereby amended, effective as of each of the dates specified below, as follows:

1. Effective May 1, 2010, section 2.9(c) is amended to read as follows:

(c) Child. The term "child" means the Employee's or spouse's or domestic partner's natural child, stepchild or legally adopted child, who satisfies the following conditions:

(i) The child is under 26 years of age. The Administrator may require proof of age from time to time.

(ii) The child is age 26 or older and is physically or mentally incapable of caring for himself or herself due to a physical, mental or developmental disability. The Administrator may require proof of the child's disability from time to time.

A child who is in the process of being adopted is considered a legally adopted child if the Claims Administrator receives from the Administrator legal evidence of both: (i) the intent to adopt; and (ii) that the Employee, spouse or domestic partner have either (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee's, spouse's or domestic partner's right to control the health care of the child.

The term "child" includes a child designated under a Medical Child Support Order (MCSO) which is determined by the Administrator in accordance with the Plan's written procedures (which are incorporated herein by reference) and ERISA to be a qualified Medical Child Support Order. Upon receipt of a MCSO, the Administrator will promptly inform the Employee and each child who is the subject of the MCSO of its receipt of the MCSO and will explain (in writing) the Plan's procedures for determining if the MCSO is qualified. Within a reasonable time, the Administrator will decide whether the MCSO is qualified and will notify the Employee and the child(ren) of its determination. Coverage cannot be discontinued for any child who is enrolled to comply with a qualified

MCSO unless the Employee submits written evidence that the MCSO is no longer in effect.

2. Effective July 1, 2010, Sections 2.11 and 2.12 are amended to read as follows:

Section 2.11 Eligible Employee or Employee

The term "Eligible Employee" means a person who is employed by a Subscribing Employer, who is regularly scheduled to work at least 750 hours per calendar year, and who satisfies any eligibility requirements established by the Subscribing Employer in the subscription agreement. For purposes of the preceding sentence, a Subscribing Employer may, by providing written notice to the Administrator, elect to use "1040 hours" instead of "750 hours" if the Subscribing Employer is located in a State that: (A) operates a health insurance purchasing exchange; and (B) provides State-subsidized health insurance coverage for individuals who do not have access to employer-sponsored health insurance coverage. Any such election will be effective only prospectively and must remain in effect for at least 24 months. When used in this Plan, the term "Employee" shall refer to an Eligible Employee unless indicated otherwise.

Section 2.12 Eligible Retiree or Retiree

The term "Eligible Retiree" means a person who is under age 65 if the person retired from a Subscribing Employer after performing services as a minister. The term "Eligible Retiree" also includes a person who is age 65 or older, who is enrolled in Medicare Parts A and B, who retired from a Subscribing Employer after performing services in any capacity and who was regularly scheduled to work at least 750 hours for a Subscribing Employer in five of the ten calendar years preceding the year of retirement. For purposes of the preceding sentence, a Subscribing Employer may, by providing written notice to the Administrator, elect to use "1040 hours" instead of "750 hours" if the Subscribing Employer is located in a State that: (A) operates a health insurance purchasing exchange; and (B) provides State-subsidized health insurance coverage for individuals who do not have access to employer-sponsored health insurance coverage. Any such election will be effective only prospectively and must remain in effect for at least 24 months. When used in this Plan, the term "Retiree" shall refer to an Eligible Retiree unless indicated otherwise.

3. Effective April 1, 2009, Section 3.6 (Other Election Changes) is renumbered as Section 3.7, and a new Section 3.6 is inserted as follows:

Section 3.6 Special Enrollment Period for Medicaid/CHIP Events

If an Eligible Employee, Eligible Retiree, Subscribing Individual or one or more Dependents is eligible but not enrolled under the Plan, and either:

(i) the Eligible Employee, Eligible Retiree, Subscribing Individual or Dependent is covered under a Medicaid plan or a State Children's Health Insurance Program, and that coverage is terminated due to a loss of eligibility for such coverage, or

(ii) the Eligible Employee, Eligible Retiree, Subscribing Individual or Dependent becomes eligible for employment assistance under a Medicaid plan or State Children's Health Insurance Program,

then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may enroll in the Plan, provided a properly completed enrollment form is received by the Administrator within 60 days of the applicable event and, provided further, that no Dependents may be enrolled in the Plan unless the Eligible Employee, Eligible Retiree or Subscribing Individual is also enrolled. If a properly completed enrollment form is received by the Administrator within 60 days of the applicable event, then the effective date of coverage for Special Enrollment under this Section 3.6 will be retroactive to the date of the applicable event. If a properly completed enrollment form is not received by the Administrator within 60 days of the applicable event, then the Eligible Employee, Eligible Retiree, Subscribing Individual and his or her Dependents may not enroll until the next annual open enrollment period.

4. Effective July 1, 2010, Section 11.14 is revised to read as follows:

Section 11.14 Information Requirements for Covered Persons, Subscribing Individuals and Subscribing Employers

Covered Persons, Subscribing Individuals and Subscribing Employers must maintain and furnish such evidence, data or information that the Administrator and the Claims Administrator, as applicable, consider necessary or desirable for Plan administrative purposes. By way of example, and without limiting the scope of the preceding sentence, Subscribing Individuals and Subscribing Employers must:

(a) Maintain documentation sufficient to verify that a Subscribing Individual, an Employee and a Retiree (as the case may be) is or was regularly scheduled to work at least the minimum number of hours specified in Sections 2.11 and 2.12;

(b) Maintain documentation sufficient to verify the age of any Dependent;

(c) Report to the Administrator the name of any Covered Individual who fails to satisfy, or ceases to satisfy, the Plan's eligibility requirements as soon as that fact becomes known; and

(d) Maintain documentation sufficient to verify the amount of contributions made by a Covered Individual, Subscribing Individual and Subscribing Employer, and report this information upon the Administrator's request.

5. Effective July 1, 2010, Section 11.21 of the Plan is revised to read as follows:

Section 11.21 Termination of Coverage and/or Subscription Agreement for Fraud, Misrepresentation or Deceit

If a Covered Person, Subscribing Individual or Subscribing Employer commits fraud, misrepresentation or deceit, or omits a material fact in an application for coverage under the Plan, in a subscription agreement, in a claim or appeal for benefits, or in response to any request for information by the Administrator, a Claims Administrator, an Appeals Fiduciary or a Subscribing Employer, the Administrator may in its discretion, take any or all of the following actions as appropriate:

(a) Terminate coverage of a Covered Person either prospectively or retroactively;

(b) Deny a Covered Person's claims for benefits under the Plan either prospectively or retroactively; and

(c) In the case of an act or omission by a Subscribing Individual or Subscribing Employer, terminate the subscription agreement either prospectively or retroactively and recommend to the Trust Committee that the Subscribing Individual or Subscribing Employer be expelled from the Plan and Trust.

6. Effective July 1, 2010, a new Section 11.24 is inserted as follows:

Section 11.24 No Liability for Post-Retirement Benefit Obligations

In no event shall the Plan or Trust be financially liable to provide post-retirement benefits to an Eligible Retiree. If a Subscribing Employer elects to provide benefits to Eligible Retirees and is unable to make timely premium payments or cure a contribution delinquency, then the Administrator shall take steps to immediately terminate coverage for any such Eligible Retirees and recommend to the Trust Committee that the Subscribing Employer be expelled from the Plan and Trust.