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UNITED AGRICULTURAL BENEFIT TRUST

YOUR HEALTH BENEFITS

SUMMARY PLAN DESCRIPTION

Please note: The Spanish translation of this Summary Plan Description and the Medical Benefits Addendum are provided by UnitedAg for your convenience only. In the event that there is a contradiction between the Spanish and English version, the English version will govern.

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UABT
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Part I, Eligibility Provisions

Section 1, Who Is Eligible for Benefits?

If you are working full-time as an employee of a participating employer of the United Agricultural Employee Welfare Benefit Plan & Trust (also known as United Agricultural Benefit Trust, UnitedAg Benefit Trust or UABT) and have met the requirements agreed upon between your employer and UABT, you are eligible to be a Participant of the Plan. You are a Participant and entitled to the benefits described under the Plan during each calendar month for which your employer has made the necessary contribution on your behalf.

The Employer, pursuant to the Trust Agreement with the UABT, is responsible for following the eligibility rules listed in the Summary Plan Description as well as any delegated Employer rules documented in the Employer Handbook or Policies that may affect Plan Participant's eligibility. Employer Handbook and Policies must be approved by UABT during the underwriting process. It is the Employer's responsibility for maintaining accurate records and methodologies to assess and offer coverage under any applicable Federal Law or Mandate and in doing so is ultimately responsible for any fines or penalties for failure to follow such laws.

If you are an owner, partner, or principal of a participating employer and draw wages, dividends, or other substantial distributions from the company on at least a monthly basis, you are considered an employee for participation purposes.

Section 2, Reinstatement of Coverage

If you have been laid-off or terminated by your employer and rehired by your employer (or affiliate or subsidiary) within thirteen (13) weeks from your date of termination of employment your coverage will be reinstated on the first of the month following rehire, so long as all other eligibility criteria are satisfied. You may be reinstated by your employer after a longer period of time based on your Employer's Handbook or Policy if approved during the underwriting process.

Employees who return to work from an approved leave or who have continued coverage under COBRA will not be required to satisfy a waiting period.

Those employees or covered dependents who return to work after active duty service as a member of the United States armed forces will also be reinstated for coverage immediately upon his/ her return to employment so long as certain requirements are met under the Uniform Services Employment and Reemployment Act of 1994 (USERRA). Employees should check with their Employer to see if their eligibility under USERRA applies to them and/ or their dependents.

Section 3, Determining Full-Time Employee Status for Applicable Large Employers (ALE)

An applicable large employer is an employer that has an average of at least 100 full-time employees or "full-time equivalents" or "FTE." For the purposes of the Affordable Care Act, a full-time employee is someone who works at least 30 hours a week.

An ALE identifies its full-time employees based on each employee's hours of service (including paid leave). Employers may determine the hours of service for hourly and non-hourly employees using either the monthly measurement method or the look-back method for different classifications of employees.

Section 4, Who Are Your Eligible Dependents?

Your current and lawful spouse (as evidenced by a valid marriage license and the marriage has not been annulled or voided in any way), Your domestic partner (as evidenced by a notarized UABT "Affidavit of Domestic Partnership" -available through UABT Member Services Department and on file with your employer *and* UABT) is an eligible dependent. Eligible dependents also include any natural and adopted children, including stepchildren, and children placed under your legal guardianship.

A spouse, domestic partner, and/or dependent child currently covered under UABT as an employee may be eligible as a spouse, domestic partner, or dependent child under the same or other UABT Employer as a covered Plan Participant if all other eligibility qualifications are met.

A child who is subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notices (NMSN) that provides for child support with respect to a child of a participant under a group health plan or provides for health benefits coverage to such a child issued pursuant to State or Federal domestic relations law issued by a court of competent jurisdiction will be considered eligible if the order does not require UABT to offer any type or form of benefit not otherwise provided under the plan.

You and Your spouse must meet the following requirements:

(a) You and your spouse shall not have been Legally Separated or engaged in a trial separation for more than 12 consecutive months upon the date a Clean Claim for Covered Service(s) provided to a spouse is received by the Plan.

(b) You and your spouse have been living together at the same residence for the majority of a calendar year. When you or your spouse are traveling or residing elsewhere as part of your employment, to care for a family member (due for instance, to Illness or Injury), and/or is residing elsewhere due to your or your spouse's Illness or Injury, formore than half of the applicable Plan Year (and thus residing with each other for less than the majority of the calendar year), but your primary residence is also your spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.
(c) The Employer may elect to limit the coverage of your spouse if your spouse has access to Group Health coverage available through his or her own Employer.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

To qualify as an eligible Domestic Partner:

(a) The Domestic Partner must be at least 18 years old and mentally competent to enter into contracts;
(b) The Domestic Partner must have joint responsibility with you for your and his/her welfare and financial obligations;
(c) You and your Domestic Partner must reside in the same residence for at least six (6) months prior to the date of anotarized "Declaration of Domestic Partnership for Health Care";
(d) You and your Domestic Partner must be in an exclusive committed relationship of mutual caring that has existed for at least six (6) months immediately prior to the date of a notarized "Declaration of Domestic Partnership for Health Care" and you both intend to continue such a relationship indefinitely;
(e) Neither you nor your Domestic Partner has a similar relationship with anyone other than each other;
(f) Neither you nor your Domestic Partner has had a different domestic partner(s) in the last six months;
(g) Neither you nor your Domestic Partner may be married; and,
(h) You and your Domestic Partner may not be related by blood in any way that would prohibit marriage in the state inwhich you reside.

A grandchild, brother, sister, niece, or nephew who is a minor may qualify as a foster child if you have been appointed legal guardian by a court of competent jurisdiction and have filed a copy of the guardianship papers with UABT. Your parents, grandparents, or other adult family members are not eligible as dependents under the Plan, even if they live with you, and/or are dependent on you for support.

An eligible dependent is entitled to the benefits described under the Plan during each calendar month for which you or your employer has made the necessary contributions.

Section 5, Age Limits of Dependent Children

To qualify for coverage, an eligible dependent child must be no more than twenty-six (26) years of age. Coverage of a dependent child will continue until the end of the calendar month he or she turns 26 years of age. For coverage after age twenty-six (26), see "Part III, Section 3, Continuation by Self-Payment through COBRA and Cal-COBRA."

Section 6, Handicapped or Totally Disabled Children

An eligible dependent child who is age 26 or older and is not capable of self-support due to mental or physical handicap or disability will be provided UABT coverage if: (a) the dependent has been continually covered by UABT or another carrier; (b) proof of total disability prepared by the state-recognized medically licensed treating physician is filed with the employer and UABT within sixty (60) days of the date the child would normally lose coverage or at time of enrollment; (c) proof of continued disability is filed yearly thereafter; (d) the child remains totallydependent on you for support; and (e) you continue to be eligible under the Trust.

Section 7, Your Effective Date of Coverage

You are eligible for coverage under the Plan on the first day of the calendar month following any waiting period set by your Employer and agreed to by UABT.

Section 8, Your Dependents' Effective Date of Coverage

Your dependent's coverage will automatically become effective on the date your coverage goes into effect, if: (a) the dependent is eligible under the Plan, (b) the dependent was listed on your enrollment card, and (c) any required contributions have been paid for the dependent.

New dependents acquired after your own effective date become eligible on the date of marriage, attestation of a domestic partnership, birth, adoption, placement for adoption, placement for foster care, legal guardianship, Qualified Medical Child Support Order or National Medical Support Notice if you complete and file a new enrollment form or an enrollment change form within thirty-one (31) days of the date the person became your dependent, and any required additional contribution is made to UABT.

Section 9, Proof of Dependent Status

UABT reserves the right to request additional information, including but not limited to copies of birth certificates, court orders, divorce decrees, or marriage certificates (licenses) as needed to establish dependent status. Requested verification of dependent status may delay the processing of a claim for benefits under the Plan until such request has been answered. Failure to respond to document requests within 60 days may result in termination of the dependent.

Section 10, Late Enrollees

A late enrollee is an eligible employee or dependent who has declined health coverage through UABT at the time he/she initially qualified for enrollment or within the thirty-one (31) days period following a qualifying event and who subsequently requests enrollment in UABT.

UABT may exclude late enrollees from coverage for up to twelve (12) months from the date of the late enrollee's request for coverage and submission of an Enrollment Form or during your employer's open enrollment, whichever occurs first. No contribution is required for the late enrollee until the initiation of coverage.

Section 11, Open Enrollment

Prior to the start of your employer's anniversary date with UABT, your Benefit Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. If you are already enrolled, you will be given an opportunity to change your coverage effective the first day of the upcoming Plan Year. If you fail to make an election during the Open Enrollment Period, you will automatically retain your current coverage. Coverage for Participants enrolling during an Open Enrollment Period will become effective on the first of the month of your employer's benefit anniversary, as long as all other eligibility requirements have been met.

The terms of the Open Enrollment Period, including the duration of the election period, shall be determined by your employer and UABT and communicated prior to the start of an Open Enrollment Period.

Section 12, Special Late Enrollees

A special late enrollee is an eligible employee or dependent who has declined benefits through UABT at the time of the initial enrollment period because of alternative coverage through another group benefits plan, COBRA, Medicaid, CHIP, or Medicare. The special late enrollee must have completed a UABT Waiver of Coverage Form during the initial enrollment period.

UABT provides "Special Enrollment," when you may enroll in the Plan, even if you declined to enroll during an initial or your employer's open enrollment period.

Special enrollment rights will not be available to you or your dependent if either of the following occurs:

(a) The other coverage is/was available via COBRA Continuation Coverage and you or your or dependent failedto exhaust the maximum time available for such COBRA coverage.

(b) You or your dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation ofa material fact in connection with the other coverage).

You or your dependent(s) who are eligible, have met the required conditions indicated in this provision, UABT eligibility will be the first of the month following the loss of other coverage, and the request is timely made within thirty (31) days from loss of coverage.

You or your dependent(s) who is/are eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if you acquired a new dependent as a result of marriage, domestic partnership, legal guardianship, birth or adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than thirty (31) days after he or she acquires the new Dependent.

The following special enrollment conditions apply to any eligible Employee and Dependents:

You or your dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if one of the following conditions are met:

(a) The eligible employee is a covered employee under the terms of this plan but elected not to enroll during a previousenrollment period.

(b) An individual has become a dependent of the eligible Employee through marriage, domestic partnership, legal guardianship, a foster child being placed with the employee birth, adoption, or placement for adoption.

(c) You or your dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and you request coverage under the Plan within 60 days after the termination.

(d) You or dependent become eligible for a contribution/premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and you request coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first of the month following the special enrollment events.

Section 13, Qualified Medical Child Support Orders (QMCSOs) and National Medical Support Notices (NMSN)

UABT recognizes qualified medical child support orders and national medical support notices. A child who is the subject of such an order is considered an “alternate recipient” and is treated as a dependent beneficiary under the Plan.

To qualify as a GMCSCO or NMSN, a medical child support order must create or recognize the existence of an alternate recipient’s right to receive benefits for which the participant is eligible under UABT; clearly identify the participant and the alternate recipient; provide a reasonable description of the type of coverage to be provided; specify each plan that the order applies to and the period to which such order applies; and, not require UABT to provide any type or form of benefit not otherwise provided under the plan.

Reimbursement of benefit payments and copies of notices with respect to the medical child support order under UABT to a QMCSO and/or NMSN may be made to the alternate recipient or to the alternate recipient’s custodial parent.

Section 14, Rescission of Coverage

Under the Affordable Care Act, rescission of your health benefits is not permitted unless you committed fraud or intentional misrepresentation of material facts on your enrollment application.

Section 15, Who is Eligible for Dental Coverage?

Payment for Covered Expenses listed may be limited by Usual, Customary and Reasonable fees, Negotiated Fee, Deductible, Percentage Payable and/or benefit maximums as shown on the Schedule of Dental Expense Benefits. Please refer to your Plan’s Schedule of Dental Expense Benefits to determine whether or not Dental Benefits are a Covered Expense under the Plan.

Part II, Termination of Coverage

Section 1, When Your Coverage Ends

Your coverage will end on the earliest of the following dates, according to UABT records:

(a) the last day of the calendar month for which your employer has made the necessary contributions on your behalf;

(b) the last day of the calendar month during which you qualify as an employee under the terms of the Plan;

(c) the date the Plan is canceled, or (d) the date your employer ceases to be a participating employer under the Trust; or,

(d) If it is determined that you or one of your dependents have falsified a claim or required document(s) (i.e. marriage license/certificate, birth certificate, etc.)

Termination of coverage *may* qualify you for continuation coverage under COBRA. See "Part III Section 3, Continuation by Self Payment through COBRA and Cal-COBRA".

Section 2, When Your Dependents' Coverage Ends

Coverage for all dependents will automatically end on the date your eligibility terminates.

While you remain eligible, coverage for any one dependent will end on the earliest of the following dates:

(a) for a spouse, the date a dissolution of marriage is effective;

(b) for a child, the last day of the calendar month in which the child ceases to qualify due to age;

(c) for a spouse or child, the date the dependent enters into "active duty" of any armed forces;

(d) for any dependent the last day of the month for which dependent contribution is received under the Plan; or,

(e) for a spouse or child, the date Dependent Coverage is canceled under the Plan.

Termination of coverage *may* qualify your dependents for the continuation of coverage under COBRA. See "Part III, Section 3, Continuation by Self-Payment through COBRA and Cal-COBRA". Your dependents may also be able to obtain benefits through the Health Insurance Marketplace (Exchange – at www.HealthCare.gov).

Part III, Continuation of Coverage

Section 1, Continuation after Employment Ends

Your employer is not allowed to make contributions for you after your full-time, active employment has ended unless your employer has an established, written, and documented employment policy or severance agreement in place (filed and approved in writing by UABT) denoting continuation of benefits in the event of occupational or non-occupational disability for a specified and limited period of time (not to exceed 6 months).

If your employer has agreed to extend your benefits in the event of an occupational or non-occupational disability, you will be offered the opportunity to elect COBRA benefits at the expiration of this continuation of benefits.

The Trust rules and regulations do not allow an employer to continue contributions for a Retiree, or any other employee once the date his or her active employment ends unless an approved severance agreement is in place.

If the employer has an established policy that applies to all employees in your job classification which has been approved by the Trust, a continuation of contributions may be permitted during restricted periods of temporary lay-off, approved leave of absence, and/or total disability due to injury or illness, not to exceed one hundred eighty (180) days.

Section 2, Continuation during Family and Medical Leave Act Absence

UABT complies with FMLA if applicable to your employer. UABT will provide these benefits to the extent required by applicable law or as documented in your Employer Handbook or Policies and approved during the underwriting process. If you are eligible for FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if you have been a continuously active employee during the entire leave period.

When an employer, who qualifies under the Family and Medical Leave Act, notifies the Trust of your qualification for family or medical leave, employer contributions are permitted throughout the duration of the family or medical leave under the condition's coverage would have been provided if you had continued working.

Section 3, Continuation by Self-Payment Through COBRA and Cal-COBRA

Your right and the right of your UABT participating dependents to this form of continued coverage was created by Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). You and your dependents will qualify for COBRA Continuation Coverage when you lose your group health coverage through your employer. Your dependents who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, you and your eligible dependents (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee.

There are several ways coverage will terminate, including you or your dependent's failure to make timely paymentof contributions (or premiums). For additional information, you should contact UABT Member Services at 800.223.4590.

*You may have other options available when group health coverage is lost***.** For example, you and your eligible dependents may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you and or your dependents may qualify for lower premium costs. You can learn more about many of these options at www.healthcare.gov. Additionally, you or your dependents may qualify for a 30-day special enrollment period for another group health plan for which you and your other dependents are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

(a) COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death, and dismemberment benefits

(b) Qualifying Events

A qualifying event is any of those listed below. After a Qualifying Event, COBRA Continuation Coverage will be offered to you and your dependents who are "Qualified Beneficiaries." A Qualified Beneficiary is someone who is or was covered by the UABT and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event.

An Employee, who is enrolled in UABT and is a covered Employee, will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1) The hours of employment are reduced.
2) The employment ends for any reason other than gross misconduct.

Your spouse will become a Qualified Beneficiary if he or she loses his or her coverage under UABT because any of the following Qualifying Events happen:

1) The Employee dies.
2) The Employee's hours of employment are reduced.
3) The Employee's employment ends for any reason other than his or her gross misconduct.
4) The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5) The Employee becomes divorced or Legally Separated from his or her spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of thefollowing Qualifying Events happen:

1) The parent-covered Employee dies.
2) The parent-covered Employee's hours of employment are reduced.
3) The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4) The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5) The parents become divorced or Legally Separated.
6) The Child stops being eligible for coverage under the Plan as a Dependent Child.

(c) Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify UABT's COBRA Administrator of the Qualifying Event.

(d) Employee Notice of Qualifying Events

In certain circumstances, you or your eligible dependents, in order to protect his or her rights under COBRA, are required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery.

These circumstances are any of the following:

1) Notice of Divorce or Separation: Notice of the occurrence of a Qualifying Event that is divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2) Notice of Child's Loss of Dependent Status: Notice of the occurrence of a Qualifying Event that is an individual'sceasing to be eligible as a Dependent Child under the terms of the Plan.
3) Notice of a Second Qualifying Event: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4) Notice Regarding Disability: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to bedisabled at any time during the first 60 days of COBRA Continuation Coverage.
5) Notice Regarding End of Disability: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

Notification of a Qualifying Event must be made in writing to UABT. You or your dependents can also call UABT Member Services at 800.223.4590

Notification must include an adequate description of the Qualifying Event or disability determination.

(e) Deadline for providing the notice

For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1) The date upon which the Qualifying Event occurs.
2) The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3) The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of his or her status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as you or your dependent's subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if any of you or your qualified dependent is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1) The date of the disability determination by the SSA.
2) The date on which a Qualifying Event occurs.
3) The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4) The date on which you or your qualified beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice. In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1) The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.

2) The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed) or (if sent digitally) when receipt is acknowledged or received by the UABT COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and your coverage under the Plan will terminate on the last date for which you or your dependents were eligible under the terms of UABT, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

(f) Who Can Provide the Notice?

You or your dependents with respect to a Qualifying Event, or any representative acting on behalf of you and your qualifying dependents, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice onbehalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

(g) Required Contents of the Notice

After receiving a notice of a Qualifying Event, UABT must provide the Qualified Beneficiary(ies) with an election notice, which describes your or your qualified dependent's rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1) Name and address of the covered Employee or former Employee.

2) Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.

3) Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if you or your dependents are already receiving COBRA Continuation Coverage and wish to extend the maximum coverage period).

4) A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).

(a) In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copyof the decree of divorce or Legal Separation.

(b) In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee,date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.

(c) In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan,name, and address of the Child, the reason the Child ceased to be an eligible Dependent (for example, attainedlimiting age).

(d) In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.

(e) In the case of a Qualifying Event that is a disability of a Qualified Beneficiary, name, and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan,the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.

(f) In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan,the date the disability ended and the date of the SSA's determination.

5) Identification of the Qualified Beneficiaries (by name or by status).

6) An explanation of the Qualified Beneficiaries' right to elect continuation coverage.

7) The date coverage will terminate (or has terminated) if continuation coverage is not elected.

8) How to elect continuation coverage.

9) What will happen if continuation coverage isn't elected or is waived.

10) What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.

11) How continuation coverage might terminate early.

12) Premium payment requirements, including due dates and grace periods.

13) A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.

14) A statement that the election notice does not fully describe COBRA or the plan and that more information isavailable from the Plan Administrator and in the SPD.

15) A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all the required information, the COBRA Administrator may request additional information. If you or your qualified beneficiary(ies) fail to provide such information within the period of time specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, you and your qualified beneficiaries, the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

(h) Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by UABT within 14 days of receiving the notice of the Qualifying Event. You and/or your Qualifying Beneficiary(ies) then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

You and your Qualifying Beneficiary(ies) will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including your spouse, and you or the parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their children.

In the event that UABT determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

(i) Waiver Before the End of the Election Period

If during the election period, you or your qualified beneficiary(ies) waive COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to UABT.

(j) Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA Continuation Coverage you or your spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which isequal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of your hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

(k) Disability Extension of COBRA Continuation Coverage

Disability can extend the 18-month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours if you or anyone in your family covered under the Plan is determined by the Social

SecurityAdministration (“SSA”) to be disabled, and you notify UABT. you and your dependents may be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18-month period of COBRA Continuation Coverage.The Plan can charge 150% of the premium cost for the extended period of coverage.

(l) Second Qualifying Event Extension of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, your dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to UABT. This extension may apply to the Employee’s death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Planif the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whetherthe first Qualifying Event had occurred.

(m) Extended Coverage Only for California Participants

An eighteen (18) month extension of coverage to a cumulative thirty-six (36) month maximum will be available to any California Qualified Beneficiary

(n) Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period, as set forth herein.COBRA Continuation Coverage may conclude prior to the latest possible date if your Employer ceases to provide a group health plan to any Employee; your and/or Qualified Beneficiary fails to make payment within thirty (30) days of the due date of any required contributions or premium; you or your Qualified Beneficiary gains coverage under another group health plan or becomes entitled to eitherMedicare Part A or Part B (whichever comes first); and/or any other event occurs which enables the Plan Administrator to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent). COBRA Continuation Coverage shall be extended to the first day of the month 30 days(or more) subsequent to the date upon which the SSA determined that the Qualified Beneficiary is no longer disabled.

(o) Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, UABT must allow for a 30-day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

(p) Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance.” These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual’s group health plan coverage ends.

You or your qualified beneficiary(ies) eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects you for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, you must choose one or the other, and if you receive both during a tax year, the IRS will reconcile your eligibility for each subsidy through your individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact UABT for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

(q) Additional Information

Please contact the UABT COBRA Services with any questions about your plan and COBRA Continuation Coverage at the following:

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact Member Services or the nearest Regional or District Officeof the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agen-cies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web- site.) For more information about the Marketplace, visit www.HealthCare.gov.

(r) Current Addresses

Important information may be distributed by mail. In order to protect your COBRA and those of your qualified beneficiary(ies) you should keep UABT informed of any changes in the addresses of family members.

Section 4, Alternative Coverage Options

You may be able to buy coverage through the Health Insurance Marketplace or Health Care Exchanges. In the Exchanges, you may also be eligible for a tax credit that lowers monthly premiums right away and you can see what the premiums, deductibles, and out-of-pocket costs will be before deciding to enroll. Being eligible for COBRA does not limit a Qualified Beneficiary's eligibility for coverage for a tax credit through the Exchange. Additionally, Qualified Beneficiaries may qualify for special enrollment opportunities for another group health plan for which they are eligible, such as a spouse's health plan.

Part IV, Benefits Extension

Section 1, Employee Life Benefits Extension

If you are totally and continuously disabled as a result of illness or injury at the time your regular eligibility for Group Life Insurance Benefits ends, you *may* qualify for an extension of benefits through a premium waiver for the duration of your totaldisability.

In the event you become totally disabled, you must file an application for a premium waiver with the Insurance Company providing group life insurance benefits to UABT when you have been unable to work for at least six (6) consecutive months,but less than twelve (12) months.

Failure to file an application for a premium waiver within the required six (6) to twelve (12) month limit may invalidate your right to premium waiver. Appropriate forms are available through the life insurance carrier indicated on your certificate of coverage or you may call UABT Member Service Department (800) 223.4590 for assistance.

Section 2, Benefits That Cannot Be Extended

No extension of benefits is provided during total disability for medical, prescription medication, dental, or vision plans provided by an independent carrier through UABT. All benefits under these coverages will end on the last day of the calendar month for which contribution is paid and accepted by the benefit provider.

Part V, General Definitions

There are several terms used in describing Plan benefits that have specific definitions. To assist you in understanding the limits of your Plan, the following definitions are included in alphabetic order. These definitions do not indicate that these are covered services or supplies and may be used to identify ineligible expenses, you should refer to the appropriate section for more information.

Section 1, Accident

The term "accident" or "accidental injury," as used in any of the Plan provisions refers to an unexpected incident that happens without the person's intent of injury, involving some external force, element, or object.

Accident benefits will not apply to any injury resulting from: (a) d (b) injury sustained during participation in any illegal activities, not including minor traffic infractions.

Section 2, Activities of Daily Living

The term "activities of daily living" or ADL's as used in the Plan provisions refers to physical, occupational, or other therapy programs designed to train patients with impaired function to perform basic tasks such as eating, writing and personal hygiene.

Section 3, ADA

"ADA" means the American Dental Association

Section 4, Adverse Benefit Determination

The term: "adverse benefit determination" means any of the following:

a) A denial in benefits.
b) A reduction in benefits.
c) A rescission of coverage resulting from an error by your employer or misrepresentation by you, even if the rescission does not impact a current claim for benefits.
d) A termination of benefits.
e) A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.
f) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
g) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Section 5, Affordable Care Act (ACA)

The term "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Section 6, Allowable Expense

The term "Allowable Expense" means the Maximum Allowable Charge for medically necessary Covered Expense. Allowable expense refers to specific types of service, which are covered in full or in part under the terms of the Plan. Coverage for an allowable expense may be limited by specific Plan provisions or benefit maximums. When some "other plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made."

Section 7, Alternative Recipient

The term "Alternative Recipient" is any child of a participant in UABT who is recognized under a medical child support order or national medical support notice as having a right to enrollment under the Plan as a dependent.

Section 8, Ambulatory Surgical Center

The term “Ambulatory Surgical Center” means a health care facility that offers you the opportunity to have selected surgical and procedural services performed outside the hospital setting. A center is a modern healthcare facility focused on providing same-day surgical care, including diagnostic and preventive procedures.

Section 9, Approved Clinical Trial

The term “Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or anon-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required). The Affordable Care Act requires that if a “qualified individual” is in an “approved clinical trial,” UABT cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “approved clinical trial” and either the individual’s doctor has concluded that participation is appropriate, or the participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device, or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. plans are not required to provide benefits for routine patient care services provided outside of the plan’s network area unless out-of-network benefits are otherwise provided under the plan.

Section 10, Assignment of Benefits

“Assignment of Benefits” shall mean an arrangement whereby the Participant, at the discretion of UABT, assigns their right to seek and receive payment of eligible Plan benefits, not including Deductibles, Co-payments, and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Document, to a Provider. The UABT Plan does not allow or recognize Assignment of Benefits, which many providers require as a condition of treatment. However, if a Provider requires an Assignment of Benefits as defined in this Document and accepts this arrangement, Providers’ rights to receive Plan benefits are equal to those of a Participant and are limited by the terms of this Document. A Provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and Deductibles, Co-payments, and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. UABT may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary. Assignment of Benefits will apply only to payment and does not transfer any other rights to a Provider from a Participant. An Assignment of Benefits does not appoint the Provider or any other person as an Authorized Representative for the purpose of pursuing legal action against UABT.

While Benefits may be payable to a Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered, UABT may pay a Provider directly under provider network agreements. If payment is made directly to a Provider, the Provider and payment amount will be identified on the Explanation of Benefits (EOB).

Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from UABT. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant’s medical condition to act as the Participant’s authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs UABT, in writing, to the contrary.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request

Any medical, dental, or vision care benefits and prescription medications provided by the Plan may be limited or reduced if services are performed outside the United States and is non-network. The Trust reserves the right to determine benefits payable, if any, for all such services. Assignment of benefits to providers located outside the United States will not be honored unless approved by UABT in advance of the date of services.

Please refer to Part VI, Section 4, Non-Panel Services Incurred Outside the U.S. for limits on assignment to providers located outside theUnited States.

Section 11, Calendar Year

The term "calendar year" means the period beginning January 1 and ending December 31 of each year.

Section 12, Certified Registered Nurse Anesthetist

The term “certified registered nurse anesthetist” means a licensed registered nurse who provides anesthetics to patients in collaboration with surgeons, anesthesiologists, dentists, podiatrists, and other qualified healthcare professionals. The registered nurse anesthetist must be certified (and/or recertified) by the Council on Certification of Nurse Anesthetists.

Section 13, Clean Claim

The term “clean claim” means a claim that can be processed in accordance with the terms of UABT without obtaining additional information from the Provider or a third party. It is a claim that does not lack required documentation, or a particular circumstance requiring special treatment which prevents timely payment. as set forth in this document, and only as permitted by this document, from being made.

A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria or fees under review for application of the Maximum Covered Expense or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claim forms, along with any attachments and additional elements or revisions to data elements, attachments, and additional elements, of which the Provider has knowledge. UABT may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

Section 14, Complications of Pregnancy

The term "complications of pregnancy" means an extrauterine pregnancy, Cesarean Section, miscarriage, or severe illness (such as a major toxemia or hyperemesis gravidarum) which is caused by the pregnancy. Elective abortion is not considered a complication of pregnancy for benefit purposes.

Section 15, Continuity of Care

Under the Consolidated Appropriations Act (CAA) of 2021, a Continuing Care Patient who is undergoing treatment for a Serious and Complex Condition is permitted to elect to continue to receive network-level benefits from a provider (including facilities) whose contractual relationship with the health plan has been terminated while the Patient is receiving care for a 90 day period.

A Continuing Care Patient is defined as an individual who is

Under treatment for a serious and complex condition from the provider or facility;

Under a course of institutional or inpatient care from a provider or facility;

Is scheduled to undergo a nonelective surgery from a provider, including post-operative care from the provider and/or facility;

Is pregnant and undergoing care for the pregnancy from the provider and/or facility;

Is, or was determined to be terminally ill and is receiving treatment for an illness from the provider and/or facility

A Serious and Complex Condition is defined as a condition that is serious enough to require specialized treatment to avoid death or permanent harm; or,
Is a condition that is considered life-threatening, degenerative, potentially disabling or congenital and requires specialized care over a prolonged period of time.

Section 16, Continuation of Coverage

The term "continuation of coverage" refers to a continuation of all applicable benefits for all eligible family members under special circumstances, according to the terms of the Plan.

Section 17, Contracting Panel

The UABT Contracting Panel or “Network Panel” is a Preferred Provider Organization (“PPO”) through which UABT contracts for health, dental, and vision care services for covered beneficiaries. These providers have contracted with the PPO to accept a competitive rate structure for medical services performed. Benefits due to any Network Panel provider will be considered “assigned” to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed.

A list of the Contracting Panel providers is available at no cost to you from UABT on request, is accessible online or you can call the PPO atthe telephone number listed on the back of your UABT Identification Card.

Section 18, Contracting Providers and Hospitals

The term "Contracting Provider" or “Network Providers” refers to a doctor, dentist, laboratory, or other service provider that has a contract with UABT or its PPO network at the time services are rendered. Contracting Providers agree to accept the negotiated fees as payment in full for covered services.

The term "Contracting Hospital" or “Network Hospital” refers to a hospital that has a contract with the Trust or its PPO network at the time services are rendered. Contracting Hospitals agree to accept the negotiated fees instead of their billed fees. Benefits due to any Network Panel provider will be considered “assigned” to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed.

A list of Contracting Providers and Contracting Hospitals is available at no cost to you from UABT on request or you can call the PPO at the telephone number listed on the back of your UABT Identification Card.

Section 19, Coordination of Benefits (C.O.B.)

The term "coordination of benefits" or "C.O.B." refers to Plan provisions which limit total payment under two or more benefit plans so that no more than the Maximum Allowable Charge for covered medical, dental, or vision care or prescription medication expense is paid by the combination of plans.

Section 20, Co-Payment

The term “Co-Payment” or “Co-Pay” means the patient’s cost sharing requirement(s) as specified in the applicable Schedule of Medical, Dental, Prescription Medication and/or Vision Expense Benefits.

Section 21, Cosmetic Surgery

The term “cosmetic surgery” refers to procedures intended to improve physical appearance where there is no functional impairment The term “cosmetic surgery” does not apply to the expense incurred for repair of an injury sustained within one year of an accident which occurred while the person was covered for benefits under the Plan, for correction of congenitaldeformity in a child who was eligible under the Plan at birth, and/or to post-mastectomy reconstructive surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema).

Section 22, Covered Expense

The term "Covered Expense" means the Maximum Allowable Charge for a medically necessary service, treatment, or supply(ies). Expense incurred for a type of treatment, service, or supply which is allowed by the Plan,if all Plan Definitions have been satisfied; the services are not excluded by Plan Limitation, and; the charges do not exceed the applicable benefit maximum which will be determined based upon all other Plan provisions designated in the schedules of benefits.. Covered Expense for an eligible Medically Necessary service, treatment, or supply, meant to improve a condition or Participant’s health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

Section 23, Custodial, Rehabilitative or Maintenance Care

The terms custodial, rehabilitative, or maintenance care refer to any care that is no longer classified as acute,when the patient's progress has essentially stabilized, and the medical impairment must be considered permanent. Such care is not

reasonably expected to improve the underlying medical condition, even though it may relieve symptoms of pain. This care includes but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in or out of bed, supervision over medication which can normally be self-administered, all domestic activities. Further, this type of care would include, but is not limited to, care in a rehabilitation wing of an acute care hospital, extended care facility, or skilled nursing facility, except as provided for under any Convalescent Hospital or Extended Care Facility provision of the plan.

Section 24, Deductible

The term "deductible" or "cash deductible" means the amount of covered expense that must be incurred by you or your dependent(s)before benefits are payable under the terms of the Plan. Charges that do not qualify as covered expense cannot be used to satisfy any part of the patient's deductible. Please note, your deductible may reset if you change to or from an HSA qualified plan.

Section 25, Dental Services

The term “dental services” means services covered in the Schedule of Dental Expense Benefits or medically necessary medical services for the payment for reduction of fractures of jaws or facial bones, severe malocclusion/impacted wisdom teeth that are not fully erupted; stones from salivary ducts; excision of malignancies of the mouth; oral surgeries that do not involve the teeth or their supporting structures and any outpatient surgery patients who may be immune-compromised. Services to treat temporomandibular joint disorder are a Covered Expense under the medical benefit.

Section 26, Diagnostic Service

The term “diagnostic service” means medically prescribed services for the purpose of providing diagnosis to promote and maintain health.

Section 27, Drug

The term “drug” means a “chemical substance, prescribed by a medical provider that is used in the diagnosis, treatment, or prevention of a condition or disease.

Section 28, Durable Medical Equipment

The term “durable medical equipment” means physician-prescribed medical equipment which 1) can withstand repeated use i.e. could normally be rented and used by successive patients and 2) is primarily and customarily used to serve a medical purpose, and 3) generally is not useful to a person in the absence of an illness or injury and 4) is appropriate for use in the home and 5) serve a specific therapeutic purpose in the treatment of an illness or injury. Examples include wheelchairs (manual and electric), hospital beds, traction equipment, canes, crutches, walkers, kidney machines, ventilators, oxygen, monitors, pressure mattresses, lifts, and nebulizers.

The Plan will limit benefits for the rental of the equipment up to the purchase price amount and will only cover the cost of standard equipment. All durable medical equipment must be prescribed by a doctor or medical professional indicating that the equipment is medically necessary.

Section 29, Doctor

The term "doctor" means only a physician who is practicing within the scope of his or her license as a Doctor of Medicine (M.D.) or Osteopathy (D.O.); or, to the extent that specific benefits are provided under the Plan, a Doctor of Acupuncture Dentistry, Podiatry, Optometry or Chiropractic who are properly licensed and credentialed in their field of medicine. A licensed Optician, Psychologist or, Christian Science Practitioner is also included when performing services covered by the Plan.

Section 30, Essential Health Benefits

The term “essential health benefits” as defined by the Affordable Care Act, shall mean, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient ser vices; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of California as permitted by the Departments of Labor, Treasury and Health and Human Services.

Section 31, Excluded Expense

The term "excluded expense" refers to charges or services that are specifically excluded by Plan Definition or Limitation.

Section 32, Experimental and/or Investigational Procedure - Medication/Procedure

The terms "experimental procedures"," investigational treatment" "investigational procedure" or "experimental treatment" refers to medications, therapy, surgery, clinical trials, treatment protocols, or other medical treatment still under study, not recognized as accepted medical practice and/or defined as experimental by the American Medical Association and/or the Centers for Medicare and Medicaid (CMS). Items, drugs, or substances which come under the jurisdiction of the United States federal Food and Drug Administration which are being tested but have not been approved by the FDA and/or CMS or approved drugs used for unrecognized, unaccepted, or not approved treatment protocol, are also considered experimental.

These services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments, or courses of treatment that meet either of the following requirements:

1) Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2) Are rendered on a research basis as determined by the United States Food and Drug Administration and theAMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A new to market drug, device, or medical treatment or procedure is experimental or investigative if one of the following requirements is met:

1) If the drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and/or the approval of the FDA Advisory Board.
2) The approval for marketing has not been given at the time the drug or device is furnished; or
3) If reliable evidence shows that the drug, device or medical treatment, or procedure is the subject of ongoing PhaseI, II, or III clinical trials or under study to determine all the following:
   (a) Maximum tolerated dose.
   (b) Toxicity.
   (c) Safety.
   (d) Efficacy.
   (e) Efficacy as compared with the standard means of treatment or Diagnosis.
4) If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment orprocedure is that further studies or clinical trials are necessary to determine all the following:
   (a) Maximum tolerated dose.
   (b) Toxicity.
   (c) Safety.
   (d) Efficacy.
   (e) Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1) Only published reports and articles in the authoritative medical and scientific literature.
2) The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3) The written informed consent used by the treating facility or by another facility studying substantially the samedrug, device, or medical treatment or procedure.

A Drug approved by the FDA but used in a non-approved treatment is not considered experimental or investigative and has the same coverage as any other prescription medication provided it is recognized as being medically necessary and medically appropriate for the specific treatment for which it has been prescribed by at least one of the following:

(a) The American Medical Association Drug Evaluations
(b) The American Hospital Formulary Service Drug Information
(c) The United States Pharmacopeia Drug Information; or
(d) A clinical study or review article in a reviewed professional journal.

Subject to medical opinion, if no other FDA approved treatment is feasible and as a result, the patient faces a life-or-death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental or Investigational.

Section 33, Explanation of Benefits (EOB)

The term "Explanation of Benefits" (EOB) means a statement UABT sends to you which shows charges, payments, and any balances owed to a provider. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Section 34, Extended Care Facility

The term "extended care facility" means either a free-standing medical facility that is licensed as a convalescent or rehabilitation hospital; or a specific area in an acute care hospital that functions primarily as convalescent care or rehabilitation unit. Such facility or unit must qualify as an "Extended Care Facility" under Federal Medicare rules and regulations.

Section 35, Facility

The term “Facility” means licensed, lawfully operating location and/or sources of medical services. They include hospitals, out-patient surgical centers, dialysis centers, hospice care, home health care, private duty nursing, clinics, out-patient care centers, and specialized care centers.

Section 36, Genetic Information

The term “genetic information” means information about an individual’s genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Section 37, Habilitative Services

The term “habilitative services” means health care services that help a person keep, learn, or improve skills and functions needed for daily living. These services may include physical or occupational therapy, speech-language therapy, and othersimilar services for people with disabilities in a variety of inpatient and/or outpatient settings.

Section 38, Health and Wellness Centers

The term “Health and Wellness Centers” means UnitedAg health and wellness centers that provide you and your dependents a full range of medical and treatment services focused on the unique needs of the agricultural community – from acute and episodic care to health-risk and disease management to wellness and prevention. Many of the services mentioned are available to you at a $0-dollar copay with no deductible for most plans.

Section 39, Health Insurance Marketplace (“Exchange”)

The term “Health Insurance Marketplace (“Exchange”) was created by the Affordable Care Act which created a new mechanism for purchasing coverage called Exchanges, which are entities that will be set up in states to create a more organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them.

Section 40, HIPAA

The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

Section 41, Home Health Care

The term “Home Health Care is means health care services that can be given in your home for an illness or injury.

Home health care may include occupational and physical therapy, speech therapy, and skilled nursing. It may involve helping older adults with activities of daily living, such as bathing, dressing, and eating. Home health care professionals are often licensed practical nurses, therapists, or home health aides.

Home health care does not include a private duty nurse.

Section 42, Hospital

The term "hospital" means only a licensed, lawfully operating medical facility which meets all of the following requirements: (a) maintains permanent facilities for the care of five or more resident bed patients, (b) has a resident doctor on duty atall times, (c) has facilities for major surgery, (d) provides twenty-four (24) hour a day nursing which is supervised by a registered graduate nurse; and (e) primarily provides general diagnostic and therapeutic medical care on a basis other than a rest home, nursing home, convalescent hospital, extended care facility, home for the aged or substance abuse treatmentcenter.

Section 43, Hospital Confinement

The term "hospital confinement" for benefits purposes means: (a) confinement in a hospital as a registered bed patient for at least twenty-four (24) consecutive hours including out-patient pre-admission testing prior to hospitalization, (b) admission to the outpatient department of a hospital for a surgical procedure or (c) treatment in the hospital emergency room within forty-eight (48) hours of an accidental injury.

Section 44, Incurred Date

The term "incurred date" for a given service or supply refers to the date the service was rendered, or the supply was furnished to the patient. If treatment is done in phases, covered expenses are incurred at stages of treatment are performed.

Section 45, Incurred Date, Pregnancy Expense

The term "incurred date" with regard to case fees for total obstetrical care means the date of actual delivery, miscarriage or termination of pregnancy, regardless of the date of billing, payment or services.

Section 46, Intensive Care Unit (ICU)

The term "intensive care unit" or "I.C.U." for benefits purposes refers to a separate hospital area, used solely for treatment of patients in critical condition, which provides round-the-clock monitoring by special duty nurses and medical equipment. The term includes Coronary Care Unit (C.C.U.) and Critical Burn Care Unit.

Section 47, Leave of Absence

The term “leave of absence” means a period of time during which you must be away from your primary job with your employer, while maintaining the status of Employee during time away from work, generally requested by you and having been approved by your employer, and as provided for in your employer’s rules, policies, procedures, and practices where applicable.

Section 48, “Legal Separation” and/or “Legally Separated”

The term “legal separation” and/or “legally separated” shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Section 49, Major Diagnostic Procedure

The term “Major Diagnostic Procedure” means diagnostic procedures commonly done in a free-standing imaging center or hospital/facility including, but not limited to the following: Bone Scans, Stress Tests, CTScans, Nuclear Medicine tests, MRI’s, MRA’s, Myelography, and PET scans.

Section 50, Maximum Allowable Charge

The term “Maximum Allowable Charge” the benefit payable for a specific service or treatment will be the contracted negotiated rate with the Trust’s contracted provider organization(s) (if one exists).

If no negotiated rate exists, the maximum allowable charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services (CMS) either multiplied by 150% or multiplied by a percentage that the Provider and/ or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of treatment, service, or supply, Medicare reimbursement rates will be calculated based on one of the following:

(a) Prices established by CMS utilizing standard Medicare Payment methods and/ or based upon supplemental Medicare or Medicaid pricing data for items Medicare does not cover based on data from CMS;

(b) Prices established by CMS utilizing standard Medicare payment methods and/ or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/ or supplies provided by similarly skilled and trained providers of care; or

(c) Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/ or supplies paid to similarly skilled and trained providers of care in traditional settings.

With respect to Non-Network Emergency Services the Plan allowance is greater of:

(a) The Qualifying Payment Amount,

(b) If applicable, the negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).

(c) The Plan’s normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).

(d) The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the maximum allowable charge based on any of the following: (i) Medicare cost data; (ii)amounts collected by providers in the area for similar services; or (iii) average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than the other, the least costly option that is no less effective than any other option will be considered within the maximum allowable charge. The maximum allowable charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or

supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision

Section 51, Medical Emergency

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in Emergency Medical Treatment and Active Labor Act (EMTALA), including (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance use disorders. Other Medical Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator’s discretion, that an Emergency did exist.

Consistent with Section 1867 of the Social Security Act, “Emergency Services” shall mean (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

An “independent freestanding emergency department” is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide emergency services, even if the facility is not licensed under the term “independent freestanding emergency department.”

No Surprises Act cost-sharing and balance billing protections continue from the emergency room to post-stabilization services in a hospital or freestanding emergency department until the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual’s medical condition. Notice and consent as well as any additional state law requirements must also be met consistent with 45 CFR 149.410(b)(1), 45 CFR 149.410(b)(2), 45 CFR 149.420(c) through (g), 45 CFR 149.410(b)(3)and 45 CFR 149.410(b)(5).

Section 52, Medical Record Review

The term “Medical Record Review” means measurement and review of medical records to compare documentation of care to measurable criteria. Service quality is measured by reviewing each clinic's process for assuring the timeliness and safety of appropriate patient care. This includes emergency, urgent and non-urgent care. The review also considers the medical necessity of the treatment and service.

Section 53, Mental or Nervous Disorder

The term “mental or nervous disorder” means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of the International Classification of Diseases, published bythe U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the plan.

Section 54, Mexico Panel

The term “Mexico Panel” refers to a doctor, hospital, clinic, dentist, laboratory, or other service providers in Mexico that has a contract with UABT at the time services are rendered. Mexico Panel providers agree to accept the negotiated fees as payment in full for covered services.

Photo identification will be required each time you visit a Mexico Panel Provider. If the provider is unable to verify your eligibility for benefits at the time of your visit, you may be required to make payment in full or place a deposit before services are rendered. This amount will be refunded as soon as eligibility is confirmed.

A list of Mexico Panel Providers is available from UABT on request at no cost to you.

Section 55, Necessary Services and Supplies

The term "necessary services and supplies" means only those services and supplies which are medically necessary for the treatment of an illness or injury. To qualify, services must be performed by or under the direction of a doctor, and supplies must be dispensed, prescribed, or ordered by a doctor.

Any service or supplies must: (a) meet the prevailing standard for medical care rendered to comparable cases in the geographic area, (b) be a medical procedure or practice which is approved in the United States; and (c) meet the requirements of any governing body or agency having jurisdiction over the type of service or supply being furnished.

"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition. The service must meet all the following requirements (a) its purpose must be to restore health; (b) it must not be primarily custodial in nature; (c) it is ordered by a physician for the diagnosis or treatment of a sickness or injury; and (d) UABT reserved the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or Covered Expense.

For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services you or your dependent(s) is receiving, or the severity of the condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting.

The mere fact that the service is furnished, prescribed, or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

Off-label drug use is considered Medically Necessary when all the following conditions are met:

(a) The drug is approved by the Food and Drug Administration (FDA).

(b) The prescribed drug use is supported by one of the following standard reference sources:

1) Micromedex® DRUGDEX®.

2) The American Hospital Formulary Service Drug Information

3) Medicare (established by Title XVIII of the Social Security Act of 1965, as amended) approved compendia.

4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals,which demonstrate that the Drug is safe and effective for the specific condition.

The drug is otherwise Medically Necessary to treat the specific condition, including life-threatening conditions or chronic and seriously debilitating conditions.

Section 56, Non-Contracting Providers and Hospitals

The terms "Non-Contracting Provider", "Non-Contracting Hospital", "Non-Network Provider", "Non-Network Hospital", "Non-Panel Provider" and "Non-Panel Hospital" refer to health service providers who do not have a contract in effect with the Trust or its contracted network(s) at the time services are rendered. Covered Expense for services rendered by a Non-Contracting Provider is limited as stated in your applicable Schedule(s) of Expense Benefits or Benefit Summaries.

Section 57, Nurse

The term "nurse" for benefit payment purposes means only a Registered Graduate Nurse (RN) who is not a member of you or your spouse's immediate family. A Licensed Vocational Nurse (LVN) or Licensed Practical Nurse (LPN) does not qualify unless an RN was ordered by the doctor and no RN was available for duty.

Section 58, Occupational Therapy

The term "occupational therapy" for benefit payment purposes means physical therapy intended to restore or strengthen hand or arm movement which has been impaired by injury or illness.

Section 59, Obesity Treatment

Obesity screening and counseling is a Covered Expense when you are determined morbidly obese by a licensed physician and have met criteria for the procedure based on nationally recognized clinical guidelines. UABT pre-authorization must be obtained for any procedure, including but not limited to Roux-en-Y gastric bypass, gastric banding (adjustable or non-adjustable), sleeve gastrectomy, malabsorption procedures (biliopancreatic diversion, duodenal switch) and vertical banded gastroplasty.

Section 60, Other Plan

The term "Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such other plan(s) include auto insurance, workers' compensation insurance, crime victims' restitution, etc. . "Other Plan" also include Medicare, Medicaid, or a state child health insurance program (CHIP). Other Plan

does not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies:

Section 61, Out-of-Pocket Maximum

The term “Out-of-Pocket Maximum” means the highest amount of Covered Expense you will be responsible to pay in anygiven calendar year before the Trust begins to pay 100% of the Covered Expense for the remainder of that year. Your Out-of-Pocket Maximum includes your deductible and co-insurance percentage payable. Your Plan may also include any applicable co-payments for specific medical services. Your Out-of-Pocket Maximums may differ for Contracted versus Non-Contracted provider services.

Unless your Medical Benefits Plan is identified as a “Grandfathered Plan”, your combined Contracting Provider Out-of-Pocket Maximum for deductibles, co-insurance percentage payable and all co-payments under both the Medical and Prescription Plans cannot exceed the ACA Out-of-Pocket Maximum in a calendar year. (Note this maximum may be adjusted by federal mandate and your plan will automatically adjust to comply with such mandate.)

Any medical and/or prescription drug expense that does not meet the Plan definition of Covered Expense cannot be applied toward your Out-of-Pocket Maximum.

Please Note, your Out-of-Pocket Maximum may reset if you change to or from an HSA qualified plan.

Section 62, Percentage Payable

The term “Percentage Payable” (or co-insurance) means a benefit plan in which you pay a share of the payment made against a claim. The percentage payable is part of your out-of-pocket costs for a claim.

Section 63, Peer Review

The term “peer review” means an appropriately credentialed, independent medical consultant(s) or review board chosen by UABT to assist in determining “necessary services and supplies”, quality of care and/or “usual and customary fees”, as defined in Part V, Sections 55 and 87. Claims sent to peer review for determination could take up to 21 days to review. You or your provider may also be requested to provide additional information in connection with the review process.

Section 64, Per Cause

The term "per cause" for benefits purposes refers to any one accident or all illnesses which are being treated at the same time. Any benefit limited by this term will renew if the patient goes six (6) consecutive months without treatment for the condition being limited.

Section 65, Per Confinement

The term "per confinement" as it pertains to you refers to any one accident, or all illnesses being treated at the same time. If you are an active employee, any benefit limited by this term will renew when you return to work for one full day or are treatment free for six (6) consecutive months between confinements. For dependents, successive hospitalization for the same cause will be considered one confinement unless the patient goes six (6) consecutive months without treatment for the condition being limited.

Section 66, Per Disability

The term "per disability" as it pertains to you, for benefit purposes, refers to any one accident, or all illnesses that are being treated at the same time. If you are an active employee, any benefit limited by this term will renew when you return to work for one full day or are treatment free for six (6) consecutive months. For dependents, the benefits will renew if the patient goes six (6) consecutive months without treatment for the condition being limited.

Section 67, Physician’s Assistant

The term “physician’s assistant” means a health professional licensed to practice medicine with physician supervision. Within the physician assistant/physician relationship, PAs may exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. Physician Assistants interview patients, compile patient’s medical histories, perform physical examinations and, as necessary, order or perform required diagnostic laboratory tests.

Section 68, Preventative Care

“Preventive care” shall mean certain preventive care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, UABT plans provide In-Network coverage for: Benefits for “preventative care” include items or services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventative Service Task Force; immunizations for routine use in children, adolescents and adultsthat have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; for infants, children and adolescents, evidence-informed preventive care and

screenings provided in guidelines supported by Health Resources and Service Administration; and, for women evidenced-informed preventative care and screening provided for in the comprehensive guidelines supported by HRSA.

Copies of the recommendations and guidelines may be found at the following websites: https://www.healthcare.gov/coverage/preventive-care-benefits/;

(a) https://www.healthcare.gov/coverage/preventive-care-benefits/;

(b) https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;

(c) https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;

(d) https://www.hrsa.gov/womensguidelines/.

(e) https://www.aap.org/periodicityschedule

(f) https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/

For more information, please contact the UABT Plan Administrator or your Employer.

Section 69, Provider

The term "provider" refers to a licensed medical professional acting within the scope of his/her license, including but not limited to, doctor, nurse, hospital, pharmacy, technician, therapist, clinic, or medical supply house which provided the service or furnished the supplies for which the patient was billed.

“Scope of practice” is defined as the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience.

Section 70, Psychological or Psychiatric Services

The term “psychological or psychiatric services” for benefits purposes includes psychotherapy, psychometric testing, pre scription drug therapy, and other medical care specifically described as treatment or diagnosis of a recognized mental or nervous disorder. The term also includes cognitive function studies and other diagnostic studies designed to measure levels of mental or cognitive impairment regardless of cause or purpose.

Section 71, Qualifying Payment Amount (QPA)

The qualifying payment amount (QPA) as established in the No Surprises Act (NSA) is the amount the Plan will base its payment amount for eligible plan expenses covered by the balance-billing provisions of the NSA. It is the median in-network contracted rate for a medical service or supply furnished in a particular geographic region. This amount is what the Plan will use as the Maximum Plan Allowable and the basis on which benefits will be calculated.

Section 72, Reasonable or Reasonableness

The term Reasonable” and/or “Reasonableness” for benefits purposes means in the Plan Administrator’s discretion, services, or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. A Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/ or charges(s).

This determination will consider but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) the Food and Drug Administration. To be Reasonable, service(s) and/ or fee(s) must be in compliance with generally accepted billing practices for unbundled or multiple procedures. Services, supplies, care and/ or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/ or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/ or malpractice is not required for service(s) and/ or fee(s) to be considered not Reasonable.

Charge(s) and/ or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/ or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/ or paid by the Plan, to identify charge(s) and/ or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Section 73, Rehabilitation Hospital

The term “Rehabilitation hospitals” means inpatient facilities devoted to the rehabilitation of patients with various neurological, musculoskeletal, orthopedic, and other medical conditions following stabilization of their acute medical issues.

Section 74, Residential Treatment Coverage

The term “Residential Treatment Coverage” means treatment at a residential treatment center, sometimes called a rehabilitation center or rehab center, which is a live-in health care facility providing therapy for substance use disorders, mental illness, or other behavioral problems.

Section 75, Semi-Private Room

The term “semi-private room” refers to a hospital room that accommodates two (2) patients.

Section 76, Skilled Nursing Facility

The term “skilled nursing facility” is an in-patient rehabilitation and medical treatment center staffed with trained medical professionals. The facility provides the medically necessary services of licensed nurses, physical and occupational therapists, speech pathologists, and audiologists. Skilled nursing facilities give patients round-the-clock assistance with healthcare and activities of daily living (ADLs).

Section 77, Special Provision (Circumstances)

The term “Special Provisions (Circumstances)”, means treatment by a non-contracting provider when no contracting providers are available within a 50 mile radius of the participant’s current address. If Special Provisions exist, services provided by the non-contracting provider will be covered at the In Network level of benefits and the in-network Deductible and Out of Pocket Maximum will apply.

Section 78, Subrogation

The term "Subrogation" refers to the Trust's right to full reimbursement (as an ERISA benefit plan) for claims expenses advanced on behalf of a participant determined injured by a third party which includes the right to file a lien against any Third Party having primary responsibility for the patient's medical, dental or vision treatment or against the proceeds of any recovery by the patient and against future benefits due under the Plan, before paying benefits under the Plan for those services.

In addition to its right to subrogate, UABT mandates that the patient and legal counsel (if utilized) contractually agree to reimburse the Trust in full from any and all judgment, settlement, compromise or verdict for benefits advanced prior to settlement for claims incurred as a result of the Third-Party injury or illness. This promise of repayment creates an “equitable lien by agreement”. UABT shall have the specific and first right of reimbursement out of the proceeds of any such judgment, settlement, compromise, or verdict resulting from a third party’s assumed or decreed liability for said accident or illness.

Section 79, Substance Abuse/Substance Use Disorder

The term "Substance Abuse" wherever used in the Plan descriptive material refers to any disease or condition that is classified as a Substance Use Disorder other addiction to or voluntary abuse of controlled substances as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, aslisted in the current edition of Diagnostic and Statistical Manual of mental Disorders, published by the American Psychiatric Association Included in this definition is voluntary abuse of inhaled, ingested or injected substances used by the patient in a manner not advised by the manufacturer and/or sanctioned by the Food and Drug Administration (F.D.A.)

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by UABT.

An exception is made for the treatment of nicotine addiction when the patient participates in a recognized smoking cessation program under the supervision of a doctor. Coverage will be limited to the charges for treatment and medication prescribedin connection with two (2) cessation programs during any 12 consecutive months.

Section 80, Transparency and Surprise Medical Bills also known as the “No Surprise Act”

In 2019, President Trump released an executive order on Improving Price and Quality Transparency in American Healthcare to Put Patients First, which directed the Secretaries of Health and Human Services, the Treasury and Labor to develop regulations promoting price transparency in the health care market. This led to the Transparency in Coverage final rule released in October 2020 and the enactment of the Consolidated Appropriations Act, 2021 (CAA) on December 27, 2020.

The CAA includes the “No Surprises Act” which includes consumer protections from surprise billing for out-of-network medical services. In addition, it includes several medical cost transparency measures that complement the transparency rules issued in October 2020. On July 1, 2021, the Office of Personnel Management, Department of the Treasury, Department of Labor and Department of Health and Human Services (“the Departments”) together passed Interim Final Rules implementing provisions of the No Surprises Act related to emergency services and surprise medical bills. Additional guidance and rules for air ambulance services and independent dispute resolution (IDR) processes were published in August 2021, October 2021 and August 2022. In addition, various rules have been challenged in the courts and may invalidate certain rule or the Departments may issue new rules in the future and in reaction to court decisions.

It is the intention of UnitedAg to comply fully and to the best of its ability with a good faith interpretation of the rules and guidance published with respect to these laws. This Summary Plan Description and Plan Document is intended to comply with the rules and regulations available at the time this document was drafted. Additional Amendments will be published in the future to ensure compliance as additional rules and regulations are published which may render the information in this document to be incorrect or in conflict with new laws, rules or regulations. If new laws, rules or regulations are in conflict with this document, UnitedAg will follow them as implemented and update this document as soon as reasonably possible but no later than one year after new laws, rules or regulations are implemented.

Section 81, Telemedicine

The term “Telemedicine” is the use of telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be available during non-business hours. Telephone or other technologies permit communications between patient and medical staff with both convenience and fidelity, as well as the transmission of medical, imaging and health informatics data from one site to another. Telemedicine services include primary care and urgent care services. Behavioral health, dermatological treatment, and smoking cessation services are also available.

Primary care and specialist referral services may involve a primary care or allied health professional providing a consultation with a patient or a specialist assisting the primary care physician in rendering a diagnosis. This may involve the use of live interactive video or the use of stored and forwarded transmission of diagnostic images, vital signs and/or video clips along with patient data for later review.

Telemedicine services provided through a UABT approved provider will be paid in full by UABT if allowed under the benefit plan.

Section 82, The Plan

The term "The Plan" refers to the United Agricultural Employee Welfare Benefit Plan and Trust, United Agricultural Benefit Trust, UABT or the "Trust" plan for which you and your dependents are eligible, as outlined in this summary. Your benefits under the plan are fully described in the applicable Schedules of Plan Benefits or Benefit Summaries and this Summary Plan Description.

Section 83, Total Disability or Totally Disabled

The term "total disability" or "totally disabled" as it pertains to you as an active employee, means a period of time when your doctor certifies that you are unable to perform the duties of your regular job, due to illness or injury, and you are not engaged in any other work for wages or profit.

With regard to your eligible dependents, or you if you are a covered retiree, the term refers to a period of time when a doctor certifies the patient is unable to engage in the normal activities of a person of the same age and sex, due to illness or injury.

The term shall also refer to any period of time you or your dependent is declared totally disabled by any government body for benefit purposes.

Section 84, Transplant Procedures

The term “Transplant Procedure” means any one of the following human to human organ or tissue transplants (a) bone marrow; (b) heart; (c) heart/lung; (d) liver; (e) lung; (f) kidney-pancreas; (g) kidney; (h) certain organ parts including only cornea, skin, bone and tendons. Also covered are transplants of certain artificial organ parts, including only: joint replacement for functional reasons, skin, heart valves, grafts, and patches (vascular), pacemaker, metal plates and eye lens. No other transplants are covered.

Organ transplants must be performed in a Transplant Network Facility or a Center of Excellence that provide specialized programs within healthcare institutions that supply exceptionally high concentrations of expertise and related resources centered on organ transplants and delivered in a comprehensive, interdisciplinary fashion.

Donor-covered expenses are only covered for donors who are participants of UABT. When both the person donating the organ and the person receiving the organ are participants under UABT, each will receive benefits under the Plan. (Donor expenses for non-UABT participants may be considered as an exception when presented during the prior authorization of the procedure).

Section 85, Treatment Therapies

The term “Treatment Therapies” means chemotherapy, hemodialysis, peritoneal dialysis, radiation therapy, IV Infusion therapies-including TPN, hypobaric oxygen therapy, and respiratory/ inhalation therapy.

Section 86, Urgent Care

The term “Urgent Care” means medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an emergency room.

Section 87, Usual and Customary Fees

The term "Usual and Customary Fees" (U&C) means only those charges for necessary services and supplies which are billed in compliance with National Correct Coding guidelines and do not: (a) exceed the amount the provider normally charges for similar services; or (b) exceed the amount charged by most providers for comparable services in the geographic area where the services were rendered, or the supplies were furnished. The term, as defined, is interchangeable with the term “Usual, Customary and Reasonable” fees (UCR) or “Maximum Allowable Charge”.

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Usual and Customary Fee based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Part VI, General Provisions and Limitations

This part of the Summary Plan Description explains the general provisions that apply to covered expense under all portions of your Schedules of Plan Benefits or Benefit Summary, including any general limitations. Those provisions that apply only to Medical Benefits or only to Dental Benefits, for example, will be found in the appropriate sections describing the specific type of coverage.

Section 1, Limits on Covered Expense

Covered expense includes only those charges for a type of service listed on the applicable Schedule(s) of Plan Benefits or Benefit Summary(ies) for which you are eligible. Covered expense does not include:

(a) the amount by which a given charge exceeds the Maximum Allowable Charge for Covered Expense;
(b) coverage for a private hospital room in excess of the cost of the average semi-private room;
(c) treatment which is not generally recognized, accepted and approved practice in the United States;
(d) experimental procedures and/or clinical trials (However routine patient costs associated with approved clinical trialsfor qualified individuals are considered Covered Expense.);
(e) items under the jurisdiction of the Federal Food and Drug Administration which have not been approved by theFDA, or are used for unrecognized, unacceptable or not approved treatment protocols;
(f) services or supplies not ordered by a doctor;
(g) charges which would not have been billed to you if this benefit coverage was not in effect;
an expense incurred more than two (2) years post-surgical proctectomy; and expense incurred when the patient is not eligible under the terms of the Plan.

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Section 2, General Exclusions

No accidental death or dismemberment, medical, prescription medication, dental or vision care benefits provided by the Plan are payable for any expense incurred in connection with an illness or injury which:

(a) is covered by Workers' Compensation Law or Statute provided the condition is one for which benefits are covered or can be recovered either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law, or occupational disease law, even if you do not claim those benefits
(b) is recoverable under the Jones Act (46 U.S.C. 688);
(c) is caused by any act of war, whether the war is declared or undeclared;
(d) is sustained during participation in felonies, misdemeanors, and or unlawful activities (even if the participant is never charged with or convicted of the crime. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (includingboth physical and mental health conditions). UABT does not deny benefits for treatment of a victim's injury causedby Domestic Violence and the injured participant other than the individual taking part is an illegal activity.;
(e) if illness or injury is caused by a third party (including but not limited to malfeasance or misfeasance by a medical provider; and/or
(f) if payment is prohibited by law.

In addition, no benefits are payable for expenses incurred for:

(a) A missed appointment;
(b) Travel expenses unless specifically mentioned elsewhere as covered;
(c) Complications/expenses related to the treatment of complications of a non-covered service or supply, breast implants/cosmetic surgery, or other non-covered service or supplies;
(d) Prescription medications not issued through the UABT pharmacy benefits network;
(e) Any medication not approved by the Food and Drug Administration and the FDA Advisory Board
(f) Account service charges or interest fees;
(g) Treatment and services involving a Participant who has taken part in any activity made illegal due to the use of alcohol, cannabis, prescribed or opioids, or any other substance that creates a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol, a state of intoxication from alcohol or under the influence of cannabis or opioids, and expenses may be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).
(h) Custodial Care that does not restore health, unless specifically mentioned otherwise.
(i) Deductible amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.
(j) Immediate Family Member. That are rendered by a member of the immediate Family Unit or person in the same household, whether the relationship is by blood or exists in law.

(k) Growth Hormones (unless determined to be medically necessary).
(l) Implantable hearing devices for natural hearing loss with age or loss of hearing because of a work-related injury;
(m) Incurred by Other Persons**.** That are expenses Incurred by other persons.
(n) Treatment, services, and/or supplies that are not Medically Necessary.
(o) Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpracticeon the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.
(p) No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.
(q) Services and treatment that are not accepted as standard practice by the American Medical Association (AMA), American Hospital Association, American Dental Association (ADA), or the Food and Drug Administration (FDA).Personal convenience items;
(r) Reversal of sterilization procedures
(s) Completion of claim forms;
(t) Other than Attending Physician. That are other than those certified by a Physician who is attending the Participantas being required for the treatment of Injury or Disease and performed by an appropriate Provider.
(u) Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.
(v) Provider Error. Services and treatment are required as a result of unreasonable Provider error.
(w) Services not actually rendered.
(x) Unreasonable. Services that are not reasonable in nature or in charge (see definition of Maximum Allowable Charge) or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection, or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expenseand are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es);
(y) Weight loss medication whether prescribed by a physician or purchased over the counter
(z) Wilderness Treatment Programs/Therapy adventure-based therapy treatment modality for behavior modification and interpersonal self-improvement, combining experiential education, individual and group therapy in a wilderness setting.

Section 3, Third Party Liability Exclusion

No medical, prescription medication, dental, or vision care benefits provided by the Plan are payable for expense incurred in connection with an illness or injury which is determined to be the liability of a Third Party. Refer to Part VIII.

Section 4, Non-Panel Services Incurred Outside the U.S.

Any medical, dental or vision care benefits and prescription medications provided by a non-panel provider may be limited, reduced or denied if services are performed outside the continental United States, Alaska, and Hawaii and are not related to a life-threatening emergency. The Trust reserves the right to determine benefits payable, if any, for all such services. Assignment of benefits to providers located outside the United States will not be honored unless approved by UABT in advance of the date of services. (This provision does not apply to the UABT Mexico Panel of Providers.)

Section 5, Right of Recovery

In the event an overpayment occurs due to erroneous, incomplete, or inaccurate information, or claim processing error, UABT reserves the right to recover such overpayment from any individual or organization that, in the judgment of the Trust, profited from such overpayment. Said overpayment may also be recovered by making the adjustment(s) or reduction(s) to anyfuture claim(s) of the patient.

Section 6, Facility of Payment

The benefits of the Plan are due and payable solely to the covered employee. However, in the event the employee dies, becomes incapacitated, or cannot be located at the time a claim is processed, the Trust reserves the right to make paymentto any individual or organization the Trust determines is equitably entitled thereto. Payment made in good faith shall discharge the Trust of its liability, and the Trust cannot be held twice liable for the same expenses if an error occurs.

Section 7, Right to Determination

The fact that a procedure or level of care is prescribed by a doctor does not bind the Trust in determining its liability under the Plan. The Trust reserves the right and discretion to determine “Necessary Services and Supplies” and “Usual and Customary Fees”, as defined in Part V based on the information submitted with the claim. To assist in such determination, the Trust may rely on nationally recognized regional fee criteria, anti-fraud detection programs, and/or appropriately credentialed, independent Peer Review.

The Trust reserves the right to deny charges for:

(a) procedures which are deemed experimental, of unproven value, or of questionable usefulness;
(b) procedures which tend to be redundant when performed in combination with other procedures;
(c) diagnostic procedures which are unlikely to provide a doctor with additional information when used repeatedly;
(d) procedures which can be performed with equal efficacy at a lower level of treatment; or,
(e) medical services, tests, or supplies by any provider that solicits patients at public events and/or by advertising that it will accept whatever payments are made by the patient’s health plan, except that this exclusion shall not apply to afacility that is a contracted provider or a member of the Trust’s preferred provider organization.

Any agreement as to fees or charges made between the individual and the doctor shall not bind the Trust in determining its liability with respect to incurred expense.

Section 8, Ineligible Provider

UABT reserves the right to determine that a provider is an ineligible provider and that no Plan benefits will be payable for services or supplies provided by that provider on the basis that such provider has performed unnecessary services, billed in an inappropriate manner, or has engaged in any questionable, unethical, or fraudulent billing practices as determined in the sole and absolute discretion of the Board of Trustees.

Section 9, Examinations and Autopsies

UABT reserves the right to examine any person for whom a claim is made whenever and as often as it may require duringany period for which a claim is pending. In the case of death, the Trust may require an autopsy where legally permitted.

Part VII, Coordination of Benefits (C.O.B.)

It is not the intent of the Plan to reimburse you for more than your actual out-of-pocket expense. Benefits payable under the Plan will be coordinated with any other group health benefits coverage you, or your dependents, may have. Coordination means that no more than one hundred percent (100%) of the Plan's Maximum Allowable Charge will be reimbursed under the combined benefits of all plans to which the patient is entitled.

Section 1, Excess Benefit Coverage/Insurance

If at the time of injury, sickness, disease, or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the UABT benefits shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

(a) Any primary payer besides the UABT.

(b) Any first-party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

(c) Any policy of insurance from any insurance company or guarantor of a third party.

(d) Workers' compensation or other liability insurance company.

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefitpayments, and school insurance coverage.

Section 2, Vehicle Limitation

When medical payments are available under any vehicle insurance, UABT shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. UABT shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their name, title, or classification.

Section 3, Order of Benefit Determination

Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The secondary and subsequent plan(s) will pay the balance due to up to 100% of the total Plan's Maximum Allowable Expense. In no event will the combined benefits of the primary and secondary plans exceed 100% of the Maximum Allowable Expense where there is a conflict in the rules, the Plan will never pay more than fifty percent (50%) of the Allowable Expenses when paying secondary.

When any patient is covered under two or more health benefit plans, UABT rules for determining the order of benefit payments are as follows:

(a) The plan that covers the patient as the "active employee" or "individual" will be the primary payor for that person forall benefits, including but not limited to medical, dental, vision, and prescription medication benefits.

(b) If the patient is eligible as a retiree under one plan and an active employee under the other, the Plan covering the individual as an active employee will be primary.

(c) If the patient is covered as an active employee under two or more plans, the plan having the earliest effective date will be primary.

(d) If the patient is a dependent child, the benefits of the plan of the parent whose birthday falls earlier in a year are primary over the plan of the parent whose birthday falls later in the year. If the natural parents are divorced, the primary payor will be the plan of the custodial parent unless coverage for the dependent child is subject to a qualified Court Order; the secondary payor will be the plan covering any stepparent with whom the child is living and the plan covering the non-custodial natural parent will be last.

(e) If the patient is a dependent child, for the purposes of mandated pediatric dental and/or vision benefits included in the medical plan, if the parent's plan provides dental and/or vision coverage independent of the medical plan, the independent dental plan and the independent vision plan shall be secondary payor of benefits.

When UABT is determined to be secondary payor, based on the rules shown above, covered expense does not include charges which would not have been billed to the patient in the absence of this benefit plan.

When a primary payor denies a claim for medical necessity, UABT may make its own determination of medical necessity and payment of benefits. If the primary payor denies a claim and UABT pays a claim, UABT will be the primary payor and apply plan benefits accordingly.

The intent of this provision is solely to maintain an orderly system of determining each carrier's liability. Your claim should be sent first to the primary payor, as determined by the above order. When notice of payment has been received from the primary payor, a copy of all bills and the explanation of benefits provided by the first payor should then be sent to the secondary carrier for coordinated payment.

Section 4, Right to Receive and Release Necessary Information

UABT and/or the Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of a similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Section 5, Facility of Payment

For purposes of coordination, UABT reserves the right to: (a) release to or obtain from any other organization or individual any claim information which the Trust or the other benefit carrier may require; (b) recover any overpayment made under the Plan because of your failure to report other coverage when submitting a claim and the Trust's failure to consider that coverage when making a payment; and, (c) to reimburse any other organization an amount UABT determines to be warranted, if payments which should have been made under the Plan were made by the other organization.

Section 6, Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by UABT with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, UABT shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

Section 7, Medicare Coordination

If you are an actively at work employee, age sixty-five (65) or older, of a participating employer, UABT will be the primary payor of benefits for you and your dependents.

If you or an eligible dependent have qualified for Medicare due to end stage renal disease (ESRD), the Trust will be primary payor for the first 30 months of Medicare coverage. UABT will become the secondary payor after the 30-month period.

If you or an eligible dependent have qualified for Medicare due to disability (other than ESRD), the Trust will be the primary payor..

Medicare can be the primary during the first month of treatment of dialysis if (i) the beneficiary takes part in a home dialysis training program in a Medicare-approved training facility to learn how to do self-dialysis treatment at home; (ii) the beneficiary begins home dialysis training before the third month of dialysis; and (iii) the beneficiary expects to finish home dialysis training and give self-dialysis treatments.

Medicare coverage can designate the month the beneficiary is admitted to a Medicare-approved hospital for kidney transplant or for health care services that are needed before the transplant if the transplant takes place in the same month or within the following two months.

Medicare coverage can be set two months before the month of the transplant if the transplant is delayed more than two months after the beneficiary is admitted to the hospital for the transplant or for health care services that are needed beforethe transplant.

If you are a qualified beneficiary receiving benefits through COBRA and have qualified for Medicare, Medicare will be the primary payor of benefits.

Section 8, Coordination within the Plan

If any medical, dental, or vision care or prescription medication charges are covered under two or more benefit plans ofthe Trust, benefits will be coordinated so that total payment will not exceed 100% of the Plan Maximum Allowable Charges for covered services and supplies.

Section 9, Cost Containment and Case Management

The Plan may, at its sole discretion and when acting on a basis that precludes individual selection, permit alternative benefits that may otherwise not be payable under the Plan. The alternative benefits, called “Case Management,” shall be determined on a case-by-case basis, and the Plan’s decision to permit the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Individual, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan. Case Management is a cost management program administered to provide a timely, coordinated referral to alternative care facilities to a Covered Individual who suffers a catastrophic Illness or Injury while covered under this Plan.

The following are examples of diagnoses that might constitute a catastrophic Illness or Injury:

(a) High Risk Pregnancy
(b) Neonatal High-Risk Infant
(c) Cerebral Vascular Accident (CVA or Stroke)
(d) Multiple Sclerosis
(e) Amyotrophic Lateral Sclerosis (ALS)
(f) Cancers/Tumor Malignancy
(g) Severe Cardio/Pulmonary Disease
(h) Leukemia
(i) Major Head Trauma and Brain Injury Secondary to Illness
(j) Spinal Cord Injury
(k) Amputation
(l) Multiple Fractures
(m) Severe Burns
(n) AIDS
(o) Transplant
(p) Any claim expected to exceed $25,000

When the Case Manager is notified of one of the above diagnoses (or any other diagnosis for which Case Management might be appropriate in the Plan's sole discretion), the Case Manager will contact the Covered Individual to discuss current medical treatment and facilitate future medical care. The Case Manager will also consult with the attending Physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Covered Individual's condition changes, with the mutual agreement of the Case Manager, the patient, and the attending Physician.

All services and supplies authorized by the treatment plan will be considered Covered Services, whether or not they are otherwise covered under the Plan. The benefit level for alternative treatment settings may be the same as the Hospital benefit level, in the absence of the Case Management program. For all other services and supplies, the benefit level will be the same as the benefit for outpatient medical treatment, in the absence of the program. In the event there are multiple settings available for treatment, the Plan may waive a portion of the Participant deductible or coinsurance if the Participant chooses the least costly setting available for treatment and follows the recommended treatment plan.

Any deviation from the treatment plan without the Case Manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

Part VIII, Third Party Recovery, Subrogation and Reimbursement

Section 1, Payment Condition

If you or one of your eligible dependents incur medical, prescription medication, dental, and/or vision expenses as a result of the act of a third party (person or entity) that would otherwise have been covered by your UABT Plan benefits and final determination of third-party liability is pending litigation, arbitration of other lengthy settlement proceedings, UABT *may* agree to advance payment of such benefits under a Subrogation Agreement. In such instances, UABT will require Participant/Patient's Reimbursement Authorization and Subrogation Agreement from you and Attorney's Acknowledgement and Assent to Reimbursement from your attorney (if one is retained) to execute an "agreement and lien.

UABT, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, illness, or disease is caused in whole or in part by, or results from the acts or omissions by you and/or your dependents, or third parties. Where any party besides UABT may be responsible for expenses arising from an incident, accident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

You and/or your dependents, your or your dependent's attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the UABT's conditional payment of benefits or the full extent of payment from any one or combination of first and third-party sources in trust, without disruption except for reimbursement to UABT. UABT shall have an equitable lien on any funds received by the injured party(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. You or your dependent(s) agree to include UABT as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event you or your dependent(s) settles, recovers, or is reimbursed by any Coverage resulting from the third-party injury you or your dependent(s) agree to reimburse the Plan hundred percent (100%) of the benefits paid or that will be paid by UABT on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of you and your dependent(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting UABT from claiming reimbursement for charges Incurred afterthe date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by UABT or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Section 2, Subrogation

As a condition to participating in and receiving benefits under this Plan, you and/or your dependent(s) agree to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, If you or your dependent(s) fail to so pursuing said rights and/or action.

If you or your dependent(s) receive or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. You or your dependent(s) are obligated to notify UABT or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. You or your dependent(s) are also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1) The responsible party, its insurer, or any other source on behalf of that party.
2) Any first-party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3) Any policy of insurance from any insurance company or guarantor of a third party.
4) Workers' compensation or other liability insurance company.

5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise, and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Section 3, Right of Reimbursement

UABT is entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. UABT shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardlessof how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If you or your dependent(s) recovery is less than the benefits paid, then UABT is entitled tobe paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored andthe Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you or your dependent(s) whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease, or disability.

Section 4, Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, executionof a release, or receipt of applicable funds.

b) Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

c) In circumstances where you or your dependent(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

d) Hold any and all funds so received in trust, on UABT's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent that you or your dependent(s) dispute this obligation to UABT under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Section 5, Release of Liability

UABT's right to reimbursement extends to any incident related care that is received by you or your dependent(s) ("incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Section 6, Excess Health Benefit Coverage/Insurance

If at the time of Injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

a) The responsible party, its insurer, or any other source on behalf of that party.

b) Any first party insurance or benefits coverage through medical payment coverage, personal injury protection, no-fault coverage, uninsured, or underinsured motorist coverage.

c) Any policy of insurance from any insurance company or guarantor of a third party.

d) Workers' compensation or other liability insurance company.

e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or otherbenefit payments, and school insurance coverage.

Section 7, Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Section 8, Wrongful Death

In the event that you or your dependent(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, UABT's subrogation and reimbursement rights shall still apply, andthe entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Section 9, Obligations

It is you and your dependent(s) obligation at all times, both prior to and after payment of medical benefits by UABT:

a) To cooperate with UABT or any representatives of the Plan and Plan Administrator, in protecting UABT's rights,including discovery, attending depositions, and/or cooperating in trial to preserve UABT's rights.

b) To provide the UABT with pertinent information regarding the Sickness, Disease, disability, or Injury, includingaccident reports, settlement information and any other requested additional information.

c) To take such action and execute such documents as UABT may require facilitating enforcement of its subrogation and reimbursement rights.

d) To do nothing to prejudice UABT's rights of subrogation and reimbursement.

e) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment isreceived.

f) To notify UABT or the Plan Administrator of any incident related claims or care which may be not identifiedwithin the lien (but has been incurred) and/or reimbursement request submitted by or on behalf of the Plan.

g) To notify UABT or the Plan Administrator of any settlement prior to finalization of the settlement.

h) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant mayhave against any responsible party or Coverage.

i) To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payeeon any settlement draft.

j) In circumstances where you or your dependent(s) are not represented by an attorney, instruct the insurance company or any third party from whom you obtain a settlement to include UABT as a payee on the settlement draft.

k) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute betweenthe Plan and Participant over settlement funds is resolved.

If you and/or your attorney fails to reimburse UABT for all benefits paid, to be paid, incurred, or that will be incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, you will be responsible for any and all expenses (whether fees or costs) associated with UABT's attempt to recover such money.

UABT's right to reimbursement and/or subrogation are in no way dependent upon you or your dependent(s) cooperation or adherence to these terms. Failure by you or your attorney to respond to UABT within sixty (60) days may result in denial of your claims.

Section 10, Offset

If timely repayment is not made, or you, your dependent(s) and/or the retained attorney fail to comply with any of the requirements of UABT, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of your amount owed to the UABT. To do this, UABT may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by you to UABT. This provision applies even if the Participant has disbursed settlement funds.

Section 11, Minor Status

In the event the injured dependent is a minor as that term is defined by applicable law, the minor's parents, or court-appointed guardian shall cooperate in any and all actions by UABT to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Section 12, Language Interpretation

The Trustees retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Trustees may amend the Plan at any time without notice.

Section 13, Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. UABT shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Part IX, Your Life Insurance Benefits

If you are eligible for Life Insurance Benefits and you are an active employee on the date your coverage becomes effective, your designated beneficiary will be entitled to the benefits amount(s) shown on the Schedule of Life Benefits page of this benefit summary provided the applicable contributions were paid on your behalf for the month in which your death occurs.

You should also be aware of the following provisions and limitations affecting these benefits. You are also entitled to request a certificate of insurance from the Trust that describes the full provisions and limitations of your Group Term Life Insurance coverage.

Section 1, Retiree Limitation

If you were already retired from active employment on the date your coverage would otherwise become effective, you are not eligible for Life, and/or Accidental Death and Dismemberment Benefits.

Section 2, Beneficiary

Any benefits payable as a result of your death will be paid to the beneficiary you designate on your enrollment card, if such card is filed with the Plan Administrator and your employer.

If you designate a beneficiary other than your legal spouse, your spouse's signature is required indicating consent to this beneficiary designation.

If you did not designate a beneficiary prior to your death, the Insurance Company has the option of paying the benefits to any of your following survivors in the following order of priority: your spouse, other adult dependents, children (in equal amounts), parents (in equal amounts); or to the executor or administrator of your estate, as defined by applicable state law.

If your beneficiary is a minor, or is incapable of giving valid receipt, the Insurance Company has the option of paying the benefits to any person or institution assuming custody and/or principal support of the beneficiary pursuant to a court order.

Section 3, Change of Beneficiary

You have the sole right to designate or change beneficiary. You may change your beneficiary at any time by filing a new enrollment card with the Plan Administrator and your employer. However, if you change designation to a beneficiary other than your legal spouse, your spouse's signature is required indicating consent to the change. A change will become effective on the date you sign a new enrollment card if that card is received by the Trust prior to the issuance of benefits.

Section 4, Consent of Beneficiary

You are not required to obtain the consent of a previous beneficiary before changing your beneficiary designation, unless you are removing your spouse as primary beneficiary. If you name someone other than your legal spouse, the spouse's signature indicating consent to this change is required.

Section 5, Optional Methods of Settlement

Your beneficiary may elect certain monthly installments, based on the amount of your insurance benefits, in place of a lump sum payment. The Insurance Company should be contacted if your beneficiary wishes this option.

Section 6, Dependent Life Insurance Benefits

Your eligible dependents are covered, and applicable Benefits are payable to you if: (a) Dependent Life Benefits are included on the Schedule of Life Benefits page; and, (b) the applicable contributions have been paid for the month in which the dependent's death occurs.

Section 7, Continuation of Life Insurance Benefits

You should refer to Part III, Continuation of Coverage, and Part IV, Benefits Extension, for the provisions that affect the continuation of your life insurance benefits if you stop full-time active employment for any reason other than your death.

You are eligible to convert your group life insurance into an individual life insurance policy because your employment ends or because you are no longer in an eligible class of employees for a reason other than (1) the group policy has terminated; (2) the Employee Life Insurance under the group policy has been terminated; or (3) your employer has ceasedto be a contributing employer. To be eligible, you must apply and pay the first premium within 31 days from the date your coverage ends.

A covered person can convert his/her coverage to permanent life insurance on a policy form the carrier then issues, without the optional riders, in an amount not to exceed the amount of insurance that is terminating under the Blanket Master Policy. Conversion coverage will not be provided for AD&D or Supplemental Life Insurance. The premium for the permanent coverage will be based on the Covered Person's Attained Age and class of risk at the time of conversion, together with the form and amount of insurance chosen. No evidence of insurability will be required.

Section 8, Continuation of Dependent Life Insurance

If the Schedule of Life and Accidental Death Benefits page shows coverage for Dependent Life, you may elect to continue such coverage by self-payment of contributions during any period when you are totally disabled. This privilege will end if applicable contributions are not paid, or if the Plan's Dependent Life Benefits are canceled.

Part X, Pharmacy Benefit Network

Section 1, Pharmacy Benefit Network

UABT contracts with a network of independent and chain-store pharmacies which agrees to furnish prescription medications for a set fee schedule. Your use of these pharmacies will limit your expense for prescription medications to a designated co-payment referenced in your Schedule of Prescription Medication Expense Benefits or your Schedule of Medical Expense Benefits. Refer to Part XI, Section 9 for Pharmacy Charges.

Section 2, Panel Pharmacy Services

When you or your eligible dependent chooses to fill a covered prescription for up to a thirty-four (34) day supply at a panel pharmacy, you will pay a designated co-payment and the balance of the cost of the medication will be paid in full by UABT after deductible, if applicable. UABT's Panel Pharmacy Services is designed to provide coverage for generic equivalents, formulary medications and brand medications. (Refer to your Pharmacy Benefit Schedule for details of your pharmacy benefits.

Section 3, Mail Order Pharmacy

When you or your eligible dependent chooses to fill a covered prescription for up to ninety (90) day supply, through UABT's mail order program, you will pay a co-payment to the mail order pharmacy and the balance of the cost of the medication will be paid in full by UABT after deductible, if applicable. The mail order option is designed for maintenance (long-term) prescriptions.

Section 4, Specialty Medications

Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy Programs. Prescriptions for these types of drugs require a prior authorization. (Call the UABT Member Services Department at 800.223.4590 for assistance).

Section 5, Appeals of Denied/Adverse Benefit Determinations

The PBM shall conduct the first level of internal appeals of denials and/or adverse benefit determinations consistent with your UABT Pharmacy Benefit Schedule of Benefits. The PBM will proved all applicable benefit of rights and appeal notifications to you or your eligible dependent relating to such first level of internal appeals in accordance with the UABT Plan and all applicable federal laws.

To appeal a pharmacy benefit denial or adverse determination, you must submit a written request (letter, emails, etc.) which are reviewed by the PBM Grievance and Appeals Coordinator. Within five (5) days of receipt of your letter, you will be notified that your letter has been received.

The PBM Grievance and Appeals Coordinator reviews the information submitted by you and contacts prescribing provider to obtain any additional documentation necessary for a clinical review. The clinical review is conducted by an independent pharmacist and will be completed within thirty (30) days of receiving the written appeal.

If the PBM Grievance and Appeals Coordinator upholds the denial or adverse benefit determination, you have the right to appeal to UABT pursuant to the Part XIV, Section 9.

Part XI, Medical Plan Benefits

You and your eligible dependents are covered for the benefits described on the Schedule of Medical Expense Benefits or Benefit Summary if applicable contributions have been made on your behalf for the month in which the covered expense is incurred.

Any benefits described in the Schedule of Medical Expense Benefits, Benefit Summary or this Summary Plan Description will be a covered expense. Any applicable Co-Payments, Coinsurance or Deductible will be collected by the provider or hospital providing care. The remaining amount of covered expense will be paid at the Percentage shown, up to the Plan Maximum, from UABT to the provider or hospital providing care.

The specific types of covered services are described in the following sections, subject to all the definitions, exclusions and limitations contained in the other Parts of this summary - including the provisions outlined in the Schedule of Medical Expense Benefits.

UABT does not require you to select a primary care provider. We encourage you to select a primary care provider. You do not need an authorization or referral to receive care or a consultation. Procedures or surgeries may need to be authorized. However, many specialists will not schedule your appointment without a referral from your primary care provider. If your specialist requires an authorization or referral, please contact your primary care provider.

Since you not required to select a primary care provider, no provider is required to meet specific treatment targets, specific numbers, maximum duration of visits or any other metric to receive payment. Provider compensation does not include any incentives or penalties related to your care.

You may obtain services outside of the network if your plan provides for this coverage in your Benefit Summary. Cost sharing will apply unless you have met your out of pocket maximum.

Consistent with federal law, you may access the emergency room for any emergency as determined by you. You may access care from any provider consistent with the provider's office hours including nighttime and weekends.

Your provider will know if a service requires a prior authorization and will request the referral for you. If your provider does not know how to request a prior authorization, your UABT ID card has the phone number for authorization on the back of your card. If your coverage is terminated and then you reenroll in UABT coverage causing a gap in coverage with UABT, you will need to obtain a new prior authorization for services.

UABT may only retroactively deny coverage for an emergency or prior authorized service if you fail to pay your premium (contribution) or if you commit fraud.

Section 1, Not Covered Medical Expenses

In addition to the General Definitions, Provisions and Limitations of the Plan, the following charges are not considered covered expense under the terms of the Plan. No benefits are payable for:

(a) Marriage counseling, nutritional supplements except as specified under Preventive Care, diet management, non- therapeutic occupational therapy, massage therapy, educational therapy, therapy directed toward Activities of DailyLiving (ADL), commercial exercise programs, gym, spa or health club memberships (however, marriage counselingand behavioral counseling is covered when services are rendered through Telemedicine);

(b) Transportation costs for travel by scheduled airline, railroad, bus, taxi or other commercial carrier, regardless of destination or purpose unless permitted as part of our Mexican Panel Network benefits, Transplant Program or abortion services.

(c) Cosmetic surgery (as defined in Part V, Section 21) does not apply to expense incurred for repair of an injury sustained within one year of an accident which occurred while the person was covered for benefits under the Plan,for correction of congenital deformity in a child who was eligible under the Plan at birth, and/or to post-mastectomy reconstructive surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema).

(d) Eyeglasses (with the exception of any pediatric vision services required to meet Minimum Essential Benefits underACA) or hearing aids; diagnosis or surgical correction of refractive error including, but not limited to, radial keratotomy, keratoplasty and/or laser eye surgery; visual motor training or other eye exercises, unless performed in lieu of surgery to correct an eye muscle disorder The Plan will pay for lenses or contact lenses to correct an impairment directly caused by an accidental injury or intraocular surgery (such as cataracts. The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of the purchase. Vision therapy may be covered if medically necessary and the services are performed by a licensed board-certified physician practicing within the scope of his/her license.

(e) Donor charges and expenses for organ transplants incurred by a non-UABT participant.

(f) Surrogate parenting (implementation of embryos and sperm) and pregnancy related medical care for the non-participant/non-dependent and/or procedures designed to reverse a previous elective sterilization, in-vitro fertilization,artificial insemination, zygote transfer, hormone therapy or any other services intended as treatment of infertility.

(g) Medical or surgical treatment related to sexual dysfunction...
(h) Use of growth hormone therapy unless demonstrated growth hormone deficiency has been medically substantiated and is determined to be medically necessary.
(i) Gait training or therapies toward Activities of Daily Living (ADL), with the exception of any therapies required to meet Essential Health Benefits under ACA.
(j) Services provided by an unlicensed provider or by any provider not acting within the scope of his/her/its license.
(k) Non-surgical treatment of feet, including but not limited to treatment of weak or fallen arches, flat or pronated feet,metatarsalgia, bunions, hammer toes, paring or excision of corns or callus, or trimming of toenails.
(l) Items or services specifically listed as not payable under Sections 2 through 23.
(m) Complications resulting from or related to a non-covered service or supply.
(n) Biofeedback..
(o) Gene Therapy and Cell Therapy.
(p) Penile implants.
(q) Home births or labor and delivery outside of an accredited medical facility.

Section 2, Hospital Charges (In Patient)

The Plan provides reimbursement for covered expense incurred in a facility that meets the Plan definition of a hospital, including: (a) room and board, and (b) other necessary medical services and supplies furnished by the hospital during hospital confinement.

No benefits are payable for (a) custodial or maintenance care; (b) occupational therapy which does not meet the plan definition of covered expense; (c) non-medical and personal items (d) over-the-counter medications except as specified under Preventive Care; and (e) high-cost implants, unless the hospital claim includes an invoice showing actual cost of thedevice(s). Covered expense for implants is limited to a maximum of 3 times the actual cost of the equipment, as verified by the invoice unless a different provision for implant is specifically defined in the facility's network contract.

Section 3, Hospital Charges (Outpatient) and Out Patient Surgical Centers

Covered expense incurred in the outpatient department and/or emergency room of a hospital is generally allowable, but benefits may be limited if the treatment was not for a medical emergency.

You should be aware that you save significant amounts of money when you visit a doctor's office for treatment of routine illness, instead of going to a hospital emergency room or out-patient clinic. Your Plan provisions take this into account and may limit coverage for non-emergency outpatient hospital charges to the benefits which would have been payable if you had gone to a doctor's office. Charges for "use of facility" will not be considered covered expense unless the treatment was for a medical emergency, accidental injury or surgical procedure.

Covered Expense for services rendered in a free standing, *outpatient surgical center* must meet the plan definition of Maximum Allowable Charge and/or Usual and Customary fees (Part V, Section 87). If two or more procedures are performed during the same operative session, covered expense will be determined based on full value for the major procedure, 1/2 value for any secondary procedure and 1/4 value for any other procedures that add significant time and complexity to the overall surgical session unless otherwise specified in the providers' network contract. Incidental procedures during the same operative session are not givenadditional consideration.

No additional consideration will be allowed for high-cost implants, unless facility's claim includes an invoice showing the cost of the device(s). If approved, Covered Expense will be limited to a maximum of 3 times the actual cost, as verified by the invoice, unless a different provision for implants is specifically defined in the facility's network contract.

Section 4, Convalescent Hospital, Skilled Nursing Facility or Extended Care Facility

Benefits are payable for necessary confinement if: (a) such charges are included as covered expense in the Schedule of Medical Expense Benefits; and (b) all conditions of any such provision have been met. No benefits are payable for custodial, rehabilitative or maintenance care.

Section 5, Professional Ambulance Service

Benefits are payable for Medically Necessary transportation by a licensed, professional ambulance service to or from the nearest hospital where appropriate care is obtainable for the sickness or injury requiring treatment (excluding charter flights).

UABT may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation cannot provide. Services of air ambulance must be pre-authorized by UABT.

Section 6, Doctor Care

Applicable benefits for office, home or hospital visits are shown on the Schedule of Medical Expense Benefits. Benefits are also payable for covered expense incurred in connection with surgery, diagnostic laboratory and X-ray services and anesthesia when such services are rendered by a practitioner who meets the Plan definition of a doctor.

Section 7, Surgery and Anesthesia

If two or more procedures are performed during the same operative session, benefits for surgery will be determined based on full value for the major procedure, 1/2 value for any secondary procedure and 1/4 value for any other procedures that adds significant time and complexity to the overall surgical session unless otherwise specified in the provider's network contract. Incidental procedures during the same operative session are not given additional consideration.

The Trust reserves the right to determine appropriate value for multiple procedures, based on the information submitted at the time of the claim.

Covered expense for an Assistant Surgeon is limited to 20% of the primary surgeon's allowance. If a second assistant is medically necessary, covered expense will be limited to 15% of the primary surgeon's allowance.

A Certified Surgical Assistant is allowable in place of, but not in addition to, an assistant surgeon. Covered expense for a CSA serving in such capacity is limited to 15% of the primary surgeon's allowance.

Surgical and anesthesia services may be limited to a specific table of benefits, referred to as the "Plan Surgical Sched ule". If so, a representative sample of the schedule is included for your reference.

Section 8, Technician, Laboratory or Clinic Fees for Diagnostic Tests

Applicable benefits are shown on the Schedule of Medical Expense or Plan Summaries Benefits for diagnostic X-rays and laboratory tests ordered by a doctor and analyzed and read by a doctor to assist in diagnosing and/or treating a covered illness or injury.

Section 9, Pharmacy Charges

Pharmacy charges will be considered a covered expense for purchase of specific drugs or medicines that cannot be legally dispensed without a doctor's written prescription. Applicable benefits for such expenses are shown on the Schedule of Medical and/or Prescription Medicine Expense Benefits.

If the plan has a separate prescription medication out of pocket maximum, the prescription medication out of pocket maximum combined with the medical expense out of pocket maximum shall not exceed the federally determined out of pocket maximum for the plan year.

Pharmacy benefits are payable for contraceptive medications and medications for treatment of erectile dysfunction. No medical or pharmacy benefits are payable for prescription drugs or medicines used to enhance sexual performance, assist fertility, improve cosmetic appearance, or suppress appetite.

No benefits are payable for any over-the-counter medicines or preparations, vitamins, minerals, dietary supplements, or any other items that can be legally purchased without a doctor's written prescription, whether or not such prescription has been written with the exception of prescription prenatal vitamins, minerals, dietary supplements prescribed by a doctor for treatment during pregnancy except to the extent as required by the Affordable Care Act.

Section 10, Formulary Drugs

A drug formulary is a list of preferred, covered medications recommended to prescribing physicians. If applicable to your Schedule of Prescription Medication Expense Benefits formularies promote the use of medications chosen which are equally effective and less costly than alternative drugs. UABT will provide you with a list of the formulary medications for your Prescription Plan. This list is subject to change without notice.

Over-the-counter products, except as specified under Preventive Care, injectables and other medications listed on the formulary may not be covered if specifically excluded by other provision(s) of this Summary Plan Description.

Section 11, Orphan Drugs, Products and Devices

An Orphan Drug, product, biologic, device or medical food must have been approved by the FDA Office of Orphan Products Development (OOPD). UABT will consider Orphan Drugs, Products and Devices a covered expense after the drug, product or device has been approved by OOPD.

Section 12, Nursing Services

Services of a licensed Registered Nurse (RN), when rendering services ordered by or performed under the direct supervision of a doctor, provided that the services performed required the skills and training of a RN and are within the scope of practice covered by the nurse's license.

Services of a licensed, private nurse at home or during an approved convalescent hospital confinement, are covered if a claim qualifies for Major Medical Benefits and the services of a nurse: (a) were ordered by the doctor; (b) were medically

necessary services requiring the specialized training of a nurse; and, (c) were not primarily housekeeping, personal hygiene, meal preparation or custodial care.

No benefits are payable for private duty nursing while a patient is confined in a hospital as a registered bed patient.

Section 13, Cobalt, Chemotherapy or Radiotherapy Expense

Charges for expense incurred during hospital confinement are payable under the Hospital Services Benefits. If a claim qualifies for Major Medical Benefits, then covered expense for out-patient cobalt therapy, chemotherapy or radiotherapy will be payable under the applicable Major Medical Benefit provisions.

Section 14, Physical Therapy, Speech Therapy and Acupuncture

Expense incurred for physical therapy during a hospital confinement will be considered payable under the Hospital Services Benefit. The term “physical therapy” includes medically necessary habilitative, rehabilitative and occupational therapies.

A patient can self-refer to a physical therapist for up to a the maximum listed in the Schedule of Benefits or Benefit Summary. Benefits may be limited to a number of combined maximum visits for therapy based on the Schedule of Benefits and/ or Plan Summaries. Any additional visits must have a physician’s prescription and prior authorization by UABT.

If your claim qualifies for coverage, and such services are not excluded under your specific plan (see your Schedule of Medical Expense Benefits or Plan Summaries), covered expense for outpatient physical therapy or acupuncture performed by or under the written direction of a “doctor” (as defined in Part V, Section 29) will be allowable if the treatment is medically necessary to restore an impaired bodily function or to alleviate pain. When rendered by another practitioner, your progress must be monitored by the prescribing doctor on a regular basis

No benefits are payable for speech therapy, unless the patient had normal speech which was interrupted or impaired by illness or injury. Speech therapy for developmental speech disorders for a dependent child is considered a Covered Expense subject to evidence of medical necessity.

No benefits are payable for massage therapy, gait training, acupuncture for other than pain management, occupational therapy which does not meet the plan definition, or therapy directed toward improvement of skills required for Activities of Daily Living (ADL) with the exception of those therapies required to meet the Minimum Essential Benefits required under ACA. Prior authorization is required for acupuncture services that extend beyond eight (8) visits.

Section 15, Medical Supplies and Durable Therapeutic

Expense incurred for medical supplies and equipment while hospital confined is payable under the Hospital Services Benefits. If the claim qualifies for Major Medical Benefits, covered expense for necessary medical supplies, including oxygen, standard model electric wheelchairs, and similar therapeutic equipment will be allowable with the following restrictions:

(a) the supply, appliance or equipment must be ordered by a doctor;
(b) the covered item must be strictly for use in treatment of the patient, and not for general family use;
(c) if the item is rentable from a medical or surgical supply house, covered expense will not exceed the rental fee for the number of months usage which is certified by the doctor as medically necessary;
(d) Covered expense for rental will not exceed the Plan Maximum Allowable Amount for purchase of the equipment;
(e) if the item is not rentable, it must be a specialty item which is not obtainable in a regular drug or department store.

No benefits are payable for Jacuzzi, spa, sauna, barbells or other home exercise equipment, home air-conditioning units, ramps, or other home building modifications to facilitate wheelchair access, luxury attachments, deluxe designs or motorized attachments, foot orthotics, tanning equipment, personal comfort items, commodes, devices to assist with personal hygiene or any similar items regardless of prescription or purpose.

Section 16, Prosthetic Devices

If the claim qualifies for Major Medical Benefits, covered expense will include: (a) the initial prosthesis for replacement of a limb or eye removed while the patient was eligible under the Plan; (b) an initial prosthesis needed to correct a congenital deformity of a child and replacement prostheses as the child matures; or, (c) repair of such a prosthetic device

Section 17, Psychological Services, Mental and Nervous Disorders

Generally recognized treatment of one or more of the Mental, Nervous and Behavioral Disorders categorized and defined as such in the most current edition of the international Classification of Diseases (ICD-10) will be paid as any other claim.

Covered Expense for treatment of Autism Spectrum Disorders including but not limited applied behavioral analysis will be limited to dependent children as defined under Part I, Section 4.

No benefits are payable for: (a) marriage or family counseling or (b) behavioral modification, educational therapy or any other therapy directed toward learning disabilities, however some behavioral health benefits may be available through UABT's Telemedicine program.

Section 18, Home Health Services

Covered Expense for Home Health Services includes skilled nursing care by an RN or LVN, laboratory tests and/or diagnostic X-rays, medical supplies, prescription drugs and physical therapy which would have been necessary had the patient remained in the hospital.

Section 19, Hospice Care

Covered Expense for Hospice Care includes any services performed or supplies dispensed for treatment of terminal illness where life expectancy approximates six (6) months or less provided such services are rendered by a provider approved by the National Hospice Organization and UABT.

Section 20, Special Rights Upon Childbirth

UABT does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods.

Section 21, Genetic Information

The Genetic Information Nondiscrimination Act (GINA) makes it illegal for group health plans and most employers to discriminate against you based upon your genetic information. UABT does not request genetic information, nor does it use your genetic information when making decisions regarding your eligibility or contribution/premium rates.

Section 22, Family Planning Services

Covered Expense includes family planning services by a contracting provider. Services include birth control pills or patches, condoms, injectables, diaphragms, IUDs, emergency contraception services (e.g., Plan B) and follow-up care; GYN exams; physician pregnancy testing and counseling; physician screening and counseling for sexually transmitted infections, HIV, pap smears, and urinary tract or female-related infections; and, male and female sterilization. Fertility treatments are not covered.

Section 23, Genetic Testing

Covered Expense includes genetic testing that is medically necessary for the diagnosis (when conventional diagnostic procedures are inconclusive); if patient risk factors or a particular family history indicate a genetic cause; when the patient meets defined criteria that place them at high genetic risk for the condition; if the test is not considered experimental; investigational and is an procedure approved by CMS; when the test is performed by a CLIA-certified laboratory; test result will directly influence the disease treatment management; and if testing is accompanied by pretest and post-test counseling. Genetic testing is not a Covered Expense for population screening without a personal or family history, with the exception of newborn screening and preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease and other hemoglobinopathies; informational purposes; minors for adult-onset conditions and a relative of a plan member who in not also a plan member.

Section 24, Preventive Care

Charges for Preventive Care services. UABT intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing. Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). See the following websites for more details:

a) https://www.healthcare.gov/coverage/preventive-care-benefits/;
b) https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
c) https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
d) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
e) https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/
f) https://www.hrsa.gov/womensguidelines/.

NOTE: The Preventive Care services identified through the above links are recommended services. It is up to the Providerand/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no

Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regard- less of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

a) **Preventive and Wellness Services for Adults and Children** - In compliance with section 2713 of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in thecurrent recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

a) **Women's Preventive Services** - With respect to women, such additional Preventive Care, and screenings as pro-vided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) nototherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guide- lines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1) Well-woman visits.
2) Gestational diabetes screening.
3) Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4) Sexually transmitted infection counseling.
5) Human Immunodeficiency Virus (HIV) screening and counseling.
6) Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7) Breastfeeding support supplies and counseling.
8) Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/

Section 25, Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

1) The clinical trial is approved by any of the following:
   a) The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
   b) The National Institute of Health.
   c) The U.S. Food and Drug Administration.
   d) The U.S. Department of Defense.
   e) The U.S. Department of Veterans Affairs.
   f) An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2) The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as paymentin full for routine patient care provided in connection with the Approved Clinical Trial.

The following items are excluded from approved clinical trial coverage under this Plan:

1) The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2) The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for aparticular Diagnosis.
4) A cost associated with managing an Approved Clinical Trial.
5) The cost of a health care service that is specifically excluded by the Plan.
6) Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for bythe research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Section 26, Smoking Cessation

Covered Expense for smoking cessation includes medically necessary services by a contracting provider and FDA approved prescription medications. Covered expense is limited to two (2) sessions in any 12 consecutive months.

Section 27, Transplants

Allowable expenses incurred for covered transplant procedures during an eligible Participant's or Dependents' Transplant benefits period will be payable provided that:

You or your dependent call the UABT Member Services Department for a referral to a Center of Excellence. (A Center of Excellence is a hospital that has specialized facilities – physicians and other practitioners whose specialty includes organ transplants. You must use a Center of Excellence facility, except when an alternative is approved by the UABT Medical Review organization. If you do not use a Center of Excellence (unless otherwise approved by Medical Review), the non-PPO benefits will apply to all care related to the organ transplant.

UABT will reimburse the following Covered Expenses incurred as the result of a covered Transplant Procedure for you or your dependent:

(a) Transportation of recipient and a companion to and from the site of the transplant. If recipient is a minor, transportation for two persons who travel with the minor will be covered. Reasonable and necessary lodging and meal costs incurred in the interim by such companions are included, except there is a daily limit of $200 for all lodging and meal costs. Total payment for all transportation, lodging and meal costs for all persons for the Transplant Procedure shall not exceed $5,000.

(b) Hospital room and board and medical supplies.

(c) Diagnosis, treatment and surgery by a Doctor.

(d) Nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.)

(e) Rental of wheelchairs, hospital-type beds and other mechanical equipment required to treat respiratory impairment.

(f) Local ambulance service, medication, x-rays, and other diagnostic services, laboratory tests, oxygen.

(g) Rehabilitation therapy, including speech therapy (not for voice training or a lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy.

(h) Surgical dressings and supplies

(i) Plan benefits will be provided to an organ donor for Covered Expense incurred by an eligible UABT participant, provided the expenses incurred are directly related to the transplant surgery and are not payable by any other medical plan in the absence of this Plan's coverage.

(j) UABT will pay Covered Expense for the following Transplant Procedures:

1) Bone Marrow
2) Heart
3) Heart/Lung
4) Liver
5) Lung
6) Kidney/Pancreas
7) Kidney
8) Cornea

l) No benefits will be payable for the (i) animal and/or mechanical organs except as provided for above; (ii) any expenses incurred for which you would not legally have to pay if there was no coverage for benefits; (iii) custodial care; (iv) if you or your dependent lose coverage under the Plan; (v) any organ or tissue transplant required as a result of an accidental injury or illness not covered by UABT; and (vi) any transplants which are considered to be experimental.

Section 28, Elective Abortion

Allowable expenses incurred for elective abortion procedures during an eligible Participant's or Dependents' benefits period will be payable provided that:

You or your dependent call the UABT Member Services Department to determine legal abortion within your state of residence. If elective abortion is not legal in your state or your Dependent's of residence, travel to the next closest state where abortion is legal will be provided to you. Travel costs may be covered as explained below.

UABT will reimburse the following Covered Expenses incurred as the result of a covered elective abortion for you or your dependent:

(a) Hospital room and board and medical supplies.

(b) Diagnosis, treatment and procedure by a Doctor.

(c) Nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

(d) Necessary diagnostic services and laboratory tests.

(e) Surgical dressings and supplies
(f) If elective abortion is not covered in your state or your Dependent's of residence, transportation for two persons (the patient and a companion) will be covered. Referral and authorization to travel to the nearest state is required. Reasonable and necessary lodging and meal costs are included, except there is a daily limit of $200 for all lodging and meal costs. Total payment for all transportation, lodging and meal costs for all persons for the procedure shall not exceed $5,000.

Section 29, Hormone Replacement Therapy

Hormone replacement therapy (HRT) using synthetic, animal-derived or bioidentical hormones delivered through any medically necessary method. Covered services includes testing an analysis required to determine appropriate treatment.

Section 30, Gender Identity Disorder Treatment

Coverage for medical benefits under the Plan shall not be denied or limited based on the individual's actual or perceived gender identity or because the individual is transgender. Additionally, medical services that are ordinarily or exclusively belong to one sex will not be denied to the other sex or to an individual who is in the process of undergoing, or has undergone, gender transition.

Treatment for transgender transition will be subject to the terms and conditions of the plan that apply to covered medical conditions, including, but not limited to, Medical Necessity, Utilization Review and exclusions for cosmetic services.

Medically Necessary services related to gender transition are a Covered Expense if comparable services are also covered when not related to gender transition, including but not limited to, transgender surgery, hormone therapy, hysterectomy, mastectomy, breast reconstruction, surgical treatment for gynomastia, reconstructive surgery for genital abnormalities, and vocal training.

Section 31, Pediatric Hearing Aids

Coverage for hearing aids for children age 18 and under are covered in Colorado and Oregon. Cost sharing may be required as permitted by law. Please see you Schedule of Benefits or Plan Summary for more information.

Part XII, Dental Plan Benefits

This section is intended to be used in conjunction with your Schedule of Dental Expense Benefits under your elected Dental Plan. Dental benefits are available for covered charges incurred by eligible Plan Participants. The Plan's payment will be limited to the Maximum Allowable Amount and/ or benefit maximums as defined in the Schedule of Dental Expenses.

Section 1, Deductible

Your Deductible is listed on your Schedule of Dental Expense Benefits. This Deductible amount is required for each eligible family member per Calendar Year. The Deductible is the amount of Covered Expense that must be incurred before benefits are payable. Charges that do not qualify as Covered Expense cannot be used to satisfy the Deductible.

Section 2, Percentage Payable

Your Percentage Payable is listed on the Schedule of Dental Expense Benefits. It is the percentage of Covered Expense payable after any applicable Deductible has been satisfied.

Section 3, Plan Maximum

Your Plan Maximum is listed on the Schedule of Dental Expense Benefits. This amount of Covered Expense is the aggregate of benefits payable during any one Calendar Year.

Section 4 Alternate Dental Procedures

If two or more procedures, services or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for payment. Such determination will be made at the Plan's discretion based upon professionally endorsed standards of care.

Section 5, Preventative Dental Services

Preventative Dental Services are detailed in your Schedule of Dental Expense Benefits and may include:

(a) Exams & Cleaning, Routine: Routine oral examinations and routine cleaning and polishing of the teeth. Limited to two (2) in a twelve (12) month period.
(b) Fluoride: Topical application of stannous or sodium fluoride. May be limited to age 19 and under. See your Schedule of Dental Expense Benefits for more information.
(c) Palliatives: Emergency treatment for the relief of dental pain.
(d) Prophylaxis: see "Exams & Cleanings, Routine."
(e) Sealants: Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration. May be limited to age 19 and under. See your Schedule of Dental Expense Benefits for more information.
(f) X-Rays: "Full mouth" X-rays one (1) every every twenty-four (24) months and routine bitewing X-rays two (2) series every twelve (12) months .

Section 6, Basic Dental Services

Basic Dental Services are detailed in your Schedule of Dental Expense Benefits and may include:.

a) Anesthesia: General anesthesia when administered in connection with oral surgery or when deemed medically necessary by the Plan. Note: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself. (the Plans I have administered cover IV sedation and Nitrous Oxide)
b) Restorative crowns
c) Stainless Steel Crowns
d) Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable. See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on veneer or facing (i.e."tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.
e) Endodontia: Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.
f) Extraction: See "Oral Surgery".

g) Filing, NON-Precious: Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary. Note: For teeth posterior to (behind) the second bicuspid, an allowance for amalgam fillings will be made. See “Cosmetic Dentistry” in the list of **Dental Limitations and Exclusions**

h) Injections: Injection of antibiotic drugs.

i) Oral Surgery: Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, Injury and defects of the oral cavity and associated structures. We cover Wisdom Teeth extractions under medical—need to verify that this should say simple extractions or strike impacted. We would also cover biopsies or other surgeries of the mouth in conjunction with a medical DX under the medical plan typically)

j) Pathology: Laboratory services required for dental procedures.

k) Periodontia: Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

l) Re-Cementing: Re-cementing of a crown, inlay, bridge or denture.

m) Visits, Non-Routine: Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure. Professional visits after hours.

n) X-Rays: Dental X-rays not included in Preventive.

Section 7, Major Dental Services

Major Dental Services are detailed in your Schedule of Dental Expense Benefits and may include:

a) Abutment crowns.

b) Implants: Materials implanted into or on bone or soft tissue and all related services or supplies, or the removal of implants, up to the allowance for a bridge or partial. (Verify)

c) Onlays & Gold Restoration: Initial placement of an inlay, onlay or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration. Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable. See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on "tooth-colored" restorations.

d) Prosthetics: Initial placement of a full or partial denture or bridge to replace one or more natural teeth that are extracted while the person is covered hereunder. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement. Replacement of or addition of teeth to an existing full or partial denture or bridge, but only if: a) the replacement or addition of teeth is required because of the extraction of one (1) or more natural teeth while the person is covered hereunder; b) the existing denture or bridge cannot be made serviceable and is at least five (5) years old; or, c) the existing denture is an immediate temporary denture to replace one (1) or more natural teeth and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

e) Repairs & Adjustments: Repair of a crown, inlay, bridge or denture or the relining of a denture. Prosthetic adjustments, but only for services provided more than six (6) months after placement.

Section 8, Orthodontia

If Orthodontia is a Covered Expense in the applicable Schedule of Dental Expense Benefits**,** services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth including:

a) initial consultation, models, X-rays and other diagnostic services;
b) initial banding or placement of orthodontic appliance(s);
c) periodic adjustments; and
d) retainers.

Orthodontia benefits will begin upon submission of proof that the orthodontia treatment program has begun. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for Orthodontia Services is shown in the “Plan Maximums” in the applicable Schedule of Dental Expense Benefits. This maximum applies to the entire period(s) a person is covered hereunder. May be limited to age 19 and under. See your Schedule of Dental Expense Benefits for more information.

Dental Limits and Exclusions

Except as specifically stated, no benefits will be payable under this Plan for:

(a) Services performed for surgical repositioning of the jaw or solely for cosmetic reasons.

(b) Replacement of a bridge or denture within 5 years of the original date of installation for any reason, including loss or theft, unless:

i. Necessity because of placement of a new opposing appliance;
ii. Due to extraction of additional natural teeth; or,
iii. The appliance, while in the patient’s mouth was damaged beyond repair by an accidental injury.

(c) Replacement of any bridge or denture, which is satisfactory or can be made satisfactory.
(d) Any appliance or restoration, except full dentures, where the primary purpose is to change position of the teeth, stabilize teeth involved in periodontal or restore and/or maintaining occlusion.
(e) Duplicate dentures or appliance, regardless of diagnosis, or protective mouth guards.
(f) Experimental procedures, training in plaque control or oral hygiene, or dietary instruction.
(g) Charges for a patient's failure to keep a scheduled appointment or for completion of claim forms.
(h) Charges for dental services for which the covered person is not legally required to pay.
(i) Charges for dental services or supplies, which are covered under any other group plan, covered or sponsored by the employer.
(j) Any care, treatment service or supplies for an Injury or Illness sustained while doing any act or thing pertaining to any occupation or employment for pay or profit.
(k) Any care, treatment, service or supplies for which the covered person is entitled to benefits under Workers' Compensation or any similar law.
(l) Any care, treatment, service or supplies resulting an injury or illness sustained while on active duty in the armed forces.
(m) Services and supplies not reasonably necessary, or not customarily performed.
(n) Loss caused by or contributed to by war or an act of war, whether declared or not.
(o) Services performed for correction of congenital or developmental malformations.
(p) Charges for relining or rebasing a denture/partial within the first six (6) months after the appliance was placed.
(q) Charges for additional treatment necessitated by lack of patient cooperation with the dentist, or noncompliance with prescribed dental care, which results in additional liability.
(r) Adjustment of prosthetic appliances within six (6) months of initial installation and not included in the cost of such appliance.
(s) Pontics for reasons other than replacement of missing teeth.
(t) Charges for characterizations of crowns, dentures or bridgework.
(u) Charges for facings, veneers or similar material placed on molar crown or pontics.
(v) Charges for take home items such as fluoride rinse, tooth brushes and floss.
(w) Charges for any temporary procedure or appliance, other than a Temporary Crown.
(x) Charges for application of desensitizing medications.
(y) Charges for services involving tooth transplants.

Part XIII, Vision Plan Benefits

This section is intended to be used in conjunction with your Schedule of Vision Benefits under your elected Vision Plan. Vision benefits are available for covered charges incurred by eligible Plan Participants. The Plan's payment will be limited to the Maximum Allowable Amount and/ or benefit maximums as defined in the Schedule of Vision Benefits.

UABT offers two types of vision Plans: an indemnity Plan without a network and network Plan that uses the VSP Network of practitioners and providers who provide necessary vision services at a minimal charge to you. If you have questions about your indemnity Plan, please call Member Services at 1-800-223-4590. To find a participating VSP provider in your area, contact VSP's Customer Service Department at 1-800-877-7195.

After any applicable Copayment, the Participating Provider will accept fees as payment in full for the balance of covered services. If you choose not to use a Participating Provider, a benefit amount for each service is listed in your Schedule of Vision Benefits.

Section 1, Vision Copayment Amount

Your Copayment is listed on the Schedule of Vision Benefits.

Section 2, Vision Benefit Maximum Amount

Your Benefit Maximum is listed on the Schedule of Vision Benefits.

Section 3, Vision Plan Benefits

Vision Examination: (each 12 months). A complete analysis of the eyes to determine the presence of vision problems or abnormalities.

Lenses: (each 12 months). Plan provides necessary single vision, bifocal, trifocal, or lenticular lenses. Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26..

Contact Lenses: (each 12 months) Contact lenses are available once every 12 months in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Covered Person shall not be eligible for lenses and frames again for 12 months. Please see your Schedule of Vision Benefits for coverage of Necessary and Elective lenses. Copayment may apply.

Frames: (each 24 months). Offers a selection of standard frames. If You select a frame that costs more than the standard, or a large frame that requires oversize lenses, there will be an additional charge to You.

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Extra Costs: The Plan is designed to cover your visual needs, not cosmetic materials. If you select any of the following and your VSP Participating Provider does not receive prior approval, there may be an extra charge to you and can be added at your option:

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.

- Contact lenses (except as noted elsewhere herein).

- Services and/or materials not indicated on your Schedule of Vision Benefits.

Experimental: A treatment of an experimental nature is one that is not used universally or accepted by the vision care profession, as determined by VSP.

Prior Authorization: Certain benefits require prior authorization to VSP before such benefits are covered. If You would like more information
regarding VSP's criteria for authorizing or denying benefits, You may contact VSP's Customer Service Department at 1-800-877-7195.

How to Use Your Vision Service Program
Network Claims for vision care are paid by Vision Service Plan, P.O. Box 254500, Sacramento, CA 95865. However, to use the Plan correctly, You should:
1. Call Vision Service Plan for a listing of member doctors at 1-800-877-7195.
2. Select a member doctor and make an appointment. Within the limits of the Plan you will be required to pay a Plan Copayment for all services of a VSP Participating Provider.

Vision Limits and Exclusions

No vision benefits will be provided for:

(a) **Employment-Required Services:** Any eye examination, or any corrective eyewear that is required by an employer as a condition of employment.
(b) **Excluded Charges:** Charges excluded or limited by the Plan design as stated in this document.
(c) **No Prescription Change:** Glasses purchased when the lens prescription has not changed.
(d) **Non-Professional Care:** A vision examination performed other than by a licensed ophthalmologist or optometrist.
(e) **Non-Prescription Lenses:** Lenses that do not correct refractive error (plano lenses) or that are not obtained upon prescription by an ophthalmologist, optometrist or optician.
(f) **Orthoptics:** Services or supplies in connection with orthoptics, vision training or other special procedures.
(g) **Radial Keratotomy/Lasik/Other Refractive Correction Surgery:** Surgery to correct refractive error.
(h) **Replacement:** Replacement of lost or broken lenses or frames.
(i) **Sunglasses:** Sunglasses or photosensitive lenses.
(j) **Training:** Charges for vision training or subnormal vision aids.
(k) **Broken appointments**
(l) **No Obligation to pay:** Charges incurred for which the Plan has no legal obligation to pay
(m) Safety glasses or goggles.
(n) Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;
(o) Medical or surgical treatment of the eyes;
(p) Corrective vision treatment of an Experimental Nature;
(q) Costs for services and/or materials above Plan Benefit allowances

Part XIV, Claims for Benefits

Section 1, How to File a Claim for Medical, Prescription Medication, Dental or Vision Benefits

Claims will be adjudicated after a full and fair review in accordance with the terms of UABT and applicable law by the Plan Administrator which has the final authority to administer the Plan.

To file a claim:

1) Take your UABT Identification Card with you to the hospital, doctor or dentist.

2) No special UABT claim form is required. You or your provider may send any standardized claim form or medical bill used by the provider's office directly to the UABT Claims Department or your Preferred Provider Organization (PPO) for processing. Acceptable billing statements include any form that includes date of service, diagnosis, treatment, patient's name *and* birth date and the name, address and UABT Identification Number of the covered participant.

3) You may choose to obtain a UABT claim form from your employer, local service representative or the Trust office before going to the hospital or doctor. If so, you should complete your section of this claim form *in full*, as it applies to your claim, sign the Authorization to Release Information on the form and leave it with your provider's office for submission with their claim.

4) The UABT Plan does not allow or recognize "assignment of benefits," which many providers require as a condition of payment. If you sign such an "assignment of benefits," UABT will treat that as your authorization to remit paymentdirectly to your health care provider. UABT will remit payment directly to your provider if you so authorize but the UABT Plan does not permit or recognize any assignment of claims or legal rights of any health care provider to pursue any legal action against UABT..

5) You, or the provider, may attach any additional bills to the claim if each bill clearly indicates the name of the patient,the date(s) of each service, what was done on each date, the fee for each service and the diagnosis involved. Billsthat you have paid in full should be clearly marked to avoid reimbursement error.

6) You or the provider may need to furnish written proof that the expenses were incurred or that the benefit is covered under the Plan. If you or the provider do not provide us with the documentation provided, the claim may be denied.

7) Confirmation of eligibility or benefit confirmation by a provider does not guarantee payment of benefits. All claims are subject to the provision, limitations and exclusions of the Plan. Oral statements and representations do not override the Plan provisions.

8) Bills for prescription drugs must show the name of the patient, the date of purchase, the name of the prescribing doctor and the name of the drug. Cash register receipts are not acceptable.

Section 2, Claims Procedures

In the case of post service claims, UABT will process your claims within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended for up to fifteen (15) days in the event that additional information and/or documentation to support the claim are necessary. If such an extension is necessary, UABT will specifically state the information necessary to decide the claim and you or your representative will have at least forty-five (45) days from receipt of the notice within which to provide the specified information.

Section 3, Health Claims Payment

A check, or explanation of benefits (EOB), will be sent as soon as possible after your claim has been received. If your benefits were assigned to a provider of service, you will be notified of the settlement at the time the provider's check is mailed. Payment of benefits may be delayed if all of the necessary information is not received with the claim, or if the claim does not include itemized bills. Payments expire after 180 days if not cashed by the Provider or the Participant. A Provider or Participant may request an expired payment to be reissued within one (1) year of the original payment date. Only one (1) reissued payment will be granted. Expired payments not requested within one (1) year from the original payment date and reissued payments not cashed within 180 days will be returned to the Trust and shall not be reissued.

An "itemized bill" is one which includes the name of the patient, each date of service, what was done on each date, the charge for each service and the diagnoses being treated. A "balance due" or "balance forward" type billing is not itemized and cannot be processed for payment.

If the bill is for a prescription drug(s) the name of the patient, name of the drug, name of the prescribing doctor and the date of purchase must be included. A cash register receipt is not acceptable.

"Necessary information" includes your full name as listed in the Trust eligibility records, your birth date, UABT Identification Number and current address. If the claim is for one of your dependents, the dependent's name, birth date and relationship to you must also be indicated.

Where benefit payment is affected, "necessary information" may also include: (a) proof that the service was ordered by a doctor, (b) information on payment made by another benefit plan, (c) details of an accident, (d) third party liability information; and (e) medical, dental or employment records.

Section 4, Life and Accidental Death/Dismemberment Claims

The insurance company that has underwritten the Trust's Schedule of Life Insurance Benefits pays claims for benefits due to death or dismemberment. However, to prevent delays in claim processing, the following steps should be followed when filing claim for these benefits:

(a) The designated beneficiary or representative of the decedent's estate should contact the UABT Member Services Department (1-800-223-4590) for claim forms and filing instructions.

(b) At the time of application, the beneficiary will be advised by the Plan Administrator of all documents necessary for completion of the claim filing.

Section 5, Claim Filing Deadlines

It is important to file a claim within ninety (90) days of the date of service to assure payment. If you do not file a claim within the ninety (90) daytime limit it will not necessarily invalidate your claim if it was not reasonably possible for you to do so, provided it is filed as soon as possible thereafter. However, under no circumstances will a claim be accepted more than twelve (12) months after the date the service was rendered.

If a claim has been received but held pending receipt of additional information needed to process the charges, acceptable response must be received within one-hundred twenty (120) days of the written request, or the claim will be denied.

Section 6, Claim Denial Procedure for Medical, Prescription Medication, Dental or Vision Claims

Any claim for Benefits under the Plan must be made in writing to the UABT Claims Department. If a claim for medical, prescription medication, vision or dental benefits is denied in whole or in part, the Claims Department will notify you of the action being taken on the claim.

If a denial is necessary, such denial shall: (a) be notified by phone for urgent procedures or in writing for claims already incurred (b) be in writing, in a manner intended to be understood by the average person, (c)contain the specific reason for denial of the claim; (d) be sent within the time limits prescribed by law; and (e) include an explanation of the claims review procedure.

Section 7, Adverse Benefit Determination

An "adverse benefit determination" is any decision by UABT that involves the denial, reduction, or termination of a benefit. ... When UABT makes an adverse benefit determination, UABT will provide adequate notice of the decision.

Section 8, Review and Appeal Procedures for Denied Prescription Medication

If a claim for prescription medication is denied in whole or in part, you have the right to appeal this decision to the UABT Pharmacy Benefit Network (PBN). This appeal process will consist of a full and thorough review and evaluation of the denial of the medication.

If you do not agree with the determination of the PBN, you have the right to request review and appeal through UABT.

Section 9, Review and Appeal Procedures for Denied Medical, Prescription Medication, Dental or Vision Claims

1) If a claim for benefits is denied in whole or in part or if there is an adverse determination of benefits, you, or a representative of your choice, may request a review of the decision within one hundred eighty (180) days of the date you receive the notice of denial or limitation by the UABT Appeals Committee

2) A request for review must be in writing, addressed to the UABT Appeals Committee, c/o United Agricultural Benefit Trust Claims, 54 Corporate Park, Irvine, CA 92606-5105, telephone 1(800)223.4590. You should state the reason you are requesting review and include any additional information that might help the Appeals Committee in evaluating your claim.

3) After the claim has been reviewed, if the denial is reversed, the disputed claim will be paid pursuant to plan provisions.

4) After the claim has been reviewed and the denial upheld, the UABT Appeals Committee will: (1) notify you in writing within seventy-two (72) hours for authorizations involving urgent care ; fifteen (15) days for other authorizations; and, sixty (60) days for post-service health claims The denial notice will include a copy of the specific Plan provisions affecting the denial; and (3) let you know how to file an appeal to the Board of Trustees; provide you with new or additional evidence or rationale and a reasonable opportunity to respond to it before making a final decision on the claim. .

5) If you disagree with the conclusions reached by the UABT Appeals Committee, you may file a written appeal or request a formal hearing of the Board of Trustees within one hundred eighty (180) days of receipt of the results of the UABT Appeals Committee review. A written appeal should include: (1) your name, address and UABT Identification number, (2) the name of the patient, (3) the claim number and date of denial

notice, (4) the specific facts upon which your appeal is being made; and, (5) all documents and evidence you have supporting those facts.

6) Any appeal should be addressed to the Board of Trustees, c/o United Agricultural Benefit Trust, 54 Corporate Park,Irvine, CA 92606-5105, to the attention of Trust Counsel.

7) Board of Trustees' consideration will be based on your written statement unless you request a formal hearing. If you request a hearing, it will be conducted at the next scheduled meeting of the Board of Trustees at the scheduled location of the meeting, upon 10 days written notice to all parties. Although not necessary, you may be represented by an attorney of your choice at the hearing.

8) The Board of Trustees has full discretionary authority to interpret the Plan, and to make decisions regarding eligibility and payment of claims. The Trustees will then conduct a full and fair evaluation of the appeal and shall base its decision on the information available at the time of consideration

9) The Board of Trustees, through UABT's Legal Counsel, shall mail a written decision of the appeal to you within seventy-two (72) hours for authorizations involving urgent care (if applicable), fifteen (15) days for other authorizations and thirty (30) days for health claims after the appeal has been reviewed. The Trustees' final decision shall: (1) be written in a manner intended tobe understood by the average person; (2) include the specific reason or reasons for the decision; and (3) contain aspecific reference to the pertinent Plan provisions upon which the decision is based.

10) You must complete UABT's claim process before filing an action in court challenging the denial of a claim (all administrative remedies must be exhausted). Any court challenge to a claim denial must be filed by the patient. The assignee of benefits is not eligible to initiate a court challenge to the denied claim.

Section 10, Independent Review

If your appeal to the Board of Trustees involved a medical judgement issue or rescission of coverage (and you are not a participant in a "Grandfathered Benefit Plan") and the Board of Trustees upheld your benefit denial, you have the right to request external review of your claim within one hundred twenty (120) days after the date of receipt of the Trustee's benefit denial notice. Upon receipt of your request for an external review, UABT must complete a preliminary review of your request within five (5) business days to determine whether (a) you were covered under UABT when your treatment was provided; (b) the benefit denial was not related to your eligibility for benefits; (c) you have exhausted UABT's internal appeals process (unless you are not required to do so under the appeal regulations); and (d) you have provided all the information and forms needed to process the external review.UABT will then submit the appeal to an accredited independent review organization (IRO) to perform the external review along with the documents and any information considered in making the benefit denial. The IRO will reviewthe claim "de novo", meaning starting from the beginning, and is not bound by any decisions or conclusions reached under UABT's internal claims and appeals process.

1) Within forty-five (45) days after the IRO received the external review request, it must provide written notice of the final review decision. This notice is delivered to both you and UABT. It will contain (a) a general description of the reason for the external request; (b) date the IRO received the assignment to conduct the review and the date of theIRO's decision; (c) reference to the evidence or documentation considered in reaching the decision; (d) discussion of the principal reason(s) for the IRO's decision; (e) statement that judicial review may be available to you; and (f) the phone number for any applicable office of health insurance consumer assistance.

2) If the IRO's decision is to reverse the plan's benefits denial, the plan must immediately provide coverage or payment of the claim.

Section 11, Appeal Procedure for Denied Life Insurance Benefits

Your Life Insurance benefits are handled separately by an independent life insurance carrier. To appeal a denial of life insurance benefits, however, you should address any written appeal as described above for medical claims. Your appeal will then be forwarded to the appropriate carrier and will be responded to in a similar manner to that described for medical claim review.

Section 12, Claim Information and Service

For bi-lingual assistance in filing a claim or for benefit information, call or write *UABT Member Service Department, 54 Corporate Park, Irvine, California 92606-5105, (949) 975.1424, (800) 223.4590, Fax (949) 892.1120.*

Si requiere de ayuda bilingüe para presentar una reclamación o para información de beneficios, llame o escriba a *UABT Member Service Department, 54 Corporate Park, Irvine California 92606-5105, (949) 975.1424, (800) 223.4590, Fax (949) 892.1120.*

Section 13, Appointment of Authorized Representative

You may designate another individual to be an authorized representative and act on your behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by you and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is separate from a Provider accepting an assignment of benefits,requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative for legal proceedings and other similar matters. Assignment and its limitations under this Plan are described below.

Section 14, Payment of Benefits

Where benefit payments are allowable in accordance with the terms of UABT, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

A medical provider which accepts the Assignment of Benefits does so as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document. (An assignment of benefits does not allow the provider to file legal action against the Trust – any legal action must be filed by the participant.)

Section 15, Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or Exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Anypayments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or otherperson or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1) In error.
2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4) With respect to an ineligible person.
5) In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions.
6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage foroccupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

Part XV, ERISA Information and Statement of Rights

The following information is provided in accordance with the Employee Retirement Income Security Act of 1974 (ERISA, 29 U.S.C. 1001 et seq.) and describes your claim filing rights, responsibilities and denied claim appeal process.

Section 1, Name and Type of Administration of the Plan

The Plan is known as the United Agricultural Employee Welfare Benefit Plan & Trust, United Agricultural Benefit Trust or UABT, and is administered by a Board of Trustees (who are participants of the Plan and elected by participating employ ers) established under the provisions of the Trust Agreement of the United Agricultural Employee Welfare Benefit Plan & Trust.

Section 2, Sponsor of the Plan

The United Agribusiness League created the Plan and Trust. You and your eligible dependents may receive upon written request, information as to whether a particular employer or employer organization is a participant of the Plan and, if so, their address.

Section 3, Name and Address of the Trustee

The Institutional Trustee in control of UABT assets is the Bank of America. The Institutional Trustee can be contacted at Bank of America, 231 South LaSalle Street, Chicago, IL 60697.

Section 4, Name and Address of the Plan Administrator

United Agribusiness League (UnitedAg or UAL) is the Plan Administrator for United Agricultural Benefit Trust. The Plan Administrator can be contacted at United Agribusiness League, 54 Corporate Park, Irvine, California 92606-5105.

UAL is responsible for reporting information regarding this Plan to the appropriate government agencies and Plan participants, in accordance with the requirements of ERISA.

Section 5, Name and Address of the Benefits Administrator

United Agribusiness League (UnitedAg or UAL) is the Benefits Administrator for United Agricultural Benefit Trust; however, the UABT Board of Trustees retains final appeal authority for appeals of adverse benefit determinations. The Benefits Administrator can be contacted at United Agribusiness League, 54 Corporate Park, Irvine, California 92606-5105.

Section 6, Service of Legal Process

UABT is a legal entity. Legal notice may be filed with, and legal process serviced upon the Plan Administrator, Legal process for United Agricultural Benefit Trust may be served upon United Agribusiness League located at 54 Corporate Park, Irvine, California 92606-5105.

Section 7, Source of Financing of the Plan

UABT is financed by contributions made to the Trust by the participating employers and, if required, contributions from covered individuals. Benefits are paid directly from the Trust Funds.

Section 8, Name and Address of Stop Loss Insurance Carrier

The Board of Trustees has contracted with Great Midwest Insurance Co. referred to as the stop loss carrier, to provide specific and aggregate stop loss insurance to UABT. The stop loss carrier can be contacted at Great Midwest Insurance Co., 800 Gessner, Houston, TX 77024.

Section 9, Name and Address of Health Maintenance Organizations

The Board of Trustees has contracted with various health maintenance organizations for medical services for UABT participants who have elected coverage through independent managed care plans. The HMOs can be contacted as follows:

Vision Service Plan, 3333 Quality Drive, Rancho Cordova, CA 95670.

Section 10, Name and Address of Group Term Life Insurance Carrier

The Board of Trustees has contracted with UNUM, referred to as the group term life insurance carrier, to provide group term life insurance to UABT. The life insurance carrier can be contacted at UNUM, 1 Fountain Square, Chattanooga, TN, 37402.

Section 11, Plan Fiscal Year

The United Agricultural Benefit Trust Fiscal Year End is December 31.

Section 12, Internal Revenue Service Number

The tax identification number assigned to United Agricultural Benefit Trust is 33-0013118.

Section 13, Amendments to Plan

The UABT Board of Trustees has the authority to amend or terminate the plan from time to time as it deems necessary.

Section 14, Plan Number

The United States Department of Labor plan number for United Agricultural Benefit Trust is Plan No. 501

Section 15, Fund Assets

The Plan's assets and reserves may be invested in savings accounts, Certificates of Deposits, other cash equivalents, treasuries, bonds, stocks, and real estate in compliance with Article 4.7 of the California Insurance Code.

Section 16, Certain Rights Under ERISA

As a participant in the UABT you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA, 29 U.S.C. 1001 et seq.). ERISA specifies that all Plan Participants shall be entitled to:

a) Examine, without charge, at the Plan Administrator's office copies of the latest annual report (Form 5500 Series) filed by UABT with the U.S. Department of Labor and available at the Public Disclosure Room of the EmployeeBenefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may set a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

d) Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under UABT as a result of a Qualifying Event. You and/or your eligible dependent(s) may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing the Participant's COBRAContinuation Coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operations of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer or any other person, may fire a participating employee or otherwise discriminate against a participating employee in any way to prevent the employee from obtaining a benefit under the Plan or from exercising his rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim (Refer to Part XV, Section 16). Under ERISA there are steps that you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order him to pay these cost and fees, for example, if it finds the claim or suit frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory; Employee Benefits Security Administration, Los Angeles Regional Office, 1055 East Colorado Blvd., Suite 200, Pasadena, California 91101, (626) 229.1000; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Section 17, Certain Rights through the California Department of Insurance

If you believe all or part of the claim has been wrongfully denied or rejected in addition to your rights to appeal your benefit denials to UABT, you may have the matter reviewed by the California Department of Insurance, Consumer Services Division, 300 South Spring Street, Los Angeles, CA 90013; (800) 927.4357.

Part XVI, HIPAA and Notice of Privacy Practices

Section 1, Commitment to Protecting Health Information

UABT will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards have been implemented and enforced in the offices of Trustees, Plan Administrator and any other entity that may assist in the operation of the Plan.

UABT believes that all patients over the age of fifteen (15) are entitled to privacy regarding their health care. But Explanation of Benefits will still be sent to the member until the dependent is eighteen (18) years or an emancipated minor unless the patient requests otherwise in writing to UABT. Additionally, patients age twelve (12) and over receiving sensitive services under California Law may request explanation of benefits and communications be sent to the patient confidentially at a location designated by the patient. For more information, please see the California Civil Code Sections 56.107, 56010 and 56.11, California Health & Safety Code Section 121020, 123110(a) and 123115(a) and California Family Code Sections 6924, 6925, 6926, 6927 and 6928.

UABT is required by law to take reasonable steps to ensure the privacy of the you and your dependent(s) PHI, and inform you about:

1) The Plan's disclosures and uses of PHI.
2) The Participant's privacy rights with respect to his or her PHI.
3) The Plan's duties with respect to his or her PHI.
4) The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5) The person or office to contact for further information about the Plan's privacy practices.

UABT provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of UABT's Notice of Privacy Practices are available by calling (800) 223.4590.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Section 2, Definitions

1) Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI")or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

2) Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA,that is created or received by UABT and that relates to the past, present, or future physical or mental healthor 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 that identifies the individual or for which thereis a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Section 3, How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit UABT to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1) To carry out payment of benefits.
2) If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Section 4, Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: UABT has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

Business Associates: UABT contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.

Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Section 5, Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that UABT may receive and use PHI for plan administration purposes, UABT and the Plan Administrator agree to:

1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law(as defined in the Privacy Standards).

2) Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received fromthe Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

3) Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.

4) Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions. Not use or disclose genetic information for underwriting purposes.

5) Report to the Plan Administrator any PHI used or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.

6) Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).

7) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526of the Privacy Standards (45 CFR 164.526).

8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining complianceby the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).

9) If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any formand retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, exceptthat, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that makethe return or destruction of the PHI infeasible.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Section 6, Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1) Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her careor payment for his or her care. The Plan is not required to agree to these requested restrictions.

2) Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3) Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.

4) Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment,payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting forthe six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include:

(a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the addressof such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure thatreasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.

5) Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she shouldcontact the Privacy Officer. A request to transmit PHI directly to another designated person must

be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.

6) Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan maydeny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.

7) Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Section 7, Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions, or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Section 8, Contact Information

Privacy Officer Contact Information:
Jayson Welter, J.D., M.A.
General Counsel
UnitedAg
54 Corporate Park
Irvine, CA 92606.5105
Phone: (800) 223.4590
Fax: 1(949) 892.1363
jwelter@unitedag.org

Part XVII HIPAA Security

Section 1, Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality, and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Section 2, Definitions

Electronic Protected Health Information (ePHI**),** as defined in Section 160.103 of the Security Standards (45 C.F.R.160.103), means individually identifiable health information transmitted or maintained in any electronic media.

Security Incidents**,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Section 3, UABT Obligations

To enable UABT to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), UABT agrees to:

1) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf ofthe Plan.

2) Ensure that any agent, including a subcontractor, to whom UABT provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and reportto the Plan any security incident of which it becomes aware.

3)Report to UABT any security incident of which it becomes aware.

4)Establish safeguards for information, including security systems for data processing and storage.

5)Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.

6)Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) ofthe Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

(a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shallbe given access to the PHI to be disclosed:

(i) Privacy Official, Legal Counsel
(ii) Privacy Contact, Executive Vice President & CFP
(iii) Security Officer, Chana Hauben, Vice President of Human Resources
(iv) Claims Department
(v) Member Services Department
(vi) Client Services Department
(vii) Information Technology Department.

(b) The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that UABT and the Plan Administrator perform.

Section 4, Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), UABT may disclose to participating employer's information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled for benefits offered by the Plan to the Plan Sponsor.

Section 5, Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims un der the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Section 6, Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officershall take appropriate action, including:

1) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, ordeliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature ofthe breach, may include oral or written reprimand, additional training, or termination of employment.
3) Mitigating any harm caused by the breach, to the extent practicable.
4) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5) Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6) Disclosing the Participant’s PHI to the Secretary of the U.S. Department of Health and Health and HumanServices when the Secretary is investigating or determining the Plan’s compliance with the HIPAA Privacy Rule.

Part XVIII, Federal Laws

Section 1, Pregnancy Discrimination Act

Any health benefits provided by the Trust must cover expenses for pregnancy related conditions on the same basis as costs for other medical conditions. Health benefits for expenses arising from abortions is not required except where the life of the mother is endangered. Pregnancy related expenses will be reimbursed exactly as those incurred for other medical conditions, whether payment is on a fixed basis or a percentage of reasonable and customary charge basis.

Section 2, Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1) Such individual's genetic tests.
2) The genetic tests of family members of such individual.
3) The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

UABT may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

UABT may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Section 3, Family and Medical Leave Act

If a covered Employee ceases active employment due to an Employer approved Family Medical Leave of Absence, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classifications).

Section 4, Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1) The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2) There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3) The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered bythe Plan (or coverage).
4) There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered inconnection with such a plan).

Section 5, Qualified Medical Child Support Order (QMSCO)

OBRA 1993 requires that an eligible Dependent child of an Employee will include a child who is adopted by the Employee or covered Dependent spouse required to provide coverage due to a Medical Child Support Order which is determined by the Plan Administrator to be a Qualified Medical Child Support Order (QMSCO). A QMSCO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under the state law and which satisfies the QMSCO requirements of ERISA §609(a). (You may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.)

Section 6, The Newborns and Mothers Health Protection Act (NMHPA)

UABT does not restrict benefits for a covered pregnancy hospital stay (for delivery) for a mother and the newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for in-patient hospital admission will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides discharge is appropriate.

Section 7, The Women's Health and Cancer Right's Act (WHCRA)

The Trust benefits includes coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient:

1) Reconstruction of the breast on which a mastectomy has been performed;
2) Surgery and reconstruction of the other breast to produce symmetrical appearance;
3) Breast prostheses; and
4) Physical complications of all stages of mastectomy, including lymphedemas.

Section 8, Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees who leave their job to perform service in the uniformed forces of the United States (the "Uniformed Forces") are eligible or continuation of coverage for themselves and Dependents under this Plan for up to 24 months while in the Uniformed Services. Whether or not continued coverage is elected, employees have the right to be reinstated when reemployed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Section 9, Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

1) What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.
2) "Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
3) "Surprise billing" is an unexpected balance bill. This can happen when you **cannot** control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.
4) <u>You are protected from balance billing for:</u>
    a) <u>Emergency services</u>
    If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
5) <u>Certain services at an in-network hospital or ambulatory surgical center</u>

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

6) You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

7) When balance billing isn't allowed, you also have the following protections:

a) You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

b) Your health plan generally must:

i. Cover emergency services without requiring you to get approval for services in advance (prior authorization).

ii. Cover emergency services by out-of-network providers.

iii. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

iv. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

8) If you believe you've been wrongly billed, you may contact UABT Member Services Department at (800)223.4590.

9) Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Part XIX, California Department of Insurance Notice

THIS MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THIS MULTIPLE EMPLOYER WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT THAT IS LICENSED BY THE STATE OF CALIFORNIA.

FOR ADDITIONAL INFORMATION ABOUT THIS MULTIPLE EMPLOYER WELFARE ARRANGEMENT, YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT (800) 927.4357

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SUMMARY PLAN DESCRIPTION

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