JEFFERSON FEDERATION OF TEACHERS HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION FOR THE HEALTH & WELFARE AND CAFETERIA PLANS

EFFECTIVE JANUARY 1, 2005

And

Amendment to Summary Plan Description effective September 1, 2005

Amendment to Summary Plan Description effective September 1, 2007

Plan Amendment 1 effective January 1, 2010

JEFFERSON FEDERATION OF TEACHERS
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January 1, 2005

INTRODUCTION

The Board of Trustees for the Jefferson Federation of Teachers Health & Welfare Fund are pleased to provide you with this revised booklet which is intended to give you an up-to-date description of the benefits currently offered under both the Health & Welfare Plan and the Cafeteria Plan. Whenever we refer to "Plan" in this booklet, we mean both plans.

The Fund and the Plan were established on the basis of the Collective Bargaining Agreement between the Jefferson Federation of Teachers and the Jefferson Parish School Board. They are both administered by a joint Board of Trustees, five (5) of whom are appointed by the Union and five (5) of whom are appointed by the School Board.

The benefits under the Plan are available only to those Employees and their Dependents who satisfy the eligibility requirements. The fact that this booklet is provided to you does not automatically mean that you are covered.

Eligible Employees are covered under the Health & Welfare Plan without cost, and eligible Dependents are covered for dental and vision benefits only if elected and paid for by the Employee. The Health & Welfare Plan provides the following benefits:

1) Death Benefit, including an Accelerated Benefit in the event of terminal illness (Active Employees only);

2) Dental Benefits; and

3) Vision Benefits.

The Cafeteria Plan currently offers eligible Employees the opportunity to elect "flexible spending accounts" for the following benefits:

1) Medical Expense Reimbursement; and

2) Dependent Care.

One of the most important features about the Cafeteria Plan is that the benefits offered are generally ones that you are already paying. Usually, you pay for those benefits with money that has first been subject to Federal and Louisiana income taxes. The Cafeteria Plan allows you to pay for the same out-of-pocket expenses with a portion of your salary before those taxes are withheld. This means that you will pay less taxes and have more money to spend and save.

We urge you to read this booklet carefully and keep it in a convenient location for easy reference. The booklet is written in layman's terms to the extent possible and is intended to give you only a summary of the benefits and rules governing their availability. In the event of an amendment to the Cafeteria Plan, a summary of the material modifications will be mailed to you and posted on the website. The Administrative Manager has a copy of the complete Health & Welfare Plan and Cafeteria Plan on file in the Fund Office for your review, if you desire. In the event of a conflict between this booklet and the Plan documents, Plan documents will control.

Sincerely,

Joe A. Potts, Jr., Chairman
Board of Trustees

HEALTH AND WELFARE PLAN

SCHEDULE OF BENEFITS

EFFECTIVE JANUARY 1, 2010

The following is a schedule of benefits offered under the terms and conditions of the Health and Welfare Plan to eligible Employees and their Dependents.

EMPLOYEES ONLY

DEATH BENEFIT:

Amount of Life Insurance $10,000*

ACCELERATED BENEFIT:

Maximum Amount of Accelerated Benefit .... 50% of Life Insurance Death Benefit*

*If an Accelerated Benefit is paid, the Death Benefit payable upon your death will be reduced by the amount of the Accelerated Benefit paid to you prior to your death.

EMPLOYEES AND DEPENDENTS

DENTAL BENEFITS

Reimbursement Percentage of Dentist's Actual Fee or, if less, the Plan's Scheduled Fee**

TRADITIONAL FEE FOR SERVICE BENEFITS

Calendar Year Deductible, Per Person (Applicable to Type I, II and III Charges) $50.00

TYPE I- Preventative and Diagnostic Charges 100%

TYPE II- Basic Charges 80%

TYPE III- Special Charges 50%

TYPE IV- Orthodontia Charges 50%

Maximum Dental Benefits:

Per Calendar Year per Participant
(excluding Type IV (Orthodontia Charges) $1,500.00

Lifetime .... Unlimited

Lifetime Orthodontia Charges (Type IV) $1,000.00

**You may obtain a copy of the Schedule of Fees upon written request to the Fund office.

VISION BENEFITS

1. OUT-OF-NETWORK PROVIDERS (Providers not contracted with Davis Vision)

The Health and Welfare Plan provides the following Vision Benefits, up to the Maximum Dollar Amount, each twelve (12) month period beginning with the date of the service or the date the supplies are furnished.

	Maximum Dollar Amount
Out-of-Network Provider Examinations	$32.00
Out-of-Network Provider Lenses, Per Pair	
Single Lenses	$32.00
Bifocal Lenses	$48.00
Trifocal Lenses	$64.00
Contact Lenses	$92.00
Out-of-Network Provider Frames	$50.00

2. NETWORK PROVIDERS (Davis Vision Providers)

The following co-payments are payable by Participants for Vision Benefits provided each twelve (12) month period beginning on the date of the service or the date the supplies are furnished.

Examinations and Eyewear

Network Provider Examinations Only	$25.00
Provider Lenses and/or Frames (not including Examination)	$25.00
Contact Lenses	$25.00

Davis Vision Contact Lens Collection (includes evaluation, fitting and followup):

Standard/Daily Wear	One pair of lenses
Disposable	Four boxes/multi-packs
Planned Replacement	Two boxes/multi-pack

Optional Services Available at No Additional Costs:

Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range

Glass grey #3 prescription lenses

Oversize lenses

Post-cataract lenses

Fashion, sun or gradient tinted plastic lenses

Polycarbonate lenses for Dependent child(ren), monocular patients and patients with prescription +/-6.00 diopters or greater

Scratch-resistant coating

Glass photochromic lenses

Blended invisible bifocals

Standard and premium progressive addition multifocal lenses*

*Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses.

Additional Lenses and Frame Features
(In addition to any co-payment for Network Provider Lenses and Frames)

Polycarbonate Lenses.. $30.00

Ultra Violet (UV) Coating $12.00

Intermediate Vision Lenses.. $30.00

Standard Anti-Reflective Coating (ARC) $35.00

Premium Anti-Reflective Coating (ARC)... $48.00

Polarized Lenses $75.00

Plastic Photosensitive Lenses $65.00

High Index Lenses $55.00

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NOTES:

1. A Network Provider is a licensed provider in both private practice and retail locations who is extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained.

2. All benefits listed on the Schedule of Benefits are subject to Coordination of Benefits rules for all covered Employees and Dependents.

3. If the Participant is also entitled to benefits or coverage through the Loss or Damage to Personal Property Fund provided for in the Collective Bargaining Agreement, benefits will be coordinated so that the benefits available from the Health and Welfare Plan are limited to those expenses incurred over and above the benefits provided by the Loss or Damage to Personal Property Fund.

4. A one-year breakage warranty is included at no additional cost.

5. All eyeglasses furnished by a Network Provider come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The warranty applies to all Plan covered eyeglasses, i.e. spectacle lenses, Davis Vision Collection frames and national retailer frames (where our exclusive Collection is not displayed).

ARTICLE I
PLAN DEFINITIONS

The following terms, whenever used in this booklet as capitalized terms, will have the meaning set forth below:

(1) **"Bargaining Unit Employee"** means a full-time or other designated Employee of the School Board who is covered under the Collective Bargaining Agreement.

(2) **"Cafeteria Plan"** means the Jefferson Federation of Teachers Cafeteria Plan, as amended from time to time.

(3) **"COBRA"** means the continuation coverage provisions added to the Public Health Service Act by the Consolidated Omnibus Budget Reconciliation Act of 1985.

(4) **"Code"** means the Internal Revenue Code of 1986, as amended.

(5) **"Collective Bargaining Agreement"** means the written agreement between the Union and the School Board that requires the School Board to make contributions to the Fund on behalf of its Employees who work in Covered Employment, as extended or amended from time to time.

(6) **"Covered Employment"** means employment of an Employee for which the Employer is obligated to contribute to the Fund for the Employee's coverage under the Plan.

(7) **"Dependent"** means:

(a) An eligible Employee's spouse (this does not include a former spouse who is legally separated (as applicable) or divorced from the Employee);

(b) An Employee's natural born child, as well as a child who is legally adopted or placed for adoption, a step-child, or a child within the Employee's legal custody, provided the child has never been married, is dependent upon the Employee for support and maintenance, and is:

(i) 18 years or younger; or

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Dependent, Eligible Dependent 7 (b) (ii) Page 8

(ii) **23** years or younger and enrolled as a full-time student in an accredited school, college or university. If the student is in his last semester, "full time" means taking the number of hours of course work required to complete the student's program; or

(iii) 19 years or older and incapable of self-support because of a mental or physical handicap, provided the handicapped child was eligible as a Dependent on the day before his 19th birthday and became handicapped prior to turning 19. The Employee must submit satisfactory proof to the Administrator of a handicapped child's incapacity and dependency, within

31 days of the date the child would otherwise no longer qualify as a Dependent and whenever the Administrator requests such proof.

An individual who is eligible as an Employee cannot also be eligible as a Dependent.

(8) **"Employee"** means a Bargaining Unit Employee and a regular full-time Employee of the Union or the Fund. "Full-time" means the individual normally works a minimum of 20 hours per week. "Regular" means the individual's employment is permanent and consistent, rather than temporary or irregular. If you are an Employee on the last day of the school year, you will be considered an Employee through August 31 of that calendar year.

(9) **"Employer"** means the School Board, the Union and the Fund.

(10) **"Family and Medical Leave"** or **"FMLA Leave"** means a leave of absence, intermittent leave or leave on a reduced schedule for up to 12 work weeks in a 12-month period, that is determined by the School Board to qualify under the Family and Medical Leave Act of 1993, in accordance with its FMLA policies and administrative procedures.

(11) **"Fund"** or **"Trust Fund"** means the Jefferson Federation of Teachers Health and Welfare Fund and Trust.

(12) **"Health & Welfare Plan"** means the Jefferson Federation of Teachers Health & Welfare Plan, as amended from time to time.

(13) **"Labor Dispute"** means that the School Board and Union have reached an impasse in negotiations regarding a proposed Collective Bargaining Agreement, or that the Collective Bargaining Agreement has expired or has been extended on a temporary basis or suspended.

(14) **"Late Dependent Enrollee"** means a Dependent who is not initially enrolled in the Health & Welfare Plan either with the Employee or by the end of the first calendar month after the individual first becomes a Dependent, or if later, before the Dependent is three years old.

(15) **"Participant"** means any current or former Employee or Dependent who is covered under the Plan.

(16) **"Physician"** means a licensed Doctor of Medicine or Osteopathy.

(17) **"Plan"** means the Health & Welfare Plan and the Cafeteria Plan.

(18) **"Plan Year"** means the 12-month period beginning September 1 and ending August 31

for the Cafeteria Plan, and the 12-month period beginning January 1 and ending December 31 for the Health & Welfare Plan.

(19) **"Retiree"** means a former Employee who is no longer employed in Covered Employment and who is eligible by service, or due to disability, to receive a retirement benefit from the Louisiana Teachers' Retirement Fund.

(20) **“Salary Reduction Agreement”** means a written agreement by an Employee to reduce his salary or compensation from the Employer in order to pay for the benefits he has elected under the Cafeteria Plan.

(21) **"School Board"** means the Jefferson Parish School Board.

(22) **"Self-Payment"** means a Participant’s contribution to the Plan to pay for continued coverage when there would otherwise be a loss of coverage.

(23) **"Trust Agreement"** means the agreement by which the Fund was established on May 9, 1983, and amended from time to time.

(24) **"Trustee"** or **"Board of Trustees"** means the Trustees who are appointed from time to time in accordance with the Trust Agreement to administer the Plan and Fund.

(25) **“Union”** means the Jefferson Federation of Teachers, Local 1559, AFT/LFT/AFL-CIO.

ARTICLE II
ELIGIBILITY AND PARTICIPATION

1. Which Employees Are Eligible To Participate In The Plan?

Only certain employees are eligible to participate in the Plan. They are:

All Employees (both full-time and other designated Employees) of the School Board who are represented by the Union in collective bargaining with the School Board;

All regular, full-time Employees of the Union; and

All regular, full-time Employees of the Fund.

2. When Can I Become A Participant In The Plan?

If you are a new Employee, you can become a participant on the first day of the calendar month following your Waiting Period. This will be referred to as your "Eligibility Date" in the Plan. If you terminate your employment but are re-employed, you can again become a participant in the Health & Welfare Plan on the first day of the calendar month after you satisfy a new Waiting Period. For the Cafeteria Plan, if you terminate your employment and are re-employed during the same Plan Year, you must wait until the next Plan Year before you can again become a participant.

3. What Is My Waiting Period?

Your "Waiting Period" begins on the first day of your eligible employment or re-employment following a termination of employment, and ends on the last day of the calendar month after you have been employed for 30 days. If you are transferred from ineligible employment to Covered Employment, your Waiting Period will end on the last day of the month following the 30-day period measured from the first day of your Covered Employment or, if later, measured from the date the Fund Office is first notified by the School Board and the Union of your status as a Bargaining Unit Employee.

4. What Must I Do To Join The Health and Welfare Plan And Cover My Dependents?

Once you satisfy your Waiting Period, you will automatically become covered under the Health & Welfare Plan on your Eligibility Date. The Health & Welfare Plan benefits are provided to you as an Employee without cost, as your coverage is funded by Employer contributions made to the Fund on your behalf.

Once you become eligible, you may enroll your Dependents for Dental and Vision Benefits (the Death Benefit is for Employees only). In order to enroll your Dependents, you must submit a completed enrollment form to the Fund Office and pay for the elected coverage. **If you enroll your Dependents before the end of your Waiting Period, they will also become covered on your Eligibility Date. If you enroll your Dependents after your Eligibility Date, they will become covered on the first day of the month after a completed enrollment form is received by the Fund Office; however, delaying their enrollment may result in their classification as "Late Dependent Enrollees" under the Traditional Fee for Service Dental Plan (see the Plan Definitions.)**

You may choose from among three levels of Dependent coverage: Dependent spouse only; Dependent children only; and family coverage (Dependent spouse and Dependent children). The Trustees set the cost for each level of coverage and have the right to change it from time to time. You will be notified of the cost of each level of Dependent coverage at the time of enrollment.

5. What Is The Consequence Of Your Dependent Being A Late Dependent Enrollee?

If you do not enroll a Dependent initially when you become a Participant, or by the end of the first calendar month after you acquire the Dependent, or if later, before the Dependent turns three years old, the Dependent will be considered a "Late Dependent Enrollee". A Late Dependent Enrollee in the Traditional Fee for Service Dental Plan is subject to an additional 12-month waiting period before the Dependent is covered for Type II (Basic), Type III (Special) and Type IV (Orthodontic) Dental Benefits. However, a Late Dependent Enrollee will be covered the first day of the month following the Fund Office's receipt of an enrollment form for Type I (Preventive and Diagnostic) Dental Benefits and all Vision Benefits without any waiting periods.

6. How Do I Pay For Dependent Coverage?

If you choose to enroll a Dependent in the Health & Welfare Plan, the cost will be deducted from your paycheck, beginning with the first paycheck issued after your Dependent's coverage begins. In the event payroll deduction is not possible because of an absence from employment, a Labor Dispute or any other similar reason, you must pay the cost in a timely manner directly to the Fund Office in order to maintain Dependent coverage.

7. What Must I Do To Join The Cafeteria Plan?

In addition to satisfying your Waiting Period, you must complete an application to participate before you can join the Cafeteria Plan. The application includes your personal choices for each of the benefits offered under the Cafeteria Plan as well as a "Salary Reduction Agreement". Under the Salary Reduction Agreement, you must authorize setting aside some of your compensation to pay for the benefits you select.

Participation is on a Plan Year basis. The Fund Office must receive your application by the end of your Waiting Period, when you first become eligible, and by the end of the Election Period for participation in subsequent Plan Years. The "Election Period" for each Plan Year begins July 1 and ends August 31, before the Plan Year begins.

The Administrator may, in its discretion, extend your Waiting Period or your Election Period, as applicable, for up to 30 days in cases of hardship. However, if an extension is granted, the effective date of your participation will be delayed to the first day of the first pay period after your application is received by the Fund Office.

ARTICLE III
OPERATION OF THE CAFETERIA PLAN

1. How Does The Cafeteria Plan Operate?

When you are first employed, you will be given an enrollment package. To participate, you must complete the application and the Salary Reduction Agreement, and return the completed forms to the Fund Office by the end of your Waiting Period. If you enroll timely, your participation will begin on the first day of the month following your Waiting Period, and continue through the end of that Plan Year. Participation is on a Plan Year to Plan Year basis, so before the start of each following Plan Year, you will again be given an enrollment package to complete for the upcoming Plan Year.

When you complete the forms, you must choose which benefits you want, and you must agree to contribute enough of your future compensation for the Plan Year to pay for the benefits you have chosen. There are two benefits available under the Cafeteria Plan, a Medical Expense Reimbursement ("Medical") flexible spending account and a Dependent Care flexible spending account. For each benefit that you choose, a "flexible spending account" will be set up in your name.

The amount of compensation that you elect to contribute will be deducted from your paychecks for the Plan Year, on a pro rata basis, so that an equal amount is deducted from each paycheck. With each paycheck, your "salary reduction" contribution will be made to the Fund and credited to the "flexible spending account(s)" that are set up for you based upon your elections. Your "salary reduction" contributions are not subject to Federal or Louisiana income taxes or applicable Social Security tax. In other words, the Cafeteria Plan allows you to use tax-free dollars to pay for eligible expenses that you normally pay for with out-of-pocket, taxed dollars. However, any reimbursements that you receive under the Cafeteria Plan cannot also be claimed as a deduction or tax credit on your Federal or Louisiana income tax returns.

The Trustees, in their discretion, may make additional contributions on a periodic basis during the Plan Year for those Employees who have elected benefits. If Fund contributions are made and you have elected both benefits, you must choose the flexible spending account to which you want the Fund's contributions for the Plan Year credited. If you have elected only one benefit, the Fund contribution will be allocated to your flexible spending account for that benefit. If you have not elected either benefit, you will not receive any share of the Fund contribution. Any contributions made by the Fund to your flexible spending account(s) will increase the amount available to you to pay benefits from such account(s).

2. How Is My Compensation Determined For Purposes Of The Salary Reduction Agreement?

When you complete the Salary Reduction Agreement with your application to participate in the Cafeteria Plan, the percentage of compensation that you elect to contribute will be deducted from the total earnings paid to you by your Employer.

3. What Happens To Contributions Made To The Cafeteria Plan?

Before each Plan Year begins, you must select the benefits that you want and how much of the contributions that will go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on covered expenses during the Plan Year. The contributions credited to your flexible spending account(s) will be used to reimburse you for your covered expenses as they are incurred during the Plan Year.

4. When Must I Decide Which Benefits I Want?

Federal law requires that you decide which benefits you want before the Plan Year begins or, if a newly eligible Employee, during your Waiting Period so that your election is made before any amounts are withheld from your paycheck and coverage begins. During the Election Period, you must decide two things: first, which benefits you want; and second, how much should go toward each benefit.

5. May I Change My Elections During The Plan Year?

Generally, the law does not permit you to change your benefit elections during a Plan Year. There are, however, certain limited situations in which you are permitted to change your elections during the Plan Year. The following is a list of those situations:

(a) Your marital status changes due to marriage, divorce, legal separation (if applicable), annulment or the death of your spouse;

(b) The number of your dependents changes because of birth, death, adoption or placement for adoption, or, for Dependent Care, because they no longer qualify as a dependent for purposes of that benefit;

(c) Your dependents have a change in employment status because of any of the following: your dependent begins or terminates employment, or begins or returns from an unpaid leave of absence; a strike, lockout or change in work site; or any change in employment status that causes your dependent to become eligible or to lose eligibility under an employer's cafeteria or employee benefit plan;

(d) Your dependent satisfies or ceases to satisfy the eligibility requirements for

coverage, such as on account of age or change in student status;

(e) There is a change in place of residence for you or your dependent;

(f) For Dependent Care only, you have a significant increase in the cost of dependent care but only if the provider is unrelated to you, or you have a significant change in coverage such as obtaining a new provider or needing fewer hours of dependent care; or

(g) For Dependent Care only, your Dependent experiences a benefit change under his employer's cafeteria or qualified benefits plan, provided the change occurs during the other plan's open enrollment period or is legally permitted under the other plan.

If you want to make a mid-year change in your election under the Cafeteria Plan because of one of these situations, you must do so by the last day of the month after the month in which the event occurs, and your change must be consistent with the reason it is being permitted. If you would like to make a mid-year change because of one of these events, you should contact the Fund Office.

6. What Happens To My Participation If I Terminate Employment But Am Re-Employed During the Same Plan Year?

If, during the Plan Year, your participation in the Cafeteria Plan terminates because your employment is terminated but you are re-employed during the same Plan Year, you must wait until the next Plan Year until you can again participate in the Cafeteria Plan as an active Employee. You may, however, continue your participation in the Medical flexible spending account, on a self-pay basis, for a limited period of time to the extent required by the federal law known as COBRA (See Article VIII).

7. Must I Make A New Election Each Plan Year?

Yes, you must. For each new Plan Year, you must complete a new application regardless of whether you want to elect the same benefits or you want to make changes. If you do not return a new application to the Fund Office during the "Election Period" before the new Plan Year begins, you will be treated as having elected not to participate in the Medical and/or Dependent Care flexible spending accounts for the upcoming Plan Year.

8. When Will I Receive Payments From My Flexible Spending Accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred during the Plan Year. Expenses are considered "incurred" when the service is performed, not when it is paid. You can obtain the necessary forms for reimbursement requests from the Fund Office or the Fund's website, www.jfthw.org. If the expense for which reimbursement is requested qualifies as a benefit or expense that the Cafeteria Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember that the reimbursements that are made from the Cafeteria Plan are generally not subject to Federal or Louisiana income tax or withholding or applicable Social Security tax.

You will only be reimbursed for covered expenses from your Dependent Care flexible spending account to the extent of the amount credited to your account. The amount credited to your account at any time during the Plan Year will be determined by the amount of contributions that have been made to your account as of that date, less any reimbursements that have been paid as of that date. If you don't have enough in your account to cover an entire reimbursement request, an additional reimbursement or reimbursements will be made to you as and when additional amounts are credited to your account.

You will be reimbursed for covered expenses from your Medical flexible spending account up to the level of benefits you have elected for the Plan Year, less any reimbursements that have already been paid.

9. What Happens If I Do Not Spend All of My Cafeteria Plan Contributions?

Any monies left in your flexible spending accounts at the end of the Plan Year will be forfeited to the Fund. Obviously, qualifying expenses that you incur late in the Plan Year, for which you seek reimbursement after the end of the Plan Year, will be paid first before any amount is forfeited. However, the Fund Office must receive your request for reimbursement no later than 60 days after the end of the Plan Year in order for your claim to be considered.

Because you will forfeit any amounts remaining in your flexible spending accounts at the end of the Plan Year if you have not incurred enough covered expenses during the Plan Year to exhaust your accounts, it is important that you decide how much to place in each account carefully and conservatively. Remember that you must make this election before the Plan Year begins, and you want to be as certain as you can that the amount you elect will be used up entirely by the end of the Plan Year.

10. Do I Receive Statements Of My Account Balances During the Plan Year?

Periodically during the Plan Year, the Administrator will provide you with a statement of your flexible spending account balances. It is important that you read these statements carefully so that you understand the balance remaining in your accounts to pay for benefits. Remember that you want to spend all the money you have designated for a particular benefit by the end of the Plan Year to avoid having your unused contributions forfeited.

AMENDMENT TO SUMMARY PLAN DESCRIPTION EFFECTIVE SEPTEMBER 1, 2005

MEDICAL EXPENSE REIMBURSEMENT PROGRAM

EXTENSION OF TIME PERIOD TO INCUR AND FILE CLAIMS IN THE MEDICAL EXPENSE REIMBURSEMENT PROGRAM

If you are a Participant in the JFT Health and Welfare Fund's Flexible Spending Account ("FSA") Medical Expense Reimbursement Program, you know that you are able to be reimbursed for certain medical claims by the FSA. In the past, only claims incurred during the FSA's fiscal year, known as the "Plan Year" – September 1 to August 31 – could be reimbursed, and these claims had to be submitted within sixty days after the end of the Plan Year.

Effective this Plan Year (which ends August 31, 2006), a "Grace Period" has been established by the Board of Trustees. This will allow you more time to use your Medical Expense Reimbursement account and to file claims. The term "Grace Period" means the period September 1 through October 31. During the Grace Period, if (1) you have unused money in your flexible spending account which was contributed by you on or before August 31, 2006 (and each August 31 thereafter) and (2) you incur reimbursable claims, the claims will be reimbursed from the unused money that you contributed. So, you have two additional months to exhaust your Medical Expense Reimbursement account each Plan Year.

Please note that Grace Period expenses cannot be applied against the Fund's contribution to your account, which if unused, will be forfeited after August 31. If any balance remains from your contributions to your Medical Expense Reimbursement account after all permissible reimbursements under the Plan have been made for the Plan Year and the immediately following Grace Period, the balance will not be carried over to reimburse you during the next Plan Year. You will forfeit all rights to this balance.

All claims for reimbursement during the Grace Period must be filed no later than December 31. The minimum value of a claim incurred during the Plan Year or the Grace Period and later submitted for reimbursement will be $25; however, if reimbursable expenses total less than $25 at the end of the Plan Year or the immediately following Grace Period, reimbursement will be made for the actual amount of the eligible reimbursable expenses, provided sufficient funds to cover the reimbursement remain in your account.

In order to file a claim for reimbursement, you must in writing state:

(1) the amount, nature and date of each expense for which reimbursement is requested;

(2) the name of the person, organization or entity to which the expense was paid;

(3) the name of the person for whom the expense was incurred and, if for someone other than you, the relationship of such person to you; and

(4) that the expense has not been reimbursed and is not reimbursable under any other health Plan coverage and, should the Trustees so request, submit an Explanation of Benefits from your health care insurer to this effect.

The Board of Trustees reserves the right to amend or terminate this benefit at any time. You must meet the eligibility requirements of the Plan in order to receive benefits.

ARTICLE IV
BENEFITS UNDER THE CAFETERIA PLAN

1. What Benefits Are Available Under The Cafeteria Plan?

Under the Cafeteria Plan, you can choose to use a portion of your compensation for the Plan Year, through salary reduction, to establish a Medical and/or Dependent Care flexible spending account that can be used to pay for expenses that qualify for reimbursement and are incurred during the Plan Year.

2. What Is The Medical Expense Reimbursement Benefit?

If you elect the Medical Expense Reimbursement benefit, a Medical flexible spending account will be established in your name. It will enable you to pay for out-of-pocket medical, dental and vision expenses incurred by you and your dependents which are not covered by your medical plan, and save taxes at the same time. An eligible "dependent", for purposes of this benefit, is anyone you claim as a dependent for Federal tax purposes.

The expenses that are eligible for reimbursement are expenses for "medical care" as defined in Code Section 213(d), as amended and interpreted by the IRS from time to time, provided the expenses are not reimbursed under other insurance or any other source, and are not used as a deduction in determining your tax liability under the Code. Expenses are incurred at the time the services to which the expenses relate are rendered, and do not include future or projected expenses or services. The following is a list of the types of medical expenses that may qualify:

(1) Ambulance services;

(2) Artificial limbs and artificial teeth;

(3) Braille books and magazines (limited to the difference in price between the Braille publication and regular printed materials);

(4) Certain fees for special schools and/or tutoring recommended by a Doctor for a child with severe learning disabilities caused by physical or mental impairments;

(5) Certain reasonable costs incurred to accommodate a home for a disabled condition of the participant or his dependents, as well as special hand controls and/or equipment installed in a car for the use of a disabled person;

(6) Contact lenses and eye glasses for medical reasons, and radial keratotomy

procedures if medically necessary and undertaken to correct a physical defect;

(7) Cosmetic surgery if necessary to improve a deformity arising from, or directly related to, congenital abnormality, a personal injury resulting from an accident or trauma or a disfiguring disease;

(8) Crutches (purchase or rental), wheelchairs and hearing aides as medically necessary;

(9) Dental treatment;

(10) Guide dog or other animal aiding the blind, deaf or disabled;

(11) Hospital services including laboratory work, therapy, nursing services and surgery;

(12) Lead-based paint removal from surfaces in the home to prevent a child who has or has had lead poisoning from eating the paint (but not the cost of repainting);

(13) Medical care and/or treatment by medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, surgeons, psychiatrists, psychologists, physical therapists, acupuncturists, psychoanalysts, Christian Science practitioners and/or other medical practitioners, including medical treatment for alcohol and/or drug addiction at a treatment center, legally performed abortions and sterilizations;

(14) Medicines, drugs and birth control pills prescribed by a doctor, as well as insulin;

(15) Nursing services connected with caring for a patient's conditions;

(16) Organ donor expenses;

(17) Oxygen equipment and oxygen to relieve breathing problems caused by a medical condition;

(18) Smoking cessation programs and related prescribed drugs;

(19) Telephone equipment that enables a deaf person to communicate over a regular telephone (cost and repair), and television audio display equipment for the deaf; and

(20) Over-the-counter medicines and drugs for "medical care," within the meaning of Code Section 213(d), provided that the over-the-counter medicines and drugs are prescribed by a health care provider, as mandated by the Patient Protection and Affordable Care

Act ("PPACA"), but not amounts paid for dietary supplements or other items that are merely beneficial to the general health of the Employee or the Employee's spouse or dependents. Effective September 1, 2010

You cannot use this benefit to obtain reimbursement for the cost of other medical coverage maintained outside of the Cafeteria Plan, for "qualified long-term care services" as defined in Code Section 7702B(c), or for expenses reimbursable under any other insurance or source. You can, however, be reimbursed for eligible expenses that are not eligible for reimbursement under other medical coverage because of deductibles or co-payments.

In order to be reimbursed from a Medical flexible spending account, you must submit, to the Fund Office, an Explanation of Benefits (EOB) from your insurance company, an adequate receipt and a medical provider's prescription for eligible over-the-counter products, or an itemized bill from the service provider. Amounts reimbursed from the Cafeteria Plan may not be claimed as a deduction on your personal income tax return. Effective September 1, 2010

3. How Much May I Contribute To A Medical Flexible Spending Account?

For each Plan Year, you may elect to contribute to a Medical flexible spending account no less than the minimum limit and no more than the maximum limit in effect for the Plan Year. The limits apply to your salary reduction contributions only and not to any discretionary contributions made by the Fund. Currently, the minimum limit is $180 and the maximum limit is $3,400. The maximum limit will increase to $4,200 beginning September 1, 2005. These limits may be amended from time to time on a prospective basis. In the event of a change, you will be notified of the new limits in advance of your election for the Plan Year to which the change applies.

4. What Is The Dependent Care Benefit?

If you elect the Dependent Care benefit, a Dependent Care flexible spending account will be established in your name. It will enable you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single Employees can also use the account.

An eligible "dependent", for purposes of this benefit, is any member of your household for whom you can claim expenses on Federal Income Tax Form 2441, "Child and Dependent Care Expenses". Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves.

Dependent care arrangements which qualify include:

(1) A dependent (day) care facility, provided that if care is provided for more than six (6) individuals, the facility complies with applicable state and local laws;

(2) Nursery school and other programs for pre-school children;

(3) Although educational institutions for older children are not covered, expenses for after-school or before-school care may be eligible; and

(4) Care provided by an individual for an eligible dependent inside or outside your home if the care provider is not your child who is under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying qualify for reimbursement under this benefit before you make your election. The law places limits on the amount of money that can be paid to you in a calendar year from a Dependent Care flexible spending account. Generally, your reimbursements may not exceed the lesser of:

(1) $5,000 (if you are married filing a joint return or head of a household) or $2,500 (if you are married filing separate returns);

(2) Your taxable compensation; or

(3) Your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself has a monthly earned income of $200 for one dependent or $400 for two or more dependents).

You should keep in mind that these limits apply to each taxable or calendar year, while your benefit elections are made for a Plan Year which spans two (2) calendar years.

In order to be reimbursed from a Dependent Care flexible spending account, you must submit, to the Fund Office, a statement from the service provider that includes the following information:

(1) The name, address and taxpayer identification number of the person, organization or entity to which the expense was paid;

(2) The amount of such expense as proof that the expense has been incurred;

(3) The name and age of the dependent for whom the service was incurred; and

(4) The relationship of the service provider to you, if any.

Federal tax laws permit a tax credit for certain dependent care expenses you may be paying even if you do not participate in the Cafeteria Plan. Depending upon your situation, you may save more money if you take advantage of this tax credit rather than using a Dependent

Care flexible spending account. You should ask your tax adviser which is better for you.

ARTICLE V
BENEFITS UNDER THE HEALTH AND WELFARE PLAN

1. What Benefits Are Provided Under The Health And Welfare Plan?

The following benefits are provided under the Health & Welfare Plan:

(a) Death Benefit;

(b) Dental Benefits; and

(c) Vision Benefits.

2. What Is The Death Benefit Provided Under The Health And Welfare Plan?

(a) Who is covered, and what is the benefit?

Only active Employees who are not self-paying for coverage under the Health & Welfare Plan have Death Benefit coverage. Under this benefit, if you should die for any reason while you are covered, a Death Benefit will be paid to your beneficiary in the amount described in the Schedule of Benefits, as in effect at the time of your death. In order to receive payment, your beneficiary must submit satisfactory proof of your death to the Administrator. The Death Benefit is provided through a life insurance policy purchased by the Trustees and issued to the Fund ("Policy"). Payment will be governed by the terms of the Policy in effect at the time of your death.

(b) Who is your beneficiary?

Your beneficiary is the person or persons you have designated in writing on a form filed with the Administrator. If you designate more than one person, they will share equally unless you state otherwise. You can change your beneficiary as often as you like, but any change will not affect payments that have been made before the properly written change is received by the Administrator. Unless you state otherwise, your beneficiary must survive you by 24 hours in order to qualify.

If you should die without leaving a qualified designated beneficiary, your Death Benefit will be paid to the following:

(i) To your surviving spouse; or if none
(ii) To your surviving child or children in equal shares; or if none

(iii) To your surviving parent or parents in equal shares; or if none
(iv) To your estate.

If your beneficiary is a minor or otherwise not competent to give a valid release, payment will be made to the legal guardian, tutor or other person determined by the Trustees to be entitled to receive payment.

(c) What happens to your Death Benefit coverage if you become totally disabled?

If your employment terminates because of a total disability (within the meaning of the Policy) before you attain age 65, your Death Benefit coverage will be extended at no cost until the earliest to occur of the following:

(i) The date you attain age 65;
(ii) The end of the 12- month period beginning with the first month after your employment terminates;
(iii) The end of the period equal in length to the time you had Death Benefit coverage as an active Employee, plus 31 days; or
(iv) The date you are no longer totally disabled.

If you should die during this period of extended coverage, a Death Benefit will be paid to your beneficiary as described in (b), provided satisfactory proof of your death and continuing total disability are submitted to the Administrator within 12 months after your death.

(d) Are any conversion rights available?

The following conversion rights are available:

(i) If your Death Benefit coverage terminates because you have terminated employment, transferred to an ineligible class of Employees or become totally disabled, you may apply to the Policy issuer to convert your Death Benefit coverage to an individual life insurance policy, other than term insurance, for an amount up to your terminated Death Benefit coverage; and

(ii) If your Death Benefit coverage terminates because the Policy has terminated and you have been covered under the Policy for at least five years, you will have the same conversion rights described in (i) above, except that the amount of coverage available under the converted policy will not exceed $2,000 or, if less, the amount of your terminated Death Benefit coverage less any other group life insurance for which you are

eligible and which takes effect during the 31-day period following termination of your Death Benefit coverage.

In order to exercise conversion rights, you must make a written application and pay the first premium within 31 days after your Death Benefit coverage has terminated. The amount of the premium will depend upon your age and class of risk, as well as the form and amount of the converted policy. No evidence of insurability is necessary. If you convert your coverage to an individual policy, it will become effective at the end of the 31-day application period; however, if you should die during the application period, the full amount available for conversion will be paid to your beneficiary regardless of whether you have made application. **THIS IS THE ONLY NOTICE YOU WILL RECEIVE OF YOUR CONVERSION RIGHTS.** If you have any questions, please call the Fund Office.

(e) Are there any circumstances in which payment of the Death Benefit can be accelerated and paid to you prior to your death?

Yes, in the event you are diagnosed with a terminal illness and meet certain eligibility requirements, you may elect to receive a lump sum payment of up to fifty percent (50%) of your Death Benefit coverage prior to your death. This accelerated payment is called an "Accelerated Benefit". An Accelerated Benefit is payable only one time. If you elect to receive an Accelerated Benefit, the amount of the Death Benefit payable to your beneficiary upon your death, and the amount available to you for conversion**,** will be reduced by the amount of the Accelerated Benefit. The Accelerated Benefit may be taxable upon distribution, and you are responsible for any taxes that are due.

In order to be eligible for an Accelerated Benefit, you must satisfy the following requirements:

(i) While you have Death Benefit coverage, you or your legal representative must apply to the Administrator for an Accelerated Benefit and submit a doctor's certificate verifying that you have a terminal illness, which means all of the following:

(1) Your life span is drastically limited; and
(2) You are expected to die within six (6) months; and
(3) You are not expected to recover;

(ii) The Administrator must accept and approve the doctor's certificate of terminal illness before any benefits are paid;

(iii) You must be younger than age 65 when you apply for an Accelerated

Benefit; and

(iv) You must submit to a physical examination if requested and paid for by the Health & Welfare Plan.

In no event, however, will an Accelerated Benefit be paid in the event of any of the following:

(i) The Administrator determines that you are terminally ill as a result of attempted suicide or having injured yourself on purpose; or

(ii) The amount of your Death Benefit coverage is less than $10,000; or

(iii) Your Death Benefit has been assigned; or

(iv) Your Death Benefit coverage is being extended at no cost following your employment termination due to total disability.

3. What Dental Benefits Are Provided Under The Health And Welfare Plan?

You and your Dependents who are enrolled in the Health & Welfare Plan will be covered for Dental Benefits. Dental Benefits are provided through a Traditional Fee For Service Dental Plan which is described below.

Traditional Fee For Service Dental Plan Benefits

A. Definitions:

The Traditional Fee For Service Dental Plan of Benefits provided under the Health & Welfare Plan are subject to the following definitions for the terms noted whenever they appear as capitalized terms:

(1) **"Chewing Injury"** means an injury which occurs during the act of chewing or biting. The injury may be caused by biting on a foreign object not expected to be a normal constituent of food; by abnormal habits such as chewing on eyeglass frames or pencils; or by biting down on a suddenly dislodged or loose dental prosthesis.

(2) **"Co-Insurance"** means the percentage of an Eligible Dental Charge which is payable under the Health & Welfare Plan, as shown in the Schedule of Benefits.

(3) **"Covered Dental Injury"** means an injury sustained by a Participant

while covered and which is caused by a sudden, violent, and External Force which could not be predicted in advance and which could not be avoided. A Chewing Injury is not considered to be a Covered Dental Injury.

(4) **"Date Completed"** means the date on which a charge for a given procedure is considered incurred, and which is determined in accordance with the following rules:

(a) For Root Canal Therapy, the date the canals are permanently filled;
(b) For Fixed Bridges (including Maryland Bridges), Crown, Inlays, Onlays, and other laboratory prepared restorations, the date that the appliance is permanently cemented in place;
(c) For Dentures and Partial Dentures, the date the final completed appliance is first inserted in the mouth, provided that no denture or partial denture will be considered completed unless and until it is accepted by the patient; and
(d) For all other services, the Date Started.

(5) **"Date Started"** will be determined in accordance with the following, and services that are started before a Participant is covered will not be payable under the Health & Welfare Plan:

(a) For Complete Dentures or Partial Dentures, the date the final impression is taken;
(b) For Fixed Bridges (including Maryland Bridges), Crowns, Inlays, Onlays, and other laboratory prepared restorations, the date the teeth are first prepared;
(c) For Root Canal Therapy, the date the pulp chamber is first opened;
(d) For Periodontal Surgery, the date the surgery is actually performed; and
(e) For all other services, the date the service is performed.

(6) **“Dental Consultant”** means the person or entity designated by the Trustees to review dental claims and render professional advice to the Trustees.

(7) **“Dentist”** means a person licensed to practice dentistry or a licensed Physician who provides dental treatment or service.

(8) **"Eligible Dental Charges"** means the eligible charges described in Section (K) below and not specifically excluded under Section 13, incurred by a Participant while covered, for dental care performed by or

under the direction of a Dentist or by a dental hygienist, for Necessary services or treatment, when and to the extent covered under the Schedule of Benefits, as amended from time to time.

(9) **"Emergency Treatment"** means any Necessary service, procedure, or supply which is rendered as the direct result of an unforeseen occurrence or combination of circumstances which requires immediate, urgent action or remedy.

(10) **"External Force"** means any sudden, unexpected impact from outside the oral cavity.

(11) **"Functioning Natural Tooth"** means a Natural Tooth which is performing its normal role in the mastication (i.e. chewing) process in the Participant's upper or lower arch and which is opposed in the other arch by another Natural Tooth or prosthetic (i.e. artificial) replacement.

(12) **"Handicapping Malocclusion"** means a malocclusion which severely interferes with the ability of a person to chew food.

(13) **"Immediate Family"** means a Participant's mother, father, sister, brother, spouse, or child.

(14) **"Natural Tooth"** means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e. not manufactured). Organic portions of a tooth include enamel and dentin, the root cementum and dentin, and the enclosed pulp (nerve).

(15) **"Necessary"** means a procedure, service, or supply which is required by, and appropriate for, treatment of the Participant's dental condition according to broadly accepted standards of care as determined by the Trustees or, if applicable, the Dental Consultant.

(16) **"Orthodontic Treatment"** means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a malocclusion of the mouth.

(17) **"Scheduled Fee"** means the maximum amount payable for a particular service as specified in the schedule of allowances established by the Trustees (a copy of which is available on request to the Fund Office), as amended from time to time by the Trustees.

(18) **"Sound Teeth"** are teeth which are fully restored to function, do not have

any decay, are not more susceptible to injury than virgin teeth, and are without significant periodontal disease.

(19) **"Treatment Plan"** means the Dentist's report of recommended treatment which:

(a) Itemizes the dental procedures and charges required for the Necessary care of the mouth; and
(b) Lists the charge for each procedure; and
(c) Is accompanied by supporting pre-operative X-Rays and any other appropriate diagnostic materials required by the Health & Welfare Plan.

Related procedures such as cleaning and root-planing, fillings and crowns will be considered part of the same Treatment Plan even if reported on different claim forms and/or on different dates of service, if they are performed within three (3) months of one another.

B. Coverage:

Dental Benefits are payable for Eligible Dental Charges incurred by a Participant at the Co-Insurance level or, if less, for the Schedule Fee for such service. In no event, however, will Dental Benefits exceed the maximum limitations reflected in the Schedule of Benefits.

C. Date Eligible Dental Charge Incurred:

An Eligible Dental Charge is "incurred" on the date the procedure or service is rendered or the supply is furnished, except as follows:

(1) For fixed partial dentures, crowns, inlays or onlays, it is considered to be incurred on the first date of the preparation of the tooth or teeth involved;
(2) For removable partial or complete dentures, it is considered to be incurred on the date the impression is first taken; and
(3) For endodontics, it is considered to be incurred on the date the tooth is opened for root canal therapy.

D. Extension of Dental Benefits Coverage Under Limited Circumstances:

Dental Benefits will be payable for Eligible Dental Charges incurred by Participants under the following circumstances, even though they are incurred after the Dental Benefits coverage has terminated:

(1) Eligible Dental Charges for a removable partial or complete denture will be payable if the impressions were taken and abutment teeth fully prepared while the Participant was covered, provided the prosthetic device is installed or delivered within sixty (60) days following the termination of coverage;

(2) Eligible Dental Charges for a fixed partial denture, crown, inlay or onlay required for the restoration of a tooth will be payable if the tooth was prepared for the crown while the Participant was covered and the fixed partial denture, crown, inlay or onlay is installed within sixty (60) days following termination of coverage;

(3) Eligible Dental Charges for root canal therapy will be payable if the tooth was opened while the Participant was covered, and treatment was completed within sixty (60) days following termination of coverage; and

(4) Eligible Dental Charges for any other covered procedure or treatment are payable provided a Necessary procedure was performed while the Participant was covered, and further provided the entire treatment was completed within sixty (60) days following termination of coverage.

Dental Benefits coverage will not be extended beyond the date a Participant is no longer covered under the Health & Welfare Plan in any other circumstances.

E. Calendar Year and Lifetime Maximums:

Dental Benefits for the Traditional Fee For Service Dental Plan will not, in any event, exceed the calendar year maximum per Participant for all types of services other than Type IV (Orthodontia Charge), or the lifetime maximum per Participant for Type IV (Orthodontia Charges) specified in the Schedule of Benefits.

F. Calendar Year Deductible $50.00

Plan Amendment No. 1
Effective January 1, 2010
Article V, Section 3 (F)

Dental Benefits are subject to a Calendar Year Deductible, as set forth in the Schedule of Benefits.

G. Co-Insurance:

Dental Benefits for the Traditional Fee For Service Dental Plan are payable at different Co-Insurance percentages depending upon the type of charge, as reflected in the Schedule of Benefits. Any charges incurred in excess of the Scheduled Fee or the maximum calendar year or lifetime limit will not apply in calculating the Health & Welfare Plan's payment obligations.

H. Treatment Plan and Predetermination of Dental Benefits:

Participants are encouraged to submit a Treatment Plan to the Administrator for

any course of treatment which may involve Eligible Dental Charges in excess of $300 before the course of treatment begins. The Treatment Plan should be accompanied by supporting pre-operative x-rays and any other appropriate diagnostic materials requested by the Administrator.

The Administrator will notify the Participant and the attending Dentist of the Dental Benefits payable based upon the Treatment Plan submitted.

I. Examinations and Participant's Disclosure of Information:

If a Participant submits a claim for payment, the Administrator may require the Participant to undergo, at the Health & Welfare Plan's expense, an examination and/or reexamination by a Dentist or Physician of the Administrator's choosing.

Upon the Administrator's request, the Participant must provide any and all information, reports, data, calculations and other documentation required by the Administrator to process the claim, including but not limited to the following information:

(1) A complete dental chart showing extractions, missing teeth, fillings, prosthesis, periodontal pocket depths, orthodontic relationships, and the date of any work previously performed;
(2) An itemized bill for dental care; and
(3) Pre-operative x-rays, study models, and laboratory and/or hospital reports.

J. Alternate Benefits:

There is often more than one service or supply that may be used to treat a dental problem or disease. In determining the Dental Benefits payable on a claim, the Administrator will consider different materials and methods of treatment. The amount covered for Dental Benefits will be limited to the amount that would be incurred for the least costly service which meets broadly accepted standards of dental care as determined by the Administrator. If the Participant and his Dentist decide on a more costly procedure or material than the Administrator has determined to be satisfactory for the treatment of the condition, the amount of Dental Benefits payable will be limited to the amount that would have been incurred had the least costly procedure or material determined by the Administrator to be satisfactory been used, subject to any co-insurance or other limitations.

K. Eligible Dental Charges:

The following is an exclusive list of the dental charges, procedures and/or treatments that qualify as an "Eligible Dental Charge", and any procedures and/or

treatments not listed will not be payable as Dental Benefits:

Type I - Preventive and Diagnostic (Payable at 100% Co-Insurance Level)

(1) Oral Examinations: Routine oral examinations including diagnosis limited to not more than two (2) such exams in any calendar year with respect to the same individual.
(2) Complete Mouth Survey (FMX) (X-Ray) and Panoramic X-Ray (Panorex): Limited to one (1) Complete Mouth Survey or Panoramic X-ray in any forty-eight (48) consecutive month period with respect to the same individual.
(3) Bitewing X-Rays (BWX): Limited to two (2) such sets of X-Rays in any calendar year with respect to the same individual, and a maximum of four (4) films per occurrence.
(4) Prophylaxis (Routine Cleaning) and Periodontal Maintenance Procedure (Routine and Below Gumline Cleaning): Includes cleaning, scaling and polishing. Limited to not more than two (2) Prophylaxis or Periodontal Maintenance Procedures in any calendar year with respect to the same individual. Periodontal Maintenance Procedure is payable for two (2) procedures per calendar year if at least six (6) months have passed since the completion of active periodontal therapy. Any Periodontal Maintenance Procedure that does not follow active periodontal therapy shall be considered as a Prophylaxis.
(5) Fluoride Treatments: Limited to one (1) time in any consecutive twelve (12) month period.
(6) Sealants: Limited to one (1) time per tooth in any three (3) consecutive year period and to Participants under age sixteen (16). Limited to unrestored premolars and to unrestored molar teeth.
(7) Space Maintainers: Includes all adjustments made within six (6) months of installation. Limited to Participants under age sixteen (16) and to recementation thereof.
(8) Harmful Habit Appliances: Limited to one (1) time per individual, to Participants under age sixteen (16), and to the recementation thereof.
(9) Periapical X-Rays: Limited to a maximum of four (4) in any twelve (12) consecutive month period with respect to the same individual.
(10) Extraoral and Intraoral Occlusal X-Rays: Limited to two (2) films each in any twelve (12) consecutive month period with respect to the same individual.
(11) Full Mouth Debridement: Limited to one (1) in a lifetime.

Type II: Basic Services (Payable at 80% Co-Insurance Level)

(1) Amalgam Restorations and Silicate Restorations: Benefits for the replacement of an existing amalgam restoration or silicate restoration are payable only in the event at least twelve (12) months have passed since the existing amalgam was placed.

(2) Composite Resin Restorations: Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth are considered single surface restorations. Benefits for the replacement of an existing composite restoration are payable only if at least twelve (12) months have passed since the existing filling was placed. Benefits for composite resin restorations on posterior teeth are based on the actual material used.

(3) Crown Repair: Limited to repairs performed more than six (6) months after initial insertion.

(4) Therapeutic Pulpotomy: Payable for deciduous (primary) teeth only.

(5) Re-Cement and Repairs to Bridges: Limited to repairs performed more than six (6) months after initial insertion.

(6) Palliative Treatment (emergency): Paid as a separate benefit only if no other service is rendered during the visit except x-rays.

(7) Gingivectomy, Gingival Curettage, Gingival Flap Procedure (Including Root Planing), Mucogingival Surgery (Per Quadrant), Osseous Surgery and Guided Tissue Regeneration (includes surgery and reentry). Limited to one (1) procedure per area of the mouth in any thirty-six (36) month period, with respect to the same individual.

(8) Crown Lengthening, Osseous Grafts, Pedicle Soft Tissue Graft, and Free Soft Tissue Graft.

(9) Periodontal Scaling and Root Planing: Limited Per Quadrant to one (1) time per quadrant of the mouth in any twenty-four (24) consecutive month period, but is not payable separately if performed on the same Treatment Plan as prophylaxis.

(10) Periodontal Appliance (Occlusal Guard): Limited to one (1) appliance in any twenty-four (24) consecutive month period with respect to the same individual.

(11) Occlusal Adjustment: Covered only when performed with periodontal surgery. Limited to one (1) full mouth treatment in any twenty-four (24) consecutive month period with respect to the same individual.

(12) Actisite: Covered only if the Participant has had a periodontal procedure in the same quadrant within one (1) year prior to the Actisite placement.

(13) Occlusion Analysis Mounted Case: If the treatment is related to Orthodontic procedures, covered only as a Type IV Orthodontic Charge.

(14) Consultations with and examinations by a Dentist other than the Dentist providing the actual treatment for the sole purpose of making a diagnosis and recommendation, when specified in a Treatment Plan.

(15) Repairs to Complete and Partial Dentures: Limited to repairs performed more than six (6) months after initial insertion.

(16) Stress Breaker.

(17) Histopathologic Examinations.

(18) Pin Retention: Covered only in conjunction with an amalgam or composite restoration. Payable one (1) time per restoration regardless of the number of pins used.

(19) Root Canal Therapy, Apexification, Apicoectomy, Retrograde Filling (per root)

and Root Amputation (per root) which includes all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

(20) Hemisection: Includes anesthesia and routine post-operative care. Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered.

(21) Simple Extractions: Includes an allowance for local anesthesia and routine post-operative care.

(22) Root Removal - Exposed Roots: Includes an allowance for local anesthesia and routine post-operative care.

(23) Root Canal Therapy, Retreatment only if Necessary.

(24) The following benefits include an allowance for local anesthesia and routine post-operative care:

- (a) Surgical Extractions.
- (b) Excision of impacted teeth.
- (c) Surgical Removal of Residual Teeth (Cutting Procedure).
- (d) Oral Antral Fistula Closure.
- (e) Tooth Reimplantation and/or Stabilization of Accidentally Avulsed or Displaced Tooth.
- (f) Tooth Transplantation.
- (g) Surgical Exposure of Impacted or Unerupted teeth for orthodontic reasons (including orthodontic attachments).
- (h) Surgical Exposure of Impacted or Unerupted Tooth to aid Eruption.
- (i) Biopsy of Oral Tissue.
- (j) Alveoplasty.
- (k) Vestibuloplasty.
- (1) Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions).
- (m) Excision of Benign Tumor.
- (n) Removal of Odontogenic Cyst or Tumor.
- (o) Removal of exostosis - maxilla or mandible.
- (p) Incision and Drainage.
- (q) Removal of Foreign Body.
- (r) Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body.
- (s) Frenectomy (Frenulectomy, Frenotomy), Separate Procedure.
- (t) Excision of Hyperplastic Tissue - Per Arch.
- (u) Excision of Pericoronal Gingiva.
- (v) Sialolithotomy.
- (w) Excision of Salivary Gland.
- (x) Sialodochoplasty.
- (y) Closure of Salivary Fistula.

(25) Intravenous Sedation and General Anesthesia: Paid as a separate benefit only when Necessary and administered in conjunction with complex oral surgical procedures which are covered.

(26) Therapeutic Drug Injections.
(27) Provisional Splinting: However, no payment will be made for crowns or inlays or other cast or laboratory prepared restorations made for the purpose of splinting.
(28) Bacteriologic Studies for Determination of Pathological Agents.
(29) Application of Desensitizing Medicaments.
(30) Re-Cement of Inlays and Crowns: Re-cementation performed more than six (6) months after initial insertion.
(31) Repair Implant: Covered only if Necessary.

Type III - Special Services (Payable at 50% Co-Insurance Level)

(1) Denture Adjustments, Relining Dentures and Rebasing Dentures: The first Adjustment, Relining and Rebasing is payable only if performed more than six (6) months after the initial insertion. Adjustment, Relining and Rebasing is limited to one (1) time in any twelve (12) consecutive month period with respect to the same individual.
(2) Tissue Conditioning: The first Tissue Conditioning is payable only if performed more than six (6) months after the initial insertion of the denture. Tissue Conditioning is limited to one (1) time in a twenty-four (24) consecutive month period.
(3) Inlays and Onlays: Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than five (5) years have elapsed since the last placement.
(4) Porcelain and Full Cast Crowns: Covered only when the tooth cannot be restored by an amalgam or composite filling, and then only if more than five (5) years have elapsed since the last placement. A Resin Crown on molar teeth is covered as an alternate benefit to an all-metal crown. For Participants under age sixteen (16), benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns.
(5) Stainless Steel and Resin Crowns: Covered only when the tooth cannot be restored by an amalgam or composite filling. Stainless steel crowns are limited to Participants under age sixteen (16) and replacement is limited to one (1) time in a thirty-six (36) consecutive month period. Resin Crowns are covered for all Participants but replacement is covered only if replaced more than five (5) years after placement. A Resin Crown on molar teeth is covered as an alternate benefit to an all-metal crown.
(6) Core Buildup (In Conjunction with a Crown or Inlay): Covered only under unusual circumstances when required for retention and preservation of tooth; includes all pins and/or prefabricated posts.
(7) Post and Core (In Conjunction with a Crown or Inlay): Covered only for endontically treated teeth requiring crowns.
(8) Labial Veneer Restoration on Anterior Teeth: Covered only when the tooth cannot be restored by a composite resin or silicate filling, and then only if more

than five (5) years has elapsed since last placement.

(9) Diagnostic Casts: Limited to one (1) time in any thirty-six (36) month period and only if diagnostic casts are required for extensive bilateral prosthetic dentistry other than dentures. Payable as a Type IV Expense if done in conjunction with orthodontics.

(10) Complete Dentures: No additional benefits are payable for individualized dentures, overdentures, or associated procedures. Denture benefits are not payable until the Denture has been accepted by the Participant; limited to one (1) time per arch per five (5) years. However, benefits for replacement of an existing full denture are payable only if the existing prosthesis is more than five (5) years old, is not serviceable, and cannot be repaired, and then only if the Participant has been continuously eligible for benefits for at least twenty-four (24) months.

(11) Partial Dentures: No additional benefits are payable for precision or semi-precision attachments. The Partial Denture benefit includes any clasps and rests, and all teeth. Limited to one (1) Partial Denture per arch per five (5) years, unless there is a Necessary extraction of an additional Functioning Natural Tooth. However, benefits for the replacement of an existing Partial Denture are payable only if the existing prosthesis is more than five (5) years old, is not serviceable, and cannot be repaired, and then only if the Participant has been continuously eligible for benefits for at least twenty-four (24) months.

(12) Add Tooth to Existing Partial Denture: Covered only if the procedure is performed more than twelve (12) months after the insertion of the Partial Denture and only for the purpose of replacing a newly extracted Functioning Natural Tooth.

(13) Endosseous Implants: Covered as an Eligible Dental Charge subject to alternate benefits and missing tooth provisions. Benefits for the replacement of an existing Implant are payable only if the existing prosthesis is more than seven (7) years old, is not serviceable, and cannot be repaired, and then only if the Participant has been continuously eligible for benefits for at least twenty-four (24) months.

(14) Removal of Implant: Limited to the Removal of an Endosseous Implant which is not serviceable and cannot be repaired.

(15) Fixed Bridges (Non-Precious Metal Pontics, Crown Abutments, and Metallic Retainers): Unless there is a Necessary extraction of an additional Functioning Natural Tooth, benefits for the replacement of an existing Fixed Bridge are payable only if the existing Bridge is more than five (5) years old, is not serviceable, and cannot be repaired, and then only if the Participant has been continuously eligible for benefits for at least twenty-four (24) months.

(16) Cast Metal Retainer for Maryland Bridge: Benefits for replacement of a Maryland Bridge are payable only if the existing Metal Bridge is more than five (5) years old, is not serviceable, and cannot be repaired, and then only if the Participant has been continuously eligible for benefits for at least twenty-four (24) months.

(17) Post and Core (In Conjunction with a Fixed Bridge): Covered only for endodontically treated teeth requiring crowns.

(18) Core Buildup For Retainer (Including any Pins): Covered only under unusual circumstances when required for retention and preservation of the tooth; includes all pins and/or prefabricated posts.

Type IV - Orthodontia (Payable at 50% Co-Insurance Level)

Orthodontic benefits are payable only for covered Orthodontic Treatment which is started after a Participant's effective date of coverage for orthodontic benefits. **IF ORTHODONTIC TREATMENT IS STARTED BEFORE THE PARTICIPANT IS COVERED FOR ORTHODONTIC BENEFITS, INCLUDING DURING ANY WAITING PERIOD FOR ORTHODONTIC COVERAGE, EXPENSES ARISING FROM THE ENTIRE ORTHODONTIC TREATMENT PLAN WILL NOT BE COVERED.** The effective date of coverage for orthodontic benefits for Late Dependent Enrollees is the first day of the 13th month following the Late Dependent Enrollee's effective date of coverage for Dental Benefits. Orthodontic benefits include the following:

(1) Orthodontic diagnosis, evaluation and pre-orthodontic treatment, including Occlusion Analysis - Mounted Case if for orthodontic purposes;
(2) Transeptal Fiberotomy;
(3) Orthodontic Appliances - furnishing and attachment of any Necessary orthodontic appliances; and
(4) Orthodontic Treatment - performed pursuant to a written Treatment Plan submitted to the Trustees.

L. <u>Special Payment Procedures and Limits For Orthodontics</u>:

Dental Benefits are payable for Eligible Dental Charges incurred for any one (1) course of covered Orthodontic Treatment (including any orthodontic diagnosis, evaluation, and pre-orthodontic treatment), at a 50% Co-Insurance level, for “A” plus “B” as follows:

“A” is an initial amount equal to one fourth (1/4) of the total Eligible Dental Charges for the course of Orthodontic Treatment, to be considered for an initial Dentist’s fee incurred for diagnosis, evaluation, pre-orthodontic treatment and the insertion of orthodontic appliances; however, the initial amount shall not exceed the Dentist’s actual charge; and

“B” is a quarterly maximum amount equal to the difference between “A”, the initial amount, and the total Eligible Dental Charges for the course of Orthodontic Treatment, divided by the number of quarters in the projected period of treatment specified in the written Treatment Plan.

Orthodontic benefits are not subject to a calendar year maximum or deductible;

however, they are subject to an annual lifetime maximum as shown in the Schedule of Benefits. Orthodontic benefits will be calculated based on the Dentist's original Treatment Plan, or representation thereof, and the covered procedures listed above.

M. Exclusions:

Regardless of any other provision to the contrary, the following charges are specifically excluded from Dental Benefits coverage and are not payable under the Health & Welfare Plan under any circumstances:

(1) Dental charges incurred for treatment which is not reasonably expected to correct a dental condition for at least three (3) years;

(2) Any expenses not submitted to the Fund for payment on or before March 31 following the end of the calendar year in which the treatment or Treatment Plan was completed;

(3) Any expenses incurred for Orthodontic Treatment started before the patient is covered for orthodontic benefits;

(4) Any charges for which, in part or whole, the patient is not responsible, including any amount for which the provider forgives payment after the Health & Welfare Plan has already made payment;

(5) Any claim for which false or fraudulent information has been furnished to the Health & Welfare Plan;

(6) Any claim for which an offset is made by the Fund to secure reimbursement of an erroneous payment or to secure payment of a debt owed to the Health & Welfare Plan by you or your family;

(7) Charges which are not included in the list of Eligible Dental Charges, or which are not Necessary, or which are experimental or investigational in nature, or for which a charge would not have been made in the absence of coverage;

(8) Crowns, Inlays, Cast Restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

(9) Appliances, Inlays, Cast Restorations, Crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;

(10) Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery; bite registration; or bite analysis;

(11) Any procedure, service, or supply provided primarily for cosmetic purposes. Facings on crowns or bridge units on molar teeth shall always be considered cosmetic;

(12) The initial placement of a full denture, partial denture, endosseous implant, or fixed bridge, including a Maryland bridge, unless it includes

the replacement of a Functioning Natural Tooth extracted while the patient is covered and the work is completed within 12 months following extraction;

(13) Replacement of a bridge, partial denture, full denture, crown, cast restoration, inlay, onlay or other laboratory prepared restoration which can be restored to function;

(14) The replacement of teeth beyond the normal complement of thirty-two (32);

(15) Athletic mouthguards; myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery; completion of claim forms; exams required by a third party; individual supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;

(16) Charges for travel time, transportation costs or professional advice given on the phone;

(17) The replacement of an existing partial denture with fixed bridgework unless upgrading to fixed bridgework is essential to the correction of the dental condition;

(18) Any charges made by a hospital;

(19) Any procedure, service, or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;

(20) Any procedure, service or treatment incurred as a result of war, insurrection, Employer clinics, U.S. Government or Government Programs, or self-inflicted injury;

(21) Any charge for services or supplies occasioned by an injury, disease or illness incurred or contracted in the scope of the individual’s occupation or employment, whether or not a claim is asserted under applicable workers' compensation laws;

(22) Unless otherwise specifically provided, any charge which is subject, in whole or part, to reimbursement or recovery under any other applicable law, insurance, or contract, including:

   (a) Any claim or cause of action which may accrue because of the alleged intentional or negligent conduct of a third party or his insurers, including claims against the individual’s own insurer under the uninsured motorists coverage provisions; or

   (b) Any claim or cause of action which may accrue because of an event giving rise to a claim under the products liability laws of any state; or

   (c) Any claim or cause of action which may accrue because of an event giving rise to a claim against the individual's own homeowner's insurance carrier;

(23) That portion of any charge in excess of the Scheduled Fees for the Dental Benefits;

(24) Replacement of a partial denture, complete denture, endosseous implant, or fixed bridge (including a Maryland bridge) or the addition of teeth to a partial denture unless:

(a) Replacement occurs at least five (5) years after the initial date of insertion of the current complete or partial denture, fixed bridge, or Maryland bridge; or

(b) Replacement occurs at least seven (7) years after the initial date of insertion of an existing endosseous implant; or

(c) The replacement prosthesis or addition of a tooth to a partial denture is required by the Necessary extraction of a Functioning Natural Tooth while the patient is covered; or

(d) The replacement is made Necessary by a Covered Dental Injury to Sound or Natural Teeth (provided the replacement is completed within twelve (12) months of the injury). Chewing Injuries do not qualify an existing prosthesis for replacement;

(25) The replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations within five (5) years of the date of insertion, or the replacement of a labial veneer restoration within five (5) years of the date of insertion;

(26) Fixed bridgework replacing the extracted portion of a hemisected tooth; and

(27) Crowns, inlays or other cast or laboratory prepared restorations made for the purpose of splinting.

N. <u>Proration of Eligible Dental Charges by Multiple Dentists</u>:

If a service, treatment, or procedure is commenced by one Dentist and completed by another, any Eligible Dental Charges incurred for the treatment as a whole, as specified in the Treatment Plan, will be prorated between the providers. No Dental Benefits are payable for duplicate charges for the same service, treatment or procedure, or for Eligible Dental Charges in excess of the total specified in the Treatment Plan.

4. What Are The Vision Benefits Provided Under The Health and Welfare Plan?

The Vision Benefits provided under the Health & Welfare Plan are described in the following provisions.

A. Definitions

The Vision Benefits provided under the Health & Welfare Plan are subject to the following definitions for the terms shown whenever they appear as capitalized terms:

(1) **"Eligible Vision Charges"** mean the charges incurred by a Participant, while covered under the Health & Welfare Plan, for covered vision services and supplies. A charge is incurred on the date the procedure or service is rendered or the supply is furnished

(2) **"Non-Panel Provider"** means any provider of vision services and supplies who is not a Panel Provider.

(3) **"Panel Provider"** means any provider of vision services or supplies which has agreed to provide such services or supplies to Participants at reduced or discounted rates.

B. Scope of Vision Benefits Coverage

The Vision Benefits available under the Health & Welfare Plan are designed to offset the expenses incurred by you and your covered Dependents for vision acuity examinations and prescribed eyewear.

C. Eligible Vision Charges and Limitations

Vision Benefits are payable only for Eligible Vision Charges and are subject to the limitations described in this Section 4 and the Schedule of Benefits. Vision Benefits for a vision examination, and for lenses or frames, are limited to one (1) examination and one (1) set of lenses and/or frames every twelve (12) months measured from the date of examination or the date the lenses or frames are furnished as applicable.

Charges incurred by a Participant, for or in connection with the following, will qualify as an Eligible Vision Charge:

(1) **EYE EXAMINATION**: a vision acuity examination performed by an ophthalmologist or optometrist (or any other Physician licensed to perform vision examinations and prescribe lenses) for the purpose of evaluating the visual acuity of the eyes. An examination includes: case history; testing near and distant visual acuity (habitual and/or uncorrected); external and internal ocular examination; tonometry for persons over age 40 and when professionally indicated; distance refraction (objective and subjective near refraction); binocular coordination evaluation (distance and near); determination of treatment plan, advice to patient; and form completion.

(2) **DISPENSING OF EYEWEAR**: dispensing of eyewear by duly licensed and certified personnel, including: fitting measurements (frame size, segment heights, etc.); choice of glass or plastic lenses in single vision, bifocal or trifocal; selection of frames from stylized, standardized frame selection specified by the network provider from time to time; all materials verified as first quality; all ranges of

prescriptions, including cataract lenses; oversize lenses; single color solid fashion tinting of glass lenses and gradient tints of any density of plastic lenses; soft standard daily wear contact lenses (in lieu of all glasses) or the initial supply of disposable or planned replacement contact lenses; verification of eyeglasses for accuracy, adjustments and follow-up adjustments. Lenses will meet the ANSI Z80.1 standards.

Vision Benefits will also include the following:

(1) **WARRANTY**: Panel Provider lenses and frames will be repaired or replaced (excluding scratched lenses) for a period of one (1) year from the date of delivery at no cost to the Participant. This warranty applies only to eyeglasses broken in normal use and returned to the Panel Provider office from which dispensed; and

(2) **VOUCHER PROGRAM**: You and your covered Dependents may purchase a voucher for additional pairs of corrective eyeglasses or contact lenses for the amount listed in the Schedule of Benefits.

D. Vision Benefit Exclusions

Regardless of any other provision to the contrary, charges incurred for any of the following are specifically excluded from Vision Benefits coverage and are not payable under the Health & Welfare Plan under any circumstances:

(1) Medical or surgical treatment of the eye;
(2) Replacement of lenses or frames which are lost or broken in normal use after a one (1) year period from the date of service;
(3) Services or supplies for which the Employee is entitled to payment or which are furnished under the School Board safety glass program;
(4) Extra charges for photosensitive or anti-reflective lenses, unless otherwise provided in the Schedule of Benefits;
(5) Drugs or any other medication not administered for the purpose of a vision examination;
(6) Special or unusual procedures such as, but not limited to, orthoptics, vision training, aniseikonic lenses and tonography;
(7) Vision examinations rendered and lenses or frames ordered:
    (1) Before the individual is covered under the Health & Welfare Plan; or
    (2) After the expiration of the service authorization, which is valid for 45 days from the date of issuance;
(8) Services or supplies not prescribed as necessary by a licensed Physician, optometrist or optician;
(9) Charges for services or supplies which are experimental in nature;
(10) Services or supplies necessitated or occasioned by any injury or illness arising in

the course and scope of employment, or which are occupationally related;

(11) Services or supplies for which the Participant is not charged or responsible or liable for payment, or for which no charge would be made in the absence of Vision Benefits coverage;

(12) Services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by a governmental body;

(13) Services or benefits which are not listed as Eligible Vision Charges under 4(A)(1) and (C); and

(14) Services or supplies to the extent covered under the Loss or Damage Fund provided for in the Collective Bargaining Agreement.

ARTICLE VI
EXTENSION AND TERMINATION OF PARTICIPATION

1. What Happens If I Go On A Leave Of Absence Without Pay Or Am Suspended Without Salary and Benefits?

If you go on a leave of absence without pay or are temporarily suspended without salary and benefits during the Plan Year, your coverage under the Plan will be as follows:

- If you go on a leave of absence without pay, your coverage under the Health & Welfare Plan will terminate unless you elect to continue it through Self-Payment under COBRA. Your covered Dependents may also elect to continue their coverage under the Health & Welfare Plan to the extent permitted under COBRA.

- If you are temporarily suspended without benefits, your coverage under the Health & Welfare Plan will continue during your suspension for up to 31 days; however, at that time it will terminate unless you elect to continue it through Self-Payment under COBRA. Your covered Dependents may also elect to continue their coverage under the Health & Welfare Plan to the extent permitted under COBRA.

- In all cases, your rights to coverage in a Medical flexible spending account will be as follows:

  – No further salary reductions and Fund contributions, if any, will be made on your behalf;

  – You will be recognized as a former Employee and will be able to continue to request reimbursement for qualifying medical expenses incurred before your termination, leave without pay or suspension without salary and benefits. Any reimbursements will be made from the balance remaining in your account. You will not, however, be able to contribute any further amounts to this account.

  – You may elect to continue your participation in the Medical flexible spending account under COBRA by continuing your monthly contributions for any number of consecutive months remaining through the end of the Plan Year. However, if you become covered by another cafeteria plan with a similar flexible spending account, you will not be eligible to continue this coverage.

  - If you do not elect to continue your participation under COBRA, your coverage will cease.

- In all cases, your rights to coverage in a Dependent Care flexible spending account will be as follows:

  - No further salary reductions and Fund contributions, if any, will be made on your behalf;

  - You will be recognized as a former Employee and will be able to continue requesting reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your account; and

  - You may not elect to continue this coverage through Self-Payment under COBRA.

If you are suspended, it is important that you cooperate in providing any information and signing any documents required by the Fund so that they can determine the necessary information about your suspension to protect any rights you have to continue coverage. If the Trustees cannot make this determination, they will presume that your suspension is indefinite and without benefits.

If, because of job action, contract grievance procedures or an award in your favor, the School Board agrees or is required to make you whole for benefits lost during a suspension period, the Fund will either reimburse you for any Self-Payments that you made to continue your participation in the Health & Welfare Plan, or it will retroactively restore your coverage in the Health & Welfare Plan. In no event, however, will you be permitted to make any retroactive changes to your coverage under the Cafeteria Plan.

The Administrator will inform you of these rights at the time you terminate employment, go on a leave without pay or are suspended without salary and benefits.

2. What Happens If I Go On Paid Leave Or Workers' Compensation Leave Or Am Suspended With Salary And Benefits?

If you go on a paid leave of absence or workers' compensation leave or are suspended with salary and benefits during the Plan Year, you may continue your coverage under the Plan as an active Employee provided your pay is sufficient to support any contributions you were making for such coverage.

3. What Happens If I Am Absent Because Of A Labor Dispute?

If you are absent from employment during a Labor Dispute, you may be able to continue your coverage as an active Employee until your employment terminates permanently or, if sooner, for one year from the date your coverage would otherwise terminate. Once your coverage as an active Employee ends, you may elect to continue your coverage to the extent permitted under COBRA.

4. What Happens If I Take Family and Medical Leave ("FMLA Leave")?

Generally, FMLA Leave is leave that is taken under certain circumstances that are critical to your family such as the birth of a child, the placement of a child with you for adoption or foster care, when you are needed to care for a child, a spouse or a parent with a serious health condition or when you are unable to perform your duties because of a serious health condition (see also the definition of "FMLA Leave" under the Plan Definitions). If you take FMLA Leave, your health coverage under the Health & Welfare Plan will continue without cost; however, if you want to continue your Dependent's coverage, you must continue to make contributions in the amount you were previously submitting for the Dependent coverage. You will also be permitted to make Self-Payments to continue any coverage you have under the Cafeteria Plan. The Administrator will inform you of your rights if you should go on FMLA Leave.

5. What Happens If I Take A Leave of Absence For Qualified Military Service?

The federal law known as the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), provides you with certain rights to continue your coverage under the Plan, including on a Self-Payment basis, in the event you take a leave of absence because of qualified military service. "Qualified military service" generally means voluntary or involuntary active duty, active duty training, inactive duty training or annual training in the United States Armed Forces or their reserve components or the National Guard. It is important that you contact the Administrator as soon as possible after you learn that you will be leaving employment because of military service in order to determine your rights and obligations.

6. Generally, When Does My Coverage As An Employee Terminate?

Generally, the following events will result in termination of your coverage under the Plan:

- Your Employee status ends because of death or termination of employment for any reason, or when you transfer to a non-covered job classification.
- The Plan is amended to terminate eligibility for the Employee class to which you belong.

- The Plan is terminated.

- You fail to pay timely a Self-Payment or contribution required to continue coverage.

- For the Cafeteria Plan only, you do not return a completed application and salary reduction agreement during an Election Period for a Plan Year.

7. What Happens To Your Participation In The Plan When Your Coverage As An Employee Terminates?

- Your participation in the Health & Welfare Plan terminates on the last day of the month in which the terminating event occurs. At that time, you and your Dependents can elect to continue coverage on a Self-Payment basis to the extent required under COBRA.

- Your participation in the Cafeteria Plan terminates on the date of the event, and your rights will generally be as follows:

  – No further salary reduction or Fund contributions will be made to your flexible spending accounts.

  – For a Medical flexible spending account, you will be recognized as a former Employee and for the remainder of the Plan Year will be able to continue requesting reimbursement for qualifying medical expenses incurred before your termination. These reimbursements will be made only from the balance remaining in your account. You may elect to continue your participation under COBRA by continuing your monthly contributions for any number of consecutive months through the end of the Plan Year. However, if you become covered by another cafeteria plan with similar coverage, you will not be eligible to continue this coverage. If you do not elect to continue your participation under COBRA, your coverage will cease.

  – For a Dependent Care flexible spending account, you will be recognized as a former Employee and for the remainder of the Plan Year will be able to continue requesting reimbursement for qualifying dependent care expenses incurred at any time during the remainder of the Plan Year. Reimbursements will be made only from the balance remaining in your account. You may not elect to continue this coverage through Self-Payment under COBRA.

The Administrator will inform you of these rights at the time your participation terminates.

8. When Does Your Dependent's Coverage Terminate?

Your Dependent's coverage under the Health & Welfare Plan will terminate on the last day of the month in which the first of the following events occurs:

(a) Your Dependent no longer qualifies as a Dependent under the Health & Welfare Plan;
(b) Your coverage under the Health & Welfare Plan as an Employee terminates;
(c) You fail to pay timely any contribution required to maintain your Dependent's coverage;
(d) The Health & Welfare Plan is amended to terminate coverage for all Dependents or for a classification of Dependents to which your Dependent belongs; or
(e) The Health & Welfare Plan is terminated.

9. What Happens To Your Dependent's Coverage Under The Health and Welfare Plan When It Terminates?

Your Dependent's coverage under the Health & Welfare Plan will terminate on the last day of the month in which the terminating event occurs. At that time, your Dependent can elect to continue coverage on a Self-Payment basis to the extent required under COBRA.

10. Do I Have Any Obligations To Notify The Plan When My Dependent No Longer Qualifies As A Dependent Or When There Is Any Other Error Involving Dependent Coverage?

Yes, you must notify the Fund Office in the event your Dependent no longer qualifies as a Dependent under the Health & Welfare Plan for any reason, or when there is any error involving Dependent coverage, such as an error in the amount being deducted from your paycheck to pay for Dependent coverage. For example, you may divorce your spouse, or your child may turn 19 and not be a full-time student or may graduate from college or may turn 26, in which case they would no longer qualify for coverage as a Dependent.

ARTICLE VII
COORDINATION OF BENEFITS UNDER THE HEALTH AND WELFARE PLAN

1. Does The Health and Welfare Plan Provide For Coordination Of Benefits?

Yes, the Health & Welfare Plan provides for coordination of benefits with any "Other Plan" that covers all or a portion of the Eligible Charges incurred by you or your Dependent under the Health & Welfare Plan. The amount of benefits payable under the Health & Welfare Plan and the Other Plan are coordinated so that the total amount paid by both plans does not exceed 100% of the Eligible Charges that you or your Dependent incurs. Payment will be made on a primary-secondary basis, such that one plan pays first, as the primary plan, and the Other Plan pays second, after taking the primary plan's payment into consideration.

2. What Does "Other Plan" Include?

The term, "Other Plan," includes any of the following plans which provide medical, dental or vision benefits, services, or treatment:

(1) Group insurance coverage including Blue Cross, Blue Shield, and any other prepayment coverage provided on a group basis;

(2) Coverage under any other health, dental or vision plan maintained or sponsored by the School Board, labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans, voluntary employees' beneficiary associations, and any other group arrangement;

(3) Any coverage provided under governmental programs or required by a statute; and

(4) Any other group plan sponsored by an Employer.

3. How Are Benefits Coordinated?

The following rules will determine which plan pays first when there is an Other Plan involved:

(1) If the Other Plan contains no coordination provisions, it will be considered primary plan;

(2) The plan which covers you as an employee pays benefits first, and the plan which covers you as a dependent pays second;

(3) If the Other Plan covers you as an employee of the School Board or as a dependent of such employee, it will be considered the primary plan;

(4) If your Dependent child is covered by both parents' plans, the plan which covers the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year is the primary plan, and the plan which covers the parent whose date of birth, excluding year of birth, occurs later in the calendar year is the secondary plan. This method of determination is called the "birth-date rule." If the Other Plan provides for gender-based rules and, as a result, the plans do not agree on the order of benefits, the birth-date rule will determine the order;

(5) For a Dependent child whose parents are divorced or legally separated, benefits will be paid according to the following rules:

(a) If a court order places financial responsibility for the child's health care on one of the parents, the plan covering that parent is the primary plan;

(b) If there is no such court order assigning responsibility for health care coverage, the plan of the parent with custody is the primary plan, and the plan of the parent without custody pays second;

(c) If the parent with custody has remarried, the order of payment will be:

(i) The plan of the parent with custody pays first;

(ii) The plan of the step-parent with custody pays second; and

(iii) The plan of the parent without custody pays third;

(6) A plan covering you or your Dependent as an active employee pays first, while a plan covering you or your Dependent as a laid-off, terminated or retired employee pays second. A plan covering a dependent of an active employee pays first, while a plan covering a dependent of a laid-off, terminated or retired employee pays second. For purposes of these coordination of benefit rules, a former employee participating in a plan pursuant to COBRA or any other self-pay provisions is considered to be covered as a laid-off, terminated or retired employee;

(7) If you or your eligible Dependent is covered under more than one plan and the above provisions do not establish an order of payment of benefits, as in the case of an award of joint custody, the plan under which the person incurring the claim was covered longer will pay first; and

(8) In coordinating with Medicare, the Health & Welfare Plan pays first with regard to active Employees and their Dependents who are eligible for Medicare, regardless of age, unless otherwise provided by applicable law.

The Trustees may release to or obtain from any other plan or person, or may obtain from you, any information they deem necessary to administer the coordination of benefit rules. The Trustees may also recover any amounts paid under the Health & Welfare Plan, in excess of what is due under the coordination of benefit rules, from any plan or person to whom such payments were made.

The Trustees have sole and absolute authority to determine the appropriate order of benefit payments under the Health & Welfare Plan's coordination of benefit rules, and such determinations are final and binding on you and your Dependents, as well as on any provider, third party or Other Plan asserting a claim.

ARTICLE VIII
SELF-PAY CONTINUATION COVERAGE (COBRA)

1. What Is COBRA And COBRA Coverage?

"COBRA" is a federal law that requires the Plan to offer you and other members of your family the option to continue your Dental and Vision Benefits coverage under the Health & Welfare Plan and your Medical flexible spending account coverage under the Cafeteria Plan for a limited period of time, when it would otherwise end due to certain life events known as "qualifying events". This temporary continuation of health coverage required under COBRA is referred to as COBRA coverage.

The qualifying events are described below. After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is any Employee or Dependent spouse or child who will lose Dental and Vision Benefits coverage under the Health & Welfare Plan and/or Medical Flexible spending account coverage under the Cafeteria Plan because of a qualifying event, as well as any Dependent child who is born to or placed for adoption with a covered Employee during the period he is self-paying for COBRA coverage. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for it.

If a qualified beneficiary who is self-paying for COBRA coverage acquires a dependent spouse or child who could be enrolled in the Plan if the qualified beneficiary was an active Employee, the qualified beneficiary may add the Dependent to his coverage for the remainder of the COBRA coverage period.

In addition, if a qualified beneficiary with COBRA coverage has a Dependent (a) who is eligible but did not enroll in the Plan at the time of the qualified beneficiary's initial enrollment because the Dependent had other coverage at that time, and (b) who lost the other coverage due to exhaustion of COBRA, loss of eligibility or termination of employer contributions (but not due to failure to pay timely a required premium or termination of coverage for cause), the qualified beneficiary may add that Dependent to his coverage, for the remainder of the COBRA period, within 30 days after termination of the Dependent's other coverage.

Please read this Article VIII carefully, as it explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Administrative Manager for the Fund, who administers COBRA coverage under the Plan. The Administrative Manager can be reached at the following address and telephone number:

Administrative Manager
JFT Health & Welfare Fund
2540 Severn Avenue, Suite 302 OR **P.O. Box 6137**
Metairie, LA 70002 **Metairie, LA 70009-6137**

Phone (504) 455-7261
Fax (504) 455-7267

Whenever written notice is required to be given to the Administrative Manager under this Article VIII, it will be effective only when mailed or hand delivered to the address listed above.

2. What Are The Qualifying Events That Trigger The Right To Elect COBRA Coverage?

If you are an Employee, you will become a qualified beneficiary if you lose your Dental and Vision coverage under the Health & Welfare Plan and/or your Medical Flexible spending account coverage under the Cafeteria Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are a covered Dependent spouse of an Employee, you will become a qualified beneficiary if you lose your Dental and Vision coverage under the Health & Welfare Plan and/or Medical Flexible spending account coverage under the Cafeteria Plan because any of the following qualifying events happens:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his gross misconduct;
- The divorce or legal separation (if applicable) of you and the Employee.

If you are a covered Dependent child of an Employee, you will become a qualified beneficiary if you lose Dental and Vision coverage under the Health & Welfare Plan and/or Medical Flexible spending account coverage under the Cafeteria Plan because any of the following qualifying events happens:

- The Employee dies;
- The Employee's hours of employment are reduced;

- The Employee's employment ends for any reason other than his gross misconduct;
- You cease being eligible for coverage under the Plan as a "Dependent child."

3. Notice Requirements

The Plan will offer COBRA coverage to qualified beneficiaries only after the Administrative Manager has been notified timely that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment or death of the Employee, the Administrative Manager will notify you and your Dependents of your COBRA rights.

For the other qualifying events (divorce or legal separation, if applicable, of the Employee and Dependent spouse or a Dependent child ceasing to be eligible for coverage as a Dependent child), you must notify the Administrative Manager in writing, and for a divorce or legal separation provide a copy of the divorce or legal separation, within sixty (60) days after the qualifying event occurs. This notice must be mailed or hand delivered to the Administrative Manager at the address set forth in Section 1. If the Administrative Manager does not receive written notice of the qualifying event within this time period, the qualified beneficiary(ies) with respect to such event will not be eligible for COBRA coverage.

4. How Is COBRA Coverage Elected?

Once the Administrative Manager has been notified timely that a qualifying event has occurred, it will furnish the qualified beneficiary(ies) specific information on when and how to elect COBRA coverage, including the cost. Notice given to an Employee or Dependent spouse will be treated as notice to all affected Dependent children living with the Employee or Dependent spouse.

Each qualified beneficiary has 60 days after the later of (a) the date coverage would otherwise terminate by reason of the qualifying event, or (b) the date of notification of COBRA rights by the Administrative Manager, in which to notify the Administrative Manager in writing of the COBRA election and names of the qualified beneficiary(ies) for which it is elected. Under a special rule, a Dependent spouse, age 50 or older, who loses coverage because of the Employee's death has 90 days from the date coverage would otherwise be lost in which to send a written election and the first self-payment to the Administrative Manager. If COBRA coverage is waived during the election period, the qualified beneficiary may revoke the waiver and elect COBRA coverage at any time before the end of the 60-day election period; however, COBRA coverage may only be provided from the date of election and not retroactive to the loss of coverage.

5. How Long Is COBRA Coverage Available?

COBRA coverage is a temporary continuation of coverage. If elected and paid for in a timely manner, it will begin on the date coverage would otherwise have been lost. For the Medical flexible spending account, COBRA coverage will be available only through the end of the Plan Year in which the qualifying event occurs and cannot be extended for any reason, regardless of the nature of the qualifying event. The "Plan Year" for the Cafeteria Plan is the 12-month period beginning September 1 and ending August 31.

For Dental and Vision Benefits coverage under the Health & Welfare Plan, COBRA coverage will be available (a) for up to a total of 36 months when the qualifying event is an Employee's death, divorce or legal separation, or a child's loss of eligibility status, or (b) for up to a total of 18 months when the qualifying event is an Employee's end of employment or reduction in hours.

The following is a description of two ways in which an 18-month period of COBRA coverage for the Dental and Vision Benefits coverage under the Health & Welfare Plan can be extended. COBRA coverage for the Medical flexible spending account under the Cafeteria Plan cannot be extended beyond the end of the Plan Year in which the qualifying event occurs.

Disability Extension of 18-month Period of COBRA Coverage

If anyone in your family is determined by the Social Security Administration ("SSA") to be totally disabled and you notify the Administrative Manager in writing in a timely fashion, you and all other family members with COBRA coverage by reason of the same qualifying event may receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. In order to receive this disability extension, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage. Written notice of the request for a disability extension, a copy of the disability determination issued by SSA and the names of the qualified beneficiaries for whom an extension is requested, must all be given to the Administrative Manager within 60 days after issuance of the disability determination and before the end of the 18-month period of COBRA coverage.

If, prior to the end of the 29 month period of COBRA coverage, SSA determines that the individual is no longer totally disabled, the qualified beneficiary(ies) must send a copy of the determination to the Administrative Manager within 30 days after its issuance. The extended COBRA coverage for the disabled individual and all related qualified beneficiary(ies) will end on the last day of the month which includes the 30th day after a final determination by SSA that the individual is no longer disabled.

Second Qualifying Event Extension

If your Dependent spouse or child experiences another qualifying event while receiving 18 or 29 months of COBRA coverage, the affected Dependents can get additional months of COBRA coverage, up to a maximum of 36 months from the date COBRA coverage originally began due to the first qualifying event. For example, a second qualifying event would occur if the former Employee dies, or gets divorced or legally separated, or if a Dependent child ceases to be eligible as a Dependent child, as long as the event would have caused the Dependent spouse or child(ren) to lose Dental and Vision Benefits coverage under the Health & Welfare Plan had the first qualifying event not occurred. In all of these cases, the qualified beneficiary must notify the Administrative Manager in writing of the second qualifying event within 60 days after it occurs, in the same manner required had it been the first qualifying event, in order to qualify for the extension.

6. Additional Plan Provisions For Extending COBRA Coverage

There are two additional non-COBRA rules set forth in the Plan which provide for a further continuation of COBRA coverage in the following limited circumstances:

(1) If your Dependent spouse loses coverage due to your death when the spouse is age 50 or older, your surviving spouse may continue coverage until the spouse becomes eligible for Medicare or other group health plan coverage or remarries, if longer than the period required under COBRA, provided s/he sends a written notice of his or her election to extend coverage and the required self-payment to the Administrative Manager no later than 90 days after the date coverage will otherwise end; and

(2) Under the Collective Bargaining Agreement, if you or your Dependents are receiving COBRA coverage under the Health & Welfare Plan because you have been laid off from Covered Employment and are placed on a recall list, or you have been granted an extended alternative maternity/adoption/child rearing leave of absence without pay, you may be able to extend your COBRA coverage for an additional period of time under the terms of the Collective Bargaining Agreement.

7. How Is The Cost Of COBRA Coverage Determined And When Is Payment Due?

COBRA coverage is available on a self-payment basis only. The amount of the required self-payment or "premium" is determined by the Trustees from time to time. The amount covers the cost of the coverage elected and may also include any additional

amounts permitted by law. The initial premium is due within 45 days from the date of the initial election and must cover the cost of coverage from the date it would otherwise terminate through the date of the election. Each subsequent premium is due on the first business day of each month, subject to a 30-day grace period. The COBRA premium rates will remain constant for a 12-month period to the extent required by law, but otherwise will change as the cost of coverage changes.

If a premium is not paid timely, COBRA coverage will terminate and cannot be reinstated. Under a special rule for the Health & Welfare Plan only, one untimely payment of a monthly COBRA premium for the Health & Welfare Plan will be excused and treated as timely, as long as it is received by the Administrative Manager within 60 days from the first business day of the month on which it is due (without regard to any grace period that normally applies.) Only one untimely payment will be excused under this special rule. COBRA coverage will not be provided until the required premium for that period of coverage is received by the Administrative Manager.

8. Are There Any Events Which Result In An Earlier Termination Of COBRA Coverage?

Generally, COBRA coverage will be available for the maximum periods described above in Sections 5 and 6; however, it will end earlier on the first, if any, of the following dates to occur:

(1) The date, after COBRA coverage is elected, on which the qualified beneficiary first becomes covered under another group health plan. If the other plan has a pre-existing condition limitation or exclusion that affects the qualified beneficiary, COBRA coverage will end when the pre-existing condition limitation or exclusion under the other plan no longer applies;

(2) The first day of the month for which the COBRA premium is not paid timely (taking into account any grace periods and the one untimely payment rule); or

(3) The date the Health and Welfare or Cafeteria Plan terminates.

Any qualified beneficiary with COBRA coverage who obtains other group health coverage that contains a pre-existing condition limitation that affects the qualified beneficiary must furnish to the Administrative Manager adequate documentation of the pre-existing condition limitation.

9. Is COBRA Coverage Optional?

Yes, COBRA coverage is optional for you and each qualified beneficiary.

Furthermore, each qualified beneficiary has an independent right to elect COBRA coverage. Even if you, as an Employee, do not elect COBRA coverage, each of your eligible Dependents may elect it.

10. What Type Of Benefits Are Available Under COBRA Coverage?

The type of coverage offered under COBRA for the Health & Welfare Plan is the Dental and Vision Benefits coverage being provided to similarly situated participants with respect to whom a qualifying event has not occurred. The type of coverage offered under COBRA for the Cafeteria Plan is the elected level of coverage that the qualified beneficiary is receiving under the Medical flexible spending account at the time of the qualifying event, taking into account reimbursements that have already been made from the Medical flexible spending account for the Plan Year. If the Dental and Vision Benefits coverage for active Employees under the Health & Welfare Plan changes, the changes in coverage will also apply to qualified beneficiaries with COBRA coverage. COBRA coverage does not include non-health benefits such as the Death Benefit under the Health & Welfare Plan or the Dependent Care flexible spending account under the Cafeteria Plan.

11. If You Have Questions

If you have questions concerning your COBRA coverage rights, you should contact the Administrative Manager.

12. Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Manager.

ARTICLE IX
EXTENDED SELF-PAYMENT COVERAGE UNDER THE HEALTH & WELFARE PLAN FOR CERTAIN RETIREES AND DEPENDENTS

The Health & Welfare Plan permits the following former Employees and their eligible Dependents, who self-pay for COBRA coverage for the entire COBRA period available to them, to extend their Dental and Vision Benefits coverage under the Health & Welfare Plan on a Self-Payment basis for an additional period immediately following exhaustion of their COBRA coverage:

(1) Any Retiree whose status as a COBRA Self-Payee is due to retirement from Covered Employment and who retains Retiree status throughout the entire period of COBRA coverage and extended Self-Payment coverage under this Article IX, and his Dependents who are Participants on the date the Retiree's COBRA coverage is exhausted; and

(2) Any Dependent of a deceased active or former Employee provided the Employee and Dependent are Participants on the date of death and the right to continue COBRA coverage expires by reason of the death.

A Participant who elects extended Self-Payment coverage may not enroll new Dependents during the period of extended coverage.

The Administrative Manager will notify eligible Retirees and Dependents, within 30 days from the date their COBRA coverage would otherwise terminate, of their option to continue coverage under extended Self-Payment and the amount of the required Self-Payment. The cost of the extended coverage will be determined by the Trustees, and the Self-Payment is payable on a monthly basis, due on the first business day of the calendar month for which coverage is sought. Payment will be considered timely as long as it is received by the Administrative Manager at the Fund Office within 30 days after the due date. Under a special rule, the Health & Welfare Plan will excuse one untimely payment of a monthly Self-Payment and treat it as timely, as long as it is received by the Fund Office within 60 days from the first business day of the month on which it is due (without regard to the 30-day grace period that normally applies). Only one untimely Self-Payment will be excused, whether it is under COBRA or under this special provision.

The extended Dental and Vision Benefits coverage will begin on the date COBRA Coverage expires, and will terminate on the earliest of the following events to occur:

(1) The date the Health & Welfare Plan is amended to discontinue the extended coverage rights for any class of participants to which you or your Dependents belong;
(2) The date you are no longer a Retiree;

(3) The first day of the month for which a required Self-Payment is not made timely (taking into account any applicable grace period);

(4) The date you or your Dependents become covered under another group dental and/or vision plan that does not have a pre-existing condition exclusion or limitation affecting you or your Dependents; or

(5) The date the Health & Welfare Plan terminates.

This right to extended Self-Payment coverage is not a vested right and is not required by law. It may be discontinued or amended at any time by the Trustees, and any such discontinuance or amendment will affect you and your Dependents regardless of whether you and your Dependents are receiving extended Self-Payment coverage at that time.

ARTICLE X
SUBROGATION, ASSIGNMENT AND REIMBURSEMENT

In the event you or your eligible Dependent incurs any eligible charges for Dental or Vision Benefits under the Health & Welfare Plan as a result of a claim or cause of action listed below, payment will not be made unless you or your Dependent executes the Health & Welfare Plan's standard subrogation, assignment and reimbursement agreement and completes all other documents and furnishes all information requested by the Trustees:

1. Any claim or cause of action which may accrue because of the alleged negligent or intentional conduct of any third party and/or his insurers, including any claim against your or your Dependent's own insurer under the uninsured motorist coverage provisions; or

2. Any claim or cause of action which may accrue because of an event giving rise to a claim under the products liability laws of any state; or

3. Any claim or cause of action which may accrue because of an event giving rise to a claim against your or your Dependent's own homeowner's insurance carrier.

Under the Health & Welfare Plan's subrogation, assignment and reimbursement agreement, you and/or your Dependent must certify that no other amounts have yet been paid in satisfaction of the claim, that your or your Dependent's claim is disputed, that the third party and/or insurer are withholding payment pending resolution of the dispute, and agree to the following:

1. To reimburse the Fund out of the proceeds of any recovery received from any such third party or insurer, whether by way of litigation, settlement or otherwise;

2. To reimburse the Fund from any gross amount recovered by you or your Dependents before any payment of attorney's fees and costs;

3. To provide to the Fund all information reasonably requested by the Trustees and to assist the Trustees in recovering all amounts paid out by the Fund that are subject to the subrogation, assignment and reimbursement agreement;

4. To execute and deliver all necessary instruments that the Trustees may require to facilitate the enforcement of their rights;

5. To recognize that the Fund has no obligation to pay or reimburse you or your Dependents or your attorneys any amounts spent in attorney's fees and costs of litigation in pursuing your claims against the third party and/or insurers;

6. To reimburse the Fund for attorney's fees and costs paid by the Trustees, the Fund or the Health & Welfare Plan in pursuing litigation or other actions to enforce the terms of the Health & Welfare Plan and the subrogation, assignment and reimbursement agreement;

7. That no settlement will be made with nor release granted to any third party or insurer without the written consent of the Trustees; and

8. To protect the Trustees' right to recovery under the subrogation, assignment and reimbursement agreement and to do nothing that would in any way prejudice their rights.

ARTICLE XI
FILING AND PAYMENT OF CLAIMS AND CLAIMS REVIEW PROCEDURE

A. Written Claim for Benefits

Generally, the following rules govern the filing and payment of claims; however, if a specific requirement for a particular benefit is discussed elsewhere, it will apply to that benefit. All claims for benefits under the Cafeteria Plan must be filed in writing on a claim form provided by the Administrative Manager for the Fund or obtained from the Fund's website, www.jfthw.org. All claims for Dental Benefits under the Health and Welfare Plan must be filed in writing on a claim form provided by the dental provider, the Administrative Manager for the Fund or obtained from the Fund's website, www.jfthw.org. Prior to receiving vision services, you may verify eligibility for Vision Benefits under the Health & Welfare Plan by calling the Vision Benefits provider. You may obtain the name and phone number of the current Vision Benefits provider by contacting the Administrative Manager at the Fund Office or checking the Fund's website at www.jfthw.org. If you obtain vision services from a Panel Provider, the filing of a claim form is not necessary. If you obtain vision services from a Non-Panel Provider, you must file a claim on a claim form provided by the Vision Benefits provider or the Administrative Manager for the Fund, or obtained from the Fund's website, www.jfthw.org. For a Death Benefits claim, you must notify the Administrative Manager for the Fund of the Employee's death.

In order to receive benefits under the Health & Welfare Plan, you or your Dependent must file a written claim and proof of loss with the Fund Office or, if appropriate, with the managed care provider, no later than March 31 following the calendar year in which the expense or loss is incurred. If a claim is not submitted timely, it will not be covered unless reasonable cause for the delay is proven to the Trustees' satisfaction and written claim is submitted as soon as is reasonably possible.

In order to receive benefits under the Cafeteria Plan, you must submit a written claim for reimbursement no later than 60 days after the end of the Plan Year in which the expense is incurred. Any claims for reimbursement made after that time will not be covered under the Cafeteria Plan. The Plan Year for the Cafeteria Plan is the 12-month period beginning September 1 and ending August 31.

B. Payment

Generally, claims under the Health & Welfare Plan will be paid within 30 days after you or your Dependent submits a proper claim form and any information required to establish proof of claim. Notice will be provided if an extension of time is needed. Dental Benefits will be paid to you, or if you have assigned your benefits, to the service provider. Vision Benefits for services rendered by Non-Panel Providers will be paid to

you. Death Benefits will be paid to your beneficiary in accordance with Article V.

Claims under the Cafeteria Plan will be paid at least once a month subject to a $25.00 minimum; however, at the end of the Plan Year or at any other time when coverage terminates, all claims will be paid without regard to a minimum amount.

If a Participant is a minor or is deceased, any amounts payable for the benefit of such person will be made to the person who is authorized to receive payment, provided satisfactory proof of such authority is furnished to the Administrative Manager for the Fund.

C. Claims Review Procedure

Generally, a determination will be made on your claim within 30 days after it is received by the Fund Office unless notice of an extension of time to respond has been given before the end of the 30-day period. You will be notified in writing if your claim is denied in whole or part. The written notice of denial will include:

(1) Specific reason(s) for the denial, with reference to the specific provisions of the Plan on which the denial is based;

(2) A description of any additional material or information necessary to process or perfect the claim and the reason why it is needed; and

(3) An explanation of the claims appeal procedure.

If you do not receive a response to your filed claim within such 30-day or extended time period, your claim will be deemed to have been denied as of the last day of the 30-day or extended response period.

D. Claims Appeal Procedure

If your claim is denied, you will have 60 days after notice of denial is given or after your claim is deemed to have been denied, in which to appeal the decision. In order to exercise your appeal right, you must submit a written request for review to the Board of Trustees at the following address:

If mailing:

JFT Health & Welfare Fund Office
P. O. Box 6137
Metairie, LA 70009-6137

If hand delivering:

JFT Health & Welfare Fund Office
2540 Severn Avenue, Suite 302
Metairie, LA 70002

Your written request for review must include an explanation of why you think the initial determination is wrong and why the claim should be accepted, as well as copies of all documents, records and information that support your position. If a written request for review is not submitted within this 60-day period, the initial decision on your claim will be final and binding. You may review all pertinent documents relating to the initial denial of your claim. Copies are also available on request for a reasonable charge to cover the cost of the copies.

E. Decision on Appeal

The decision on appeal will be made within 60 days after the written request for review is received. The 60 days may, however, be extended for an additional 60 days if additional time is needed to make a determination, provided notice of any extension is given to the claimant within the first 60 day period. The decision on review shall be in writing and shall include an explanation of the reasons for the decision, with specific reference to the provisions of the Plan on which the decision is based. A decision on appeal is final and binding on all parties.

F. Limitation On Judicial Review

You, your Dependents and/or your beneficiary must first exhaust all of the claims filing and appeals procedures under the Plan before pursuing any action in court to recover benefits under the Plan**.**

ARTICLE XII
MISCELLANEOUS

A. Plan's Right to Reimbursement For Claims Paid In Error

The Trustees may recover any amounts paid in error under the Plan from any person to or for whom such amounts were paid, or they may offset amounts paid in error from future benefits payable to you, your Dependents or your Beneficiary(ies).

B. Refund of Self-Payment Made in Error

The Trustees may refund any overpayment made by a Participant to the Plan, provided that in no event will they refund more than six (6) consecutive months of self-payments, less any claims paid during that same period.

C. False Statements

The Trustees may withhold or deny payment of any claim which they reasonably believe may be based on false statements by you, your Dependents, your beneficiary(ies) or any provider. They also have the right to recover any payments made on the basis of such false statements.

D. Discretionary Authority of Trustees To Administer Plan

The Trustees have the sole authority and full power and discretion to interpret all provisions of the Plan, to determine all questions of coverage and eligibility under the Plan, and to construe all disputed, doubtful or ambiguous terms under the Plan. Any such determinations, interpretations, or constructions adopted by the Trustees in good faith will be conclusive and binding upon all parties, and in no event will the Trustees be personally liable for any such act or omission taken by them in good faith.

ARTICLE XIII
GENERAL INFORMATION ABOUT THE PLAN

The following is a list of certain general information about the Plan that you may need to know.

1. Name and Effective Date of Plan

A. The "Jefferson Federation of Teachers Health & Welfare Plan" is the name of the Health & Welfare Plan. It was initially adopted on May 9, 1983 and has been amended from time to time; and

B. The "Jefferson Federation of Teachers Cafeteria Plan" is the name of the Cafeteria Plan. It was initially adopted effective January 1, 1997 and has been amended from time to time.

2. Plan Administrator Information

The Administrator keeps the records for the Plan and is responsible for administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan is administered by a joint board of trustees consisting of an equal number of Trustees appointed by the Union and the School Board. The full board may designate a committee, comprised of less than the full board, to act on their behalf in Plan matters. The name, address, business telephone and fax numbers of the Administrator are:

Board of Trustees
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002
Telephone: (504) 455-7261
Fax: (504) 455-7267

The Board of Trustees has appointed an Administrative Manager to assist in handling day-to-day administrative matters. The name, address, business telephone and fax numbers of the Administrative Manager are:

Administrative Manager
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002
Telephone: (504) 455-7261
Fax: (504) 455-7267

3. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

Board of Trustees or any individual Trustee
Jefferson Federation of Teachers Health and Welfare Fund
2540 Severn Avenue, Suite 302
Metairie, Louisiana 70002

4. Funding Medium

Benefits under the Plan are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and Trust Agreement, and held for the purpose of providing benefits and defraying reasonable administrative expenses under the Plan.

IMPORTANT

It is important that you and your Dependents notify the Administrative Manager whenever:

1. You change your name;
2. You change your home address;
3. You terminate your employment with the Employer or you are no longer an eligible Employee;
4. You wish to change your beneficiary(ies) for your death benefits coverage;
5. You are receiving Workers' Compensation benefits; or
6. You enter qualified military service.