FLORIDA UBC HEALTH FUND

SUMMARY PLAN DESCRIPTION

AMENDED AND RESTATED

January 1, 2019

IMPORTANT CONTACT INFORMATION

Southern Benefit Administrators, Incorporated:
Local Phone Number: (615) 859-0131
Toll-Free Number: (800) 831-4914
Fax Number: (615) 859-0818

United Healthcare (PPO):
Hospital Pre-Certification: (800) 764-6810
Nurseline: (877) 543-3811
Healthy Pregnancy Program: (888) 246-7389

United Healthcare Website:
welcometouhc.com/uhss

Express Scripts:
(800) 501-7290

Express Scripts Website:
www.express-scripts.com
Password: FLUBC

BE SURE TO ENROLL

It is extremely important that you contact the Fund office when you satisfy the Initial Eligibility requirements. You will be required to complete an enrollment form and a beneficiary designation. You should advise the Fund office whenever you change your address, add a dependent, become married or divorced, retire, or have a dependent reach the limiting age.

You should also contact the Fund office if you need help in locating a PPO provider.

FLORIDA UBC HEALTH FUND

Dear Plan Participant:

The following pages contain a summary of the plan of benefits of the Florida UBC Health Fund.

Federal law requires that the following information be provided to you on a periodic basis. This booklet represents an important document for you and your family, and we would request that you take the time to review it.

This booklet describes in detail the benefits available to you, and to your dependents if applicable. There are many important sections of this booklet, including instructions on how to file claims, a section that describes your right to appeal any denied claims, and a statement of your additional rights under the provisions of the Employee Retirement Income Security Act.

Please read this booklet carefully. Along with your Fund ID cards it will help you understand and access important health coverage for you, and for your family members if applicable. If you do not have a current Fund ID card, please contact the Fund office and one will be provided to you free of charge.

If you should have absolutely any questions regarding any of the information contained in this booklet, please feel free to contact the Fund office at the address and telephone numbers listed in this booklet.

Best regards,

Your Board of Trustees

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FLORIDA UBC HEALTH FUND

This Fund Is Administered By:
THE BOARD OF TRUSTEES

The Trustees of the Fund are:

UNION TRUSTEES:

MR. JAMES BANKS, JR.
Executive Secretary/Treasurer
Florida Carpenters Regional Council
2860 NW 27th Avenue
Fort Lauderdale, Florida 33311

MR. BILLY CAMPBELL
105 Malley Cove Lane
Fleming Island, Florida 32003

MR. FRANK D'ANGELO
2860 NW 27th Avenue
Oakland Park, Florida 33311

MR. PAUL FRENCH
Millwrights Local Union 2411
4000 Union Hall Place
Jacksonville, Florida 32205

MR. JIMMIE JORDAN
Millwrights Local Union 1000
9711 US Hwy 92 East
Tampa, Florida 33610

MR. RANDY PAGE
Carpenters Local Union 702
4000 Union Hall Place
Jacksonville, Florida 32205

MR. MATTHEW SWANSON
Carpenters Local Union 1905
4700 Distribution Court
Orlando, Florida 32822

MR. CLIFFORD TUCKER
Millwrights Local Union 1000
9711 US Hwy 92 East
Tampa, Florida 33610

EMPLOYER TRUSTEES:

MR. JODY CREWS
W.W. Gay Mechanical Contractors, Incorporated
524 Stockton Street
Jacksonville, Florida 32204-2535

MR. BUTCH KINNEY
Milton J. Wood Company
4415 Drane Field Road
Lakeland, Florida 33811

MR. CARLOS RANON
Ranon General Contractor, Incorporated
5109 N. Howard Avenue
Tampa, Florida 33603

MR. AL REAUX
Milton J. Wood Company
3805 Faye Road
Jacksonville, Florida 32226

MR. HAROLD RICHARDSON
W.W. Gay Mechanical Contractors, Incorporated
524 Stockton Street
Jacksonville, Florida 32204-2535

MR. KIRK RIDDLE
C.R. Wilson Construction Company, Incorporated
2532 Old Okeechobee Road
Unit 15
West Palm Beach, Florida 33409

MR. DAVID TANKERSLEY
3805 Faye Road
Jacksonville, Florida 32226

EMPLOYER TRUSTEES:

MR. PRESTON TAYLOR
Executive Vice President
Union Contractors and Subcontractors
Association, Incorporated
1108 North Wheeler Street
Plant City, Florida 33563

MR. CONRAD VARNUM
Central Maintenance and Welding
2620 East Keysville Road
Lithia, Florida 33547

MR. DOUG WALKER
Walker Commercial Interiors
2121 University Park Drive, Suite 140
Okemos, Michigan 48864

Administrative and Consulting Services Are Provided By:

SOUTHERN BENEFIT ADMINISTRATORS, INCORPORATED
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131 • Toll Free (800) 831-4914
Fax: (615) 859-0818

The Fund Attorney is:

VENABLE LAW FIRM, P.A.
7402 N. 56th Street, Suite 380
Tampa, Florida 33617
Phone: (813) 985-7122

HOW TO USE THE PPO

The Plan utilizes United Healthcare's Choice Plus Preferred Provider Organization (PPO). UHC has negotiated discounts with doctors, hospitals and other medical providers. These discounts reduce the dollars spent by the Plan as well as your out-of-pocket expenses.

If you need help locating a PPO provider you can call Southern Benefit Administrators at (800) 831-4914. You can also contact UHC by using their website at http://welcometouhc.com/uhss. You are responsible for determining whether or not a provider is in the PPO.

1. If you need to make an appointment with a doctor, or if you do not have a doctor, you should contact Southern Benefit Administrators to locate a doctor in your area. Once you have located a doctor, call him for an appointment. When you arrive they will likely ask for a copy of your Fund ID card. If you do not have one please contact the Fund office. The toll-free number is (800) 831-4914.

2. If your doctor needs to refer you to a specialist, admit you to a hospital, or send out lab work or x-rays, ask your doctor to make referrals to PPO providers whenever possible. If the doctor knows you are in United Healthcare's PPO he will most likely be able to make any referrals to other network providers. **Remind the doctor that lab work should be sent to an in-network laboratory.**

3. If you are scheduled for a hospital admission or for outpatient surgery, be sure to contact UHC for pre-certification. That number is (800) 764-6810.

4. If you are admitted to a hospital on an emergency basis, you or your doctor must contact the pre-certification and utilization review department within 48-hours following your admission.

5. PPO providers will likely submit claims on your behalf. To submit medical bills for reimbursement you should obtain a claim form from the Fund office. Complete the claim form and send it along with copies of all itemized bills to Southern Benefit Administrators, Inc. Please be sure each bill shows the patient's name, date of each treatment, charge for each treatment, nature of illness (diagnosis), and the type of service rendered.

OTHER SERVICES AVAILABLE THROUGH UNITED HEALTHCARE

Through the Fund's relationship with United Healthcare, you have access to other services as outlined below:

Nurseline – UHC provides access to a 24/7 nurseline where you can receive immediate answers from nurses backed by medical professionals who can help you:

- Understand your symptoms and understand your medications;
- Decide if you should see a doctor, go to the ER, or wait and try self-care;
- Find a network doctor or hospital;
- Explore treatment options so you can make the decision that's right for you; or
- Learn more about a new diagnosis.

If you would like to use the nurseline, please call the number on the back of your Fund ID card. That number is **(877) 543-3811** toll free.

Healthy Pregnancy Program – UHC has a Healthy Pregnancy Program to ensure that expectant mothers have a smooth pregnancy, delivery and healthy baby. A registered nurse will consult with you, via telephone, to help you determine what, if any, risks or complications could arise during your pregnancy. UHC can help you learn and practice healthy pregnancy habits and protect the well being of your baby. If you have individual needs, a healthy pregnancy program nurse will provide one-on-one support throughout your pregnancy.

If you would like to take advantage of this program, you can access the program online at **www.healthy-pregnancy.com**. From there you will be able to access a full range of articles covering nutrition, exercise, childbirth preparation and more. To enroll for these benefits please call **(888) 246-7389** toll free.

Transplant Centers of Excellence – UHC gives you access to their Transplant Centers of Excellence network. UHC invests resources to identify the programs that have delivered superior outcomes. The network is designed for access and choice with 144 facilities and 750 programs for both adults and pediatrics. If a transplant is needed, UHC's transplant clinical team will contact you and assist you in accessing a Center of Excellence and will manage your care.

Other Tools – If you log onto UnitedHealthcare's shared services website at **http://welcometouhc.com/uhss** you will also have access to other tools and resources. These include the Optum Health System checker, a BMI calculator, a calories burned calculator, a heart attack risk calculator, a healthy weight calculator, as well as an abundance of information about other popular topics related to lifestyle choices.

SCHEDULE OF BENEFITS

Following are summaries of the benefits provided under the Plan to Covered Persons who may be entitled to these benefits in accordance with the Eligibility Rules found elsewhere in this booklet. Further in the booklet you will find complete explanations of each of the benefits outlined below.

PLAN A SCHEDULE OF BENEFITS

EMPLOYEES AND RETIREES ONLY:

	ACTIVE EMPLOYEE	RETIREE
DEATH BENEFIT	$10,000	$2,500
ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT		
PRINCIPAL SUM	$10,000	$2,500

MAJOR MEDICAL BENEFITS FOR EMPLOYEES, RETIREES AND ELIGIBLE DEPENDENTS:

DEDUCTIBLE

Calendar Year Deductible or General Cash Deductible:

	In PPO Network	Outside Network
Per Person	$750	NO BENEFIT
Family Unit Limit	$1,500	NO BENEFIT

PERCENTAGES PAYABLE

Eligible Expenses After Deductible:	
With PPO Provider	75%
Out-of-Pocket Limit (applies to PPO expenses only)	$4,000
Non-PPO Provider	NO BENEFIT
Prescription Drugs outside Prescription Drug Program	NO BENEFIT
Recommended Preventive Care – In-Network Only	100%

- Once an individual has satisfied the deductible and has paid $4,000 in PPO Covered Medical Expenses in a calendar year, eligible PPO expenses which would normally be reimbursed at 75% will be reimbursed at 100% for the remainder of that calendar year. The $4,000 is the individual's 25% of PPO medical expenses.
- There is a separate limit on out-of-pocket expenses under the Prescription Drug Program. This limit is $2,000 per individual or $4,000 per family.
- The family "out-of-pocket" limit for all Covered Medical Expenses combined is $13,500 in a calendar year including deductibles.
- So long as you are treated at a participating PPO Hospital, the Plan will cover eligible expenses incurred with non-PPO ancillary providers such as anesthesiologists, radiologists, pathologists and emergency room Physicians at the PPO level of benefits. PPO benefits will also be paid for non-PPO providers if a PPO provider cannot be located within 50 miles of your home. PPO benefits will also be paid for emergency room expenses at a non-PPO hospital in the event of a medical Emergency.

OTHER PROVISIONS

Hospital Room and Board –
Daily Limit - the most common semi-private room rate

Intensive Care (ICU) or (CCU) –
Daily Limit - full charge, subject to Usual and Reasonable Charges

Skilled Nursing Facility (SNF) –
Daily Limit - One-half of the most common semi-private room rate of the Hospital from which the person was discharged
Maximum Number of SNF Days Payable - 90 days per calendar year

Home Health Care –
Maximum Number of Visits - 100 visits per calendar year

Chiropractic Care –
Limited to one visit per day and 12 visits per calendar year

PRESCRIPTION DRUG CARD PROGRAM FOR EMPLOYEES, NON-MEDICARE ELIGIBLE RETIREES AND THEIR DEPENDENTS*:

After satisfaction of the following co-payments, the Plan will pay the cost of prescription drugs under the Prescription Drug Program:

	RETAIL	**MAIL ORDER**
	30-Day Supply	90-Day Supply
Generics	$5	$15
Preferred Brand	$35	$105
Non-Preferred Brand	$70	$210
Specialty Drugs	$300	Not Available

The maximum out-of-pocket expense each calendar year for Prescription Drugs is $2,000 per individual and $4,000 per family.

If a brand name drug is dispensed when a generic is available, you will be responsible for the generic co-pay as well as the difference in cost between the generic alternative and the brand name drug.

INJECTABLE PRESCRIPTIONS – Injectable medications are included in the Prescription Drug Program. To obtain these medications, you must be under the Plan's Case Management program and medications must be purchased through the Plan's Prescription Drug Card Service Program or through the Plan's PPO.

*Prescription drug coverage is not provided to Medicare-eligible Retirees who are not employed, or to their Medicare-eligible Dependents.

DENTAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS:*

DEDUCTIBLE

Class I – Preventive Services . . . . . None
Class IV – Orthodontic Services. . . . . None
Class II and Class III Services:
Calendar Year Deductible Per Person $50
Family Unit Deductible Limit. $150

PERCENTAGES PAYABLE

Class I – Preventive Services 100%
(Oral exams, routine cleanings
bitewing x-rays and fluoride treatments)

Class II – Basic Services. 80%
(Fillings, oral surgery, endodontic
treatment, non-surgical periodontic
treatment)

Class III – Major Services. 50%
(Crowns, bridges, partials and dentures)

Class IV – Orthodontic Services. 50%
(Children to age 19)

MAXIMUM BENEFITS

Lifetime Maximum Benefit Per Person for Orthodontia $1,000
Calendar Year Maximum Benefit Per Person for All Other Covered Charges . . . $1,000**

*Dental Benefits are not provided to Retired Employees.

**This benefit maximum does not apply to Class I services that are otherwise covered when provided to a Covered Person under 19 years of age (through the end of the calendar month in which the individual attains age 19).

PLAN B SCHEDULE OF BENEFITS

MAJOR MEDICAL BENEFITS FOR EMPLOYEES, RETIREES AND THEIR DEPENDENT CHILDREN ONLY (SPOUSES ARE NOT COVERED):

DEDUCTIBLE

Calendar Year Deductible or General Cash Deductible:

	In PPO Network	Outside Network
Per Person	$1,000	NO BENEFIT
Family Unit Limit	$2,000	NO BENEFIT

PERCENTAGES PAYABLE

Eligible Expenses After Deductible:

With PPO Provider	65%
Out-of-Pocket Limit (applies to PPO expenses only)	$4,500
Non-PPO Provider	NO BENEFIT
Prescription Drugs outside Prescription Drug Program	NO BENEFIT
Recommended Preventive Care – In-Network Only	100%

- Once an individual has satisfied the deductible and has paid $4,500 in PPO Covered Medical Expenses in a calendar year, eligible PPO expenses which would normally be reimbursed at 65% will be reimbursed at 100% for the remainder of that calendar year. The $4,500 is the individual's 35% of PPO medical expenses. The family out-of-pocket limit for Covered Medical Expenses is $9,000 plus calendar year deductibles.
- There is a separate limit on out-of-pocket expenses under the Prescription Drug Program. This limit is $2,400 per individual or $4,800 per family.
- The family out-of-pocket limit for all Covered Medical Expenses combined is $15,800 in a calendar year, including deductibles and the drug out-of-pocket maximum.
- So long as you are treated at a participating PPO Hospital, the Plan will cover eligible expenses incurred with non-PPO ancillary providers such as anesthesiologists, radiologists, pathologists and emergency room Physicians at the PPO level of benefits. PPO benefits will also be paid for non-PPO providers if a PPO provider cannot be located within 50 miles of your home. PPO benefits will also be paid for emergency room expenses at a non-PPO hospital in the event of a medical Emergency.

OTHER PROVISIONS

Hospital Room and Board –
Daily Limit - the most common semi-private room rate

Intensive Care (ICU) or (CCU) –
Daily Limit - full charge, subject to Usual and Reasonable Charges

Skilled Nursing Facility (SNF) –
Daily Limit - One-half of the most common semi-private room rate of the hospital from which the person was discharged
Maximum Number of SNF Days Payable - 90 days per calendar year

Home Health Care –
Maximum Number of Visits - 100 visits per calendar year

Chiropractic Care –
Limited to one visit per day and 12 visits per calendar year

PRESCRIPTION DRUG CARD PROGRAM FOR EMPLOYEES AND THEIR DEPENDENT CHILDREN*:

After satisfaction of the following co-payments, the Plan will pay the cost of generic prescription drugs under the Prescription Drug Program:

	RETAIL	**MAIL ORDER**
	30-Day Supply	90-Day Supply
Generics	$5	$15

The maximum out-of-pocket expense each calendar year for Prescription Drugs is $2,400 per individual or $4,800 per family.

YOU WILL HAVE TO PAY THE ENTIRE DISCOUNTED COST OF BRAND NAME PRESCRIPTION DRUGS AFTER SATISFACTION OF THE CALENDAR YEAR DEDUCTIBLE. THE DISCOUNTED COST OF BRAND NAME DRUGS WILL BE REIMBURSED AT 65%. THESE EXPENSES MUST BE SUBMITTED TO SOUTHERN BENEFIT ADMINISTRATORS FOR REIMBURSEMENT.

*Prescription drug coverage is not provided to Medicare-eligible Retirees who are not employed, or to their Medicare-eligible Dependent children.

CLAIM PROCEDURE

HOW TO FILE YOUR CLAIMS

When you have a claim, please follow the instructions outlined below:

1. Time Limit for Filing a Claim—All claims must be submitted within 90 days of the date charges for the service are incurred. Failure to file a claim within this time limit will not invalidate your claim if it was not reasonably possible to file the claim within the time limit and the claim is filed within 12 months from the date the charges were incurred.

2. When you receive services from a doctor, hospital or other medical care provider, you must furnish to that provider the information needed to file a claim. This information is found on your Fund ID card. The provider should then file the necessary bills and related information with the Fund's PPO.

3. Claims for other types of benefits must be filed by you or your beneficiary directly with the Fund office. Forms for these types of claims are available at the Fund office.

4. If a claim is filed without sufficient information or documentation regarding the claim, you will be notified within 30 days after the Fund office receives the claim. To the extent possible, missing information will be requested from your health care provider. However, on some occasions, it may be necessary to request some information directly from you.

Remember, it is your responsibility to provide your doctor, hospital and any other medical service providers with information about your coverage under the Plan and about their responsibility to file all claims with the Fund office.

PAYMENT OF CLAIMS BY FUND OFFICE

Once the information required to make a determination as to whether a claim is payable has been received, a decision will be made promptly by the Fund office staff and you will be notified regarding any benefit payments. However, in no event will the decision regarding payment be made more than 30 days after the claim has been fully and properly filed.

If the Fund office determines that additional information is required from you or in your behalf, you will be given 45 days in which to provide any missing information necessary to process the claim.

PRE-APPROVAL OF A CLAIM

See pages 29 and 30 for information regarding pre-admission and pre-surgical review requirements. Additionally, you should be aware that certain treatments and procedures are not covered under the Fund, so you may wish to contact the Fund office at certain times prior to receiving treatment in order to assure that the treatment will be covered. The following rules apply to pre-approval of treatment:

1. Approval of Medically Necessary Treatment—As explained in this booklet, a charge must be Medically Necessary to be covered by the Plan. If there is any doubt about whether your expected treatment will be considered Medically Necessary under the Plan, you may contact the Fund office

for an advance decision. As explained in this booklet, you may appeal any adverse decision made by the Fund office regarding medical necessity.

2. Compliance With Plan Provisions, Exclusions and Limitations—In an effort to help control the cost of providing benefits under the Plan, and in order to limit coverage to benefits for treatment of a medical nature, various Plan provisions, exclusions and limitations have been adopted and/or included in the Plan. These are very specific and they are described in this booklet. However, questions sometimes arise as to whether a particular provision, exclusion or limitation applies to a specific condition or treatment.

   If there is any question as to whether your anticipated treatment will be covered under the Plan, you should contact the Fund office in advance. Once appropriate information is received, the Fund office staff will let you know whether your expected treatment will be covered under the Plan. If you receive an adverse decision, you may of course appeal that decision as explained in this booklet.

THE PLAN'S RESPONSIBILITIES TO RESPOND TO YOUR REQUESTS FOR PRE-APPROVAL

As explained in the preceding section, you may want to request pre-approval of treatment to ensure that it will be covered under the Plan.

The Fund office staff will respond to all such requests in a timely manner, as follows:

1. Urgent Care Claims—If proposed treatment is determined to be **urgent** in nature, as defined below, a decision on your request for pre-approval will be made and communicated to you within 72 hours of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, you will be notified of such as soon as possible but in no instance more than 24 hours after receipt of the request. You will then be given not less than 48 hours to provide the required information.

   An **Urgent Care Claim** is a claim which, if treated as a claim for non-urgent care:

   (a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

   (b) In the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Non-Urgent Care Claims—If proposed treatment is determined to be of a **non-urgent** nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If it is determined that additional information is necessary to make a decision on your claim, the Plan may require up to an additional 15 days to make a decision on your request. If such an extension is required, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension

is required because it is necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.

These procedures for processing requests for pre-approval of both urgent and non-urgent care claims have been adopted solely as guidelines and to assure compliance with applicable federal law. It will continue to be the practice of the Trustees, as the Plan administrator, along with the Fund office staff, to timely process all requests for pre-approval and to respond to all such requests immediately where possible, but always within the time periods prescribed above.

ELIGIBILITY RULES

The Plan offers two Schedules of Benefits with corresponding eligibility provisions. Your benefits are determined based on the contribution rate in effect in the jurisdiction where you are employed. As of the date of the printing of this booklet, benefits are determined as follows:

Plan A Benefits – An hourly contribution rate of $4.00 or more and a minimum of $1,600 in contributions in each Qualifying Period.

Plan B Benefits – An hourly contribution rate of $3.99 or less and a minimum of $1,000 in contributions in each Qualifying Period.

NEW ELIGIBILITY

An employee who works in covered employment for a contributing employer will become eligible for benefits on the first day of the first month following the date the required contributions have been made, or were required to be made, in his behalf by contributing employers. The contribution requirements for new eligibility are as follows:

Plan A – $1,600 in three consecutive months or less
Plan B – $1,000 in three consecutive months or less

Upon satisfying the requirements above, an Employee will be covered for a minimum of three months.

An Employee who performs services for more than one participating employer will not be entitled to benefits greater than those which would apply if services were performed for only one participating employer.

Expedited New Eligibility for Newly Signatory Employers:

New eligibility for an Employee working in covered employment who is working for an employer on the date the employer first begins participation under the Fund will be established as follows:

1. The employer must pay contributions to the Fund for all hours worked by each covered Employee in the full calendar month during which the employer first becomes bound by a written agreement to make contributions;

2. Each employee who was covered under the employer's group health insurance program immediately preceding the month described under 1. above will become covered on the first day of the month in which the agreement first becomes effective and will remain covered, provided the Employee remains employed with the employer through the end of the Coverage Period corresponding with the first full Qualifying Period immediately following the first month for which contributions are required under the agreement;

3. After the initial coverage period described in 2. above, continuing eligibility will be determined as outlined in the following section;

4. No contributions will be credited to the employee's Contribution Bank during the first eight months of continuous eligibility under this provision;

5. Self-contributions as outlined in Self-Contributions for Continued Coverage will be permitted during the first eight months of eligibility under this provision only if the employer continues to be bound by the terms of a written agreement requiring contributions to the Fund;

6. Following six continuous months of eligibility under this provision, continuing eligibility will be calculated the same as for other Employees; and

7. If the employer later ceases participation in the Fund, the eligibility of all Employees described under this provision will terminate as of the date the employer's obligation to make contributions to the Fund ceases. No further eligibility will be granted under any provision of these Eligibility Rules, except as may be required under the COBRA provisions, as applicable.

QUALIFYING AND COVERAGE PERIODS FOR CONTINUING ELIGIBILITY

For continuing eligibility purposes, a year is divided into four Coverage Periods commencing January 1, April 1, July 1 and October 1. Each Coverage Period has a corresponding Qualifying Period as shown below. The close of the Qualifying Period is separated by three months from the corresponding Coverage Period to allow time for reporting by the participating employers and records processing. All employees who satisfy the minimum contribution requirement will continue to be eligible for benefits during the three-month Coverage Period corresponding with the three-month Qualifying Period. The Qualifying Periods and Coverage Periods are:

QUALIFYING PERIOD	COVERAGE PERIOD
July 1 through September 30	January 1 through March 31
October 1 through December 31	April 1 through June 30
January 1 through March 31	July 1 through September 30
April 1 through June 30	October 1 through December 31

The minimum contribution requirement is an amount established by the Board of Trustees in order to maintain eligibility. This minimum contribution requirement may change from time to time. The requirements as of January 1, 2019 are as follows:

Plan A – $1,600 in three consecutive months or less
Plan B – $1,000 in three consecutive months or less

These requirements may be satisfied in any of the following ways or combination of ways:

- Contributions from contributing employers
- Disability credits
- Self-contributions
- Credit for "salted" employment
- Contribution Bank credits

For the purpose of maintaining eligibility for continuing benefit purposes, a month of proven disability will count as a month of employment to the extent described in this paragraph. Subject to approval of the Trustees, a month of proven disability is defined as any calendar month in which an eligible Employee can medically substantiate that he has been unable to perform the duties of his trade for a minimum of twenty consecutive days. Disability credits commence with the month during which proven disability commences. Disability credits will be provided as follows:

Plan A – $533.34 per month
Plan B – $333.34 per month

The maximum credit for disability is limited to six consecutive months. Disability credits may not be used to establish new eligibility or for reinstatement of an employee who was previously terminated.

Employees must file a request for disability credit along with medical proof of disability.

For the purpose of maintaining continuing eligibility, "salted" employment credit will be provided. "Salted" employment is defined to mean employment for an employer that has been targeted by a local union sponsoring the Plan for organization, provided the individual has executed an agreement with the appropriate local union agreeing to act as a "salted" employee of the targeted employer. The eligible Employee will be credited with each hour worked for the salted employer. The maximum credit for salted employment is limited to 40 hours per week for nine weeks during any Qualifying Period, which weeks must be consecutive. The hours of credit will be multiplied by the appropriate contribution rate for contribution credits. Salted credit may not be used to establish new eligibility or to reinstate an employee who was previously terminated.

CONTRIBUTION BANK – FOR PLAN A EMPLOYEES ONLY

All employer contributions reported in a Qualifying Period in excess of $1,900 in behalf of an Employee participating under Plan A will be credited to that Employee's individual contribution bank. These contribution credits will be withdrawn as necessary to continue the Employee's eligibility in effect. The maximum contribution credit that may be accumulated by an Employee is limited to $1,600, except that any Employee whose contribution bank balance exceeded $1,600 as December 31, 2018 will retain his balance for future use, but no contributions will be credited to that Employee's contribution bank until his remaining contribution bank balance falls below $1,600, at which time his maximum contribution credit will be limited to $1,600. Employees participating under Plan B are not entitled to contribution bank credits.

TERMINATION

A review of the contributions credited for each Employee will be made as of January 1, April 1, July 1, and October 1 of each year. Eligibility for benefits will terminate on the applicable date if the Employee has not accumulated the minimum amount of employer contributions during the corresponding Qualifying Period. The coverage of an Employee and all Dependents will also terminate on the date the Plan terminates.

No person will be eligible to participate in this Plan and to obtain health benefits unless he is working for, or is available for work with, a contributing employer in a category of work covered by a collective

bargaining agreement. This provision will not be applicable to disabled Employees, Retired Employees, Employees working in salted employment, or Employees who are working for, or available for work with, a contributing employer of a reciprocating local union. Termination will be immediate upon receipt of written notification of such person's status in the Fund office. If an employee is working at the trade for a non-contributing employer he is deemed to be unavailable for work with a contributing employer. An employee who is terminated under this provision will not be eligible for Self-Contributions other than COBRA self-contributions, if applicable.

REINSTATEMENT

An employee whose eligibility for benefits has been terminated must satisfy the requirements of New Eligibility to regain eligibility. Further eligibility will be determined in accordance with the requirements of the section titled Qualifying and Coverage Periods for Continuing Benefits.

SELF-CONTRIBUTIONS FOR CONTINUED COVERAGE

An Employee who does not have sufficient employer contributions during a Qualifying Period, and who would otherwise be terminated under these eligibility rules, will be allowed to self-pay to continue coverage. The Employee will be notified shortly before the end of the current Coverage Period of the amount of self-contribution required to continue coverage for the next Coverage Period. He may make a self-contribution for the full Coverage Period or may make self-contribution payments monthly. The amount of self-contributions required will be determined by subtracting contributions reported during the Qualifying Period from the respective continuing eligibility requirements. However, if any self-contribution is not received in a timely manner, coverage will be terminated and the employee will not be allowed to self-pay in the future until reinstated for coverage in accordance with the reinstatement section. An Employee who does not make timely self-contributions may be entitled to COBRA.

An Employee whose eligibility has been terminated due to unavailability for work with contributing employers is not eligible to make self-contributions in order to maintain eligibility.

Once an Employee has self-paid for a Qualifying Period during which he is not credited with any Employer contributions, he will not be permitted to make additional self-contributions. He may then be able to continue eligibility under COBRA.

RETIREE ELIGIBILITY

Former employees who have terminated, and who have retired under the Florida UBC Pension Plan, the South Florida Carpenters Pension Plan, the Florida Carpenters Pension Fund, or the Central/North Florida District Council of Carpenters Pension Fund, and who are members in good standing with a participating union as certified by the union, may continue to make self-contributions after the right to make self-contributions would otherwise terminate. However, the plan of benefits applicable to such Retired Employees will be determined by the Trustees and may differ from the plan of benefits provided for non-retirees. As of January 1, 2019, Retired Employees will have the Benefit Plan applicable when they last had eligibility for coverage due to active employment.

A Retired Employee who is not eligible for Medicare, or who has Dependents who are not eligible for Medicare, may continue benefits under this provision for a maximum of 36 months. For those Retired

Employees who retired prior to January 1, 2017, the 36 month period began January 1, 2017. For those who retire on and after January 31, 2017, the 36 month period begins on the date the Retired Employee first makes self-contributions as a Retired Employee. The self-contribution rate for Retired Employees will be established from time to time by the Trustees. Self-contributions by Retired Employees must be made in a timely manner.

A surviving spouse of a deceased Retired Employee who at the time of his death was a member in good standing of a participating union may continue to make self-contributions to maintain eligibility after the death of the Retired Employee until the earlier of the date the surviving spouse becomes eligible for Medicare, the date of remarriage, or the maximum of 36 months has been reached. Dependent children of the Retired Employee will be permitted to maintain eligibility by continuing to make self-contributions as described above until they reach the limiting age, but again subject to the 36 month maximum. The required self-payment for spouses and/or Dependent children will be determined by the Board of Trustees. Payments must be continuous and timely.

A Retired Employee who is not employed and who is eligible for Medicare, and his Dependents who are eligible for Medicare, will be able to maintain eligibility beyond the thirty-six month period described above by making the required self-contributions. Retired Employees in this classification will not be eligible for Prescription Drug Benefits.

The Trustees reserve the right to amend, restrict or entirely eliminate self-contributions or the plan of benefits for past, present or future Retired Employees.

NON-COLLECTIVE BARGAINING UNIT EMPLOYEES

The following rules apply to partners, directors, officers, majority stockholders and any salaried employees of employers who have applied to and been accepted by the Board of Trustees prior to January 1, 2006, and who have agreed to contribute on behalf of such employees. These provisions also apply to employees who were formerly covered under the terms of a collective bargaining agreement with one of the participating local unions.

1. Contributions must be made at the maximum rate established in the collective bargaining agreement for a minimum of forty hours per week.

2. Contributions must be made at least monthly on a separate reporting form for the employees not covered by the collective bargaining agreement.

3. Contributions must be continuous and without interruption. In the event contributions are discontinued for more than sixty days, the Trustees may refuse to accept any future contributions.

4. Eligibility for benefits will become effective in accordance with the Eligibility Rules outlined for all other employees.

5. Employees whose eligibility is established as a result of contributions made on their behalf under these rules will have no right to continue coverage under the self-contribution rules of the Plan. This rule is not applicable to former officers of a participating local union.

6. All benefits to which an eligible Employee is entitled will be determined in accordance with the Eligibility Rules.

7. The agreement to remit contributions will terminate if and when the collective bargaining agreement terminates.

The following rules apply to Non-Bargaining Unit Employees for whom an employer submits an application and are approved by the Trustees on and after January 1, 2006. The application must be submitted within 30 days of the employee's employment.

1. Contributions must be made at the maximum rate established in the collective bargaining agreement for a minimum of 173 hours per month.

2. Contributions must be made at least monthly on a separate reporting form for the employees not covered by the collective bargaining agreement.

3. Contributions must be continuous and without interruption. In the event contributions are discontinued for more than sixty days, the Trustees may refuse to accept any future contributions.

4. Eligibility for benefits will become effective on the first day of the month for which the employer makes monthly contributions on at least 173 hours. Eligibility will terminate at the end of the month during which the last contributions are made. Employers must submit contributions prior to the first day of the month during which the employee is to be covered.

5. Employees whose eligibility was granted as a result of contributions made on their behalf under these rules will have no right to continue coverage under the self-contribution rules of the Plan.

6. Employees under these rules will not be eligible for Disability Credits nor Contribution Bank accumulation.

7. All benefits to which an eligible Employee is entitled will be determined in accordance with the Plan's Schedules of Benefits.

8. The agreement to remit contributions will terminate if and when the collective bargaining agreement terminates.

UNIFORMED SERVICES

An Employee who is inducted or enlists or is otherwise called to active duty in the Uniformed Services of the United States of America will be entitled to credit or the right to make self-contributions for continued coverage as follows:

1. For active uniformed service of 31 days or less - the Employee will be credited with contributions equal to 8 hours per day for each day (Monday-Friday) of active uniformed service provided the Employee reports to work no later than the first regularly scheduled working period one week after termination of active duty.

2. For active uniformed service of more than 31 days, - all benefits for an Employee and his Dependents will be terminated on the date the Employee enters active uniformed service in excess of 31 days. However, an Employee will have the right to continue coverage for the period of the active service, not to exceed 24 months, by making COBRA self-contributions in the amount and under the terms outlined in this booklet. In order to be entitled to make self-contributions, the Employee must notify the Trustees in writing within 60 days of his entry into active uniformed service.

Employees who are discharged from active uniformed service of 60 months or less will be reinstated for benefits provided the Employee submits an application for reemployment or seeks reemployment through a participating local union within 14 days (if the active uniformed service is for 31 to 181 days) or 90 days (if the active uniformed service is more than 181 days). The time for reemployment application will be extended in the event of injury or hospitalization as further provided in the Uniformed Services Employment and Reemployment Rights Act of 1994.

The term active uniformed service includes active duty with the Armed Forces, the Army National Guard and the Air National Guard (when engaged in active duty training, inactive duty training or full time National Guard duty), the commissioned corps of the Public Health Service and any other category of persons designated by the President of the United States in the time of war or emergency.

EXTENDED COVERAGE FOR DEPENDENTS OF DECEASED EMPLOYEES

Benefits for the covered Dependents of a deceased eligible Employee will be extended through the date the Employee's coverage would have otherwise terminated, had he not died, based on employer contributions remitted in his behalf, including any accumulated Contribution Bank credits. Any period of extended coverage granted under this provision will reduce the period for which self-contributions may be paid to continue coverage under the COBRA continuation of coverage provisions.

VOLUNTARY REFUSAL OF COVERAGE

An Employee may voluntarily elect to opt out of coverage for himself and any or all of his eligible Dependents for all benefits provided under this Plan. This election must be made on an "Acknowledgment of Coverage Refusal" form available in the Fund office. Upon receipt of the signed and notarized form in the Fund office, coverage for the eligible Employee and/or Dependent(s) will be terminated immediately. If coverage of a Dependent spouse is to be refused, the "Acknowledgment of Coverage Refusal" must also be signed by the spouse. If coverage of a Dependent child who has not reached legal age is to be refused, both the Employee and spouse must sign the "Acknowledgment of Coverage Refusal." If coverage of any Dependent of legal age is to be refused, the "Acknowledgment of Coverage Refusal" must be signed by the Dependent.

Coverage may be reinstated immediately upon receipt in the Fund office of an express and unequivocal written notice signed by the Employee and spouse confirming the decision to revoke the "Acknowledgment of Coverage Refusal." Any expenses incurred during the period of time coverage was refused will not be credited toward deductibles or be payable under the Plan.

POWERS OF THE TRUSTEES

These Eligibility Rules, in whole or in part, may be modified, altered or augmented, without notice, by the Trustees. The Trustees have the power to make additional rules as may be required.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This section contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower-out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct; or

4. You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;

2. The parent-employee's hours of employment are reduced;

3. The parent-employee's employment ends for any reason other than his or her gross misconduct; or

4. The child stops being eligible for coverage under the plan as a Dependent.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a contributing employer and that bankruptcy results in the loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary with respect to the bankruptcy. The Retired Employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or commencement of a proceeding in bankruptcy with respect to a contributing employer, the employer must notify the Fund office of the qualifying event. However, it may be in the best interest of qualified beneficiaries to contact the Fund office as well in the event of the death of an employee so that notification can be given as timely as possible.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce, legal separation or a dependent child's losing eligibility for coverage as a Dependent child), you must notify the Fund office within 60 days after the qualifying event occurs. You must send this notice to the Fund office at the address listed in this section. In the event of divorce or legal separation, you must also furnish a copy of the divorce decree or separation papers. In the event of a child ceasing to qualify as a covered Dependent, you must furnish a copy of the dependent's birth certificate or other proof of date of birth.

HOW IS COBRA COVERAGE PROVIDED?

Once the Fund office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA con-

tinuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

HOW LONG DOES COBRA COVERAGE LAST?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce, legal separation or a dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended, as explained below:

Disability Extension of 18 Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan are determined by the Social Security Administration to be disabled and you notify the Fund office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Fund office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must send this notice and proof of determination of disability to the Fund office at the address listed in this section.

Maximum Period of 24 Months for Service in the Armed Forces

As described on pages 20 and 21, if you enter active duty in the Uniformed Services of the United States of America for a period of 31 days or more, the maximum period of COBRA coverage that you may elect is 24 months, provided you notify the Fund office in writing within 60 days of your entry into active uniformed service.

Second Qualifying Event Extension of 18 Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the employee or former employee dies or gets divorced, or if the dependent child stops being eligible under the Plan as a Dependent child,

but only if the event would have caused the spouse or Dependent child to lose coverage under the plan had the first qualifying event not occurred.

PROCEDURE FOR OBTAINING CONTINUATION COVERAGE

Once the Fund office knows that an event which qualifies you or a dependent for continuation coverage has occurred, the Fund office will send an election notice to your last known address or to the address of your dependent, as applicable. You will have sixty days after the date on the election notice in which you or your dependent must notify the Fund office of an election to continue coverage. If you or your dependent do not elect coverage within the sixty day time period, the right to continue group health coverage will end. A period of forty-five days will be allowed from the date of an election of continued coverage in which to make any retroactive payment due under this provision. Each employee, or each covered dependent of electing separately, will be required to make monthly payments in an amount and manner which will be determined by the Trustees in accordance with applicable law. The monthly amount of each payment will be established no more often than once a year.

TYPE OF COVERAGE EXTENDED

The benefits extended under COBRA will be the same as those provided to the class of employees under which you participated at the time of termination of your coverage.

CANCELLATION OF COBRA COVERAGE

Continued coverage will be canceled by the Fund upon the occurrence of any of the following events:

1. You do not make the required monthly payment by the due date, including the allowable 30 day grace period;

2. The Plan terminates;

3. You become covered under any other group health care plan; or

4. You become covered by Medicare.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of those options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the plan office at the address listed below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of

the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov.cbsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Fund office 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 Fund office.

PLAN CONTACT INFORMATION

Information about the Plan and about your rights and obligations under COBRA can be obtained at the Fund office by writing or calling:

Florida UBC Health Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Telephone: (615) 859-0131
Toll-Free: (800) 831-4914

DEATH BENEFIT – PLAN A ONLY
(For Active and Retired Employees)

A Death Benefit will be payable in the event a covered Employee's death occurs from any cause, at any time or place, while covered.

AMOUNT AND PAYMENT

The amount of Death Benefit is outlined in the Schedule of Benefits.

Upon receipt by the Plan of due written proof of claim, the Death Benefit will be promptly paid to the Employee's beneficiary in a single sum.

An Employee may change his beneficiary at any time, in the manner explained below. This coverage may not be assigned.

BENEFICIARY

The beneficiary for any amount of benefit becoming payable under the Plan on account of an Employee's death will be the beneficiary(ies) designated by the Employee on a form furnished by or satisfactory to the Plan and filed at the Plan's administrative office prior to the date the benefit is paid.

If no beneficiary is designated, or if no designated beneficiary survives the Employee, the benefit will be payable to:

1. The surviving spouse of the Employee; if none, it will be payable in the following order:

2. The child or children of the Employee, in equal shares, with the share of any deceased child to be distributed among the descendants of that child; if none, it will be payable to:

3. The parents of the Employee, in equal shares or all to the surviving parent; if none, if will be payable to:

4. A duly appointed executor or administrator of the Employee's estate; if none, it will be payable to:

5. The Employee's next of kin under the laws of the Employee's state of domicile at the time of his death.

If more than one beneficiary is designated and their respective interests are not specified, the beneficiaries will share equally. However, if any designated beneficiary is not living at the time of the Employee's death, the share that beneficiary would have received will, unless specified otherwise in the beneficiary designation, be payable equally to the remaining designated beneficiaries, if any, who survive the Employee.

In any case, the Plan may, at its option, pay an amount not exceeding the lesser of actual expenses incurred or the Death Benefit payable to any person it determines to be equitably entitled to receive the payment by reason of having incurred funeral or other expenses incident to the last illness or death of the Employee. The Plan's obligations will be completely discharged to the extent of any such payment.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT – PLAN A ONLY

(For Active and Retired Employees)

Accidental Death and Dismemberment Benefits are payable for losses resulting from Injury sustained by an Employee in an accident occurring while covered. The loss must occur within 90 days after the accident and directly result from such Injury independently of all other causes. The Injury must be evidenced by a visible wound or contusion on the exterior of the body, except in case of drowning or internal Injury revealed by an autopsy. Benefits are payable to the Employee, if living at the time payment is made, otherwise to the Employee's beneficiary. This benefit may not be assigned.

AMOUNT AND PAYMENT

For Loss of:	**Amount Payable**
Life	The Principal Sum
Both Hands or Both Fee	The Principal Sum
Sight of Both Eyes	The Principal Sum
One Hand & One Foot	The Principal Sum
One Hand & Sight of One Eye	The Principal Sum
One Foot & Sight of One Eye	The Principal Sum
One Hand	One-Half of the Principal Sum
One Foot	One-Half of the Principal Sum
Sight of One Eye	One-Half of the Principal Sum

Loss of a hand or foot means actual severance through or above the wrist or ankle joint. Loss of an eye means entire irrecoverable loss of sight of such eye.

Not more than the Principal Sum is payable for all losses resulting from injuries sustained in any one accident.

EXCLUSIONS

No benefits are payable for losses resulting from an accident occurring while not covered or resulting directly or indirectly from:

1. An accident, sickness, or injury arising out of or in the course of any employment for compensation or profit, and sickness or injury covered by any workers compensation act or similar acts whether or not arising out of self employment or employment by others;

2. Bodily or mental infirmity; treatment or diagnosis of injury; ptomaine or bacterial infection unless there is a visible accidental cut or wound; or suicide, attempted self destruction or intentionally self-inflicted injury while sane or insane;

3. Any act resulting from or attributable to insurrection, riot, civil commotion, or war (whether declared or undeclared); or committing or attempting to commit an assault or felony; or

4. Injuries received while operating or riding in any aircraft, except while riding as a passenger in a commercial aircraft that is on a regularly scheduled passenger flight.

COST MANAGEMENT SERVICES

Benefit payments for certain Covered Medical Expenses may be reduced if the Plan's Cost Management Services are not used. Please review the following provisions.

Pre-Admission Review Service

1. **Payment of Covered Hospital Charges.** This service applies to Covered Medical Expenses that are billed by a Hospital for confinement. The scheduled benefits will be paid for such charges if the days are approved by the Cost Management Administrator; otherwise, those charges will be paid at 50%.

2. **Pre-admission Review.** This review will determine the number of days of Hospital confinement authorized for payment of the scheduled benefits. The Employee is responsible for contacting the Cost Management Administrator and obtaining pre-authorization of Hospital confinement from the Cost Management Administrator.

3. **Non-emergency Confinement.** Before a Covered Person is Hospital confined, a request for Pre-admission Review must be submitted. The request must be made by phone, in advance, by calling toll-free (800) 764-6810.

4. **Emergency Confinement.** This is a Hospital confinement for a covered Injury or Sickness that, unless treated at once on an inpatient basis, would either be a threat to life or would seriously impair bodily functions.

   A request for Pre-admission Review must be phoned in toll-free to (800) 764-6810 within 48 hours after the start of an Emergency confinement.

5. **Extra Confinement Days.** If extra days of confinement are necessary, the Cost Management Administrator must be notified. This request must be made before the extra days are used.

Pre-Surgical Review Service

1. **Payment of Covered Surgical Charges.** This service applies to Covered Medical Expenses for surgery and anesthesia billed by a Physician for a Focused Procedure. The scheduled benefits will be paid for those charges if a Focused Procedure is performed after it is confirmed by a second opinion or confirmed or not by a third opinion. Otherwise, the charges of those Physicians will be paid at 50%.

2. **Pre-surgical Review.** Prior to performing a Focused Procedure, a Pre-surgical Review must be requested from the Cost Management Administrator. This is done by calling toll-free the Cost Management Administrator at (800) 764-6810. The Cost Management Administrator may then require a second opinion to confirm the need for surgery.

These additional consultations must be performed by Physicians who are:

(a) Board certified specialists in the area in which the operation is concerned; and

(b) Not financially associated with either the surgeon originally recommending surgery or with each other.

If the second opinion does not confirm the need for surgery, a third opinion is required to obtain the scheduled benefits for the surgery. Even if the third opinion does not confirm the need for surgery, full Plan benefits will be paid if the Covered Person desires the procedure. All such consultations will be paid at the rate of 100% of the Usual and Reasonable Charge. Charges for second opinions and, if necessary, third opinions are not subject to the calendar year deductible.

Focused Procedure means:

Adenoidectomy

Angioplasty

Back Surgery (including disc removal)

Breast Surgery
(mammoplasty, mastectomy)

Carotid Endarterectomy

Pacemaker Implant-
permanent cardiac

Coronary Artery Bypass

Herniorrhaphy

Hip Replacement

Hysterectomy

Knee Surgery
(excluding diagnostic arthroscopy)

Nasal Surgery
(septoplasty, rhinoplasty,
submucous resection,
reconstruction)

Prostatectomy

Varicose Vein Surgery

Heart Catherization

Cost Management Services will include preadmission review, length of stay reviews, utilization reviews, retrospective reviews, audits and managed care to such an extent as is appropriate to ensure that neither persons covered under the Plan nor the Plan incur avoidable hospitalization or other costs in obtaining quality appropriate medical care covered by the Plan.

Individual Case Management

Under the Individual Case Management Program, Hospital admissions in large claim risk categories are reviewed to determine if an alternate (and more efficient) site for medical care is indicated.

TRUSTEES' SOLE DISCRETION

The Plan may pay benefits in an individual case, or more generally, for services and supplies not specifically covered by this Plan. This applies only if the Trustees determine that such services and supplies

are in lieu of more expensive services and supplies which would otherwise be covered under the Plan and are required for the care and treatment of a Covered Person.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate deductible amounts to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment will be conclusive and will be binding upon the Covered Person and all medical providers.

DEDUCTIBLE

Deductible Amount. This is the amount of Covered Medical Expenses for which no benefits will be paid. Before benefits can be paid, a Covered Person must meet the deductible shown in the Schedules of Benefits.

General Deductible Carry-Over. Covered Medical Expenses incurred in one calendar year can also be used in the next calendar year if they were incurred in the last three months of the prior year and were part of the prior year's deductible.

Family Unit Limit. When the cumulative dollar amount shown in the Schedules of Benefits has been applied for covered members of a family unit toward their calendar year deductible, the deductible of all covered members of that family unit will be considered satisfied for the remainder of that calendar year.

BENEFIT PAYMENT

Each calendar year, benefits will be paid for the Covered Medical Expenses of a Covered Person that are in excess of the deductible. Payment will be made at the rate specified in the Schedules of Benefits.

COVERED MEDICAL EXPENSES

Covered Medical Expenses are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits and exclusions of the Plan. A charge is incurred on the date that the service or supply for which it is made is performed or furnished.

1. **Hospital Care.** Medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for Room and Board will be payable as shown in the Schedule of Benefits.

   Charges for an Intensive Care Unit stay are payable as described in the Schedules of Benefits.

2. **Skilled Nursing Facility Care.** Room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

   (a) The patient is confined as a bed patient in the facility;

   (b) The confinement starts within 14 days of a Hospital confinement of at least three days; and

   (c) The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement.

Covered Medical Expenses for a Covered Person's care in these facilities is limited to the covered daily charge limit shown in the Schedules of Benefits.

3. **Physician Care.** Professional services of a Physician for surgical or medical services.

4. **Private Duty Nursing Care.** Private-duty nursing care by a licensed nurse (RN, LPN, or LVN). Covered Medical Expenses for this service will be determined as follows:

   (a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and is not custodial in nature and when the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

   (b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and is not custodial in nature.

5. **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness where Hospital or Skilled Nursing Facility confinement would otherwise be required, and must be provided under a Home Health Care Plan.

   Benefit payment for nursing, home health aide and therapy services is subject to a limit of one visit per day and 100 visits each calendar year.

   A home health care visit will be considered a periodic visit by either a nurse or a therapist, as the case may be, or four hours of home health aide services.

6. **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

7. **Coverage of routine nursery and well child care.** Routine nursery and well child care for a newborn will be considered Covered Medical Expenses of the child. A separate deductible will apply to any such charges incurred on behalf of the child itself apart from its mother. Covered Medical Expenses include:

   (a) Charges for Routine Nursery Care. Routine nursery care is room, board and other normal care that is customarily furnished by a Hospital to a newborn baby who is neither injured nor sick. It includes necessary laboratory tests performed in the Hospital but it does not include routine pediatric care or ambulance service.

   The Usual and Reasonable Charge made by the Hospital for confinement of a newborn child during the first seven days after its birth or until the child's mother is discharged from the Hospital, whichever is longer, will be deemed to be well baby care unless satisfactory evidence is provided that a different Period of Hospital Confinement is customary at the Hospital in which the child is confined.

   This coverage is only provided if the mother is a Covered Person whose pregnancy is covered under the Plan and the child is a Covered Person who is neither injured nor ill.

(b) Charges for Well Child Pediatric Care. Well child pediatric care includes routine pediatric care by a Physician including the child's initial exam, circumcision and immunizations.

Benefits are limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined immediately following birth.

8. **Coverage for Pregnancy.** Coverage of the Usual and Reasonable Charges for the care and treatment of pregnancy are covered the same as any other Sickness for a covered Employee or Retiree or an eligible Dependent spouse of a covered Employee or Retiree. Pregnancy of a Dependent, other than the Employee's or Retiree's spouse, is not covered.

9. **Other Medical Services and Supplies.** The following services and supplies not otherwise included in the items above:

(a) Anesthetics; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(b) Diagnostic x-rays.

(c) Laboratory studies.

(d) Radiation or chemotherapy and treatment with radioactive substances. Materials and services of technicians are included.

(e) Rental of Durable Medical Equipment or surgical equipment to be used only for therapeutic care. These items may be bought rather than rented, but only if approved by the Fund office.

(f) Local professional land ambulance service. A charge for this item will be a Covered Medical Expense only if the service is to or from a local Hospital. Service is local if the Covered Person is carried no more than 50 miles from the place of pickup to or from the nearest PPO hospital.

(g) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(h) Artificial prosthetic devices and their replacements that replace all or part of an internal body organ. This does not include dental or ophthalmic devices.

(i) Leg, arm, back and neck braces or trusses which are required as a result of a disabling congenital condition or an Injury or Sickness that started within five years of the date of service.

(j) Artificial legs, arms or eyes required to replace a natural body part lost no more than twelve months prior to the incurred date of placement of the prosthetic device. Replacement of covered prosthetic appliances will be considered only if the original prosthesis is accidentally broken or damaged and cannot be repaired or made serviceable, or if the Covered Person's physical condition changes so that the replacement is Medically Necessary.

(k) Physical therapy by a licensed therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.

(l) Speech therapy by a licensed speech therapist. Speech therapy must be ordered by a Physician.

(m) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness, and improve a body function.

(n) Sterilization procedures, but not reversals.

(o) Reasonable medical, surgical and Hospital expenses incurred in connection with breast reconstruction surgery required as the result of a mastectomy in a manner consistent with benefits provided for other Medically Necessary expenses including:

(1) Reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(3) Prostheses and physical complications of all stages of a mastectomy, including lymphedemas.

(p) Injectable medication, provided it is dispensed under the Case Management Program and subject to the major medical deductible and payment percentages. These medications must be purchased through the Plan's Prescription Drug Card Service Program or through the Plan's PPO.

(q) Reasonable medical, surgical and Hospital expenses incurred by Covered Persons who are eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition and either; (1) the referring health care professional is a participating provider and has concluded that the individual's participation in such trial would be appropriate, or (2) the Covered Person provides medical or scientific information establishing that participation in such trial would be appropriate.

10. **Dental-Type Care.** Charges for the care of the mouth, teeth, gums and alveolar processes will be covered only if that care is for the following oral surgical procedures:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required.

(b) Emergency repair due to Injury to natural teeth. This repair must be made within 12 months from the date of an accident unless, in the case of a child, it is not medically appropriate to do the repair within twelve months.

(c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth when the Injuries occurred no more than twelve months prior to expenses being incurred.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and draining of cellulitis.

(f) Incision of sensory sinuses, salivary glands, or ducts.

(g) Removal of impacted teeth.

No benefits are payable under this benefit for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

11. **Recommended Preventive Services.** Charges for recommended preventive services as required by the Patient Protection and Affordable Care Act of 2010 ("ACA"). Coverage is provided only for services rendered by PPO providers with no cost-sharing (Fund payment percentage is 100% with no deductible or co-payment.). These "recommended preventive services" generally include the following:

(a) Evidenced-based items or services with a rating of A or B, that are considered to be current recommendations of the United States Preventive Services Task Force (USPSTF) for purposes of ACA;

(b) Immunizations for routine use in children and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);

(c) For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

(d) For women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA.

If preventive services are received from a non-PPO provider, they will not be covered. If the federal guidelines are unclear about which preventive benefits must be covered, the Trustees will determine if a particular benefit is covered under this preventive services benefit. For recommendations in effect for less than one year, coverage of the newly recommended preventive service will become effective as of the first plan year beginning at least one year after the effective date unless otherwise required by law. The following is intended to be a list of the recommended preventive services that are current as of the printing of this booklet:

COVERED PREVENTIVE SERVICES FOR ALL ADULTS

Abdominal Aortic Aneurysm	One-time screening for men ages 65-76 who have ever smoked
Alcohol Misuse	Screening and counseling to reduce alcohol misuse in primary care settings
Aspirin Use (Counseling)	To prevent cardiovascular disease for men (ages 45 to 79) and women (ages 55 to 79). Over the counter aspirin is covered when prescribed by a Physician
Blood Pressure	Screening for adults (age 18 and older)
Cholesterol Screening (Lipid Disorders)	For men age 35 and older; men age 20-35 if at increased risk for coronary heart disease; women age 20 and older if at increased risk for coronary heart disease
Colorectal Cancer Screening	Fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults ages 50-75
Depression	Screening for adults
Type 2 Diabetes	In asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80 mm Hg
Diet	Counseling for adults at higher risk for chronic disease
HIV	Screening for all adults at higher risk
Immunization	Vaccines for adults – doses, recommended ages, and recommended populations vary: Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diptheria, Pertussis Varicella
Obesity	Screening and counseling for all adults
PSA Test	For men
Sexually Transmitted Infection (STI)	Prevention counseling for all adults at higher risk
Tobacco Use	Screening for all adults and cessation interventions for tobacco users
Syphilis	Screening for all adults at higher risk
Well visits—To obtain Recommended Preventive Services	

COVERED PREVENTIVE SERVICES FOR WOMEN

Anemia	Screening on a routine basis for pregnant women
Bacteriuria	Urinary tract or other infection screening for pregnant women
BRCA	Counseling about genetic testing for women at higher risk
Breast Cancer Chemoprevention	Counseling for women at higher risk
Breastfeeding	Comprehensive support and counseling from trained providers, as well as access to breast feeding supplies for pregnant and nursing women
Cervical Cancer	Screening for sexually active women
Chlamydia Infection	Screening for younger women and other women at higher risk
Contraception	Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
Domestic and Interpersonal Violence	Screening and counseling for all women
Folic Acid	Supplements for women who may become pregnant
Gestational Diabetes	Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea	Screening for all women at higher risk
Hepatitis B	Screening for pregnant women at their first prenatal visit

Human Immunodeficiency Virus (HIV)	Screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test	High Risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
Osteoporosis	Screening for women over age 60 depending on risk factors
Rh Incompatibility	Screening for all pregnant women and follow-up testing for women at higher risk
Tobacco Use	Screening and interventions for all women and expanded counseling for pregnant tobacco users
Sexually Transmitted Infection (STI)	Counseling for sexually active women
Syphilis	Screening for all pregnant women or other women at increased risk
Well-woman Visits to obtain Recommended Preventive Services	

COVERED PREVENTIVE SERVICES FOR CHILDREN

Alcohol and Drug Use	Assessments for adolescents
Autism	Screening for children at 18 and 24 months
Behavioral	Assessments for children of all ages
Blood Pressure	Screening for children
Cervical Dysplasia	Screening for sexually active females
Congenital Hypothyroidism	Screening for newborns
Depression	Screening for adolescents
Developmental	Screening for children under age 3 and surveillance throughout childhood
Dyslipidemia	Screening for children at higher risk of lipid disorders
Fluoride Chemoprevention	Supplements for children without fluoride in their water source
Gonorrhea	Preventive medication for the eyes of all newborns
Hearing	Screening for all newborns
Height, Weight, and Body Mass Index	Measurements for children
Hematocrit or Hemoglobin	Screening for children
Hemoglobinopathies or Sickle Cell	Screening for newborns
HIV	Screening for adolescents at higher risk
Immunizations	Vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary: Diphtheria, Tetanus, Pertussis Haemophilus Influenzae type b Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza (Flu Shot) Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella
Iron	Supplements for children ages 6 to 12 months at risk for anemia
Lead	Screening for children at risk of exposure
Medical History	For all children throughout development
Obesity	Screening and counseling
Oral Health	Risk assessment for young children (10 years and younger)
Phenylketonuria (PKU)	Screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI)	Prevention counseling and screening for adolescents at higher risk

Tuberculin	Testing for children at higher risk of tuberculosis
Vision	Screening for all children
Well Child Visits to obtain Recommended Preventive Services	

CHANGE IN BENEFITS

Any change in the amount of coverage of a Covered Person by reason of a change in classification, change in benefit structure and/or schedule, or for any other reason, will become effective on the first of the month coincident with or next following the effective date of the change.

EXCLUSIONS

Any charges incurred for services or supplies not specifically covered by the Plan are excluded. Examples of charges not covered include, but are not limited to, the following:

1. Care and treatment of any occupational Injury or Sickness. The term "occupational Injury or Sickness" includes any Injury, Sickness, illness or disease arising out of, related to or sustained in the course of any employment (or self-employment) for compensation or profit.

   An Injury or Sickness will be deemed to have arisen out of or be related to or sustained in the course of employment if an employment related cause is a substantial contributing cause of the Injury or Sickness being treated.

   The following presumptions apply to this exclusion:

   (a) The filing of a notice of injury or claim for worker's compensation benefits will give rise to a presumption that an occupational Injury or Sickness exists.

   (b) The filing of suit or bankruptcy claim contending that an Injury or Sickness arises from one's occupation will give rise to a presumption that an occupational Injury or Sickness exists.

   (c) The receipt of any benefit under a worker's compensation or similar law or the receipt of any recovery through settlement or otherwise as a result of filing of a suit or bankruptcy claim under the preceding paragraph will give rise to a conclusive presumption that the Injury or Sickness for which such payments are received is an occupational Injury or Sickness.

2. Care, treatment or supplies for which there would not have been a charge if no coverage had been in force (subject to the right, if any, of the United States government to recover reasonable and customary charges for care provided in a military or veterans' hospital).

3. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or where otherwise prohibited by law.

4. Care and treatment that is either not Medically Necessary or is Experimental or Investigative in nature.

5. Supplies or equipment for personal hygiene, comfort or convenience including but not limited to telephone, television, cosmetics, guest trays, magazines, beds or cots for family members or other guests.

6. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

7. Loss incurred due to injuries sustained while committing a felony, while participating in a riot or civil insurrection, or if caused during a Covered Person's violation of local, state, or federal law. This exclusion will not apply to acts of domestic violence.

8. Any loss that is due to a declared or undeclared act of war.

9. Any loss due to an intentionally self-inflicted injury, unless the self-inflicted injury is proven to be the result of a medical condition, including depression.

10. Care, treatment, services and supplies directly or indirectly provided for realignment of teeth or jaws, including but not limited to atrophy of the lower jaw, occlusion, maxillofacial surgery and retrognathia. Expenses incurred for treatment of temporomandibular joint dysfunction (TMJ) will be covered provided treatment is for medical conditions caused by the temporomandibular joint dysfunction.

11. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or otherwise exists in law.

12. Care and treatment provided for cosmetic reasons, whether or not recommended for psychological reasons. This exclusion will not apply if the care and treatment;

    (a) Is for repair of damage from an accident that occurred no more than five years prior to the date expenses are incurred;

    (b) Is due solely to surgical removal of all or part of the breast tissue caused by an Injury or Sickness; or

    (c) Is for correction of an abnormal congenital condition in a child born within five years of the date expenses are incurred.

13. Radial and hexagonal keratotomy or other eye surgery to correct near and far sightedness, astigmatism, or other refractive errors. Also, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

14. Audiology tests, hearing aids, or the fitting of such items.

15. Routine physical exams, lab tests and routine chest x-rays beyond any such coverage specifically allowed by the Plan except mammograms and pap smears at medically recommended intervals.

16. Services or supplies provided mainly as a rest cure, maintenance or custodial care, or which are palliative in nature. This exclusion also applies to any services or treatment that cannot reasonably be expected to lessen the patient's disability enough to enable the patient to live outside of an institution.

17. The following care, treatment or supplies for the feet:

    Orthopedic shoes; orthotics or orthopedic appliances including orthopedic prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and treatment of corns, calluses or toenails, except the surgical removal of nail roots or treatment required in connection with metabolic or peripheral-vascular disease.

18. Spare items of the nature of: braces of the leg, arm, back or neck; artificial arms, legs or eyes; or lenses for the eye.

19. Services that are of the nature of stress management, family planning, marital counseling, social counseling, educational or vocational testing or training and treatment of learning disabilities, behavior problems and behavioral modification therapy, biofeedback and other forms of self-care or self-help training.

20. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and is paid by the Hospital or facility for the service.

21. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercise equipment, vibratory equipment, elevators or stair lifts, hot water bottles, rubber gloves, home enema equipment, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, devices for simulating natural female body contours (except for post-mastectomy surgery), first-aid supplies and non-hospital adjustable beds.

22. Care and treatment of obesity, weight loss, or dietary control including but not limited to weight loss programs, liposuction and gastric stapling, whether or not it is, in any case, a part of the treatment plan for another sickness.

23. Care, treatment and counseling for gender identification, sex transformations, sexual impotency and sexual dysfunction, including any complications arising therefrom.

24. Care and treatment for reversal of surgical sterilization.

25. Care and treatment for infertility, artificial insemination or in-vitro fertilization and any charges for a surrogate mother to bear a child, for inseminating a surrogate mother with a Covered Person's sperm, and any complications thereof.

26. Pre-natal testing, including amniocentesis, when done for the purpose of determining the sex of the child or without medical diagnosis.

27. Care and treatment for hair loss unless caused by an underlying medical condition. Male pattern baldness is not considered an underlying medical condition.

28. Exercise programs, travel and lodging for treatment of any condition, whether or not recommended by a Physician.

29. Any transplant procedures deemed by the Trustees to be experimental, and all donor expenses.

30. Abortion, except that a legal abortion performed on any Covered Person, including a Dependent daughter, will be covered if the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of incest or rape.

31. Care and treatment of pregnancy, childbirth, and miscarriage of an eligible Dependent other than the covered Employee's or Retiree's spouse. Benefits due to pregnancy are provided only for the Dependent spouse of an Employee or Retiree covered under Plan A.

32. Acupuncture, accupressure, or hypnosis, except when performed by a Physician in lieu of anesthesia.

33. Charges incurred due to handling of nuclear materials.

34. Charges for any drugs or medication that can be purchased without a prescription. Other items specifically excluded whether or not prescribed or recommended by a Physician include Yohimbine preparations or similar products for treating sexual impotency; Clomid, Serophene or similar products for treating infertility; Sandimmune or similar products for immuno-suppression; Antabuse or similar products for treating alcoholism or substance abuse; anorexiants (diet pills), Minoxidil preparations (Rogaine) or similar products; Retin-A or similar products when used primarily for cosmetic purposes after the age of 26; enzymes, herbs, vitamins, minerals, nutritional supplements and special diets (except as listed under the Recommended Preventive Services).

35. Charges for chelation therapy except for treatment of acute arsenic, gold, mercury or lead poisoning.

36. Charges for missed appointments or for completion of claim forms.

37. Care and treatment for alcoholism, chemical dependency or drug abuse.

38. Care and treatment for Sickness or Injuries sustained as the result of the misuse of any controlled substance when not prescribed by a Physician.

39. Care and treatment for senile deterioration, Alzheimer's Syndrome or organic mental and nervous disorders.

40. Care or treatment of any Sickness or Injury incurred or aggravated while in the uniformed service.

41. Expenses incurred outside the United States unless you or your Dependent are a U.S. Resident and the charges are incurred while traveling on business or for pleasure.

42. Charges incurred for or relating to laser spine treatment or surgery.

43. Charges incurred relating to engagement in an inherently dangerous hobby. This includes, but is not limited to, the following activities: racing of any motorized vehicle or vessel, rodeo activities, mountain climbing, skydiving, competition skiing, competitive skin diving and cave diving.

44. Charges incurred for transportation by air ambulance.

45. Charges incurred for a loss caused or contributed to by the Covered Person's use of alcohol, intoxicants or drugs, except for those drugs prescribed by a Physician when being used as prescribed.

PRESCRIPTION DRUG CARD SERVICE PROGRAM

(For Employees, Covered Retirees and Covered Dependents)

The Prescription Drug Card Service Program will provide you and your Dependents, if covered, with a card to purchase prescription drugs at a Participating Pharmacy.

Individuals will not be eligible under this Plan until records have been received and updated with the Fund office.

ELIGIBLE PRESCRIPTIONS

1. State and Federal legend drugs including compounded prescriptions with at least one legend drug.

2. Insulin.

3. Needles and disposable insulin syringes.

4. Drugs approved by the FDA for the indicated diagnosis.

5. Maintenance drugs, when written by a duly authorized Physician.

DISPENSING LIMITATIONS

1. 30 day supply or 100 units whichever is greater.

2. Maintenance drugs are limited to a ninety (90) day supply.

3. Non steroid anti-inflammatory medications and H2 receptor medication are limited to a 30 day supply only (e.g., Motrin, Naprosyn, Tagamet, Zantac).

EARLY REFILL POLICY

Refills will not be allowed unless at least 75% of the prescription is used, according to the Physician's directions.

LIMITATIONS

The prescription drug card will not be applicable toward the purchase of:

1. Medication for which cost is recoverable under any Workers' Compensation, occupational disease law or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the patient;

2. Any drug labeled "Caution: limited by law to investigational use" or "experimental drug";

3. Medical supplies or devices;

4. Fertility agents, fluoride preparations, anti-obesity drugs, antacids, laxatives, cosmetic drugs (Retin A and Rogaine), vitamins, and reusable needles; and

5. Over-the-counter medications.

Viagra is not an eligible drug under the Prescription Drug Program. Coverage for this drug will be provided under the Major Medical Benefits, subject to the appropriate payment percentage, only when prescribed by a urologist, and limited to ten pills during any 90 consecutive day period.

DENTAL BENEFITS – PLAN A ONLY

(For Active Eligible Employees and their Dependents)

The Dental Benefits outlined below are provided to Active Employees and their Dependents who are eligible for Plan A benefits only. No Dental Benefits are provided to Retired Employees or their Dependents. A Covered Person may obtain dental services from any provider of his choice.

BENEFITS

The maximum benefit payable per person is shown in the Schedule of Benefits. The following describes covered dental benefits.

Class I – Preventive Services

1. Two routine oral examinations per calendar year;

2. Prophylaxis (cleaning, scaling and polishing of teeth), two times per calendar year;

3. Topical application of fluoride in conjunction with prophylaxis for covered Dependent children under 18 years of age, two times per calendar year;

4. Bitewing x-rays once per calendar year, complete mouth x-rays or panoramic x-rays once in any 36 consecutive month period (a panoramic x-ray will be considered a complete mouth x-ray and subject to the same limit), periapical (root area) x-rays as required; and

5. Periodontal maintenance procedures (following active therapy).

Class II – Basic Services

1. Palliative (emergency) treatment of an acute condition requiring immediate care;

2. Application of desensitizing medicines;

3. Sealants for covered Dependent children through age 16;

4. Panoramic x-rays for the removal of third molars when performed by a different provider on a different date of service;

5. Repair of broken partial or complete dentures;

6. Space maintainers (not made of precious metals) that replace prematurely lost teeth for covered Dependent children under 14 years of age. No payment will be made for duplicate space maintainers;

7. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth;

8. Routine extractions;

9. Endodontics, including pulpotomy (removal of the soft tissue in a decayed tooth), and root canal treatment. No payment will be made for root canal therapy until treatment is completed. Treatment is considered to be complete on the date the canals are sealed;

10. General anesthesia given in a dentist's office for services that are; (a) performed by a person qualified to administer general anesthesia; (b) billed by such dentist; and (c) in connection with covered dental services. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation. The allowance for the administration of a local infiltration or block anesthetic in connection with other covered dental services is included in the allowance for these covered dental services;

11. Tissue conditioning treatments for upper and lower dentures, two times per calendar year;

12. Adjustments to maxillary and mandibular dentures, two times per calendar year beginning six months after the initial placement date;

13. Recementation of space maintainers once per calendar year (must be six months after the initial placement date);

14. Replacement of core buildup, if satisfactory proof is provided that at least five years has passed since the date the procedure was performed;

15. Relining and rebasing of immediate dentures if more than six months after the insertion of an initial or replacement denture with not more than one relining or rebasing in any 36 consecutive month period;

16. Repair of broken crowns, inlays, onlays or bridges;

17. Surgical removal of teeth;

18. Surgical removal of maxillary or mandibular intrabony cysts;

19. Procedures performed for the preparation of the mouth for dentures;

20. Apicoectomy (dental root surgery);

21. Gingival curettage, payable once per quadrant every 36 months;

22. Gingivectomy and gingivolasty;

23. Periodontal scaling, payable once per quadrant every 24 months;

24. Root amputation;

25. Hemisection – (including any root removal), not including root canal therapy;

26. Alveoloplasty;

27. Gingival flap procedure – once per quadrant every 36 months;

28. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis – payable every 36 months; and

29. Cephalometric x-rays, but only in connection with orthodontic diagnosis, and only once in any 36 consecutive month period.

Class III – Major Services

1. Clinical crown lengthening of hard tissue only, subject to dental consultant review for coverage approval and pricing; office notes are required for review;

2. Replacement of cast post and core along with prefabricated post and core procedures, if satisfactory proof is given that at least five years has passed since the date of service when the procedure was performed;

3. Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays);

4. Partial or complete dentures (including the initial insertion and any adjustments during the six month period following insertion);

5. Replacement of an existing partial or complete denture or bridge by a new denture or by a new bridge, if satisfactory proof is given that:

    (a) The existing denture or bridge was inserted at least five year before it is replaced; and

    (b) The existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable;

6. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure payable once per quadrant every 36 months;

7. Free soft tissue graft procedure, including donor site;

8. Frenulectomy;

9. Mucogingival surgery – once per quadrant every 36 months;

10. Bone replacement graft – once per site every 36 months;

11. Pedicle soft tissue graft – once per site every 36 months;

12. Guided tissue regeneration – once per site every 36 months; and

13. Subepithelial connective tissue graft – once per site every 36 months.

Class IV – Orthodontic Services

The following is a list of covered orthodontic services for the correction of an existing malocclusion and its attendant sequelae through the correction of malposed teeth:

1. Diagnosis, including radiographs and study models;

2. Active treatment, including necessary appliances; and

3. Retention treatments following active treatment.

LIMITATIONS AND EXCLUSIONS

Limitations:

1. Any retreatments of root canals are payable one year after completion date of root canal therapy.

2. Restorations made of amalgam, silicate, acrylic and composite materials to restore diseased teeth are only payable on the same tooth surface once every 12 consecutive months.

3. The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.

4. Sealants are limited to the first and second molars for primary teeth and the bicuspids and molars for the permanent teeth of covered Dependent children.

5. General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.

6. Periodontal prophylaxis is limited to two times per calendar year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two times per calendar year.

7. Periodontal services are limited to covered persons age 18 and older.

8. Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.

9. Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.

10. Orthodontia services will be limited to the lifetime orthodontia maximum show in the Schedule of Benefits.

11. Benefits for covered orthodontia services will be payable in equal monthly amounts during the period covered by the approved treatment plan and while coverage is in effect, not to exceed 36 months.

12. If the treatment plan for covered orthodontia services is completed in less time than specified in the approved treatment plan, the Plan will make payment in the amount of the remainder of the liability after receipt of notice from the dentist.

13. Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with orthodontic appliance therapy.

14. Benefit payment for orthodontic services will be limited to 36 consecutive months' active treatment or 18 consecutive months' retention treatment. These limits will include the number of months of such treatment received prior to commencement of this coverage.

Exclusions:

The following are excluded under this benefit:

1. Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to a Covered Person's effective date of coverage, until the Covered Person has been covered under the Plan for 12 consecutive months.

2. Services or supplies which are not Medically Necessary according to accepted standards of dental practice or which are not recommended or approved by the attending dentist.

3. Charges for services or supplies when billed by other than a dentist.

4. Benefits for services rendered by a member of the Covered Person's family (the spouse, children, brothers, sisters and parents of either the Covered Person or his spouse).

5. Services rendered primarily for cosmetic purposes, except for orthodontic services rendered for correction of defects incurred through traumatic Injuries which occurred while this coverage is in force.

6. Charges incurred for failure to keep a dental appointment.

7. Services rendered through a medical department, clinic or similar facility provided or maintained by, or on behalf of, an employer, mutual benefit association, labor union, trustee or similar person or group.

8. Medical services related to the treatment of temporomandibular joint (TMJ – temporal bone/lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).

9. Experimental or Investigative treatment.

10. Dental services received or rendered:

    (a) Through or in a veteran's hospital or government facility due to a service connected disability;

    (b) Which are covered and paid under Worker's Compensation or a similar law; or

(c) Which are coordinated with another plan or insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total reasonable expenses that are actually incurred.

11. Services for which the Covered Person incurs no charge.

12. Procedures, appliances or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.

13. Local anesthesia when billed separately by a dentist.

14. Any services paid or payable under the Covered Person's health or medical plan, policy or contract.

15. Services not listed under the Benefits provisions of this section.

16. Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this benefit will be based on the allowance for the least costly service, procedure or course of treatment.

17. Any additional treatment required due to the Covered Person's failure to follow instructions, or lack of cooperation with the dentist.

18. Treatment for any illness, injury or medical conditions arising out of: war, or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.

19. Services rendered before the effective date of coverage or after termination of coverage.

20. Services rendered after termination of this Plan.

21. Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.

22. Any denture or bridge replacement made necessary by reason of loss, or alteration by a Covered Person, or as a result of theft.

23. Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge, if treatment began prior to the Covered Person's coverage under this benefit.

24. Duplicate or temporary denture, crown or bridge.

25. Labial veneer restorations.

26. General anesthesia and intravenous sedation administered exclusively for patient management or comfort.

27. Charges for nitrous oxide.

28. Services with respect to congenital (hereditary) or developmental malformations or for cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), if paid or payable under a Covered Person's health or medical plan, policy or contract.

29. Prescribed drugs, premedication or analgesia.

30. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues).

31. Charges for oral hygiene, plaque control or diet instruction.

32. Charges for the replacement and/or repair of any orthodontic appliance furnished under a treatment plan or for any duplicate orthodontic device or appliance.

ADDITIONAL BENEFIT PROVISIONS

RIGHT OF REFUND OR SUBROGATION

If the negligence or wrongful act of a third-party causes the death or injury of a Covered Person, and benefits are paid or payable by the Plan for such death or injury, the Plan and/or the Trustees will be subrogated to the rights of the Covered Person and those entitled by law to proceed against such third party, its insurance carrier or, in the case of an automobile accident, any uninsured or under-insured motorist coverage available to the Covered Person to the extent of the benefits paid or payable under the Plan. In addition, in the event that benefits are paid by a third party, its insurance carrier, or in the case of an automobile accident, any uninsured or under-insured motorist, the Plan shall be paid out of the proceeds of such payment any and all benefits paid by the Plan.

The Plan specifically acknowledges the application of the "equitable lien by agreement" doctrine and disavows any application of the "make whole" doctrine or "common fund" doctrine and may therefore exercise a right of subrogation or reimbursement against any and all such proceeds without regard to the nature and characterization of such proceeds or the expenses incurred by the Covered Person to procure such proceeds (including attorney's fees), without regard to any comparative or contributory negligence on the part of the Covered Person, and without regard to any ability or inability of the injured person to recover due to limited insurance.

In the event that benefits are paid as a result of any occupational injury or sickness, the Plan and/or Trustees will be subrogated to the rights of the Covered Person and those entitled by law to proceed against any worker's compensation carrier, covered persons or any person claiming for him, or through him or for his benefit, may be required to execute documents to protect the interest of the Plan as a condition to receiving benefits under this Plan.

The Plan and/or Trustees at its or their option, may:

1. Recover from the Covered Person or any person claiming for him, through him or for his benefit, any and all benefits paid by the Plan out of the proceeds of any settlement, judgment, or other award; and/or

2. Proceed directly against the third-party causing the death or injury in its own name or under the name of the Covered Person or those entitled to sue as plaintiff or in the name of the plaintiff for the benefit of the Plan and/or the Trustees; and/or

3. Proceed directly against the worker's compensation carrier in its own name or under the name of the Covered Person or those entitled to make claim for the person or in the name of the claimant for the benefit of the Plan and/or the Trustees.

The Plan's subrogation rights of full recovery may be from the third party, any liability or other insurance covering the third party, any uninsured motorist coverage or under-insured motorist insurance providing coverage to the Covered Person, any medical payments, no-fault, worker's compensation, or school insurance coverages which are paid or payable.

HOW MEDICARE AFFECTS PLAN PAYMENTS

There are times when federal law determines whether this Plan or Medicare will pay its benefits first.

Benefit Payment Order. The following explains which benefits of the Plan or Medicare will be paid first for the same charges:

1. This Plan pays first when an active employee or covered spouse is age 65 and over. However, if the Active Employee or spouse chooses to have Medicare pay first, he or she must reject coverage under this Plan. Any Employee or spouse who elects Medicare as primary coverage will not be covered for any medical expense benefits under this Plan, nor will any of his Dependents.

   If the Employee ceases to be in active employment, Medicare will pay first. An Employee who is eligible due to hours worked is considered an active employee. An Employee who has to make self-contributions in order to maintain eligibility is not considered an Active Employee.

2. This Plan pays first for a person receiving Social Security Disability Benefits when covered as an Active Employee or Dependent of an Active Employee but who is disabled and covered by Medicare because of disability.

3. This Plan will pay first during the first 30 months of a covered Employee's or Dependent's treatment for end-stage renal failure. After this initial 30 month period, Medicare will pay first.

4. Benefits otherwise payable under this Plan will be reduced by the amount of any similar benefits payable under Medicare, **whether such person has or has not enrolled**, under Part A or Part B of Medicare.

NON-DUPLICATION AND COORDINATION OF BENEFITS

Effect of Non-Duplication or Coordination of Benefits. If scheduled to pay first, the benefits of this Plan will be paid as if there were no other sources of benefits. If this Plan does not pay first, benefits under this Plan will be coordinated with benefits scheduled to be paid from other sources so that no more than 100% of eligible expenses will be reimbursed under all plans.

Benefit Plan. This provision will apply to all medical and dental benefits of a benefit plan. The term benefit plan means this Plan and any one of the following plans:

1. Group or blanket benefit plans.

2. Blue Cross and Blue Shield group plans.

3. Group practice and other group pre-payment plans.

4. Federal government plans or programs. This includes Medicare.

5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow for coordination or non-duplication of benefits.

6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered by one or more of the plans.

In the case of HMO/PPO (Health Maintenance Organization or Preferred Provider Organization) plans: This Plan will not consider any charges in excess of what an HMO/PPO provider has agreed to accept as payment in full. Also, when an HMO/PPO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO/PPO had the Covered Person used the services of an HMO/PPO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

1. Plans that do not have a non-duplication or coordination of benefits provision, or similar provision, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a non-duplication or coordination of benefits provision will pay their benefits by these rules up to the allowable charge:

    (a) The benefit plan that covers the patient as an employee or member will be considered before a benefit plan that covers the patient as a dependent.

    (b) The benefits of a benefit plan that covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan that covers that person as a laid-off or retired employee. The benefits of a benefit plan that covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan that covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    (c) When a child is covered as the dependent of both parents, the plan of the parent whose birthday (omitting the year of birth) is earlier in the calendar year will be considered before that of the other parent. However, when a child's parents are divorced or separated, these rules will apply:

        (1) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

        (2) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(3) This rule will be in place of items (1) and (2) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(d) If there is still a conflict after these rules have been applied, the benefit plan that has covered the patient longer will be considered first.

3. Medicare will pay last to the extent stated in federal law. When Medicare pays first, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Claims Determination Period. Benefits will be calculated on a calendar year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan. Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of overpayment from the source to which it was paid.

NO EXTENSION OF BENEFITS PAST TERMINATION

This provision applies to all benefits.

Regardless of whether or not a Covered Person is hospitalized, totally disabled or undergoing a course of treatment for an illness or injury, all coverage for benefits cease immediately upon termination of eligibility. There is absolutely no extension of benefits whatsoever past termination.

CLAIMS APPEAL PROCEDURE

A Covered Person whose claim for benefits has been denied under the terms of the Plan is entitled to certain rights, including the right to receive a full explanation of the denial and an opportunity to appeal the denial. The following procedures have been adopted by the Board of Trustees explaining those rights:

NOTICE OF ADVERSE BENEFIT DETERMINATION (Notice of Denial)

Upon determination that a claim submitted by you or on your behalf is not covered under the Plan, you will be notified in writing within the time frame outlined in the "Claim Procedure" section of this booklet regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by you, all of the following information.

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why the material or information is necessary;

4. A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;

5. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, practice or procedure will be provided to you free of charge upon request;

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that you will be provided free of charge upon request an explanation of the scientific or clinical judgment applied to the terms of the Plan with respect to your medical circumstances used in making the determination;

7. If the claim involves urgent care, a description of the expedited review process applicable to such claims. If an adverse benefit determination involves an urgent claim, the contents of the notice may be provided orally to you. However, in such instances a written notification will be furnished to you not later than three days after the oral notification;

8. Information sufficient to identify the claim involved, including

   (a) The date of service,

   (b) The health care provider,

   (c) The claim amount (if applicable), and

(d) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

9. If the claim is contingent on your determination of disability for purposes of granting continuation of eligibility under the Plan, and you have failed to establish proof of disability:

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you,

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

(3) A disability determination presented by you to the Plan made by the Social Security Administration,

(b) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner.

YOUR RIGHT TO INTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION

If your claim for benefits has been denied under the terms of the Plan and a notice of adverse benefit determination has been issued to you, you will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which you may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below.

1. Review Procedure

The procedure will:

(a) Provide you at least 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination;

(b) Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of that individual;

(c) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or their committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(d) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(e) Provide that the health care professional engaged for purpose of this appeal is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(f) Provide, in the case of a claim involving urgent care, for an expedited review process under which—

(1) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you, and

(2) All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other similar method; and

(g) Additional Provisions Applicable to Claims Contingent on Determination of Disability.

In the event of a claim for benefits contingent on determination of your disability for purposes of granting continuation of eligibility under the Plan, if the claim is denied due to failure to establish proof of disability, the Trustees, or a committee appointed by them, will:

(1) Provide that before the Plan can issue an adverse benefit determination on review, the Plan will provide to you, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you reasonable opportunity to respond prior to that date, and

(2) Provide that, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, the Plan will provided you, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you reasonable opportunity to respond prior to that date.

2. Notice of Trustees' Decision

The Board of Trustees, or their committee, will review your appeal in accordance with the following and will notify you as indicated:

(a) Urgent Care Claims—When the appeal of a claim involving urgent care, as that term is defined on page 13, is received, a decision on the appeal will be made and will be communicated in writing (and otherwise as appropriate) within 72 hours of receipt of your request for review of an adverse benefit determination. Appeals of adverse benefit determinations involving urgent care will be addressed promptly by the Trustees, or their committee, taking into account the urgent nature of the claim, but in no instance will the decision be made later than 72 hours after receipt of your request.

(b) Non-Urgent Care Claims—Appeal of an adverse benefit determination which is of a non-urgent care nature will be reviewed by the Trustees, or their committee, in accordance with the following guidelines, and notification of the decision will be communicated in writing to you within the time period prescribed:

(1) Pre-Service Claims—If your appeal involves a request for review of an adverse benefit determination for medical services which have not yet been provided, the Trustees or their committee will make a decision on the appeal and the decision will be communicated to you in writing not later than 30 days after receipt of your request for review.

(2) Post-Service Claims—If your request for review of an adverse benefit determination involves a claim for medical services which have already been provided, a decision on your appeal will be made by the Trustees or their committee and communicated to you in writing within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee which immediately follows the Plan's receipt of your request for a review, unless your request for review is filed within 30 days preceding the date of that meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of your request for review, but in no instance more than 120 days following receipt of your appeal.

(c) Regardless of the above, notice of every appeals determination will be given to you within 5 days of the determination.

3. Access to Plan Documents

At any time during the course of these appeal proceedings you will be granted access to, and copies of, documents, records and other information relied upon by the Trustees or their committee in making their decision, as requested by you.

4. Notification of Decision on Appeal

You will receive notification in writing, within the time period outlined above, of the Trustees' or the committee's decision. The notification will set forth, in a manner calculated to be understood by you:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;

(d) A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures, should the Board of Trustees adopt such procedures, and a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended;

(e) The following information where applicable—

(1) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge upon request;

(2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request; and

(3) A statement that you and the Plan may have other voluntary alternative dispute resolution options, although the Plan is not required to offer such options, and that you may contact the local U.S. Department of Labor office, or your state insurance regulatory agency, to determine what options might be available to the Plan or to you; and

(f) If the claim is contingent on determination of your disability for purposes of granting continuation of eligibility under the Plan, and the claim was denied because you failed to establish satisfactory proof of disability:

(1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and

(iii) A disability determination presented by you to the Plan made by the Social Security Administration;

(2) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(3) The statement required under (d) above will also describe any contractual limitations period that applies to your right to bring such an action, including the calendar date on which the limitations period expires.

YOUR RIGHT TO EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION

1. Claims Subject to Review

Those claims involving medical judgment which have either been denied or otherwise not acted upon are eligible for external review, including only:

(a) Claims for urgent care that have not been acted upon within 72 hours of receipt of the claim/ request;

(b) Other claims for which the Plan fails to act within the time limits applicable to other pre-service and post-service claims, or where the claim procedure has not been followed by the Plan; and

(c) Claims for which the internal review process (including Trustee review) has been exhausted.

2. Claims Not Subject to Review

Claims not eligible for external review include:

(a) Claims relating to your failure to meet the requirements for eligibility (such as insufficient hours worked, failure to self-pay, classification of employment, failure to meet the definition of Dependent, etc.)

(b) Claims incurred while you are not eligible for benefits.

(c) Claims incurred for health care service that is not a covered service under the Plan.

(d) Claims for which the internal review process has not been exhausted, except as outlined under 1. above.

(e) Claims incurred for other than medical expenses.

(f) Claims denials not involving medical judgment.

3. Standard External Review

This paragraph sets forth procedures for standard external reviews. Standard external review is external review that is not considered expedited as described in 4. below.

(a) Request for external review. You may file a request for an external review if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth

month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

(b) Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(1) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(2) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

(3) You have exhausted the Plan's internal appeal process; and

(4) You have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to you. If the request is complete but not eligible for external review, the notification will include the reason for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect the request for external review within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later.

(c) Referral to Independent Review Organization. The Plan will refer the review to an Independent Review Organization (IRO).

(1) Within five business days after the date of assignment of the IRO, the Plan will provide to the IRO the documents and any information considered in making the adverse benefit determination or final adverse benefit determination.

(2) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final adverse benefit determination. The external review may be terminated as a result of the reconsideration if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse benefit determination and provide coverage or payment. The assigned IRO will then terminate the external review upon receipt of the notice from the Plan.

(3) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to you and to the Plan.

(d) Reversal of Plan's Decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

4. Expedited External Review

(a) Request for expedited external review. The Plan will allow you to make a request for an expedited external review at the time you receive:

(1) An adverse benefit determination, if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from a facility.

(b) Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the requirements for standard external review. The Plan will immediately send a notice that meets the requirements for standard external review to you of its eligibility determination.

(c) Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other similar method.

(d) Notice of final external review decision. The IRO must provide notice of the final external review decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and to the Plan.

5. Definitions

(a) "Adverse benefit determination" means any claims denial, or partial denial, as determined by the Plan.

(b) "Final adverse benefit determination" means any claims denial, or partial denial, upheld by the Trustees, or by their claims review committee, upon appeal.

(c) A claim denial involving "medical judgment" is a claim that involves medical judgment as determined by the external reviewer, including, but not limited to, those claims denials based

on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational.

APPOINTMENT OF AUTHORIZED REPRESENTATIVES

Under Department of Labor Regulations, your authorized representative is not precluded from acting on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. In order to assure that the person purporting to be your authorized representative has been and continues to be authorized to act on your behalf, with respect to the particular benefit claim or appeal, any written benefit claim or appeal of an adverse benefit determination must bear your notarized signature. (A general appointment is insufficient; the specific claim or appeal must bear your notarized signature.) If evidence is presented that you are disabled and/or incompetent to the extent that your signature cannot be obtained, then such benefit claim or appeal shall bear the notarized signature of your spouse, a health care surrogate of yours or a person holding a plenary power of attorney for you. A copy of the documents establishing the health care surrogate or power of attorney shall be furnished.

A general appointment of a health care provider, as representative, prior to the rendering of services that are the subject of the benefit claim or appeal of an adverse benefit determination will not be considered as a satisfactory appointment of an authorized representative in pursuing a benefit claim or appeal of an adverse benefit determination.

Nothing in the foregoing provision would limit the ability of a health care professional, with knowledge of your medical condition, form acting as your authorized representative in the case of a claim involving urgent care without such a notarized signature.

RIGHTS GRANTED HEREUNDER ARE LIMITED TO ONE APPEAL

In appealing an adverse benefit determination under these procedures, you may choose to make a written appeal, in which event the Plan's administrative manager will present all documents in your behalf, or you may choose to personally appear before the Trustees for the purpose presenting an appeal, or designate a representative to appear in your behalf. Your appeals rights are limited to one written or personal appeal per denied claim.

COMPLIANCE WITH APPEAL PROCEDURE

You may at your own expense have legal representation at any stage of these appeal procedures. The Trustees will interpret Plan provisions in a consistent and equitable manner. You will be required to exhaust these appeals procedures before proceeding to litigation.

LIMITATION OF ACTIONS

No legal action may be commenced or maintained unless that action is filed in the appropriate court no more than 180 days following the exhaustion of the administrative procedures set forth herein (generally the earlier of:

1. The date a decision on review was mailed or otherwise furnished to you; or

2. A date that is 120 days following receipt of your request for review by the Trustees.)

DEFINITIONS

The following terms have special meanings when used in this booklet:

Active Employee means an Employee who performs, or is actively available to perform, all of the duties of his trade with participating employers on a regular basis and is not retired under a defined benefit pension plan sponsored by any of the participating local unions.

Alcoholism means the condition caused by regular excessive drinking of alcohol that results in harm to either physical health or personal or social functioning.

Ambulatory Surgical Center means a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (RNs) when patients are there and does not provide for overnight stays.

Approved Clinical Trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or any other life-threatening disease or condition and is described in any of the following:

1. Federally funded trials – The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   (a) The National Institutes of Health,

   (b) The Centers for Disease Control and Prevention,

   (c) The Agency for Health Care Research and Quality,

   (d) The Centers for Medicare and Medicaid Services,

   (e) A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs,

   (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

   (g) Any of the following if the conditions described below are met:

      (1) The Department of Veterans Affairs

      (2) The Department of Defense

      (3) The Department of Energy

      The conditions for inclusion hereunder, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of such Department determines to be comparable to the system

of peer review of studies and investigations used by the National Institutes of Health, and that assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Birthing Center and like terms mean an institution which is not a Hospital but is a place where births take place following normal, uncomplicated pregnancies. Such centers must be: (1) constituted, licensed, and operated as set forth in the laws that apply, where required; (2) equipped with those items needed to provide low-risk maternity care; (3) adequately staffed with personnel who are qualified and, where required, licensed, and who provide care at childbirth and are practicing within the scope of their training and experience; and (4) equipped and ready to initiate emergency procedures in the event of life threatening events to mother and baby.

Covered Medical Expense means those expenses outlined in this booklet which are actually incurred by a Covered Person for treatment of a Sickness, Injury or congenital defect, or in connection with the pregnancy of an Employee or Retiree or the Dependent spouse of an Employee or Retiree, or the routine care of a newborn infant during the Hospital confinement immediately following birth, unless otherwise specified, or for a surgical sterilization procedure performed on an Employee or Retiree or the Dependent spouse of an Employee or Retiree, or for those routine preventive services specifically listed, and subject to all the limitations outlined in this booklet. Further, "Covered Medical Expenses" are limited to those expenses that are Medically Necessary, and that are Usual and Reasonable Charges, as those terms are defined in this section.

Covered Person means an Employee, a Retiree and/or a Dependent who is covered under this Plan.

Dependent means any one of the following persons who is not covered as an Employee of a contributing employer:

1. An Employee's spouse. The term "spouse" excludes a common law spouse by civil union whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred.

2. An Employee's children from birth to the end of the month during which the child attains age 26. The term "children" includes natural children, adopted children (from the moment of placement in the home after assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child), step-children, children under legal guardianship, and an alternate recipient according to the terms of a qualified medical child support order.

3. An Employee's dependent children who, upon attaining age 26, are mentally retarded or physically handicapped so as to be incapable of self-support, provided such proof is furnished to the Plan administrator within 30 days of the date benefits would otherwise terminate. The Plan administrator may require, at reasonable intervals during the two years following the Dependent reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan administrator may require subsequent proof not more often than once each year. The Plan reserves the right to have the Dependent child examined by a Physician of the Plan administrator's choice, at the Employee's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents:

1. A common law spouse whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred;

2. The legally separated or divorced former spouse of the Employee;

3. Any person who is on active duty in any military service of any country; and

4. Any person who is eligible for coverage under the Plan as an Employee

If both the husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both. No person can be covered simultaneously under this Plan as both an Employee and a Dependent.

Drug means any substance designated as subject to the Federal Controlled Substances Act or which has been designated as a depressant or stimulant drug pursuant to federal food and drug laws, or which has been designated by the Commissioner of Consumer Protection as having a stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and as having a tendency to promote abuse or psychological or physiological dependence, or both. Such drugs include but are not limited to amphetamines, cannabinoids, cocaine, phencyclidine (PCP), methaqualones, opiates, barbiturates, benzoidiazepines, LSD, synthetic narcotics, designer drugs, and a metabolite of any of the substances listed herein.

Drug Abuse means physical dependence on Drugs. This includes (but is not limited to) dependence on drugs that are medically prescribed. This does not include dependence on alcohol, tobacco (nicotine), and ordinary caffeine-containing drinks.

Durable Medical Equipment means equipment that is able to withstand repeated use, is primarily and customarily used only to serve a medical purpose, and is not generally useful to a person in the absence of Sickness or Injury.

Emergency means circumstances which require immediate care and treatment of a medical condition. It must be reasonably expected that failure to obtain immediate care would place the patient's life in jeopardy or would lead to serious physical impairment of an organ or organ system.

Employee means an Employee of a participating employer who satisfies the Eligibility Rules outlined in this booklet.

Experimental or Investigative – A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:

   (a) Maximum tolerated dose, or

   (b) Toxicity, or

   (c) Safety, or

   (d) Efficacy, or

   (e) Efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

   (a) Maximum tolerated dose, or

   (b) Toxicity, or

   (c) Safety, or

   (d) Efficacy, or

   (e) Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature; or

2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or

3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Home Health Care Agency means an agency that meets all of these tests:

1. Its main function is to provide Home Health Care Services;

2. It is federally certified as a Home Health Care Agency; and

3. It is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan means a plan that meets these tests:

1. It must be a formal written plan made by the patient's attending Physician which is reviewed every 30 days;

2. It must certify that the home health care is in place of hospital confinement; and

3. It must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies means:

1. Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);

2. Part-time or intermittent home health aide services provided through a Home Health Care Agency. This does not include general housekeeping services;

3. Physical, occupational and speech therapy;

4. Medical supplies; and

5. Laboratory services.

Hospice Agency means an agency, the main function of which is to provide Hospice Care Services and Supplies, and that is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan means a plan that fully meets these tests:

1. It is supervised by a Physician;

2. It has a team comprised of:

    (a) A Physician who provides hospice care,

    (b) Nurses (RNs and LPNs),

    (c) A mental health specialist,

    (d) A social worker,

    (e) A volunteer chaplain, and

    (f) Lay volunteers; and

3. It is responsible for:

    (a) The patient's plan of care,

    (b) Regular reviews of the patient's care,

(c) Informing the proper persons of any changes in the patient's condition, and

(d) Complying with governmental regulations.

Hospice Care Services and Supplies means the following when provided through a Hospice Agency and under a Hospice Care Plan:

1. Inpatient care under a Hospice Care Plan in a Hospital, Hospice Unit, or other licensed facility.

2. Home care under a Hospice Care Program.

3. Palliative care (social, psychological and spiritual care).

4. Dietary and nutritional aid.

5. Family counseling during the bereavement period up to a maximum of six sessions.

Hospice Unit means a facility that provides treatment under a Hospice Care Plan, is separate from any other facility or is a separate place in a Hospital designated only for providing hospice care, and admits at least two unrelated persons who are expected to die within six months.

Hospital means an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests:

1. It is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals or the Joint Commission on Osteopathic Hospitals;

2. It is approved by Medicare as a Hospital;

3. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians;

4. It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered nurses (RNs); and

5. It is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" also includes a facility operating legally as a psychiatric hospital and licensed as such by the state in which the facility operates.

Injury means a Non-Occupational accidental bodily injury resulting directly from an unforeseen external cause independently of all other causes. Injury does not include anything caused by disease or bodily infirmity regardless of how it may have been contracted.

Intensive Care Unit means a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." This area should have:

1. Facilities for special nursing care not available in regular rooms and wards of the Hospital;

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

Medically Necessary means that care and treatment:

1. Is recommended or approved by a Physician;

2. Is consistent with the patient's condition and accepted standards of good medical practice;

3. Is not performed mainly for the convenience of the patient or provider;

4. Is medically proven to be effective treatment of the condition; and

5. Is not conducted for research purposes.

The fact that a Physician may prescribe, recommend, order or approve a service or supply does not, of itself, determine medical necessity.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Mental Disorder means neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind, including but not limited to neurological disorders with a physical cause such as trauma or disease.

Outpatient Care means treatment performed in a Hospital on a basis other than as a registered bed patient. Outpatient Care includes:

1. Services, supplies and medicines provided by and used at a Hospital under the direction of a Physician by a person not admitted as a registered bed patient; and

2. Services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Period of Hospital Confinement means the period a person is confined as a bed patient in a Hospital. Hospital confinements due to the same or related causes will be considered the same Hospital confinement unless separated by the following:

1. For Active Employees – Separated by return to active full-time work for one day.

2. For Dependents and Retired Employees – Separated by at least 90 full days.

Physician means a person who is a licensed practitioner of the healing arts who is licensed to prescribe and administer drugs or to perform surgery and who is acting within the scope of that license. The term Physician includes a Doctor of Medicine (MD), a Doctor of Osteopathy (DO), a Doctor of Dental Surgery (DDS), a Doctor of Podiatry (Pod.D.), an Optometrist (OD), and a certified Mid-wife acting within the scope of his respective profession. Physician also includes a licensed or certified clinical Doctor of Psychology (PhD or a PsyD), when the person being treated was referred to such psychologist by a licensed Doctor of Medicine or Doctor of Osteopathy. Certified Registered Nurse Anesthesiologists (CRNA) Physician Assistants (PA), Advanced Registered Nurse Practitioners (ARNP), and Registered Nurse First Assistants (RNFA) will also be recognized provided they are practicing within the scope of their license. Personnel at PPO "Minute" or "Convenience" type clinics will also be covered while practicing within the scope of their license. The term Physician does not include interns, residents, fellows, or others enrolled in a residency training program.

The Plan will not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable law. This provision does not require the Plan to accept all types of providers into its network. Services that are covered by the Plan will be covered, consistent with reasonable medical management techniques with respect to frequency, method, and treatment setting.

Retired Employee or Retiree means a former Active Employee who satisfies the Retiree Eligibility rules as outlined in this booklet.

Room and Board charges means all charges for actual use by an inpatient for room, board, general duty nursing, and any other charges by whatever name called that are customarily made by a Hospital as a condition of occupancy for the class of accommodations occupied and which are necessary for the treatment of Sickness or Injury or other covered condition. Room and Board charges do not include charges for professional services, personal convenience items or to reserve an unoccupied room.

Sickness means a person's illness, disease or pregnancy, except for pregnancy, childbirth and miscarriage of an eligible Dependent other than the covered Employee's spouse. For a newborn child after birth, but before release from a medical facility, Sickness also includes a congenital defect, a birth abnormality or a premature birth.

Skilled Nursing Facility means a facility that fully meets all of these tests:

1. It is licensed to provide, for persons convalescing from Injury or Sickness, professional nursing services on an inpatient basis. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities must be provided.

2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a registered nurse.

3. It provides 24-hour-per-day nursing services by licensed nurses under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally retarded individuals, custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, or any other similar designation.

Total Disability (Totally Disabled) means, in the case of an Active Employee, the complete inability to perform, because of Injury or Sickness, any and every duty of his occupation or employment. In the case of a Dependent or Retired Employee, it means the complete inability to perform the normal activities of a person of like age and sex in good health.

Usual and Reasonable Charge means a charge that is not higher than the usual charge made by the provider for the care or supply and does not exceed the usual charge by most providers of like services in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. This Plan will recognize only the amount of charges considered to be reasonable based on a database of usual, customary and reasonable fees which takes into consideration the medical condition and locality in which the services were rendered. The Plan administrator's decision on what constitutes a Usual and Reasonable Charge will be conclusive and binding.

Walk-in Clinic means a licensed facility used primarily for performing, on an unscheduled basis, outpatient diagnostic, therapeutic and minor surgical treatment. The facility must be staffed by Physicians. The facility must provide continuous care by registered nurses (RNs), and treatment rendered must be under the supervision of a Physician. The facility must not provide for overnight stays. A Physician's office is not considered a Walk-in Clinic.

MISCELLANEOUS INFORMATION

THE TRUSTEES INTERPRET THE PLAN

Any interpretation of the Plan's provisions is the responsibility of the Board of Trustees. However, the Board of Trustees has authorized the Plan administrator to handle routine requests from participants regarding eligibility rules, benefits and claims procedures. But, if there questions involving interpretation of any Plan provisions, the administrator will secure from the Board of Trustees a final determination for you. No person other than a Trustee or a member of the Fund office staff, acting with the consent of the full Board of Trustees, may provide interpretation of Plan provisions.

THE PLAN MY BE CHANGED

The Trustees have the authority to change the Plan.

Although the Trustees expect to maintain and to improve benefits, this can only be done within the limits of available financial resources. The Trustees have an obligation to make whatever Plan changes are necessary to assure the financial stability of the Plan.

The Trustees also may change the Plan in any way to protect its tax-exempt status under Internal Revenue Service rules.

DISCRETIONARY PAYMENT OF CLAIMS TO MEDICAL PROVIDERS

At the sole discretion of the Trustees, benefits payable under the Plan may be paid directly to a health care provider. Any direct payment to a medical provider is in lieu of payment to you.

NON-ASSIGNMENT OF CLAIMS, ERISA RIGHTS OR OTHER RIGHTS

No assignment by a Covered Person of claims, ERISA rights or other assignment of rights will be valid against the Fund, the Plan, the Trustees or their service providers, except as specifically approved by the Board of Trustees in writing. Assignment pursuant to a Qualified Medical Child Support Order will be allowed.

A medical provider may represent a Covered Person in the filing of an appeal to the extent provided by regulations issued by the Department of Labor but may not file an appeal in behalf of a Covered Person, except in accordance with the representative rules set forth herein.

NO THIRD PARTY BENEFICIARY

The terms and provisions of this Plan inure solely to the benefit of Covered Persons, and no other persons shall have any rights, interest or claims hereunder or be entitled to sue for breach thereof as a third party beneficiary or otherwise. Health care providers shall not be third party beneficiaries under the Plan.

NO CONVERSION PRIVILEGE

No benefits provided by the Fund may be converted to individual coverage.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health care plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

IMPORTANT NOTICE REGARDING THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under federal law, group health plans and insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as a part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (i) reconstruction of the breast on which a mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. As a part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and payment percentages.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will honor the provisions of a Qualified Medical Child Support Order. The Fund office has established procedures for determining whether such an order meets all of the legal requirements. A copy of these procedures will be furnished to you, without charge, upon written request filed with the Fund office.

RIGHTS OF PLAN PARTICIPANTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA,

ENFORCE YOUR RIGHTS

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

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

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

ASSISTANCE WITH YOUR QUESTIONS

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

INFORMATION OF INTEREST REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

You most likely have heard abut ERISA. ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans including this one. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken whatever steps are necessary to assure full compliance with ERISA.

ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

TYPE OF PLAN

This Plan provides certain death, accidental death and dismemberment, hospital, medical, prescription drug and dental benefits.

For specific coverage, see the Schedules of Benefits outlined in this booklet.

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR AS DEFINED BY ERISA

This Plan is maintained and administered by a Board of Trustees on which labor and management are equally represented. A list of all the Trustees as of the date this booklet was prepared is contained in the front of this booklet.

This Board has the primary responsibility for decisions regarding eligibility rules, types of benefits, administrative policies, management of Plan assets and interpretation of Plan provisions.

Any communication with the Board of Trustees should be addressed to the Fund office at:

Board of Trustees
Florida UBC Health Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

TYPE OF ADMINISTRATION

Although the Trustees are legally designated as the Plan administrator, they have delegated the performance of the day-to-day administrative duties to a professional administrative manager, Southern Benefit Administrators, Incorporated.

The Fund office staff maintains the eligibility records, accounts for employer contributions, processes claims, informs participants of Plan changes and performs other routine administrative functions in accordance with Trustee decisions.

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained under one or more collective bargaining agreements. Copies of any or all of these agreements shall be made available to you for your inspection and a copy of any or all of these agreements may be examined at the Plan office during normal business hours or at your local union office during normal business hours. Further, should you so request, a copy of the agreements will be made available at your place of employment within 10 days of your request if you will advise your employer of your desire to examine the agreements. If you request a copy of the agreements, a reasonable charge for them will be made by the administrator, the amount of which will be stated to you before you order.

PLAN SPONSORS

This Plan is maintained under the terms of collective bargaining agreements negotiated by the unions with participating employers.

Employers who sign or become party to an agreement are obligated to contribute to the Plan and are considered "Plan sponsors." If any employer is not a party to a collective bargaining agreement, then he has no legal obligation to contribute on your behalf. Consequently, in order to obtain benefits under this Plan, you must be working for a "Plan sponsor."

In most cases, your local union can tell you whether your employer is a Plan sponsor: But if there is any uncertainty, check with the Fund office.

Specify the name of your employer (or potential employer) and the name of his company or firm. The Fund office will tell you whether the employer is a Plan sponsor and if he is, will furnish you with the employer's address as well as advise you if the employer is making timely contributions to the Plan on your behalf.

SOURCE OF CONTRIBUTIONS

The primary source of financing for the benefits provided under this Plan is employer contributions. The rate of contribution is spelled out in the collective bargaining agreements negotiated by the unions with participating employers.

No money is deducted from your paycheck to pay for Plan benefits. However, under the terms of this Plan, a participant may make self-contributions in order to retain his eligibility if he does not work sufficient hours.

A portion of the Plan assets are invested and this produces additional fund income.

FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS

All contributions and investment earnings are accumulated in a trust fund. Benefits are provided by the trust fund. Some Plan assets are invested.

CIRCUMSTANCES THAT MAY RESULT IN LOSS OF ELIGIBILITY OR BENEFITS

Throughout this booklet those circumstances that might lead to a loss of your eligibility and a description of the limitations, exclusions or restrictions applicable to specific benefits are explained to you.

Please familiarize yourself with this information, especially as it relates to the requirements which must be met in order to maintain your eligibility for benefits. You must work the required number of hours in order to maintain your eligibility or make up the difference by timely self-payment. If at any time you are uncertain about how specific circumstances might affect your eligibility or benefit coverage, please contact the Fund office and, if possible, do so before the circumstance arises.

AGENT FOR SERVICE OF LEGAL PROCESS

Every effort will be made by the Trustees of this Plan to resolve any disagreements with participants promptly and equitably. It is recognized, however, that on occasion, some participants may feel that it is necessary for them to take legal action. Be advised that the following has been designated as agent for service of legal process:

Venable Law Firm, P.A.
7402 N. 56th Street, Suite 380
Tampa, Florida 33617

Or legal papers may also be served on the Trustees collectively or individually as well as the Fund office manager.

PLAN IDENTIFICATION NUMBERS:

When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to properly identify the Fund and Plan including:

Employer Identification Number (EIN)
assigned by the Internal Revenue Service. 59-6134278
Plan Number 501

FISCAL YEAR

The accounting records of this Plan are kept on the basis of a fiscal year which ends on December 31.