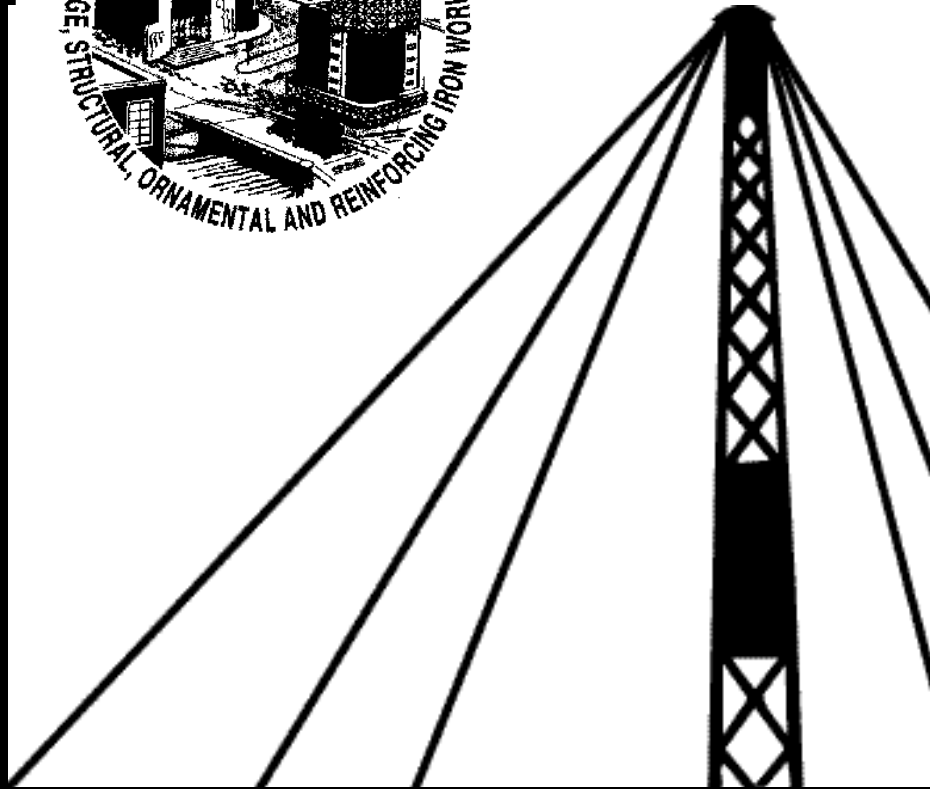


SOUTHEASTERN IRON WORKERS

Health Care Plan

Summary Plan Description



EFFECTIVE
OCTOBER 1, 2002

SOUTHEASTERN IRON WORKERS
HEALTH CARE PLAN
P.O. BOX 721648
HOUSTON, TX 77272-1648

FIRST CLASS



SOUTHEASTERN IRON WORKERS HEALTH CARE PLAN

ZENITH ADMINISTRATORS, INC.

P.O. Box 721648

HOUSTON, TEXAS 77272-1648

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CONSULTANT & ACTUARY

Brennan & Associates, Inc.

Southeastern Iron Workers Health Care Plan

October 1, 2002

To All Eligible Iron Workers:

We are pleased to present you with this Benefit Booklet (Summary Plan Description) which will describe for you the current Plan of Benefits to which you and your family may be entitled as a result of your participation in the Southeastern Iron Workers Health Care Plan.

The booklet is designed to familiarize you with the highlights of your Plan. It includes the benefits to which you and your family may be entitled; the method by which you may become eligible; and the procedures which you must follow in order to successfully file your claim for benefits. Therefore, you are strongly urged to read this booklet completely and to familiarize yourself with it.

Please note that employment with a Participating Employer who is three months delinquent will not be credited to the Plan's Eligibility Rules starting with the fourth (4th) month. You can make Self-Payment during this period. Please see pages 14 and 15 for special Self Pay rules.

After September 30, 2002 Employer Contributions at the \$.50 rate will no longer be made to the Plan. As a result, Plan 3 (\$.50) will terminate on March 31, 2003.

If you have any questions about the Plan, please call or write the Administrative Manager's Office for an explanation at the address shown in this booklet.

Sincerely,

The Board of Trustees

Participants may obtain a listing of Medical Service Providers in their area by calling the toll free number or going online:

1. Local 601 Physicians Care Network
 1-888-323-9271
 www.physicianscarenet.com

2. Locals 387 SouthCare
 and 709 1-800-395-2425
 www.southcareppo.com

3. Locals 272, Beech Street
 397, 402, 597, 1-800-937-2277
 698 and 808 ***www.beechstreet.com***

Participants who are outside the Plan's area should contact the Plan Office for assistance in finding a Medical Service Provider.

TABLE OF CONTENTS

Definitions	4
Eligibility and Termination	13
Self Pay	15
Pre-Existing Conditions & Creditable Coverage	16
COBRA	17
Retiree Medical	21
Reciprocity	24
Local Union Participation.....	29
Schedule of Benefits	30
Employee Life Insurance Benefit.....	41
Accident and Sickness Benefit	47
Utilization Review Program	48
Basic Benefits	49
Major Medical Benefits.....	49
Preferred Provider Organization (PPO).....	55
Wellness Program Benefits	55
Review of Medical Charges.....	56
Prescription Drug Card	57
Dental Care Benefits	58
Orthodontia Benefits	60
Vision Care Benefits	61
Laser Eye Surgery Benefit.....	63
Coordination of Benefits.....	63
Subrogation and Contract of Reimbursement	64
Women's Health and Cancer Rights Act	68
Newborns' and Mothers Health Protection Act	69
Family and Medical Leave Act (FMLA)	69
Military Service (USERRA)	70
Claims Procedure	71
Claims Review (Appeal) Procedure.....	72
Amendment and Termination.....	76
Statement of Your Rights Under ERISA	78
Important Information About Your Plan	81

DEFINITIONS

Accident or Accidental Bodily Injury

The term "Accident" or "Accidental Bodily Injury" as used herein shall mean an accidental bodily injury which requires treatment by a Physician. It must result in loss, while eligible under the Plan, independently of sickness and other causes.

Active Work

The term "Active Work" and "Actively at Work" as used herein shall mean the actual expenditure of time and energy by the Employee, performing each and every duty pertaining to his job in the place where and the manner in which such job is normally performed.

Beneficiary

The term "Beneficiary" as used herein shall mean a person designated by a Participant, or by the terms of the Welfare Plan who is or may become entitled to a benefit thereunder.

Benefit Quarters

The term "Benefit Quarters" as used herein shall mean the period of the Employee's eligibility for benefits not the period in which the Employee works to become or remain eligible.

Child or Children

The terms "Child" or "Children" shall mean the unmarried:

1. Natural Child/ren both to the Employee and his Spouse,
2. Child/ren legally adopted by the Employee (irrespective of whether the adoption has or does become final) or a child/ren placed for adoption.
 - a. "Adopted Child/ren" means, in connection with any adoption, or placement for adoption, of the Child/ren, and the individual who has not attained age 19, or age 23 if a Full Time Student, as of the date of such adoption or placement for adoption.
 - b. "Placement" or being "placed" for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.
3. Stepchild/ren who is living in the Employee's residence and is chiefly dependent on the Employee for support.

4. Child/ren over whom the Employee has legal custody; is raising as his own; living in the Employee's residence; chiefly dependent on the Employee for support and for whom the Employee has full parental responsibility and control and is approved by the Plan in writing as a Child/ren.

However, this does not include a Child including a grandchild living temporarily in the Employee's residence; a child placed with the Employee by a Social Service Agency which retains control of the child, or whose natural or adoptive parents are in a position to exercise or share parental responsibility and control.

The Employee is responsible for providing the Administrative Manager proof acceptable to the Board of Trustees that any Child/ren meets or continues to meet any of the above categories.

Covered and Non-Covered Employment

"Covered Employment" means employment for which an Employer is obligated to make contributions to the Health Care Plan. However, if an Employer does not make payment when contractually due to the Plan for a three (3) consecutive month period, hours worked starting with the fourth (4th) consecutive month will be considered as "Non-Covered Employment." Accordingly, no such hours starting with the fourth month will be considered in the application of the Plan's Eligibility Rules until actual payment is made. Any subsequent payment made by the Employer will be applied toward the oldest amount owed the Plan.

Custodial Care

The term "Custodial Care" as used herein shall mean the care which consists of services and supplies, including room and board and other institutional services, furnished to an individual primarily to assist him in activities of daily living, whether or not he is disabled. These services and supplies are custodial care regardless of the practitioner or provider who prescribed, recommended or performed them.

Dentist

The term "Dentist" means an individual duly licensed to practice dentistry in the state where the dental service is performed and operating within the scope of his license.

Dependent

The term "Dependent" shall mean:

1. An Employee's legal Spouse, provided they are not legally separated,

2. An Employee's unmarried Child/ren from birth to 19 years of age (Limiting Age),
3. An Employee's unmarried Child/ren from age 19 to age 23 (Limiting Age) who are Full Time Students; i.e., regularly attending an accredited school, vocational or technical school, junior college, college or university, school of nursing, not including a home school, and
4. An Employee's Child/ren who are considered Incapacitated Child/ren as defined by the Plan,
5. Child/ren whom the Plan is required to cover pursuant to a Court or Administrative Order including Qualified Child Support Medical Order (QCSMO), whose age is less than the Limiting Age.

Elective Abortion

The term "Elective Abortion" means any abortion other than one where the mother's life would be endangered if the fetus were carried to term.

Employee

The term "Employee" as used herein shall mean an or a:

- (a) Employee represented by one of the Local Unions and working for an Employer as defined herein, and with respect to whose employment an Employer is required to make contributions into the Trust Fund, under a collective bargaining agreement or other agreement between an Association or Employer, and the Union, and who has satisfied the requirements established by the Trustees.
- (b) Officer or salaried employee of the Union or the Southeastern Iron Workers District Council or the Joint Apprenticeship and Training Program or an Employer who shall have been proposed for benefits, agrees in writing to contribute to the Trust Fund for at least forty-hours per week at the rate fixed for contribution by the collective bargaining agreement.
- (c) Employee, if any, of this Trust Fund who is not employed by an Employer as defined in this section, but who shall be proposed and accepted for such benefits by the Trustees. For such employees of the Trust Fund, the Trustees shall be deemed to be an Employer, and shall contribute to the Trust Fund for at least forty hours per week at the rate fixed for contribution by the collective bargaining agreement.
- (d) Person, represented by or under the jurisdiction of the Union, who shall be employed by a governmental unit or agency, and on whose

behalf payment of contributions shall be made at the times and at the rate of payment equal to that paid by an Employer in accordance with a written agreement, ordinance or resolution, or a person who had been so employed and who is temporarily making self-payments under rules established by the Trustees.

- (e) Person, who qualifies as an Employee, and whose Spouse likewise qualifies as an Employee under this section, shall be considered an Employee under this Plan.
- (f) Person who is employed by an Employer and for whose benefit an Employer makes contributions at the times and rate of payment equal to the amount paid according to a written agreement for non-collectively bargained Employees and is accepted for participation by the Trustees.

Employer

The term "Employer" as used herein shall mean an or a:

- (a) Employer who is a member of, or is represented in collective bargaining by an Association and who is bound by a collective bargaining agreement with one of the Local Unions providing for the making of payments to the Southeastern Iron Workers Welfare Plan with respect to Employees represented by the Union.
- (b) Employer who is a member of, or is represented in collective bargaining by an Association, but who has duly executed, or may execute, or is bound by a collective bargaining agreement with one of the Local Unions providing for the making of payments to the Trust Fund on behalf of Employees represented by the Union.
- (c) Union, which, for the purpose of making the required contributions into the Trust Fund, shall be considered as the Employer of the salaried officers and/or Employees of the Union or the Southeastern Iron Workers District Council or Joint Apprenticeship and Training Program of the Unions who contribute to the Trust Fund.
- (d) Employer who, while not generally recognizing the Union as the representative of its Employees, is bound to make contributions on behalf of certain of its Employees.
- (e) Board of Trustees of the Southeastern Iron Workers Health Care Plan, who, with the consent and approval of the Trustees, shall make like payments or contributions to the Trust Fund on behalf of the Employees of the Trust Fund.

- (f) Employers who are original parties to this Agreement Declaration, or as described in this Section, shall, by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.
- (g) An Association of Employers which have Collective Bargaining Agreements with at least one of the Unions having jurisdiction over the Employers work.

Expense Incurred

An expense will be considered to be incurred at the time the service or the supply is provided for services and supplies which a prudent person would consider to be

- (a) reasonably priced; and
- (b) reasonably necessary in light of the injury or sickness being treated.

Employer Contributions

The term “Contribution” shall mean payments required of any Employer by a collective bargaining agreement or other such agreement to this Fund.

Family and Medical Leave Act (FMLA)

“Family and Medical Leave” or “Family Leave” means a family, or medical leave of absence, intermittent leave or leave on a reduced schedule, taken under the Family and Medical Leave Act of 1993 (“FMLA”); A FMLA Leave cannot exceed 12 work weeks in a 12-month period and must be certified by an Employer as a FMLA Leave in accordance with FMLA and the Fund’s policies and procedures.

Health Care Plan

The term “Health Care Plan” as used herein shall mean the Rules and Regulations governing the eligibility of Employees for the benefits to be provided, as the Plan may from time to time be amended.

HIPAA

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

Hospital

The term “Hospital” as used herein shall mean an institution which meets all of the following tests:

- (a) It is primarily engaged in providing on an inpatient basis diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a Physician;
- (b) It has a laboratory, X-ray equipment, and an operating room where major surgical operations may be performed;
- (c) It continuously provides 24 hour a day nursing service by registered graduate nurses; and
- (d) It is not, other than incidentally, a rest home, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel or the like.

Hospice

The term “Hospice” as used herein shall mean a licensed facility or program whose primary purpose is to provide counseling, medical services and sometimes room and board to terminally ill persons who have less than six (6) months to live. It must provide 24-hour service, be supervised by a Physician and have a registered nurse on staff. It must provide counseling by a licensed social worker and a licensed pastoral counselor.

Incapacitated Child/ren

Benefits are provided for dependent child/ren under the Plan and such dependent benefits will terminate in accordance with the provisions of the Plan. If, however, an unmarried child, on such child’s termination date, is and continues to be both:

- (a) incapable of self-sustaining employment by reason of mental or physical handicap as determined by the Office of Rehabilitation Services in the State Department of Education; and
- (b) chiefly dependent on the Employee for support and maintenance, and further provided such incapacity commenced prior to the Limiting Age stated in the Plan.

The Plan will continue the health benefits for such child so long as the Employee’s benefits remain in force and such incapacity continues, provided proof of such incapacity is submitted to the Plan within 31 days of the date such dependent’s benefits would otherwise terminate, and subsequently, as may be required, but not more frequently than annually after the two-year period following such child’s attainment of limiting age.

Individual

An "Individual", or "Person" as the term is used herein, shall mean the Employee and/or his Dependents.

Inpatient or Bed Patient

The term "Inpatient" or "Bed Patient" as used herein shall mean a person who is a resident patient using and being charged for the Room and Board facilities of a Hospital for a full day.

Joint Apprenticeship and Training Committee

The term shall mean an apprenticeship or Training Program sponsored by an Employer and Union participating in this Plan.

Medically Necessary

The term "Medically Necessary" as used herein shall mean that the service received is required to identify or treat the illness or injury which a Physician has diagnosed or reasonably suspects. The service must be:

- (a) consistent with the diagnosis and treatment of the condition;
- (b) in accordance with standards of good medical practice;
- (c) required for reasons other than the Employee's convenience or his Physician's; and
- (d) performed in the least costly setting required by the condition.

The fact that a service is prescribed by a Physician does not necessarily mean that such service is Medically Necessary.

Network

The term "Network" shall refer to any Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), or similar organization providing Health Care Services to the Plan and its Participants.

Outpatient

"Outpatient" as used herein shall mean a person receiving services or treatment for care of sickness or injury in a hospital who is not defined as an Inpatient.

Participant

The term "Participant" as used herein shall mean any Employee or former Employee of an Employer who is or may become eligible to receive a benefit under this Plan. The term "Participant" shall not include any Employee or former Employee who has not been credited with the required

number of hours of Covered Employment in a specified period, under the eligibility rules established by the Trustees as stated on page 13.

Physician

The term "Physician" as used herein shall mean an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery. Notwithstanding the foregoing, licensed chiropractors, licensed optometrists, licensed ophthalmologists and licensed nurse-midwives (with respect to maternity care) are included in the definition of a Physician.

Primary Care Physician

As used herein shall mean a General Practitioner, Internist, Pediatrician, or Gynecologist.

Qualifying Quarters

The term "Qualifying Quarters" as used herein shall mean the calendar quarters of 1) January, February and March, 2) April, May, and June, 3) July, August, and September, 4) October, November and December during which the Employee works the required number of hours in Covered Employment to be eligible for a Benefit Quarter as set forth on page 14.

Licensed Nurse(s)

The term "Licensed Nurse" shall mean a professional nurse who has the right to use the following designations: 1) Registered Graduate Nurse – R.N.; 2) Licensed Practical Nurse – L.P.N.; 3) Licensed Vocational Nurse – L.V.N.

Room and Board

The term "Room and Board" as used herein includes all of the charges commonly made by a hospital on its own behalf for room and meals and for all general services and activities essential to the care of bed patients.

Sickness

The term "Sickness" as used herein shall mean a non-occupational disease, disorder or condition which requires treatment by a Physician. It includes both childbirth and pregnancy.

Totally and Permanently Disabled

A person who is Totally and Permanently Disabled as used herein shall mean because of Sickness or Injury:

- (a) the Employee is completely and continuously unable to perform the material and substantial duties of any job for which he is qualified; or

(b) the Dependent is completely and continuously unable to perform the normal activities of a person of the same age and sex.

Trust Agreement

The term "Trust Agreement" as used herein shall mean the Declaration of Trust entered into as of February 20, 1995 restating prior Trust Agreements establishing the Southeastern Iron Workers Health Care Plan and as may be amended from time to time.

Trustees

The term "Trustees" as used herein shall mean the Trustees designated in the Trust Agreement, together with their successors, designated and appointed in accordance with the terms of the Trust Agreement.

Trust Fund

The term "Trust", "Trust Fund" and "Fund" as used herein shall mean the entire trust estate of the SOUTHEASTERN IRON WORKERS HEALTH CARE PLAN as it may, from time to time be constituted, including, but not limited to all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits there from, all policies of insurance, and any and all other property of funds received and held by the Trustees by reason of their acceptance of the Agreement and Declaration of Trust, for the uses and purposes of the Trust.

Union or Local Union

The term "Union" or "Local Union" as used herein, shall mean one of the Local Unions of the International Association of Bridge, Structural and Ornamental and Reinforcing Iron Workers associated with the Southeastern States District Council, including Locals 272, 387, 397, 402, 597, 601, 698, 709, 808 and their successors and assigns. The term shall also include such other Union or Unions which have a collective bargaining agreement with an Employer, or Association, where the Union and Employer may from time to time be accepted to participate and become party to the Trust Agreement under such terms and conditions as may be required by the Trustees.

Urgent Care

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

USERRA

"USERRA" means the Uniformed Services Employment and Re-Employment Rights Act of 1994, as amended.

Usual and Customary Charges

Charges made for services or supplies Medically Necessary to the Employee's care will be considered "Usual and Customary" if they do not exceed the average charges made in 1992 for those services or supplies in the locality where the services or supplies are received, with due consideration given for the nature and severity of the condition being treated.

ELIGIBILITY AND TERMINATION

Active Employees

General Provisions and Benefit Plans

Employees may become eligible for benefit coverage subject to the Plan's Pre-Existing Conditions if they perform work in Covered Employment under the jurisdiction of a participating Local Union. The Benefit Plan as set forth on pages 30 – 40 is determined according to the contribution rate paid on behalf of the Employee by a Contributing Employer. If the Employee works under differing contribution rates, he shall remain at the existing benefit level until he has worked at least 300 hours in a Qualifying Quarter at the differing contribution rate.

In such event, the Employee shall transfer to the new benefit plan on the first day of the corresponding Benefit Quarter.

Initial Eligibility – New Employees

All Employees whether or not previously covered under another Iron Workers Welfare Plan must initially qualify for benefits on the first day of the first Benefit Quarter following the date on which contributions for a minimum of 1,000 hours have been made on the behalf of the Employee during any twelve (12) consecutive calendar months.

Continuation of Eligibility and Termination of Eligibility

The following Rules have been designed in an effort to make certain that all Employees working in Covered Employment on a regular basis will continue to remain eligible if employed a nominal number of hours each Qualifying Quarter.

Continuation of Eligibility

If an Employee has worked the minimum required hours of Covered Employment in a Qualifying Quarter, he will continue to be eligible for benefits during the corresponding Benefit Quarter.

QUALIFYING QUARTER(S)

1. Jul, Aug, Sep (300 hours)
2. Oct, Nov, Dec (300 hours)
3. Jan, Feb, Mar (300 hours)
4. Apr, May, Jun (300 hours)

BENEFIT QUARTER(S)

- Jan, Feb, Mar
- Apr, May, Jun
- Jul, Aug, Sep
- Oct, Nov, Dec

Termination of Eligibility

If an Employee has not worked the minimum required hours in Covered Employment in a Qualifying Quarter, and he has not elected to continue his coverage either by self-payment or COBRA, his coverage will terminate for the corresponding Benefit Quarter.

Reinstatement of Eligibility

Reinstatement of Eligibility shall mean the Participant's coverage will be restored, after he has been without coverage for at least one Benefit Quarter, but not more than 24 months, if he works at least 300 hours in the specific Qualifying Quarter or works a minimum of 500 hours in six consecutive calendar months, he becomes eligible for coverage on the first day of the corresponding Benefit Quarter.

In no event may hours be used in the application of this Reinstatement Provision that were used to provide eligibility.

Termination of Benefits for Dependents of Deceased Employees

In the event may an Employee dies while eligible under the Plan, his Dependents' benefits will extend to the normal Termination Date based upon the Employee's employment records, as outlined in the Termination of Eligibility section. Thereafter, the Dependents' benefits are governed by "Continuation Coverage – COBRA", as stated on page 17.

Self-Pay

An Employee may continue his eligibility for benefits through self pay if his eligibility would otherwise terminate due to insufficient hours worked. In order for an Employee to continue his eligibility through self pay, he must earn a minimum of 250 hours for which contributions have been paid on his behalf in each Qualifying Quarter. If this occurs, the Employee is then eligible to self pay the difference between the 250 hours earned and the 300 hours required for Continued Eligibility in the corresponding Benefit Quarter. If he earns fewer than 250 hours, the Employee will not be eligible to continue his coverage under this self pay provision (See COBRA Continuation coverage provisions on page 17).

However, if an Employee works in Non-Covered Employment for a Participating Employer who is more than three (3) months delinquent

to the Plan, such Employee may make self-payments based on actual hours worked up to one hundred sixty (160) hours per month for such months of Non-Covered Employment (See Page 5). Any such self-payments will be refunded to the Employee if the Employer makes payment for such period.

The Amount of Self Pay

The amount of Self Pay will be equal to the hourly rate of the Employer Contribution applicable to the Employee's current plan of benefits multiplied by the hours needed to equal the 300 hours required for continued eligibility.

Self Pay Notices

The Administrative Manager will send a written notice advising the Employee that he is eligible to Self Pay in order to continue his eligibility. The Employee will have 30 days from the effective date of the written notification in which to remit the required amount of Self Pay to the Administrative Manager. If the self payment is not received by the date due, Employee coverage will automatically terminate in accordance with the Plan provisions (subject to the COBRA Continuation provision on page 20).

Reserve Accumulation Account (Hour Bank)

Certain hours an Eligible Employee works for the Contributing Employers of Locals 387, 402, 709 and 808 are credited to the Employee's Hour Bank. From these hours are deducted the minimum eligibility hours requirement as shown in the Termination of Eligibility provisions. All hours earned in excess of four hundred (400) during a Qualifying Quarter will be held in each Employee's Reserve Accumulation Account (Hour Bank), up to a maximum of three hundred (300) hours. Such Reserve Accumulation Account (Hour Bank) will be used for Continued Eligibility, Reinstatement of Eligibility, Self-Pay and COBRA provided the Employee is Actively At Work or Available For Work in the jurisdiction of the Plan. At any time if the Employee is not Actively At Work or Available For Work in the jurisdiction of the Plan, his Hour Bank will be cancelled.

Disability Credits

For the purpose of maintaining eligibility, a month of proven disability shall count as a month of employment. Subject to the approval of the Trustees, a month of proven disability is defined as any calendar month in which an Employee can medically substantiate that he has been Totally Disabled for a minimum of twenty (20) consecutive days during such month. During such periods of disability, an Employee shall be automatically credited with 100 hours of employment for each calendar month of proven disability. The maximum credit for any one period of disability shall be limited to two consecutive Benefit Quarters.

Additional disability credits will be awarded for subsequent disabilities provided that the Employee has returned to active full-time work in accordance with the provisions of this section.

Disability credits awarded as provided in this provision will not be counted towards qualifying the Employee for Initial Eligibility or Reinstatement of Eligibility following termination.

Service in the Armed Forces For More Than 31 Days

The Employee must notify the Administrative Manager prior to entering military service and again when he is discharged so that the Administrative Office may assist with his rights under the Uniform Services Employment and Reemployment Act of 1994 (USERRA) and any COBRA benefits that may be available to him and/or his Dependents.

Benefits will be continued for military service less than 31 days provided the Employee notifies the Administrative Manager and is otherwise eligible for benefits under this Plan.

If an Employee is inducted into the Armed Forces of the United States, or if he enlists in the military service, his benefits and the benefits of his Dependents (if any) will cease immediately. Upon his discharge from the Armed Forces, his eligibility and all accumulated hours toward continuation of eligibility will be reinstated on the day he returns to work with a Contributing Employer, provided such return to work is within 90 days from the date of his discharge.

If he does not return to work with a Contributing Employer within 90 days from the date of his discharge, he will be considered as a new Employee and required to satisfy the requirement on page 13. "Initial Eligibility - New Employees."

Conversion Benefits Not Provided

The health benefits of this Fund are self funded and as such are **NOT** subject to conversion to individual policies following the expiration of Self Pay or COBRA Benefits.

Pre-Existing Conditions

"Pre-Existing Condition" ("PEC") is any condition (excluding pregnancy), disease, disorder or ailment for which medical advice, diagnosis, care or treatment is recommended to or received by a covered individual within the 90-day period preceding his Enrollment Date. Benefits will become payable for a Participant's PEC after the one year period beginning with his Enrollment Date and reduced by any Creditable Coverage, or if sooner, at the end of the first 90 consecutive day period, beginning on or after his initial effective date of coverage, during which he received no medical advice, diagnosis, care or treatment with respect to his PEC.

An Employee or Dependent can demonstrate prior Creditable Coverage by submitting a copy of a certificate of Creditable Coverage from a prior

health plan or issuer, or any other documentation reflecting his prior Creditable Coverage. The Employee or Dependent may also contact the Plan if assistance is needed, and the Plan will assist in obtaining a certificate from a prior plan or issuer if necessary.

It is important to submit proof of any prior Creditable Coverage in order to reduce and/or eliminate the one-year waiting period before a PEC is covered under the Plan. There shall be a PEC waiting period, however, for (i) a newborn who is covered within 30 days of birth and does not have a Break in Coverage; or (ii) a child who is adopted or placed for adoption prior to age 18, has Creditable Coverage within 30 days thereof and does not have a Break in Coverage. The determination of whether a PEC exists and whether a waiting period for the PEC will be applied shall be determined when an individual's coverage under the Plan begins, initially and at any time following a six month lapse in coverage for any reason, based upon the facts at that time.

Creditable Coverage

"Creditable Coverage" means all of an individual's prior periods of health coverage for which he is required to be given credit under HIPAA. Creditable Coverage includes most prior health coverage such as coverage under COBRA, any group or individual health care plan or insurance policy, Medicare, Medicaid, military-sponsored health care, the Indian Health Service, state health benefits risk pool, the federal employees health benefit program, a public health plan, and any health benefit plan provided under the Peace Corps Act. However, if the individual experiences a Break in Coverage, he will not be credited with any periods of Creditable Coverage that he had prior to his Break in Coverage.

Break in Coverage

Break in Coverage means a period of 63 days or longer during all of which the individual does not have Creditable Coverage. A leave of absence under FMLA or USERRA is not counted as a Break in Coverage.

CONTINUATION COVERAGE – COBRA

Qualified Beneficiary

A Qualified Beneficiary who loses coverage under the Plan as a result of a Qualifying Event may elect Continuation Coverage, in accordance with the requirements of this section. A Qualified Beneficiary is an Employee, Spouse and/or Dependent child who is covered under this Plan on the day before the Qualifying Event occurs. A Dependent Child born or placed for adoption with an Employee during a period of COBRA Coverage also becomes a Qualified Beneficiary.

Qualifying Event

A Qualifying Event shall mean any one of the following events that result in, or will result in loss of health coverage under the Plan:

- (1) the termination of the Employee's employment, except for gross misconduct;
- (2) the reduction of hours worked by the Employee;
- (3) the death of the Employee;
- (4) divorce or legal separation of the Employee and spouse;
- (5) a Dependent Child ceasing to be a Dependent; or
- (6) a Dependent ceasing to be eligible due to the Employee becoming entitled to Medicare.

Notice Requirements

No later than 30 days after a Qualifying Event described in (1), (2), or (3), the Employer will notify the Administrative Manager of such Qualifying Event. No later than 14 days after the date on which the Administrative Manager receives the Employer's notification, the Administrative Manager will notify any Qualified Beneficiary affected by the Qualifying Event of his rights to Continuation Coverage.

In the case of a Qualifying Event described in (4), (5) or (6), a Qualified Beneficiary must notify the Administrative Manager within 60 days of such event.

No later than 14 days after the date on which the Administrative Manager receives the Qualified Beneficiary's notification, the Administrative Manager will notify any Qualified Beneficiary of his rights to Continuation Coverage.

Type of Benefit Coverage

A Qualified Beneficiary will be provided medical coverage under the Plan which, as of the time the coverage is being provided, is identical to the medical coverage that is provided to similar beneficiaries with respect to whom a Qualifying Event has not occurred. If coverage provided to active Employees changes, such change(s) will apply to Qualified Beneficiaries covered under Continuation Coverage.

Election of Continuation Coverage

A Qualified Beneficiary must elect Continuation Coverage within 60 days after the later of the dates on which the Qualified Beneficiary's eligibility terminates under the Plan as a result of a Qualifying Event; or the date on

which the Qualified Beneficiary is notified by the Administrative Manager of his rights to Continuation Coverage by self payment of the required premium.

Maximum Period Allowed Under Continuation Coverage

- (1) Up to 18 months maximum are allowed from the date coverage would have otherwise terminated, if coverage is being continued for the Employee and his Dependents because of a termination in Covered Employment, including retirement or a reduction in hours of employment or any reason, other than gross misconduct; or
- (2) Up to 36 months maximum from the date coverage would have otherwise terminated, if coverage is being continued for the Dependent spouse and/or child(ren) for reasons other than those referred to in (1) above, except in the case where the individual initially declined Continuation Coverage. In this case, the Employee's spouse and/or Dependent Child(ren) are allowed Continuation Coverage for the 36 months maximum period.
- (3) If an Employee is determined to have been disabled at the time of his Qualifying Event, as described in (1) or (2) on page 18, the period of coverage for the Employee only may be extended from 18 to 29 months, provided the Employee notifies the Fund Office, by submitting documentation within 60 days of the determination that he is entitled to disability benefits from the Social Security Administration.

The same extension of coverage applies if the Employee or Dependent becomes disabled according to the Plan Definition within 60 days after the Qualifying Event and notifies the Fund office within 60 days of becoming disabled. In the case of a Qualifying Event described in (6) on page 18, the period of coverage for spouse and/or Dependent for such event or any subsequent event, will not terminate before the end of the 36-month period beginning on the date the Employee becomes entitled for Medicare.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of the following dates:

- (a) The first day of the month for which the contribution is not paid on time;
- (b) The date the Individual becomes covered under another employer sponsored group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition;

(c) The date the Individual first becomes entitled to Medicare (whether or not he applies for Medicare); or

(d) The date this Plan terminates.

If the Employee does not pay the required contributions for COBRA continuation coverage on a timely basis, he will no longer be covered under the Plan and any claims filed during the election period or following termination for non-payment of contributions will not be paid by the Plan. Reinstatement of coverage is not permitted.

Contribution for COBRA Continuation Coverage

A contribution for continuation coverage will be charged to Qualified Beneficiaries in an amount established by the Board of Trustees. The contribution may, at the election of a Qualified Beneficiary be paid in monthly, quarterly or semi-annual installments. No benefits are provided, however, until payment is received.

The contribution due for coverage between the termination date of coverage and the date this election was made must be paid within 45 days of the date the Qualified Beneficiary elects Continuation Coverage. Thereafter, contribution payments must be made no later than 30 days after the first day of the month of which Continuation Coverage is to be provided.

COBRA Self Payment Premiums

Self Payment, if elected, must be made from the date of termination. No lapse in coverage is permitted. It is further provided that:

- (1) If an Employee elects Continuation Coverage within 60 days after his eligibility terminates, the initial contribution due for coverage must be postmarked and sent to the Administrative Manager within 45 days after the election; this includes contributions required for months of coverage between the termination date of coverage and the date the initial contribution is due.
- (2) After the initial election and payment of contributions, subsequent payments must be postmarked and sent to the Administrative Manager before the last day of the month for which coverage is to be provided. Once the Employee is initially notified, he will not receive any further notices from the Administrative Manager.
- (3) The Employee will be notified of any change in contribution rates that he is required to pay.

(4) The full contribution rate due will be reduced by any contributions which have been made by the Employer on the behalf of the Employee. Otherwise, the full contribution rate will be charged.

Timely Receipt of Notice of Election and Premium

Receipt by the Administrative Manager's office of a properly executed election form and/or payment of contribution shall be considered timely if postmarked within the specified time limitations.

RETIREE MEDICAL PLAN

Special Self-Pay Rules for Certain Retired Employees

Upon retirement from a Participating Union's pension plan, an Employee and/or his spouse will be eligible for retiree benefits as shown in the Schedule of Benefits provided that the Employee:

1. was an Eligible Employee of the Southeastern Iron Workers Health Care Plan for at least three (3) months immediately prior to retirement;
2. was an Eligible Employee of the Southeastern Iron Workers Health Care Plan for at least 18 months of the 36 months immediately prior to the date of the Employee's retirement; and
 - (a) was at least age 55 but under age 65 on the date of retirement, and has retired with at least five (5) years service credits earned in a Participating Union's pension plan; or
 - (b) was at least age 50 but under age 55 on the date of retirement or complete withdrawal from Covered Employment anywhere as an Ironworker and has earned at least thirty (30) years service credits in a Participating Union's pension plan.

Employees must first elect or reject COBRA coverage, prior to making self payment under this provision. Employees may continue coverage under another Group Medical Plan on a continuous basis prior to participating in this Plan. Employees or spouses must elect retiree coverage immediately thereafter.

Employees who qualify for this provision will be permitted to make self-payments until the age of 65 or their termination date, whichever comes earlier, as set forth hereafter. Benefits for spouses may continue after the Retiree reaches age 65 or becomes eligible for Medicare. See Section C.

Employees who are over age 65 when they retire and who otherwise meet the eligibility requirements above, may elect coverage for their spouses who are younger than age 65. Coverage for such spouses will terminate in accordance with Section C.

If an Employee elects to Self-Pay in accordance with these provisions, he must make a Timely Self Payment, equal to the monthly cost of coverage, directly to the Fund Office; such payment must be received by the Administrative Office no later than 30 days following the first day of the month when payments are due which he is self-paying. The monthly cost of coverage will be determined by the Board of Trustees and be adjusted at the beginning of any month.

Medical coverage under the Special Self-Pay Rules for certain retired Employees and their eligible spouses will end on the earliest of the following dates:

A. For the Retiree:

- (1) the Retiree attains age 65;
- (2) the Retiree first becomes entitled to Medicare (whether or not he applies for Medicare);
- (3) The Retiree becomes covered (as an Employee or as a Dependent) under any other group medical benefits plans;
- (4) The Retiree returns to work with a non-participating Employer who engages in any work similar to Employers who participate in the Plan;
- (5) The Retiree is no longer receiving a disability pension;
- (6) The Retiree fails to make Timely Self-Payments; or
- (7) This provision terminates.

B. For the Spouse of a Retiree who has not attained age 65 or become entitled to Medicare;

- (1) the Retiree or Spouse becomes covered (as an Employee or as a Dependent) under any other group medical benefits plan;
- (2) the Retiree returns to work with a non-participating Employer who engages in work similar to Employers who participate in the Plan;
- (3) The Retiree is no longer receiving a disability pension;
- (4) The Retiree and Spouse divorce,

- (5) The Retiree fails to make Timely Self-Payments; or

- (6) This provision terminates.

C. For the Surviving Spouse of a Retiree who dies or the Spouse of a Retiree who reaches age 65 or becomes entitled to Medicare:

Coverage for such spouse (or Surviving Spouse) will end on the earliest of the following dates:

- (1) the Spouse attains age 65;
- (2) the Spouse first becomes entitled to Medicare (whether or not she applies for Medicare);
- (3) the Spouse becomes covered (as an Employee or as a Dependent) under any group medical plan;
- (4) the Surviving Spouse remarries;
- (5) the end of 7 years of coverage next following the Retiree's death;
- (6) the end of 7 years of coverage next following the Retiree's attainment of age 65 or eligibility for Medicare;
- (7) the Spouse fails to make Timely Self-Payments; or
- (8) the Plan or this provision terminates.

No benefits will become effective until application is made in advance of the month they are to be effective. Applications should be made at the Administrative Office.

As retired Employees are not eligible for the Prescription Drug Card Program, eligible charges for prescription drugs for retired Employees and their Spouses will be reimbursed at 50% provided the deductible is met.

COBRA Continuation of Coverage is not available after termination of Retiree Benefits.

Timely Self-Payments shall mean payments received by the Administrative Office no later than 30 days following the first day of the month when payments are due.

The Benefits and Special Self-Pay Rules may be changed, modified, amended or terminated at any time in order to maintain the Health Care Plan's financial stability and actuarial soundness. The granting of medical coverage hereunder for retired Employees and their spouses is neither a vested nor a contractual right.

IRON WORKERS INTERNATIONAL RECIPROCAL HEALTH AND WELFARE AGREEMENT

A. Point of Claim Reciprocity

Purpose – Eligibility is continued for health, welfare and insurance benefits under this Reciprocal Agreement for Employees who would otherwise lose eligibility for health, welfare and insurance benefits because their employment is divided between Local Union jurisdictions and in some cases such Employees may not have sufficient hours of contributions in one Fund to be eligible for benefits because of the division of hours and contributions among such Funds.

Definitions for Point of Claim Reciprocity

- (1) “Employee” shall mean any employee on whose behalf payments are required to be made to a Cooperating Fund by an Employer pursuant to a collective bargaining agreement or other written agreement with a Local Union or District Council of the International Association of Bridge, Structural and Ornamental Iron Workers.
- (2) “Employer” shall mean any employer signatory to a collective bargaining agreement or other written agreement providing for contributions to a Cooperating Fund.
- (3) “Cooperating Fund” shall mean any Health, Welfare or Insurance Fund which by resolution of the Board of Trustees, has approved participation in and executed the Iron Workers International Health and Welfare Reciprocal Agreement.
- (4) “Home Fund”, each Employee who has Employer contributions made on his behalf to one or more of the Cooperating Funds shall have a determined Home Fund. In the absence of evidence substantiating a claim to the contrary, the following rules shall be used in determining an Employee’s Home Fund:
 - i. If the Employee is a member of a local union and he has established eligibility in a Health and Welfare Fund in which his local union participates, that Fund shall be his Home Fund.
 - ii. If an Employee is not a member of a local union or if he has not established eligibility in a Health and Welfare Fund, his Home Fund shall be that Cooperating Fund which has received the largest amount of contributions on his behalf in the preceding twelve month period.

Transfer of Contributions

- (1) Employment in Other Than Home Fund Jurisdiction - If an Employee is working in the jurisdiction of a Cooperating Fund other than his Home Fund, and he is not eligible for benefits from that Cooperating Fund, he shall continue to file all claims incurred with his Home Fund for so long as he remains eligible in another Cooperating Fund, such claim shall be filed with that Cooperating Fund. If the Employee is not eligible in any Cooperating Fund, then the claim shall be filed with his Home Fund which shall contact the other Cooperating Funds in whose jurisdiction the Employee worked to determine if a transfer of contributions will reinstate the Employee’s eligibility in his Home Fund at the time the claim was incurred. If such a transfer will make the Employee so eligible in his Home Fund the contributions shall be transferred in accordance with the following paragraph (ii).
- (2) **Transfer of Contributions to Home Fund**
 - i. Upon a request by a Home Fund to another Cooperating Fund in whose jurisdiction an Employee has worked, the Cooperating Fund shall, subject to the conditions of (c) (1) of this Section, transfer all Employer contributions made on Employee’s behalf back to his Home Fund. The amount of contributions transferred shall be based on all of the Employee’s hours of work up to and including the month in which the claim was incurred during the eligibility period set forth in the Home Fund’s Plan. Such hours shall be multiplied by the contribution rate of the transferring Cooperating Fund. Upon transfer of hours and contributions, such hours transferred shall not be used for determining future eligibility for the Employee under the Cooperating Fund’s rules.
 - ii. Hours and contributions shall first be transferred from the Cooperating Fund in whose jurisdiction the Employee was working when the claim was incurred. If those hours and contributions do not result in establishing the Employee’s eligibility on the basis of hours, then contributions shall be transferred from all other Cooperating Funds in reverse order of employment until such eligibility is established within the Home Fund’s eligibility period.
 - iii. Upon the transfer of contributions by a Cooperating Fund in connection with an Employee’s claim, the hours represented by such contributions transferred shall not be included in a determination of eligibility for benefits for that Employee under that Cooperating Fund’s rules. However, subsequent hours worked, but not trans-

ferred, in the jurisdiction of the Cooperating Fund shall be used in the determination of such an Employee's eligibility for benefits.

Designation of New Home Fund

If an Employee changes his membership from one Local Union to another Local Union, his Home Fund shall be the Health, Welfare or Insurance Fund on the jurisdiction of his new Local Union. Claims incurred by such an Employee shall be filed with his new Home Fund. If he is not eligible in his new Home Fund, but is eligible in his prior Home Fund, such claims shall be filed with his prior Home Fund. If he is not eligible either in his new Home Fund or the prior Home Fund, the contributions shall be transferred to the New Home Fund as designated below.

Transfer of Contributions to New Home Fund

Upon a request from a new Home Fund to a prior Home Fund, the prior Home Fund shall transfer Employer Contributions made on the Employee's behalf to the new Home Fund. The amount of contributions transferred shall be based on the Employee's actual hours of work during the period that will establish his eligibility in the new Home Fund for the claim he has incurred.

However, such hours shall be limited to those worked after the date on which such Employee lost eligibility in his prior Home Fund. In any event, such hours shall be multiplied by the contribution rate to be transferred.

Information To Be Transferred

The transfer of hours and contributions specified in this Section shall be made within thirty (30) days of the date requested by the Home Fund or the new Home Fund.

B. Transfer of Contributions – Money-Follows-The-Man

Purpose – Eligibility is continued for health, welfare and insurance benefits under this Provision for Employees who would otherwise lose eligibility for health, welfare and insurance benefits because their employment is divided between Local Union jurisdictions and in some cases such Employees may not have sufficient hours of contributions in one Fund to be eligible for benefits because of the division of hours and contributions among such Funds. The provisions of this Article are operative only if both the Point-of-Claim and Transfer of Contributions Exhibits of the Iron Workers International Reciprocal Health and Welfare Agreement have been adopted by the signatory Funds in the jurisdiction the Employee works.

Definitions

- (a) "Employee" shall mean any employee on whose behalf payments are required to be made to a Cooperating Fund by an Employer pursuant to a collective bargaining agreement or other written agreement with a Local Union or District Council of the International Association of Bridge, Structural and Ornamental Iron Workers.
- (b) "Employer" shall mean any employer signatory to a collective bargaining agreement or other written agreement providing for contributions to a Cooperating Fund.
- (c) "Cooperating Fund" shall mean any Health, Welfare or Insurance Fund which by resolution of the Board of Trustees, has approved participation in and executed the Iron Workers International Health and Welfare Reciprocal Agreement.
- (d) "Home Fund", each Employee who has Employer contributions made on his behalf to one or more of the Cooperating Funds shall have a determined Home Fund. In the absence of evidence substantiating a claim to the contrary, the following rules shall be used determining an Employee's Home Fund:
 - (1) If the Employee is a member of a local union and he has established eligibility in a Health and Welfare Fund in which his local union participates, that Fund shall be his Home Fund.
 - (2) If an Employee is not a member of a local union or if he has not established eligibility in a Health and Welfare Fund, his Home Fund shall be that Cooperating Fund which has received the largest amount of contributions on his behalf in the preceding twelve month period.

Employee Authorization – If contributions are or will be made on an Employee's behalf to a Cooperating Fund signatory to Exhibits A and B of the Iron Workers International Reciprocal Health and Welfare Agreement, he may, provided his Home Fund is also signatory to Exhibits A and B of said Agreement, file a request with the Cooperating Fund that such contributions be transferred to his Home Fund on his behalf. Such request shall be made in writing on a form approved by the respective Funds which is signed and dated by the Employee. Said request form shall release the Board of Trustees of the respective Funds from any liability or claim by an Employee, or anyone claiming through him, that the transfer of contributions may not work to his best interest. Said completed request form shall be filed by the Employee with the Cooperating Fund within sixty (60) days

following the beginning of his employment within the Cooperating Fund's jurisdiction, provided however, that the Board of Trustees of the Cooperating Fund may, at its discretion, grant an extension of that sixty (60) day period for special circumstances.

If the Employee does not file a timely request form with the Cooperating Fund, he will be treated as electing not to authorize a transfer of contributions and the Point-of-Claim provisions of the Cooperating Fund's Plan shall apply to the Employee. By filing a request for transfer of contributions, the Employee agrees that his eligibility for benefits and all other participant rights are governed by the terms of the Home Fund's Health and Welfare Plan and not by the terms of the Cooperating Fund's Health and Welfare Plan.

Transfer or Contributions – Upon receipt of a timely and properly completed request for a transfer of contributions to the Employee's Home Fund, the Cooperating Fund shall collect and transfer to the Employee's Home Fund the contributions required to be made to the Cooperating Fund on the Employee's behalf. Said contributions shall be forwarded to the Employee's Home Fund within sixty (60) calendar days following the calendar month in which the contributions were received. Any delay in transferring contributions shall be considered a violation of the Iron Workers International Health and Welfare Reciprocal Agreement and subject to its provisions for arbitration. The contributions so transferred shall be accompanied by such records or report which are necessary or appropriate. The Cooperating Fund shall transfer the actual dollar amount of contributions received regardless of any difference in the contribution rates between the Funds.

Eligibility – The Board of Trustees of each Home Fund shall be responsible for determining whether an Employee is eligible to receive benefits under the Home Fund's plan based on the Home Fund's eligibility rules and a uniform application of how such transferred contributions should be credited.

LOCAL UNION PARTICIPATION

ACTIVE PLANS

PLAN 1 – LOCALS 402 AND 808

PLAN 1A – LOCAL 387

PLAN 2 – LOCALS 272, 397, 597, 698 AND 709

PLAN 2A – LOCAL 601

PLAN 3 (\$.50 PLAN) – ACTIVE EMPLOYEES ONLY OF EMPLOYERS WHOSE CONTRIBUTION RATE PER HOUR IS \$.50.

NOTE: PLAN 3 (\$.50 PLAN) WILL TERMINATE ON MARCH 31, 2003.

RETIREE PLANS

PLAN 1R – LOCALS 272, 387, 397, 402, 601, 709 AND 808

PLAN 2R – LOCAL 597

NO RETIREE BENEFITS FOR ACTIVE PLAN 3 (\$.50 PLAN) EMPLOYEES

SCHEDULE OF BENEFITS

<u>EMPLOYEE</u>	<u>PLAN 1 Actives</u>
Death Benefit	\$8,500
Additional Accidental Death & Dismemberment Benefit	\$8,500
Accident and Sickness	
Non-Occupational – Payable	
1st day Accident & 8th day Sickness for 26 weeks	\$100
Occupational – Payable 1st week	\$100
2nd through 26th week	\$50
<u>EMPLOYEE & DEPENDENTS</u>	
<u>BASIC BENEFITS</u>	
Supplemental Accident	
Calendar Year Maximum	\$600
Chiropractic – Maximum per Visit	\$25
Maximum Visits (Calendar Year)	10
<u>COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)</u>	
In Network (PPO)	100%
Out of Network (Non-PPO)	50%
<u>SPECIAL NETWORK (PPO ONLY) BENEFITS</u>	
Annual Physicals (Employee only)	\$300
Primary Care Network (PPO) Physicians Office Visits*	\$10 Co-Pay
<u>MAJOR MEDICAL BENEFITS</u>	
Daily Maximum Room & Board Charge	Semi-Private
Lifetime Maximum for:	
Eligible Charges	
In Network (PPO)	\$250,000
Out of Network (Non-PPO)	\$50,000
<u>DEDUCTIBLE</u>	
Individual Calendar Year	\$200
Family Calendar Year	\$400
<u>COINSURANCE</u>	
In Network (PPO)	90%
Out of Network (Non-PPO)	50%
<u>Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction</u>	

SCHEDULE OF BENEFITS

	<u>PLAN 1 Actives</u>
<u>ANNUAL OUT OF POCKET MAXIMUM PER INDIVIDUAL</u>	
Network (PPO) Eligible Charges Only	
Per Calendar Year	\$4,000
Payable at 100% of Eligible	
Network (PPO) Charges to Plan Maximums	
<u>DENTAL BENEFITS</u>	
Calendar Year Maximum	\$1,500
Deductible (Combined with Medical) Co-insurance	85%
<u>ORTHODONTIA BENEFITS</u>	
Lifetime Maximum	\$2,000
Deductible (Combined with Medical) Co-Insurance	85%
<u>PRESCRIPTION DRUG CARD</u>	
\$5 Generic	
\$10 Brand or 20% of cost, whichever is higher	
Prescription Out of Drug Card Plan Paid	
At 50% after Calendar Year Deductible	
<u>VISION CARE BENEFITS</u>	
	See Page 60
<u>LASER EYE SURGERY</u>	
Lifetime Maximum per eye	\$750

**Primary Care Network Physician: Network (PPO) General Practitioner, Internist, Pediatrician, or Gynecologist Only.*

SCHEDULE OF BENEFITS

<u>EMPLOYEE</u>	<u>PLAN 1A</u> <u>Actives</u>
Death Benefit	\$8,500
Additional Accidental Death & Dismemberment Benefit	\$8,500
Accident and Sickness	
Non-Occupational – Payable	
1st day Accident & 8th day Sickness for 26 weeks	\$100
Occupational – Payable 1st week	\$100
2nd through 26th week	\$50
<u>EMPLOYEE & DEPENDENTS</u>	
<u>BASIC BENEFITS</u>	
Supplemental Accident	
Calendar Year Maximum	\$600
Chiropractic – Maximum per Visit	\$25
Maximum Visits (Calendar Year)	10
<u>COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)</u>	
In Network (PPO)	100%
Out of Network (Non-PPO)	50%
<u>SPECIAL NETWORK (PPO ONLY) BENEFITS</u>	
Annual Physicals (Employee only)	\$300
Primary Care Network (PPO) Physicians Office Visits*	\$10 Co-Pay
<u>MAJOR MEDICAL BENEFITS</u>	
Daily Maximum Room & Board Charge	Semi-Private
Lifetime Maximum for Eligible Charges	
In Network (PPO)	\$1,000,000
Out of Network (Non-PPO)	\$50,000
Calendar Year Maximum for Eligible Charges	
In Network (PPO)	\$250,000
Out of Network (Non-PPO)	\$50,000
<u>DEDUCTIBLE</u>	
Individual Calendar Year	\$200
Family Calendar Year	\$400
<u>COINSURANCE</u>	
In Network (PPO)	90%
Out of Network (Non-PPO)	50%

Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction

SCHEDULE OF BENEFITS

	<u>PLAN 1A</u> <u>Actives</u>
<u>ANNUAL OUT OF POCKET MAXIMUM PER INDIVIDUAL</u>	
Network (PPO) Eligible Charges Only	
Per Calendar Year	\$4,000
Payable at 100% of Eligible	
Network (PPO) Charges to Plan Maximums	
<u>DENTAL BENEFITS</u>	
Calendar Year Maximum	\$1,500
Deductible (Combined with Medical) Co-insurance	85%
<u>ORTHODONTIA BENEFITS</u>	
Lifetime Maximum	\$2,000
Deductible (Combined with medical) Co-Insurance	85%
<u>PRESCRIPTION DRUG CARD</u>	
	See Page 56
\$5 Generic	
\$10 Brand or 20% of cost, whichever is higher	
Prescription Out of Drug Card Plan Paid	
At 50% after Calendar Year Deductible	
<u>VISION CARE BENEFITS</u>	
	See Page 61
<u>LASER EYE SURGERY</u>	
Lifetime Maximum per eye	\$750

Primary Care Network Physician: Network (PPO) General Practitioner, Internist, Pediatrician, or Gynecologist Only.

SCHEDULE OF BENEFITS

<u>EMPLOYEE</u>	<u>PLAN 2 Actives</u>
Death Benefit	\$8,500
Additional Accidental Death & Dismemberment Benefit	\$8,500
Accident and Sickness Non-Occupational – Payable	
1st day Accident & 8th day Sickness for 26 weeks	\$100
Occupational – Payable 1st week	\$100
2nd through 26th week	\$50
<u>EMPLOYEE & DEPENDENTS</u>	
<u>BASIC BENEFITS</u>	
Supplemental Accident	
Calendar Year Maximum	\$600
Chiropractic – Maximum per Visit	\$25
Maximum Visits (Calendar Year)	10
<u>COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)</u>	
In Network (PPO)	100%
Out of Network (Non-PPO)	50%
<u>SPECIAL NETWORK (PPO ONLY) BENEFITS</u>	
Annual Physicals (Employee only)	\$300
Primary Care Network (PPO) Physicians Office Visits*	\$20 Co-Pay
<u>MAJOR MEDICAL BENEFITS</u>	
Daily Maximum Room & Board Charge	Semi-Private
Lifetime Maximum for:	
Eligible Charges	
In Network (PPO)	\$250,000
Out of Network (Non-PPO)	\$50,000
<u>DEDUCTIBLE</u>	
Individual Calendar Year	\$350
Family Calendar Year	\$700
<u>COINSURANCE</u>	
In Network (PPO)	85%
Out of Network (Non-PPO)	50%
<u>Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction</u>	

SCHEDULE OF BENEFITS

	<u>PLAN 2 Actives</u>
<u>DENTAL BENEFITS</u>	
Calendar Year Maximum	\$600
Deductible (Combined with Medical) Co-insurance	80%
<u>PRESCRIPTION DRUG CARD</u>	
	See Page 56
\$10 Generic	
\$20 Brand or 30% of cost, whichever is higher	
Prescription Out of Drug Card Plan Paid	
At 50% after Calendar Year Deductible	
<u>VISION CARE BENEFITS</u>	
	See Page 61

**Primary Care Network Physician: Network (PPO) General Practitioner,*

SCHEDULE OF BENEFITS

<u>EMPLOYEE</u>	<u>PLAN 2A</u> <u>Actives</u>
Death Benefit	\$8,500
Additional Accidental Death & Dismemberment Benefit	\$8,500
Accident and Sickness	
Non-Occupational – Payable	
1st day Accident & 8th day Sickness for 26 weeks	\$100
Occupational – Payable 1st week	\$100
2nd through 26th week	\$50
<u>EMPLOYEE & DEPENDENTS</u>	
<u>BASIC BENEFITS</u>	
Supplemental Accident	
Calendar Year Maximum	\$600
Chiropractic – Maximum per Visit	\$25
Maximum Visits (Calendar Year)	10
<u>COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)</u>	
In Network (PPO)	100%
Out of Network (Non-PPO)	50%
<u>SPECIAL NETWORK (PPO ONLY) BENEFITS</u>	
Annual Physicals (Employee only)	\$300
Primary Care Network (PPO) Physicians Office Visits*	\$20 Co-Pay
<u>MAJOR MEDICAL BENEFITS</u>	
Daily Maximum Room & Board Charge	Semi-Private
Lifetime Maximum for:	
Eligible Charges	
In Network (PPO)	\$250,000
Out of Network (Non-PPO)	\$50,000
<u>DEDUCTIBLE</u>	
Individual Calendar Year	\$250
Family Calendar Year	\$500
<u>COINSURANCE</u>	
In Network (PPO)	85%
Out of Network (Non-PPO)	50%
<u>Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction</u>	

SCHEDULE OF BENEFITS

	<u>PLAN 2A</u> <u>Actives</u>
<u>DENTAL BENEFITS</u>	
Calendar Year Maximum	\$600
Deductible (Combined with Medical) Co-insurance	80%
<u>PRESCRIPTION DRUG CARD</u>	
	See Page 56
\$5 Generic	
\$10 Brand or 20% of cost, whichever is higher	
Prescription Out of Drug Card Plan Paid	
At 50% after Calendar Year Deductible	
<u>VISION CARE BENEFITS</u>	
	See Page 61

**Primary Care Network Physician: Network (PPO) General Practitioner, Internist, Pediatrician, or Gynecologist Only.*

SCHEDULE OF BENEFITS

<u>EMPLOYEE</u>	<u>PLAN 3</u> <u>Actives</u>	
Death Benefit	\$5,000	
Additional Accidental Death & Dismemberment Benefit	\$5,000	
Chiropractic – Maximum per Visit	\$25	
Maximum Visits (Calendar Year)	10	
<u>COMPREHENSIVE MEDICAL BENEFITS</u>		
Daily Maximum Room & Board Charge		Semi-Private
Lifetime Maximum for:		
Eligible Charges		
In Network (PPO)	\$100,000	
Out of Network (Non-PPO)	\$25,000	
<u>CALENDAR YEAR MAXIMUM FOR</u>		
In Network (PPO)	\$25,000	
Out of Network (Non-PPO)	\$12,500	
<u>DEDUCTIBLE</u>		
Individual Calendar Year	\$500	
Per Non-Network (Non-PPO)		
Hospital Admission	\$100	
<u>COINSURANCE</u>		
In Network (PPO)	70%	
Out of Network (Non-PPO)	50%	
<u>Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction</u>		
<u>No Prescription Drug Card</u>		

NOTE: PLAN 3 (\$.50 PLAN) WILL TERMINATE ON MARCH 31, 2003.

SCHEDULE OF BENEFITS

	<u>PLAN 1R</u> <u>Retirees</u>
<u>RETIREE & DEPENDENTS (BASIC BENEFITS)</u>	
Supplemental Accident	
Calendar Year Maximum	\$600
Chiropractic – Maximum per Visit	\$25
Maximum Visits (Calendar Year)	10
<u>COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)</u>	
In Network (PPO)	100%
Out of Network (Non-PPO)	50%
<u>MAJOR MEDICAL BENEFITS</u>	
Daily Maximum Room & Board Charge	Semi-Private
Calendar Year Maximum for Eligible Charges	
In Network (PPO)	\$100,000
Out of Network (Non-PPO)	\$10,000
<u>DEDUCTIBLE</u>	
Individual Calendar Year	\$500
Family Calendar Year	\$1,000
<u>COINSURANCE</u>	
In Network (PPO)	80%
Out of Network (Non-PPO)	50%
Prescription Drugs	50%
<u>Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction</u>	
<u>No Prescription Drug Card</u>	

SCHEDULE OF BENEFITS

PLAN 2R Retirees

RETIREE & DEPENDENTS (BASIC BENEFITS)

Supplemental Accident Calendar Year Maximum	N/A
Chiropractic – Maximum per Visit Maximum Visits (Calendar Year)	\$25 10

COINSURANCE WITH NO DEDUCTIBLE (BASIC BENEFITS)

In Network (PPO)	N/A
Out of Network (Non-PPO)	N/A

MAJOR MEDICAL BENEFITS

Daily Maximum Room & Board Charge Calendar Year Maximum for Eligible Charges	Semi-Private
In Network (PPO)	\$15,000
Out of Network (Non-PPO)	\$5,000

DEDUCTIBLE

Individual Calendar Year	\$250
Family Calendar Year	\$500

COINSURANCE

In Network (PPO)	85%
Out of Network (Non-PPO)	60%
Prescription Drugs	50%

Hospital Admissions or Outpatient Surgery not Precertified: 10% Reduction

No Prescription Drug Card

EMPLOYEE LIFE INSURANCE BENEFIT

NOTE: EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE IS UNDERWRITTEN BY UNION LABOR LIFE INSURANCE COMPANY (ULLICO)

DEATH BENEFIT AND TO WHOM PAYABLE

The Life Insurance Benefit will be paid if you die while insured under this benefit.

Benefit Determination

The amount of benefit to be paid will be the Amount of Insurance as shown in the **Schedule of Benefits** which is in force for you on the date of your death, subject to all the terms and conditions of this Policy.

Benefit Payment

The benefit will be paid to your named Beneficiary, upon receipt of due proof of death, as provided in the **Claim Payment** Section.

CONVERSION PRIVILEGE

If your Life Insurance Benefit, or any portion thereof, terminates, you are entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). You will not be required to submit proof of good health to convert.

Conversion Rights for Persons

Conversion Rights, upon Individual Termination or Class Change

If your Life Insurance Benefit, or any portion thereof, terminates because you:

1. cease to be eligible under the terms of the Plan; or
2. transfer from one Class of Eligible Persons to another, and the class to which you have transferred, offers lesser benefits;

you may convert up to the Amount of Insurance which terminated, less any amount for which you become eligible under the Life Insurance Benefit of this Policy or under any other group policy within 31 days from the date of termination.

Conversion Rights Upon Policy Or Class Termination

If your Life Insurance Benefit terminates because this Policy:

1. terminates; or
2. is amended to terminate coverage for a Class of Eligible Persons under which you were insured;

then you may convert to an amount that does not exceed the lesser of the following, provided you have been continuously insured under the Life Insurance Benefit of this Policy (or the plan which this Policy replaced) for at least 5 years:

1. the amount of Life Insurance Benefit in effect for you on the date of termination, less any amount for which you are or become eligible under this Policy or any other group policy (which replaces this Policy) within 31 days after the date of termination; or
2. \$2000

Notice of Conversion Privilege

The Fund office must notify you of your right to convert. If the notice is not given by the 16th day of the 31-day Conversion Period you will have an additional period in which to convert. The additional period will expire 15 days from the date you are notified, but in no event will the right to convert be extended more than 91 days beyond the date your insurance terminated under this Policy. Written notice presented to you, or mailed to your last known address, shall constitute notice for purposes of this provision.

In no event is your Life Insurance Benefit extended beyond the end of the 31-day Conversion Period, whether or not notice is given.

Conversion Period

To qualify for a Conversion Policy, you must submit a written application to ULLICO and pay the first premium due within 31 days from the date your Life Insurance Benefits terminates under this Policy, unless an additional period in which to convert has been granted as shown in Notice of Conversion Privilege in this Section.

Conversion Policy

You are entitled to convert to any individual policy which is then being offered by ULLICO, other than term insurance, or insurance which provides disability or other supplemental benefits.

Premium Rates

The premium rates for the Conversion Policy will be ULLICO's premium rates in effect for the amount and type of policy elected and based on your class of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy.

Effective Date

The individual Life Insurance Conversion Policy will take effect at the end of the 31-day period provided the premium has been paid before the end of such period.

Death Within the Conversion Period

If you die during the 31-day Conversion Period, the maximum Amount of Insurance which you were entitled to convert under the Life Insurance Benefit will be paid as a benefit under this Policy, to the last Beneficiary you named, whether or not conversion was applied for, and premium paid.

If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. ULLICO will return any premium paid for the Conversion Policy.

Limitation on Amount Converted

No individual who is insured or who becomes insured under this Policy and who holds an individual life insurance policy obtained through exercise of the Conversion Privilege of this Policy, shall again be entitled to exercise the Conversion Privilege for which he or she is otherwise eligible as long as such individual policy of life insurance remains in effect.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Upon receipt of due proof of loss, the Accidental Death and Dismemberment Benefit will be paid if:

1. you, while insured under this benefit, suffer an accidental injury; and
2. as the direct result of the accident, and independent of all other causes, suffer a Covered Loss within 90 days after the accident.

A "Covered Loss" means permanent loss of:

1. life; or
2. a hand, by complete severance at or above the wrist joint;
3. a foot, by complete severance at or above the ankle joint; or

- 4. an eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under Exclusions in this Section, and subject to all the terms and conditions of this Policy. The amount of benefit to be paid for a Covered Loss is determined as follows:

SCHEDULE OF LOSSES

FOR LOSS OF:	THE BENEFIT IS
LIFE	THE PRINCIPAL SUM
TWO HANDS	THE PRINCIPAL SUM
TWO FEET	THE PRINCIPAL SUM
SIGHT OF TWO EYES	THE PRINCIPAL SUM
ONE HAND AND ONE FOOT	THE PRINCIPAL SUM
ONE HAND AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE FOOT AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE HAND OR ONE FOOT	ONE-HALF THE PRINCIPAL SUM
SIGHT OF ONE EYE	ONE-HALF THE PRINCIPAL SUM

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Exclusions

No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

- 1. bodily or mental illness or disease of any kind;
- 2. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- 3. suicide or attempted suicide while sane or insane;
- 4. intentional self-inflicted injury;
- 5. war or act of war, declared or undeclared; or any act related to war, or insurrection;
- 6. medical or surgical treatment of an illness or disease;
- 7. intake of any drug, medication or sedative unless prescribed by a doctor, or the intake of any alcohol in combination with any drug, medication or sedative; or

- 8. driving while intoxicated as defined by applicable state law.

CLAIM PAYMENT

Your Beneficiary is the party or parties named by you as shown on ULLICO's records, to receive the benefits payable under this Policy upon your death. You may name one or more Beneficiaries to receive the death benefit.

You may change the Beneficiary at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing on a form furnished by or satisfactory to ULLICO. Such change will take effect upon receipt of the signed form at the Executive Office of ULLICO.

Upon receipt of satisfactory Proof of Claim, the Claims Administrator will pay the death benefit due under the Life Insurance and Accidental Death and Dismemberment Benefits to your named Beneficiary as follows:

- 1. If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by you when the Beneficiaries were named.
- 2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:
 - a. the surviving spouse;
 - b. your children, in equal shares;
 - c. your parents, in equal shares;
 - d. your brothers and sisters, in equal shares; or
 - e. the executors or administrators of your estate.

In order to determine which class of individuals is entitled to the death benefit, the Claims Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such an affidavit, ULLICO will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Claims administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. ULLICO will be fully discharged of its liability for any amount of benefit so paid in good faith.

Proof of Claim

Satisfactory Proof of Claim will include a certified copy of your death certificate and any other data that the Claims Administrator may require to establish the validity of the claim.

Facility of Payment

If an individual appears to the Claims Administrator to be equitably entitled to compensation because he or she has incurred expenses on behalf of your burial, the Claims Administrator may pay to such individual the expenses incurred up to \$500. Such payment, however, shall not exceed the amount due under this Policy. ULLICO will be fully discharged of its liability for any amount of benefit so paid in good faith.

Mode of Payment

Death benefit proceeds will be paid to the Beneficiary in one lump sum.

Maximum Payment of Benefits

The total benefits payable under this Policy for Life Insurance will never exceed the Amount of Insurance shown in the Schedule of Benefits Section. In no event will payment be made under more than one of the following Life Insurance provisions:

1. Life Insurance Benefit; or
2. Conversion Privilege.

ACCIDENT AND SICKNESS BENEFIT (Occupational or Non-occupational)

General Provisions

An Employee will be paid the Weekly Benefit shown in the Schedule of Benefits if he is Totally Disabled and under the care of a Physician as the result of an Accident or Sickness while he is eligible under the Health Care Plan.

The benefit is payable from the first day of disability caused by an Accident and from the eighth day of disability caused by a Sickness, up to the maximum number of weeks during any one period of disability as shown in the Schedule of Benefits while you are eligible under the Health Care Plan.

Payments will be made for each separate and distinct period of disability. Successive periods of disability separated by less than two (2) weeks of active full time work shall be considered one period of disability unless they arise from different and unrelated causes in which case return to active full time work is required.

Limitations

Accident and Sickness Benefits will not be payable for any period of disability:

- (a) prior to the first attendance of a Physician;
- (b) during which the Employee is not under the direct care of a Physician;
- (c) which occurs prior to the Employee's effective date for benefits under the Health Care Plan; or
- (d) which occurs as of the Employee's termination of eligibility for benefits under the Health Care Plan.

The Trustees reserve the right to require the Employee to be examined by a Physician selected by the Trustees. If in the opinion of such examining Physician the Employee is able to return to work, the Trustee shall have the right to discontinue payments even if the Employee does not return to work.

Extended Benefits

If an Employee's eligibility terminates after Accident and Sickness benefits have begun, the Accident and Sickness benefit will be extended subject to the limitation above until the earliest of the following events:

- (a) the date the disability ceases;
- (b) the maximum number of weeks of benefits shown in the Schedule of Benefits are used.

UTILIZATION REVIEW PROGRAM

Utilization Review Program (UR)

The Utilization Review Program (UR) provides pre-admission review for scheduled admissions, concurrent review and discharge planning for all Hospital admissions and certifications of surgery when recommended by a Physician whether performed on an inpatient or outpatient basis. The procedures that an Employee and his Dependents must follow are as described:

(a) Scheduled Hospital Admissions or Outpatient Surgery

If an Employee or any of his Dependents are scheduled for a Hospital admission or Outpatient Surgery, the Physician recommending the hospitalization or Outpatient Surgery must call the UR company before the admission takes place. In addition, the Physician and Patient are required to cooperate in concurrent review and discharge planning.

It is the responsibility of the Employee and his Dependents to verify that the Physician has notified the UR company prior to the scheduled admission. The Employee or one of his family members is required to call the UR company prior to the scheduled date of the admission to verify that proper notification has been made by the Physician.

(b) Non-Scheduled Admissions

If an Employee or Dependent is admitted to any Hospital on a Non-Scheduled basis, such as on an urgent or emergency basis, the admitting Physician must call the UR company within 48 hours after the Employee or any Dependent has been hospitalized.

If the above procedures for Scheduled, including Outpatient Surgery, or Non-Scheduled Hospital Admissions are followed, the Covered Charges relative to the hospital admission for which the Employee and any Dependents are eligible will be paid up to the maximum allowable under the Plan. However, if the above procedures are not followed, all benefits payable relative to the hospital admission including Outpatient Surgery will

be reduced by 10%; such as Hospital Room and Board and miscellaneous, medical, surgery, anesthesiologist, etc. as set forth in the Schedule of Benefits.

BASIC BENEFITS

Chiropractic Benefits

If an Employee or Dependent receives treatment in connection with the detection and correction of structural imbalances or subluxation in the human body, benefits will be payable for the expenses incurred up to the calendar year maximum shown in the Schedule of Benefits, limited to no more than 10 visits in a calendar year.

Supplemental Accident Benefits

If an Employee or Dependent sustains Bodily Injuries because of a Non-occupational Accident, he will be reimbursed the amount of the charges which are in excess of any other benefits payable under the Plan, except Major Medical Benefits, with respect to all such injuries, up to the calendar year maximum shown in the Schedule of Benefits for:

- (a) Room and Board and other services provided by the Hospital;
- (b) diagnosis, treatment, or surgery made by a Physician;
- (c) private duty nursing services; or
- (d) X-ray and laboratory tests.

Limitations on Supplemental Accident Benefits

No payment will be made for:

- (a) expenses incurred for or in connection with any Sickness;
- (b) expenses not payable under the Plan according to the Section entitled "Major Medical Benefits – General Limitations."

MAJOR MEDICAL BENEFITS

Major Medical Benefits

Major Medical Benefits may, depending on the Schedule of Benefits, include substantial benefits for Non-Occupational Injury or Sickness which involves Hospital, Surgical and Medical expenses.

Deductible Amount

The deductible is the amount of Medical Expenses in excess of any Basic Medical Benefits which the Employee or Dependent pays before

Major Medical Benefits are payable. The deductible amount payable in each calendar year is shown in the Schedule of Benefits.

The deductible applies only once in any calendar year even though the Employee or Dependent may have several different disabilities. So that the Employee will not have to pay the deductible late in one calendar year and soon again the following calendar year, any expenses applied against the deductible in the last three (3) months of a calendar year may also be applied against the deductible for the next calendar year.

- (a) Family Deductible – Once the total amount of Medical Expenses in excess of any Basic Medical Expenses for all members of a family satisfies the Family Deductible amount in the Schedule of Benefits, the remainder of such Medical Expenses may be considered for payment under the Schedule of Benefits.
- (b) Common Accident – If two (2) or more members of the Employee's family are injured in the same accident, the Employee will pay only one individual deductible amount for all family members injured in that accident.

Maximum Benefit

The amount payable with respect to all injuries, sickness or disease during the Employee's lifetime and of each of his Dependent's lifetimes will be the Lifetime Maximums shown in the Schedule of Benefits. Out-of-Network charges shall be included in Network Lifetime Maximums.

Reinstatement of Benefits Provision

If benefits have been paid under the Plan, thereby decreasing the Employee's Lifetime Maximum, up to \$5,000 will be automatically reapplied to his Lifetime Maximum on January 1st of each year without having to provide evidence of insurability and no action is required on the Employee's part.

Furthermore, the Employee may apply for a new maximum at any time after he has collected at least \$5,000 if the Employee submits medical evidence of good health to the Board of Trustees at his own expense. The new maximum will become effective on the date the Trustees acknowledge the evidence as satisfactory.

This reinstatement provision shall not apply to expenses incurred for alcoholism, drug addiction, or mental and nervous disorders.

In no event will the total benefit, including the amount reinstated, exceed the Lifetime Maximum indicated in the Schedule of Benefits.

Annual Out Of Pocket Maximum

For Plans 1 and 1A, a \$4,000 annual Out-of-Pocket Maximum is provided for each Individual including the Calendar Year Deductible for

Eligible network (PPO) expenses. After the Individual has paid \$4,000 of Eligible Network (PPO) expenses in a calendar year, the Plan will pay 100% of Eligible Network (PPO) expense thereafter for the remainder of the calendar year.

Non-Covered Expenses and Non-Network Expenses do not apply toward the Out-of-Pocket Annual Maximum. In-Network (PPO) Primary Physician co-pay and Prescription Drug Card co-pay and coinsurance do not apply toward the Out-of-Pocket Annual Maximum or once the Annual Out-of-Pocket maximum is reached, these are not reimbursed at 100%.

Description of Benefits

The Plan pays the Employee for Covered Medical Expenses at the applicable percentages shown in the Schedule of Benefits, in excess of any Basic or Wellness Benefits subject to the Deductible, and the Utilization Review requirements as described on page 48.

Medical Expenses Covered

Medical Expenses included under the Plan are the lesser of the Usual and Customary Charges or PPO Negotiated Charges outlined below for Medically Necessary care and services which are ordered by a Physician:

- (a) Hospital care – The semi-private Room and Board charges during a Hospital confinement, up to the maximum daily amount set forth in the Schedule of Benefits. Hospital services and supplies furnished by a Hospital;
- (b) Physician care – Medical treatment, including diagnosis, treatment and surgery by a Physician, unless otherwise excluded;
- (c) Nursing Services – Private duty nursing of a registered graduate nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.);
- (d) Prescription Drug – Charges for drugs and medicines obtainable on a Physician's written prescription in accord with the Prescription Drug Card Program;
- (e) Ambulance service for local travel;
- (f) Anesthetics, oxygen and their administration;
- (g) X-ray and laboratory tests;
- (h) Radium, radioactive isotope or similar therapy;
- (i) Blood, blood plasma and their administration;

- (j) Medical supply charges for oxygen, casts, splints, trusses, braces, crutches, and surgical dressings;
- (k) Rental of durable medical equipment such as a hospital bed, wheelchair or iron lung, not to exceed the purchase price of such items;
- (l) Braces, crutches or artificial limbs;
- (m) Physiotherapy;
- (n) Dental treatment required as a result of an Accidental Injury which occurs while the Individual is eligible, provided that the Individual is eligible under the Plan at the time treatment is rendered;
- (o) Physician services provided in connection with the detection and correction of structural imbalances or subluxation in the human body, limited to no more than 10 visits in a calendar year;
- (p) Outpatient surgery benefits for covered surgeries and all related charges (anesthesiologist, pathologist, radiologist, Physician's office charges for supplies, outpatient Hospital charges, etc.), if the surgery is performed in a Physician's office or as an Outpatient in a Hospital.
- (q) Second Surgical Opinion benefits for all such consultations including any necessary X-ray and laboratory examinations if the Employee or Dependent consult a surgeon for a second surgical opinion regarding a covered surgical procedure of a non-emergency nature as required under the Utilization Review program;
- (r) Routine bassinet and nursery charges for a newborn for the days the mother and child are jointly confined; and
- (s) Pregnancy related expenses, other than expenses incurred for Elective Abortion, except for complications which are the result of an Elective Abortion.
- (t) Breast Reconstructive Surgery – Services provided for breast reconstructive surgery in connection with a mastectomy including (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

- (u) Home Modification – Expenses up to \$15,000 Lifetime for home modifications for an Employee or Dependent who is Totally and Permanently Disabled provided it is determined by the Plan managed care company that such modifications to the home are reasonable, necessary and can replace other covered medical expenses. The judgment of the Trustees shall be final and binding.
- (v) Disease Management Training by a health professional when recommended by a Physician.

General Limitations

Limitations that apply only to certain services have been described in the appropriate sections. In general, no payment will be made for the following medical expenses:

- (a) Charges not prescribed as necessary by a Physician;
- (b) Charges incurred for treatment of mental and nervous disorders (including drug abuse and alcoholism);
- (c) Charges for cosmetic surgery, unless required to repair scars which are the result of an Accidental Injury which occurred while the Employee was eligible under the Plan at the time the treatment is rendered;
- (d) Charges for dental work or treatment or dental X-rays, except as provided for in the Schedule of Operations regarding dental surgery and as required because of Accidental Injury which occurred while the Employee was eligible under the Plan at the time the treatment is rendered;
- (e) Eye refractions, hearing tests, hearing aids or the fitting thereof;
- (f) Charges for transportation, except as provided for in the Covered Charges on page 51 (e);
- (g) Charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits;
- (h) Charges for services or supplies in connection with a service related disability in a Service Facility or Veteran's Administration Hospital owned or operated by the United States Government; unless otherwise required by law;
- (i) Charges due to Elective Abortion except for any complications which are the result of Elective Abortion;

- (j) Charges incurred due to an injury or illness resulting from an intentionally self-inflicted injury, provided that the action which caused said injury or illness is determined by the appropriate investigative authority;
- (k) Charges for therapeutic X-rays;
- (l) Charges due to an Accidental Bodily Injury arising out of and in the due course of employment or for Sickness covered by Workers' Compensation or similar legislation;
- (m) Charges due to an injury as a result of war, declared or undeclared, including armed aggression;
- (n) Charges in excess of the lesser of Usual and Customary Charges, PPO Negotiated Charges or charges for unnecessary care or treatment;
- (o) Expenses for which no charge is made that the Employee is required to pay;
- (p) Services rendered for remedial reading and recreation, visual and occupational therapy, behavioral modification therapy and pain rehabilitation control; and dietary instruction for any sickness or condition;
- (q) Charges incurred for speech therapy, except when ordered by a Physician for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation, laryngitis, cerebral palsy, Accidental Injury or other similar structural or neurological disease;
- (r) Service, supplies or treatment in connection with or related to transsexuality or reverse sterilization or any attempts of these procedures;
- (s) Any treatment, surgical procedure, facility equipment, drugs, drug usage or supplies requiring Federal or other governmental agency approval, which is not granted at the time the services are rendered, or which the Trustees, with appropriate consultation determine to be experimental or not accepted medical practice;
- (t) Any service, supply or surgery performed for the treatment of obesity or weight reduction, except when the cause for the condition is glandular (endogenous), then benefits will be allowed for the diagnostic work necessary to establish the diagnosis as well as any subsequent surgery performed. If the diagnostic work confirms the diag-

nosis of exogenous obesity (a condition usually caused by overeating), no benefits will be payable for expenses incurred;

- (u) Charges made in connection with routine health check-ups except as provided in the Wellness Program;
- (v) Charges for any service, supply or surgery performed for the treatment of Temporomandibular Joint Dysfunction (TMJ);
- (w) Standby surgical fees or charges;
- (x) Custodial care or rest care;
- (y) Injuries or sickness incurred in the commission or attempted commission of an illegal act or a crime or while in the custody of a law enforcement official or agency or a penal institution; or
- (z) Sexual dysfunction drugs such as Viagra.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan entered into an agreement with a Preferred Provider Organization (PPO). The PPO is a network of Hospitals, Physicians, and Other Service Providers, that will, when used, provide a discount on Eligible Charges.

PPO Network Hospitals, Physicians and Other Service Providers

The Plan will reimburse the Employee or a Dependent at the coinsurance level for your Benefit Plan after the Calendar Year Deductible is satisfied as set forth in the Schedule of Benefits.

Non-PPO Network Hospitals, Physicians and Other Service Providers

If an Employee or a Dependent uses a non-PPO Hospital, Physician or other Service Provider, the Plan will reimburse the Employee less than the coinsurance percentage for your Benefit Plan as set forth in the Schedule of Benefits.

However, if an Employee or a Dependent lives and receives treatment outside a thirty-five (35) mile radius of the Network (PPO) Hospitals, Physicians or other Service Providers, or requires immediate limb or life threatening emergency care, the Plan will reimburse at the In Network (PPO) coinsurance rate set forth in the Schedule of Benefits.

WELLNESS PROGRAM BENEFITS

Benefit for Employees Only

The Plan will pay up to \$300 for an annual physical examination for an Employee if the Service is provided by a Primary Care Network (PPO) Physician. The benefit is not subject to a deductible or coinsurance and is paid at 100% up to the \$300 limit.

Benefit for Employees and Dependents

Benefits will be paid at 100% after a Plan Co-Pay for office visits to a Primary Care Network (PPO) Physician's office. The benefit covers, without deductible or coinsurance, Physician's fees including other office charges such as laboratory fees and charges for X-rays, pap smears, immunizations, PSA tests and minor surgeries performed in such Physician's office.

Primary Care Network (PPO) Physicians

Primary Care Network (PPO) Physicians include PPO general practitioners, internists, pediatricians, and gynecologists only.

PARTICIPANT REVIEW OF MEDICAL CHARGES FOR SERVICES NOT RECEIVED

Controlling costs is important to you as a Participant in the Health Care Plan. When you or your dependent incurs medical expenses and in your review of the billing charges from the Providers you discover that you were charged for services not received, you should notify the Fund Office within 14 days.

Controlling cost can now be financially rewarding to you also. If there is a charge for services not received and the Fund Office obtains a refund from the Provider, you will receive a bonus of 25% of the recovered amount up to a maximum of \$1,000. This does not apply to any such charges that would have been discovered by the Fund Office in the normal course of processing the claim.

The final determination of this award is at the discretion of the Board of Trustees whose decision shall be final.

PRESCRIPTION DRUG CARD SERVICE PROGRAM

Active Employees and Dependents

Prescription Drug Card Benefits

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

Employees and the Eligible Dependents will not be eligible under this Plan until records have been received and updated with the Prescription Drug Card Company.

Participating Pharmacies

Most major chains and many local pharmacies participate in the program. Check with the Plan Office if you have a question about a particular pharmacy's participation.

Co-Pay

There is **no deductible** that has to be satisfied in order to participate in the prescription card benefit. When purchasing a prescription, you or your Dependent will be required to co-pay an amount as set forth in the Schedule of Benefits directly to the Participating Pharmacy.

Eligible prescriptions that are paid for outside of this program may be submitted directly to the Plan for processing and are payable at 50% after the individual or Family Calendar Year Deductible is satisfied as set forth in the Schedule of Benefits. Such payment shall in no event be coordinated or otherwise reimbursed at more than 50%.

Eligible Prescriptions

- (a) State and Federal legend drugs including compounded prescriptions with at least one legend drug;
- (b) Insulin and disposable insulin;
- (c) Needles and disposable insulin syringes; and
- (d) Maintenance drugs, when written by a duly authorized Physician.

Dispensing Limitations

- (a) 30 day supply or 100 units whichever is greater;
- (b) Maintenance drugs are limited to a one hundred (100) day supply;

- (c) Non steroid anti-inflammatory medication 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.

Limitation on Prescription Card Program

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

- (a) All 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;
- (b) Any drug labeled "Caution: limited by law to investigational use" or "experimental drug";
- (c) Injectable medication;
- (d) Medical supplies or devices;
- (e) Fertility agents, contraceptives (oral, topical and implants), fluoride preparations, anti-obesity drugs, antacids, smoking deterrents, laxatives, cosmetic drugs (Retain A and Rogaine), vitamins (except pre-natal vitamins dispensed by prescription), and reusable needles;
- (f) Over-the-counter medications; or
- (g) Sexual dysfunction medication.

DENTAL CARE BENEFITS

Dental Care Benefits

If an Employee or Dependent receives dental care, excluding Orthodontics, by a Dentist, he will be entitled to an amount equal to 80% (85% for Plans 1 and 1A) of the Eligible Dental Charges in excess of the Combined Deductible shown in the Schedule of Benefits. The Maximum Benefit payable during any one Benefit Period is shown in the Schedule of Benefits.

Deductible

The deductible is the Calendar Year Deductible you must pay before an Individual is entitled to Dental Expense Benefits. The deductible per individual and family, per Benefit Period, is shown in the Schedule of Benefits.

Benefit Period

"Benefit Period" is the period applicable to each person covered. The first Benefit Period will begin on the first day that an Eligible Employee or Dependent is under the care of a Physician for treatment of any Sickness or Injury and shall continue to December 31 of that year. A new Benefit Period for each person covered will begin on January 1 of the following year and continue until December 31 of that year.

Eligible Dental Charges

Eligible Dental Charges include only the charges of a Dentist (or hygienist with respect to prophylaxis) for necessary services and supplies described below:

- (a) Routine oral examination, prophylaxis and X-rays but limited to not more than two (2) examinations per benefit period which are separated by not less than six (6) consecutive months;
- (b) Fillings, extractions and oral surgery;
- (c) Root canal therapy;
- (d) Periodontal treatment and other diseases of the gums and tissues of the mouth;
- (e) Crowns, initial installation of partial dentures and bridges; and
- (f) Initial installation of complete dentures.

Complete Denture Replacement Benefit

Benefits are payable for a portion of the cost for replacement of complete dentures, which is not the result of the theft or loss of a previous denture, provided the Employee has been eligible under the Plan for at least one year prior to such replacement.

No benefits will be paid for any replacement of a previous denture which was paid for under this Plan, either as an initial complete denture or as a replacement, unless the services provided are separated by a period of at least five (5) years in which the Employee was eligible under the Plan.

Exceptions

No benefits shall be paid for dental care and services;

- (a) Resulting from any injury arising from or relating to the occupation of the Individual or one for which benefits are payable under any Worker’s Compensation Act or similar legislation;
- (b) Resulting from war, declared or undeclared, including armed aggression;
- (c) Paid for, furnished by, or at the direction of any government agency, but only to the extent so paid or furnished;
- (d) Paid by the Plan under any other part of the Plan;
- (e) Incurred prior to the date the Employee or Dependent became eligible for benefits under the Plan;
- (f) Incurred after the termination date of eligibility for benefits under the Plan; or
- (g) Which are furnished without charge.

**ORTHODONTIA BENEFITS
(PLANS 1 & 1A ONLY)**

If you or your eligible Dependent incurs expenses for charges by a Dentist for necessary orthodontic treatment which begins while eligible under the Plan, the Plan will pay at eight-five percent (85%) co-insurance an amount not to exceed the Lifetime Maximum Benefit of two thousand dollars (\$2,000) after the Individual Calendar Year Deductible is satisfied. The maximum benefit amount is payable only once during your lifetime and will be paid on a quarterly basis as follows:

- (a) If the treatment period is to last two (2) years or more, one-eighth of the entire charge will be deemed to have been incurred on the day the first treatment is given. Thereafter, one-eighth of the charge will be deemed to have been incurred quarterly up to a maximum of two (2) years, from the date the first charge was incurred; or
- (b) If the treatment period is to last less than two (2) years, the overall charge will be divided by the number of complete three (3) month periods in the treatment period. This divided charge will be deemed to be incurred quarterly during the treatment period, the first such charge occurring on the day the first treatment is given.

Exceptions

No benefits shall be paid for dental care and service;

- (a) Resulting from any injury arising from or relating to the occupation of the individual or one for which benefits are payable under any Workers’ Compensation Act or similar legislation;
- (b) Resulting from war, declared or undeclared, including armed aggression;
- (c) Paid for, furnished by, or at the direction of any government agency, but only to the extent so paid or furnished;
- (d) Paid by the Plan under any other part of the Plan;
- (e) Incurred prior to the date you or your eligible dependent became eligible for benefits under the Plan; or
- (f) Which are furnished without charge.

VISION CARE BENEFITS

If an Employee or Dependent incurs Eligible Expenses made by an Ophthalmologist or Optometrist for a complete eye examination or lenses or for frames purchased in conjunction with and at the same time as new lenses are prescribed, the Plan will pay for such expenses up to the maximum amount shown below.

SCHEDULE OF BENEFITS

<u>Eligible Expenses</u>	<u>Payment</u>
Complete Examination/Not in excess of one in one 12 consecutive month period:	
Ophthalmologist (M.D.)	\$56.00
Optometrist.....	\$40.00
Lens, Pair/Not in excess of one pair in a 12 consecutive month period:	
Single Vision	\$40.00
Bi-Focal RX	\$50.00
Tri-Focal, RX	\$65.00
Lenticular	\$85.00
Frames	
Not in excess of one pair in a 24 month period	\$50.00

Contact Lenses

Benefits for contact lenses will be paid on the basis of that benefit which would have been payable had conventional glasses been purchased. For example, for single vision contact lenses, payment will be made on the basis of that benefit which would have been paid for single vision glasses; i.e., examination, frames, and a pair of single vision lenses.

Limitation – No benefits shall be paid for vision care services for the following:

- (a) Examinations, not otherwise excluded under these Limitations, in excess of one in a twelve (12) consecutive month period;
- (b) Lenses in excess of one pair in a twelve (12) consecutive month period;
- (c) Frames in excess of one pair in a twenty-four (24) month period;
- (d) Sunglasses, and the frames therefore, unless they are prescribed to be worn at substantially all times, by a licensed Ophthalmologist or similar Physician, because of an ocular medical condition;
- (e) Routine yearly examinations required by an employer in connection with the occupation of the individual;
- (f) Expenses resulting from an accidental bodily injury arising out of or in the course of employment or one for which benefits are payable under any Workers' Compensation Act or similar legislation;
- (g) Services paid for, furnished by, or at the direction of any government agency, but only to the extent so paid or furnished;
- (h) Services furnished for which the individual is not required to pay;
- (i) Surgical care of eye diseases or injury
- (j) Radial Keratotomy or Eximer Laser Surgery (except as provided in Laser Eye Surgery Benefit, if applicable);
- (k) Artificial eyes;
- (l) Visual training, reading rate and comprehension studies; or
- (m) Expenses incurred after termination of benefits.

LASER EYE SURGERY BENEFIT (PLANS 1 & 1A ONLY)

If you or your Dependent incurs an expense for outpatient laser eye surgery to correct vision, the Plan will pay for that expense up to a Lifetime Maximum of \$750 per eye. This coverage will be available to all Employees and their Dependents who have been covered for at least three (3) consecutive years immediately prior to the date of the surgery. The coverage is not subject to either the Deductible or the Coinsurance shown in the Schedule of Benefits.

COORDINATION OF BENEFITS

Coordination of Benefits

The Coordination of Benefits provision will be applicable to all the benefits covered under the group health care plan, except the Death and Accident and Sickness Benefits.

Quite frequently, because both husbands and wives are working, members of a family are covered under more than one plan of group benefits. Thus, there are many instances of duplication of coverage. For that reason, a Coordination of Benefits provision has been adopted which will coordinate the benefits payable under other plans, including no fault automobile insurance, other Government Programs and Programs required by law, but excluding Medicare benefits with respect to eligible Active Employees and Dependents.

Under the Coordination of Benefits provision, if an Employee or Dependent is also covered under any other group plan, the total payment received for any one person from all such programs combined may not amount to more than 100% of the Allowable Expenses, or 50% of Allowable Expenses if the Employee fails to follow the Plan's cost containment rules, and as a result, the Plan will pay a reduced benefit. In no event will the amount of benefit paid under the Plan exceed the amount which would have been paid if there were no other plan involved.

An Employee must report duplicate group health insurance coverage on the Statement of Claim which he submits to secure reimbursement of medical expense.

"Allowable Expenses" are any Preferred Provider negotiated fees or Usual and Customary Expenses for Medically Necessary services, treatment, or supplies covered by one of the plans under which the individual is insured.

Order of Determination

In the event two or more of the plans involved do provide a limitation against duplicate benefits, then the "Order of Benefit Determination" shall take precedence.

Sequence of payment by “Order of Benefit Determination” is established as follows:

1. The primary plan for a married Employee is the plan which covers the Employee or Dependent as an Employee or as the certificate holder.
2. The primary plan for child(ren)’s expenses when the parents are not separated or divorced shall be determined by the birth dates, excluding year of birth, of the parents. The parent whose month and day of birth is earlier in the year shall be the primary plan. If the other plan does not have a rule similar in intent to this, then the plan covering the father as an Employee will pay first and the plan covering the mother will pay second.
3. For child(ren)’s expenses when the parents are separated or divorced, if there is a court decree that establishes responsibility for the financing of medical, dental, or other health care expenses with respect to the children, the benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has remarried, the primary plan is the plan of the parent with custody, secondary plan is the step-parents, and the third plan is the plan of the parent without custody.
4. If the rules above do not create an Order of Benefit Determination, the primary plan will be the one that has covered the person for the longer period of time, with the following exception:

If the other plan lacks a Coordination of Benefits provision, it is the primary plan.

Subrogation (Assignment of Rights) and Contract of Reimbursement

The Trustees of this Plan seek to conserve the assets of the Plan by imposing the expense for accidental injuries suffered by Employees and Dependents on those responsible for causing the injury. The Trustees claim the right of first reimbursement by an Employee or Dependent even if the Employee or Dependent is not made whole. Medical and disability benefits are not payable to or for a person covered under this Plan when the injury or illness to the Employee or Dependent occurs through the act or omission of a third party. However, payment for medical expenses incurred by an Employee or a Dependent for an injury or illness occurring through the act or omission of another person may be advanced by the Plan. For this to occur, the Employee or Dependent, or in the case of a minor, the parent or guardian, must sign an agreement to repay to the Plan in full any payments, which this Plan may advance for medical expenses, to the extent the Employee or Dependent receives payment from any third party, or its agent by judgment, settlement, or in any other fashion. Upon

refusal by any Employee or Dependent required by the Plan to sign the agreement to repay any monies as described above, the payment that has accrued to that date may be withheld until the necessary documents of assignment and contract or subrogation, as the case may be, are executed. If the Employee or Dependent is represented by an attorney in reference to the injuries, the attorney may be required to execute an agreement that all monies received on behalf of the Employee or Dependent will first be applied to satisfy the payments advanced by this Plan to pay the medical care expenses of the Employee or Dependent. If a dispute arises, the sums may be held in escrow until resolution.

In the event of any payment of benefits under this Plan, the Plan shall be subrogated to all the rights of recovery of either an Employee or a Dependent against any person or entity and the Employee or Dependent shall execute and deliver instruments, documents, papers and whatsoever else is necessary to secure such rights including, but not limited to, an additional Subrogation Agreement. Neither the Employee nor the Dependent shall do anything after a loss to prejudice such rights.

If requested in writing by the Trustees, their Administrative Manager or Legal Counsel, the Employee or Dependent shall take, through any representative designated by the Trustees, such action as may be necessary or appropriate to recover such payment as damages from any person or entity with the action to be taken in the name of the Employee or the Dependent. In their sole discretion, the Trustees reserve the right to prosecute an action in the name of the Employee or Dependent against any third parties and/or entities potentially liable to the Employee or Dependent in an effort to recover monies paid by the Plan; or to intervene in the name of the Trustees into any legal proceeding initiated by the Employee or Dependent against any third parties and/or entities.

Upon any payment of benefits under this Plan, a lien shall be established upon any action on behalf of the Employee or Dependent against any person or entity allegedly or legally responsible for the injury or illness for which such payment was made. The Plan shall be entitled, to the extent of any payments made to or on behalf of an Employee or Dependent, to the first reimbursement of monies from the proceeds of any settlement, judgment or other recovery that may result from the exercise of any rights of recovery asserted by or on behalf of any Employee or Dependent against any person or entity allegedly or legally responsible for the injury or illness for which such payment was made. The Plan shall be reimbursed an amount of money equal to all sums paid by the Plan on behalf of the injured Employee or Dependent and all expenses, costs and attorneys’ fees incurred by the Plan in connection with the prosecution and collection of the Plan’s subrogation interest. The right is given to the Trustees to receive from any third party(ies), attorney(s) insurance company(ies) an amount equal to the amount paid to or on behalf of the Employee or Dependent. These obligations and rights are without regard to and supersede any

common, statutory or codified laws or legal theories that purport to limit, reduce or eliminate the contractual subrogation rights of the Plan including, but not limited to, the “make whole doctrine,” “common fund” or other federal or state “common law” theories, or any similarities or variances thereof.

Amounts recovered in excess of the Plan’s current reimbursement and costs may be paid to the Employee or Dependent, but such excess shall apply as a credit against liability of the Plan for further payment to or on behalf of the Employee or Dependent, which has arisen or may arise from the injury to injuries, illness or illnesses that form the basis of the claim asserted by or on behalf of the Employee or Dependent.

In the event any monies are received by the Employee or Dependent in relation to any injury received because of the act or omission of a third party, from whatever source, and payment is not made to this Plan, the Trustees may deny or withhold payment until the assignment or contract of reimbursement or subrogation, as the case may be, is discharged,

The Employee and/or the Dependent shall cooperate with the Trustees, Administrative Manager and Legal Counsel to provide all documentation required by the Plan and the Administrative Manager. This includes prior notification of any settlement or disposition of any claim and the filing of any lawsuit related to the claim. The claimant shall also provide the Plan with a copy of any insurance policies involved.

Any controversy or claim arising under this provision shall be resolved by final and binding arbitration administered in accordance with the American Arbitration Association Commercial Arbitration Rules or another comparable organization and rules to which the Employee or Dependent and the Plan agree. Judgment upon any award rendered by the arbitrator may be entered in any court having jurisdiction. This provision does not limit the claims review procedure available to the Employee or Dependent that may be required prior to arbitration.

The Trustees shall have the absolute discretion to settle Subrogation claims on any basis they deem warranted and appropriate under the circumstances.

Coordination of Benefits with Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended. Medicare benefits are available only in the United States. Resident aliens are eligible for Medicare only if they are eligible for Social Security benefits or they have lived in the United States for at least five (5) years.

Hospital and Medical Expense Benefits for persons age 65 or older are available through Medicare. If an Employee or Dependent becomes disabled at any age, they may also be eligible for Medicare benefits after they have been entitled to Social Security Disability Benefits for at least twenty four (24) consecutive months.

Because benefits may not be duplicated, benefits provided under the

Welfare Plan may be coordinated with any Medicare benefits the Employee or Dependent is entitled to receive by virtue of actual enrollment for Medicare benefits.

There is no charge for Part A but there is a charge for Part B. Contact the Social Security Office for details on cost.

Employees or Dependents become eligible for Medicare Part A (Hospital Benefits) and Part B (Medical Benefits) on the first day of the month in which they turn age 65. However, to be eligible for Medicare Part B benefits, the Employee or Dependent must enroll within three (3) months prior to their 65th birthday but no later than three (3) months after their 65th birthday in order to become covered on a timely basis with no delays. If there are any questions about Medicare enrollment, please contact the local Social Security Office.

The Order of Benefit Determination shall be:

1. For the Eligible Employee – The Plan has primary responsibility for the Employee’s claims, if all of the following apply:
 - (a) the Employee is age 65 or older;
 - (b) the Employee is eligible for Medicare Part A solely because of age; and
 - (c) the Employee is actively employed.

The Plan has secondary responsibility for the Employee’s claims when he or she is eligible for Medicare Part A because of age, if the Employee is not actively employed.

2. For Dependent Spouse – The Plan has primary responsibility for the claims of the Employee’s Dependent spouse, if all of the following apply:
 - (a) the spouse is age 65 or older;
 - (b) the spouse is eligible for Medicare Part A solely because of age; and
 - (c) the Employee is actively employed.

The Plan has secondary responsibility for the claims of the Employee’s Dependent spouse when the spouse is eligible for Medicare Part A because of age, if the Employee is not actively employed.

As long as the Employee or Dependent remains actively employed and eligible under this Plan, all other benefits provided under the Plan will remain fully in force, whether or not they are eligible for the health benefits provided by the Medicare Program

Coordination of Benefits with State and Federal Programs other than Medicare

If an Employee or eligible Dependent is eligible for coverage under a governmental health benefit program or a program established under a state or federal statute, whether or not election has actually been made to obtain such coverage, the amount of benefits payable under this Plan will be coordinated so that the total amount of benefits paid by both plans shall not exceed 100% of the Usual and Customary expenses covered under this Plan.

Benefits will be paid first by the other plan, unless otherwise declared by law, after which this Plan will make their coordinated benefit payment. In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if no other plan was involved.

Women's Health and Cancer Rights Act

Effective October 21, 1998 and after, as required by the Women's Health and Cancer Rights Act, coverage will be provided to a member who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy for:

1. reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the other medical and surgical benefits.

Newborns' and Mothers' Health Protection Act (NMHPA)

This plan will 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 may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, this plan 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, the plan 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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, the participant may be required to obtain precertification.

Family and Medical Leave Act of 1993 (FMLA)

If your Employer has employed at least 50 employees during 20 weeks or more of the current or preceding calendar year, you may be eligible to take FMLA Leave. However, if you are employed at a worksite within a 75 mile distance at which your Employer does not employ at least 50 employees, you will not qualify for leave even though the Employer's total workforce is more than 50. To qualify for leave you must have been employed by *the same contributing Employer* for a minimum of 1,250 hours within the 12 months immediately preceding the commencement of your FMLA Leave. If you qualify for such leave, you may take up to a total of 12 workweeks of FMLA Leave during any 12-month period.

Under What Circumstances Can You Take FMLA Leave?

You may take FMLA Leave for any of the following reasons:

1. for the birth and care of a newborn child;
2. for the placement of a newly adopted child or foster child;
3. for the care of your spouse, son, daughter or parent with a "serious health condition"; or
4. for your "serious health condition" that makes you unable to perform your job.

Generally, a “serious health condition”, as defined under FMLA, is an illness, injury, impairment or physical or mental condition that involves any period of incapacity or treatment in connection with inpatient care in a hospital, hospice or residential medical care facility; or any period of incapacity of more than three (3) calendar days that involves the continuing treatment by a health care provider; or continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that if untreated will result in a period of incapacity of more than three (3) calendar days.

If you are considering taking FMLA Leave, you and your Employer should contact the Plan Office to receive a copy of the Plan’s policies and administrative procedures and the necessary forms to assure that you receive continued health coverage during your FMLA Leave.

Uniformed Services Leave of Absence (USERRA)

If an Employee enters a uniformed services leave of absence (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard), any service he has earned and any contributions credited to his benefit with respect to Initial Eligibility shall, to the extent required under USERRA, be protected during his uniformed services leave of absence if he returns to work or seeks re-employment with an Employer within ninety (90) days following an honorable discharge. If, however, the Employee is not honorably discharged or does not return to work or seek re-employment within such ninety (90) day period, he will forfeit his credited service and contributions. Employees are obligated to notify the Fund as soon as they are called up for uniformed service and again when they are discharged, and to present written proof of the term of their uniformed service and honorable discharge, to ensure protection of their rights under USERRA.

If an Employee is covered under the Plan at the time his uniformed services leave of absence commences, his and his Dependents’ coverage under the Plan will terminate immediately, except that he may continue his medical benefits coverage for the period of his leave up to a maximum of 18 months. If the leave exceeds 31 days, he must pay for such continued coverage in the amount of the COBRA self-payment rates. An Employee’s right to maintain and reinstate coverage by reason of a uniformed services leave of absence, will be administered and interpreted by the Plan in accordance with the requirements of USERRA. The contributions, if any, credited to the Employee or accumulated in his Hour Bank will be kept in the records of the Plan during his uniformed services leave of absence, his and his Dependents’ coverage will be reinstated upon his re-employment with an Employer within the time period protected under USERRA. If he does not return to work with a Contributing Employer within 90 days from the date of an honorable discharge, he will be considered a new Employee and required to satisfy the requirements in “Initial Eligibility – New Employees.”

CLAIMS PROCEDURE, CLAIMS REVIEW PROCEDURE AND MISCELLANEOUS

Application for Benefits

Written notice of claim and proof of loss acceptable to the Plan must be given to the Plan Office within 90 days after the expense or loss was incurred. The Trustees may require, as part of the proof, authorization to obtain medical and non-medical information. For example, if a Hospital expense is incurred, all or part of which is payable under this Plan, application for payment must be made within 90 days after the expense is incurred. It is the responsibility of the participant to obtain promptly statements and bills from providers and to file application for benefits within the time required. The Trustees may permit an extension of the 90-day deadline if they deem it to be reasonably necessary under the circumstances; however, in no event will any claims submitted more than 12 months after the date the expense or loss was incurred be covered under the Plan. In the case of death benefits, proof of death should be submitted with the application for benefits within 90 days after the date of the Employee's death. It is the responsibility of the beneficiary or the representative of the decedent's estate to obtain the required proof of death and to make application for benefits within the time required. Failure to file a claim in accordance with these requirements will result in non-payment.

Payment

All benefits will be paid upon receipt and verification of written proof on forms furnished by the Fund, covering occurrence, character and extent of the event for which claim is made. The Trustees in their discretion may require a claimant to submit proof of each charge as well as a statement from the treating physician as to the service rendered and the charge for those services.

Benefits for Hospital charges and Physician’s fees may be assigned to the Hospital or Physician by the execution of a written assignment by the claimant. Except where a written assignment is received by the Fund or where the Fund guarantees payment of Hospital or Physician’s fees, all benefits shall be paid to the Employee.

If an Individual, in the Trustee’s opinion, is not capable of giving a valid receipt for payments due and no guardian has been appointed for such a person, the Trustees may make payment to the Individual(s) who, in their opinion, has assumed care and principal support of the Individual. If the Individual should die before all amounts that are due have been paid, the Trustees may, at their option, make payment to the executor or administrator of the estate of the Individual or to his surviving spouse, parent, child(ren), or to any Individual who, in the Trustee’s opinion, is entitled to benefits.

Any payments that are made by the Trustees in accordance with these provisions discharge the liability of the Trustees to the extent of the payments.

Under any circumstances where a claim is overpaid by the Plan, the Plan has the right to recover the overpayment from the Employee or to deduct overpayment from future claims. Under the provisions of Coordination of Benefits with other Insurance Carriers, the Plan has the right to recover any excess payments made which should have been made by other insurers under the Coordination of Benefits provisions for any excess payment made by the other company when their position is secondary carrier and the Plan is obligated as primary carrier.

CLAIMS REVIEW OR APPEAL

Claims Review Procedures

If a claim is wholly or partially denied, the Trustees shall notify the claimant of the adverse benefit determination within a reasonable period of time not to exceed 60 days, or 45 days for a claim for disability benefits, after receipt of the claim by the Trustees, without regard to whether all information necessary to make a determination accompanies the filing.

The notice will include the following:

1. Specific reason(s) for the determination.
2. Reference to the specific Plan provision(s) on which the determination is based.
3. A description of any additional material or information necessary to perfect the claim and the reasons why it is needed.
4. A copy of the Review Procedure.
5. A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse determination on review.
6. With regard to disability benefits, if an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol or criterion, or a statement that it was relied upon and that a copy will be provided free of charge upon request.
7. With regard to disability benefits, if the determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the Plan to the claimant's medical circumstances, or a statement

confirming that such statement will be provided free of charge upon request.

Review Procedure

1. In the case of a claim involving Urgent Care, the Plan shall notify the Employee of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of the Plan's receipt of the claim, unless the Employee fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan shall notify the Employee as soon as possible, but not later than twenty-four (24) hours after the Plan's receipt of the claim, of the specific information necessary to complete the claim. The Employee shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours to provide the specified information. The Plan shall notify the Employee of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded the Employee to provide the specified additional information.
2. Where there has been an adverse benefit determination, the claimant may appeal the determination in accordance with this procedure and have a review.
3. Within 60 days, or 180 days for disability benefits, after receipt of the determination, the claimant or his representative may make a written request for a review to the Board of Trustees, Southeastern Ironworkers Health Care Plan. If the claimant fails to make a timely request for review, the initial decision on the claim shall be final. If a timely request for review is made, the claimant may submit written comments, documents, records and other information relating to the claim. The claimant may also obtain, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information "relevant" to his claim and, for disability benefits, identification of any medical or vocational experts whose advice was obtained by the Plan. A document, record or other information is "relevant" to the claim if (i) it was either relied upon in making the determination or it was submitted, considered or generated in the course of making the determination; or (ii) it relates to administrative processes and safeguards used to ensure and verify that claim determinations are consistent with the Plan and consistently applied with respect to similarly situated claimants; or (iii) in the case of

disability benefits it is a statement of Plan policy or guidance concerning the denied benefit without regard to whether it was relied upon.

4. With regard to a claim for disability benefits, no deference shall be given to the initial determination. If the initial determination is based in whole or part on a medical judgment, the individual deciding the appeal shall consult with a health care professional, with appropriate medical training and experience, who was not consulted in connection with the initial determination and who is not a subordinate of any individual who was consulted.
5. A decision on appeal shall be made promptly and no later than 60 days, or 45 days with respect to a claim for disability benefits, after the request for appeal is received. The decision on review shall be in writing and shall set forth the following information; (i) the specific reasons for the decision on review; (ii) a reference to the specific Plan provisions on which the determination is based; (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information "relevant" to the claim and a statement of the claimant's right to bring an action under ERISA Section 502(a); and (iv) for disability benefits, any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination or a statement that it was relied upon and that a copy will be provided free of charge upon request.
6. A decision on review shall be final and binding.

No legal action may be commenced or maintained against the Plan or Fund, or to recover any benefits under the Plan, unless the participant (or his legal representative, if any) has first fully complied with and timely exhausted all of the application of benefits, claims review procedures and review procedures under the Plan, and in no event may any such action be brought later than 120 days following the Trustees' final decision on review or, if 120 days is not reasonable under the circumstances, such extended time that is reasonable not to exceed, if any event, one (1) year following the Trustees' final decision on review.

Arbitration

If a claim is denied on appeal, a remedy to resolve a claim is with binding arbitration administered under the American Arbitration Association Commercial Arbitration Rules or another comparable organization's rules to which the employee or dependent and the Plan agree. Your request for arbitration must be submitted within ninety (90) days after the Claimant

receives written notice that the appeal was denied. The Claimant or his representative shall make a written request for arbitration to the Board of Trustees, Southeastern Iron Workers Health Care Plan c/o Zenith Administrators at the address on the inside front cover of this book. The arbitrator may grant the appeal, in whole or in part, only if the arbitrator determines that the appeal is justified because there was an error on an issue of law, the Plan acted arbitrarily and capriciously in denying the claim, or the Plan's finding of facts was not supported by the evidence.

Miscellaneous

- A. Law Applicable – This Plan is created in the State of Georgia and all questions pertaining to the validity or construction of the Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Georgia, except as to matters governed by Federal Law or Regulations.
- B. Savings Clause – Should any provisions of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Plan.
- C. Construction – All questions of interpretation of this Plan shall be decided by the Trustees under the express authority granted to them by the Restated Agreement and Declaration of Trust as may be amended from time to time. The Trustees shall be the sole arbiter of all questions arising under or out of this Plan, including those of Plan interpretation, eligibility, and the amounts of benefits. This Plan is intended to comply with the terms and conditions of the Agreement and Declaration of Trust as may be amended from time to time. The Trustees reserve the right to amend this Plan as they deem necessary.
- D. Gender – Except as the context may specifically require otherwise, use of masculine (feminine)gender shall be understood to include both masculine and feminine genders.
- E. False or Erroneous Claims –The Trustees may withhold or deny payment of any claim which they determine may be based on erroneous or misstated fact or representations by any claimant or provider of covered services or supplies, and shall have the right to recover any payments made on the basis of such false or erroneous representation.
- F. Qualified Medical Child Support Orders – Benefits shall be paid in accordance with a Qualified Medical Child Support Order as defined in

Section 609 of the Employee Retirement Income Security Act of 1974 as amended (ERISA), and with written procedures adopted by the Trustees in connection with such Orders, which shall be binding on all other participants, beneficiaries and other parties. In no event shall the existence or enforcement of a Qualified Medical Child Support Order cause the Fund to pay enforcement with respect to a participant which requires the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to the medical child support including the exclusion of any pre-existing provision. This law is described in Section 1908 of the Social Security Act (as added by Section 13823 of the Omnibus Budget Reconciliation Act of 1993).

G. Effect of Medicaid Coverage

1. Payment for benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or beneficiary of the Participant as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912 (a) (1) (A) of such Act, as in effect of August 10, 1993.
2. In enrolling an Individual as a Participant or beneficiary or in determining or making any payments for benefits of an Individual as a Participant or beneficiary, the fact that the Individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.
3. To the extent payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

AMENDMENT AND TERMINATION

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Employees, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time but upon a non-discriminatory basis:

- (a) to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued;
- (b) to alter or postpone the method of payment of any benefit; and
- (c) to amend or rescind any other provisions of the Plan's Rules and Regulations and Summary Plan Description.

Circumstances under which the Plan may be terminated include, but are not limited to:

- (a) When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;
- (b) When there are no longer any employers who are required to make contributions under the appropriate Collective Bargaining Agreement or other written agreement;
- (c) When the last surviving participant or beneficiary entitled to receive benefits has died;
- (d) With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement;
or
- (e) With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees shall, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED

As a Participant in the Southeastern Ironworkers Health Care 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:

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 Pension and Welfare Benefit 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.

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

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 (pension, 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 right. 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 the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

PLAN DOCUMENT

The foregoing explanation of the Plan is no more than a brief and very general statement of the most important provisions of the Plan Document. No general statement such as this can adequately reflect all of the details of the Plan. We have tried to write this explanation in clear, understandable and informal language. Nothing in this statement is meant to interpret, extend or change in any way the provisions of the Plan itself.

Therefore, your rights can only be determined by consulting the actual text of the Plan. You may inspect a copy of the Health Care Plan in the office of the Administrative Manager during the hours of 8:30 a.m. to 4:30 p.m. Monday through Friday or obtain a copy of the Plan upon request.

IMPORTANT INFORMATION ABOUT YOUR HEALTH CARE PLAN

Plan Administrator

A Board of Trustees is responsible for the administration of this Health Care Plan. The Board of Trustees consists of Employee and Employer representatives, selected by the Union and the Employers who have entered into collective bargaining agreements which relate to the Health Care Plan. The names and addresses of the Trustees are as follows:

Employee Trustees:

Philip C. Lee, Chairman
Ironworkers Local 601
7326 Pepperdam Avenue
North Charleston, SC 29418-8433

Edward D. Dees
Ironworkers Local 397
P.O. Box 18
Mango, FL 33550

Dean Dryden
Ironworkers Local 387
109 Selig Drive
Atlanta, GA 30336

Sean P. Mitchell
Ironworkers Local 402
1001 West 15th Street
Riviera Beach, FL 33404

Alan Parker
Ironworkers Local 808
200 East Landstreet Rd.
Orlando, FL 32824

Dewey L. Tyler
Ironworkers Local 272
1201 NE 7th Avenue
Ft. Lauderdale, FL 33304

Employer Trustees:

Mark S. Wood, Secretary
Milton J. Wood Co.
P.O. Box 52088
Jacksonville, FL 32201

Wes Atkison
Coreslab Structures
10501 NE 121 Way
Medley, FL 33178

Tony Crump
Williams Erection Company
P.O. Box 756
Smyrna, GA 30081

Michael J. Edwards
Southeastern Council of
Ironworkers Employers, Inc.
5585 Donnelly Circle
Orlando, FL 32821

Billy Sheffield
Met-Con, Inc.
P.O. Box 910
Cocoa, FL 32923-0910

R. L. Taylor
R. L. Taylor, Inc.
P.O. Box 72075
Charleston, SC 29415

Tommy Tyler
Ironworkers Local 597
9616 Kentucky St.
Jacksonville, FL 32218

Conrad Varnum
Central Maintenance
And Welding, Inc.
P.O. Drawer 216
Lithia, FL 33547

Edgar West
Ironworkers Local 709
409 Grange Road
Port Wentworth, GA 31407

Plan Administration

The administrator of the Plan is Zenith Administrators, Inc.

Identification Number

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 63-0334002.

Plan's Fiscal Year End

The date of the end of the Plan Year is January 31.

Source of Contribution

The amount of employer contributions is determined by the provisions of their collective bargaining agreements with employee representatives.

Agent for Service of Legal Process

The Plan's agent for service of legal process is:

Norman J. Slawsky, Esq.
Jacobs, Slawsky & Barnett
Attorneys At Law
100 Peachtree Street, Suite 1950
Atlanta, GA 30303

Funding Medium

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

Fund Assets

All assets and reserves are invested by an Investment Manager retained by the Board of Trustees.

Plan Information

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are briefly described in this booklet.

Plan Termination

The right to terminate the Plan is reserved by the Board of Trustees and by the Employers and the Union who are signatory to the Plan's Trust Agreement. Circumstances under which the Plan may be terminated include, but are not limited to:

- (a) When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan's benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;
- (b) When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;
- (c) When the last surviving Participant or beneficiary entitled to receive benefits has died;
- (d) With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when that Employer is declared by the Board of Trustees to be in default; or
- (e) With respect to a particular employer, when that employee ceases to be an eligible employee according to the Plan's Rules and Regulations.

If the Plan terminates, the Board of Trustees will within the limits of Plan's resources adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

Filing Claims

See "How to File a Claim" on page 71 for information on filing claims.

Appeal of Denied Claims

See "Claims Review Procedures" on page 72 for information on appealing denied claims.

IMPORTANT

It is important that you notify the Plan Office whenever:

- 1. You change your home address.**
- 2. You wish to change your beneficiary.**
- 3. You are receiving Workers' Compensation Benefits.**
- 4. You enter or return to work after disability ceases.**
- 5. You get married, separated or divorced.**
- 6. You have a new dependent.**
- 7. You become totally disabled.**
- 8. You have qualified for COBRA (See page 17).**
- 9. You are injured due to an accident for which someone else is responsible.**
- 10. You enter or are discharged from the Armed Services.**
- 11. You are moving from or to another Health Plan.**

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