LETTER FROM THE BOARD OF TRUSTEES

To: ALL ELIGIBLE PARTICIPANTS

This booklet and Summary Plan Description describe the Comprehensive Benefit Program available to you and your qualified dependents under the Southeastern Iron Workers Health Care Fund. The Trust Fund is maintained pursuant to Collective Bargaining Agreements between participating Locals and Employers signatory to Collective Bargaining Agreements with these Locals. You may obtain copies of the Collective Bargaining Agreement upon written request from the Local Union.

The Fund's primary purpose is to provide Health Care benefits to you and your qualified dependents. These benefits will be provided promptly upon submission of a properly completed claim form and all other necessary information required for the processing of the claim.

The cost of the benefits provided by your Health Care Plan is being borne by your employers through contributions made on your behalf to the Southeastern Iron Workers Health Care Fund as required by the Collective Bargaining Agreement and the Agreement and Declaration of Trust.

The Board of Trustees has retained Southern Benefit Administrators, Inc. (SBA) to handle the routine administrative duties for the efficient operation of the Fund. In addition to handling all administrative functions, SBA is responsible for processing all medical and dental claims. Please be sure your providers know this change has been made.

We will continue to use CIGNA's OAP Network. Please remember that although the Plan uses CIGNA's OAP Network, CIGNA does not provide any insurance. Medical, Dental and Vision Benefits are fully self-funded. Benefits are paid directly from the Fund's assets. Because of the "unlimited" maximum medical benefits the Fund has purchased stop-loss insurance coverage to protect the Fund from catastrophic claims.

It is important that you provide Southern Benefit Administrators with enrollment information. This will make it easier for you to use the Plan when necessary. You will also be asked to designate a beneficiary for the Death benefits. You should contact SBA to update their records when you change addresses, get married, have a baby, divorced, retire, become disabled, or have a dependent reaching the limiting age. You should also contact SBA when your coverage is terminated.

This booklet has been written in everyday language to summarize the benefits, rights and obligations you have under your Plan. We hope you will find this information helpful and will discuss it with your family. If you have any questions, or if you would like to discuss the details further, SBA, or the Board of Trustees, will be glad to help you. You can be assured that the Board of Trustees will do everything possible to maintain the Health Care Fund on a sound and effective basis, so that the best benefits available can be provided for you and your qualified dependents.

THE BOARD OF TRUSTEES

IMPORTANT PHONE NUMBERS AND WEBSITES

If you need information about your Health Care Plan, please use the following guide to help you determine whom to contact:

Pre-Admission Certification (PAC)

- The Hospital, your Physician or you should call **1-800-768-4695** or the number on the back of your ID card. Please see page 30 for information on this Plan's PAC requirements.

Contact CIGNA at 800.768-4695 if:

- You need to locate an in-network provider.
- You wish to contact Case Management about your medical needs.
- You can also access information, search for network providers, research health issues and much more at **www.cignasharedadministration.com**.

U.S. Imaging (877) 874-6385

* Have your doctor refer necessary x-rays to U.S. Imaging.

ADMINISTRATIVE OFFICE CUSTOMER SERVICE

Contact the Administrative Manager (SBA) at **800.831.4914** if:

- You need a replacement ID card.
- You have a question about a medical, dental, vision or prescription drug claim.
- You have a question about eligibility for you or a dependent.
- You have a question about Death or AD&D Claims.
- You have a question about payment of Retiree, Self-Pay or COBRA contributions.
- There is a problem with the eligibility/dependent information shown on your ID cards.
- You are receiving Workers' Compensation Benefits.
- There is a problem with an unresolved issue with CIGNA.

NOTE: Beginning October 1, 2015 Southern Benefit Administrators is responsible for handling claims processing and payment regardless of when bills were incurred.

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SCHEDULE OF BENEFITS – ACTIVES (PLAN A-1)

PLAN A-1 IS APPLICABLE TO ACTIVE PARTICIPANTS AND
DEPENDENTS FROM ALL LOCALS EXCEPT LOCAL 387
(Effective February 1, 2016 Local 387 is included under this Schedule)

BENEFITS FOR ACTIVE EMPLOYEES ONLY

DEATH BENEFIT……………………………………………………………………………… $8,500.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT – PRINCIPAL SUM … $8,500.

MAJOR MEDICAL BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE

CIGNA OPEN ACCESS PLUS (OAP) NETWORK

CALENDAR YEAR DEDUCTIBLE

PER INDIVIDUAL………………………………………………………………………… $500.
PER FAMILY ……………………………………………………………………………… $1,000.
Inpatient Hospital Deductible – Per Admission…………………………….. $ 200.
Outpatient Hospital Surgical Deductible – Per Occurrence ……………… $ 200.
Does not apply to surgery in a OAP Primary Care Physician's office
Emergency Room Deductible – Per Occurrence ………………………………….. $ 200.
Waived if inpatient admission occurs directly from ER

MAXIMUM BENEFIT PAYABLE ……………………………………………………………… UNLIMITED

MAXIMUM OUT OF POCKET EXPENSES - EFFECTIVE - June 1, 2015

In Network Medical
Per individual …………………………………………………. $5,350
Per Family ……………………………………………………… $10,700
Non-Network………………………………………………………………….. Not Covered

Inpatient Hospital Room & Board Benefit

Daily Maximum Charge Allowed ……………………………………. Semi-Private

COINSURANCE PERCENTAGES Plan Pays

In-network Office Visits – after co-pays……………………………….. 100%
Other Covered In-Network charges – after deductibles……………… 75%
Emergency (In-Network or Non-Network) – after deductibles …… 75%
In-Network/Emergency after reaching out-of-pocket maximum… 100%
Other Non-Network ………………………………………………………….. Not Covered

MAJOR MEDICAL BENEFITS – EMPLOYEE AND DEPENDENTS - CONTINUED

In-Network Office Visit copays

Primary Care Physician (PCP)………………………………	$30 Copay
CIGNA Care Network (CCN) Specialist ……………………	$40 Copay
Other Specialist (Non-CCN) …………………………………	$50 Copay

In-Network Chiropractic

Office Visit Copay – Chiropractor ………………………..	$25 Copay

In-Network Preventative Care Services

All PPACA Mandated Preventative Care ………………..	Plan pays 100% No deductibles or copays

In-Network Mental Health/Substance Abuse Related Services

Mental Health Office Visit Copay …………………………	$30 Copay
Mental Health Inpatient Services ……………………	Plan pays 75%, after deductibles
Mental Health Outpatient Services …………………	Plan pays 75%, after deductibles
Alcohol/Substance Abuse Related Services……..	Not Covered

Notes:

- Failure to pre-certify a Hospital Admission, Outpatient Surgery or Advanced Imaging procedure will result in a reduction or denial of benefits payable.
- Primary Care Physicians (PCP) include General and Family Practitioners, Internists, Pediatricians or Gynecologists only.

PRESCRIPTION DRUG CARD BENEFITS –EMPLOYEE AND DEPENDENT COVERAGE

Provided Through Participating CIGNA Network Pharmacies

Calendar Year Deductible ………………………………………….	None
Maximum Out-of-Pocket - Effective June 1, 2015…………	$1,000. Individual $2,000. Family

In-Network Copays	Retail Pharmacy	Tel-Drug Mail Order
PPACA Mandated Preventative Care Drugs	$0 Copay	$0 Copay
Tier 1 Generic Drugs	$10 Copay	$25 Copay
Tier 2 Brand Drugs	Lesser of 30% or $35	Lesser of 30% or $87.50
Tier 3 Brand Drugs	Lesser of 40% or $75	Lesser of 40% or $187.50
After Maximum Out-of-Pocket	$0 Copay	$0 Copay
Maximum Days Supply	30 days	90 Days

Notes:

- Contact CIGNA for a list of Tier 2 Brand Drugs.
- Coverage for certain Brand Drugs may be subject to Step Therapy Programs.
- Plan does not cover non-sedating antihistamines, H2 antagonists or proton pump inhibitors.
- Per CIGNA's formulary provisions there are some drugs not covered by the Plan. Contact CIGNA to determine if your drug is covered.

DENTAL BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE
CIGNA Dental PPO Network

Calendar Year Deductible – Per Individual	
In-Network	$50.00
Non-Network	$75.00
Maximum Benefit Payable per Calendar Year	$800.00
In-Network Coinsurance	
Class I – Preventative Care	100%, no deductible
Class II – Minor Restorative	70%, after deductible
Class III – Major Restorative	50%, after deductible
Non-Network Coinsurance	
Class I – Preventative Care	50%, no deductible
Class II & III – Minor and Major Restorative	50%, after deductible

Notes:

- Class I includes prophylaxis, standard fluoride treatments, examinations, and reasonable x-rays.
- Class II includes amalgam or other comparable fillings and simple extractions of teeth.
- Class III includes crowns, bridges and dentures.
- Treatment of TMJ and orthodontics are not covered by the Plan.
- Maximum Benefits Payable per Calendar Year does not apply to Essential Pediatric Dental Benefits, which includes Class I – Preventative Care Services for participants under age 19.

SCHEDULE OF BENEFITS – ACTIVES (PLAN B-1)

PLAN B IS APPLICABLE TO ACTIVE PARTICIPANTS AND DEPENDENTS FROM LOCAL 387
(Beginning February 1, 2016 Local 387 will be under Plan A-1)

BENEFITS FOR ACTIVE EMPLOYEES ONLY

DEATH BENEFIT ……………………………………………………………………………… $8,500.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT – PRINCIPAL SUM … $8,500.

MAJOR MEDICAL BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE

CIGNA OPEN ACCESS PLUS (OAP) NETWORK

CALENDAR YEAR DEDUCTIBLE

PER INDIVIDUAL…………………………………………………………………………… $1,000.
PER FAMILY …………………………………………………………………………… $2,000.

Inpatient Hospital Deductible – Per Admission…………………………… $ 200.
Outpatient Hospital Surgical Deductible – Per Occurrence ……………… $ 200.
Does not apply to surgery in a OAP Primary Care Physician's office
Emergency Room Deductible – Per Occurrence …………………………………. $ 200.
Waived if inpatient admission occurs directly from ER

MAXIMUM BENEFIT PAYABLE ………………………………………………………………… UNLIMITED

MAXIMUM OUT OF POCKET EXPENSES - EFFECTIVE June 1, 2015

In Network Medical
Per individual …………………………………………………… $5,350
Per Family (Class I only)……………………………………….. $10,700
Non-Network………………………………………………………………….. Not Covered

Inpatient Hospital Room & Board Benefit

Daily Maximum Charge Allowed ……………………………………. Semi-Private

COINSURANCE PERCENTAGES	Plan Pays
In-network Office Visits – after co-pays………………………………..	100%
Other Covered In-Network charges – after deductibles………………	60%
Emergency (In-Network or Non-Network) – after deductibles ……	60%
In-Network/Emergency after reaching out-of-pocket maximum…	100%
Other Non-Network ……………………………………………………….	Not Covered

MAJOR MEDICAL BENEFITS – EMPLOYEE AND DEPENDENTS - CONTINUED

In-Network Office Visit copays

Primary Care Physician (PCP)………………………………….	$30 Copay
CIGNA Care Network (CCN) Specialist …………………….	$40 Copay
Other Specialist (Non-CCN) ……………………………………	$50 Copay

In-Network Chiropractic

Office Visit Copay – Chiropractor ………………………….	$25 Copay

In-Network Preventative Care Services

All PPACA Mandated Preventative Care ………………..	Plan pays 100% No deductibles or copays

In-Network Mental Health/Substance Abuse Related Services

Mental Health Office Visit Copay ……………………………	$30 Copay
Mental Health Inpatient Services ……………………	Plan pays 60%, after deductibles
Mental Health Outpatient Services …………………	Plan pays 60%, after deductibles
Alcohol/Substance Abuse Related Services……..	Not Covered

Notes:

- Failure to pre-certify a Hospital Admission, Outpatient Surgery or Advanced Imaging procedure will result in a reduction or denial of benefits payable.
- Primary Care Physicians (PCP) include General and Family Practitioners, Internists, Pediatricians or Gynecologists only.

PRESCRIPTION DRUG CARD BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE

Provided Through Participating CIGNA Network Pharmacies

Calendar Year Deductible – Per Individual………………………..	$ 50
Maximum Out-of-Pocket – **Effective June 1, 2015** ……………	$1,000. Individual $2,000. Family

In-Network Copays	Retail Pharmacy	Tel-Drug Mail Order
PPACA Mandated Preventative Care Drugs	$0 Copay	$0 Copay
Tier 1 Generic Drugs	$10 Copay	$25 Copay
Tier 2 Brand Drugs	Lesser of 30% or $35	Lesser of 30% or $87.50
Tier 3 Brand Drugs	Lesser of 40% or $75	Lesser of 40% or $187.50
After Maximum Out-of-Pocket	$0 Copay	$0 Copay
Maximum Days Supply	30 days	90 Days

Notes:

- Contact CIGNA for a list of Tier 2 Brand Drugs.
- Coverage for certain Brand Drugs may be subject to Step Therapy Programs.
- Plan does not cover non-sedating antihistamines, H2 antagonists or proton pump inhibitors.
- Per CIGNA's formulary provisions there are some drugs not covered by the Plan. Contact CIGNA to determine if your drug is covered.

DENTAL BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE
CIGNA Dental PPO Network

Calendar Year Deductible – Per Individual	
In-Network	$50.00
Non-Network	$75.00
Maximum Benefit Payable per Calendar Year	$800.00*
In-Network Coinsurance	
Class I – Preventative Care	100%, no deductible
Class II – Minor Restorative	70%, after deductible
Class III – Major Restorative	50%, after deductible
Non-Network Coinsurance	
Class I – Preventative Care	50%, no deductible
Class II & III – Minor and Major Restorative	50%, after deductible

Notes:

- Class I includes prophylaxis, standard fluoride treatments, examinations, and reasonable x-rays.
- Class II includes amalgam or other comparable fillings and simple extractions of teeth.
- Class III includes crowns, bridges and dentures.
- Treatment of TMJ and orthodontics are not covered by the Plan.

- Maximum Benefits Payable per Calendar Year does not apply to Essential Pediatric Dental Benefits, which includes Class I – Preventative Care Services for participants under age 19.

SCHEDULE OF BENEFITS – RETIREES (Plan R-1)

BENEFITS SHOWN ARE THOSE IN EFFECT AS OF October 1, 2015. THERE ARE CHANGES MADE AFTER THAT DATE WHICH ARE NOTED.

MAJOR MEDICAL BENEFITS – RETIRED EMPLOYEE AND DEPENDENT SPOUSE

CIGNA OPEN ACCESS PLUS (OAP) NETWORK

CALENDAR YEAR DEDUCTIBLE

PER INDIVIDUAL…………………………………………………………………………… $500.

PER FAMILY……………………………………………………………………………………. $1,000.

MAXIMUM BENEFIT PAYABLE ……………………………………………………………………… UNLIMITED

MAXIMUM OUT OF POCKET EXPENSES - EFFECTIVE June 1, 2015

In Network Medical

Per individual ………………………………………………… $5,350

Per Family ……………………………………………………….. $10,700

Non-Network………………………………………………………………….. Not Covered

Inpatient Hospital Room & Board Benefit

Daily Maximum Charge Allowed ……………………………………. Semi-Private

COINSURANCE PERCENTAGES **Plan Pays**

In-network Office Visits – after deductible…………………………….. 75%

Other Covered In-Network charges – after deductible……………… 75%

Emergency (In-Network or Non-Network) – after deductible …… 75%

In-Network/Emergency after reaching out-of-pocket maximum… 100%

Other Non-Network ……………………………………………………….. Not Covered

In-Network Chiropractic

Office Visit Copay – Chiropractor …………………………. $25 Copay

Maximum Covered Visits per Year …………………….. 10 Visits

In-Network Preventative Care Services

All PPACA Mandated Preventative Care ……………….. Plan pays 100%
No deductibles or copays

In-Network Mental Health/Substance Abuse Related Services

Mental Health Inpatient Services …………………… Plan pays 75%, after deductibles

Mental Health Outpatient Services ………………… Plan pays 75%, after deductibles

Alcohol/Substance Abuse Related Services…….. Not Covered

Notes:

- Failure to pre-certify a Hospital Admission, Outpatient Surgery or Advanced Imaging procedure will result in a reduction or denial of benefits payable.

PRESCRIPTION DRUG CARD BENEFITS – EMPLOYEE AND DEPENDENT SPOUSE

Provided Through Participating CIGNA Network Pharmacies

Calendar Year Deductible - Individual……………………………..	$ 50
Maximum Out-of-Pocket Effective June 1, 2015	$1,000. Individual $2,000. Family
Coinsurance: Retail Pharmacy	
PPACA Mandated Preventative Care Drugs	Plan pays 100%
Prior to Reaching Maximum Out-of-Pocket	Plan pays 50%
After Maximum Out-of-Pocket is Reached	Plan pays 100%
Maximum Days Supply – Retail Pharmacy	30 days

ELIGIBILITY – ACTIVE EMPLOYEES

Employees become eligible for benefit coverage under the Plan if they perform work in Covered Employment under the jurisdiction of a Local Union that is participating in the Plan and the appropriate contributions are paid into the Plan on the Employees' behalf. This section explains the rules for how an Employee first gains and then continues eligibility under the Plan, when Dependents become eligible, as well as what happens if eligibility should terminate.

Journeymen, non-journeymen and apprentices employed pursuant to a collective bargaining agreement for which the "High" rate of contributions (at least $3.50 per hour worked plus all supplemental contributions) is paid are considered as Class 1 employees. Journeymen, non-journeymen, and apprentices employed pursuant to a collective bargaining agreement for which the "Lesser" rate of contributions (at least $3.65 per hour worked but do not pay all supplemental contributions – currently only Local 387) shall become eligible and remain eligible under the provisions set forth herein as Class 1 employees but under Plan B-1.

INITIAL ELIGIBILITY – NEW EMPLOYEES OR EMPLOYEES RETURNING AFTER MORE THAN 24 MONTHS WITHOUT COVERAGE

Class 1 – All Employees, whether or not previously covered under another Iron Workers welfare plan, including those previously covered as Class 2 employees, shall initially qualify for benefit coverage on the first day of the first Benefit Quarter following the date on which contributions for a minimum of 750 hours have been made on behalf of the Employee during any eleven (11) consecutive calendar months.

CONTINUING ELIGIBILITY

Once an Employee has met the above qualification for Initial Eligibility, ongoing coverage will be subject to the Continuing Eligibility rules for the following Benefit Quarters. If payment is made on behalf of an Employee for the minimum required hours (375 hours) or more of Covered Employment in a Qualifying Quarter, that Employee will continue to be eligible for benefits during the corresponding Benefit Quarter as follows:

Contributions received for a minimum Of 375 hours or more for work in this QUALIFYING QUARTER	Provide coverage during this BENEFIT QUARTER
1. Jan, Feb, Mar	1. Jul, Aug, Sep
2. Apr, May, Jun	2. Oct, Nov, Dec
3. Jul, Aug, Sep	3. Jan, Feb, Mar
4. Oct, Nov, Dec	4. Apr, May, Jun

HOUR BANK (Reserve Accumulation Account)

The purpose of an Hour Bank is to assist Employees in retaining your benefits during short periods of illness or seasonably low periods of employment. After establishing initial eligibility, all hours paid on behalf of an Employee in excess of 400 hours during a Qualifying Quarter will be credited to the Hour Bank. The maximum number of hours that may be accumulated in the Hour Bank at any one time is 750 hours. If an Employee does not meet the minimum required 375 hours during a Qualifying Quarter to continue eligibility, the necessary number of hours to reach

375 hours will, if available, be automatically withdrawn from the Employee's Hour Bank to continue coverage for the next Benefit Quarter. If at any time the Employee is not actively at Work or available for Active Work in the jurisdiction of the Plan, his Hour Bank will be cancelled and any remaining hours will be forfeited.

ADJUSTMENT OF RECIPROCAL HOURS

From time to time, the Plan receives a transfer of contributions under the terms of the Iron Workers International Reciprocal Health and Welfare Agreement, or other "money follows the man" reciprocal agreements, which are included in this Plan document. When that occurs, the contributions transferred are at the rate provided for in the Cooperating Fund and are transferred to the Southeastern Iron Workers Health Care Plan as the Home Fund. In those instances where contributions are transferred, the number of hours credited for Initial Eligibility, Continuing Eligibility, Reinstatement of Eligibility and Hour Bank purposes are adjusted by multiplying the hours worked times a fraction, the numerator of which is the hourly contribution rate of the Cooperating Fund and the denominator is the contribution rate for the Southeastern Iron Workers Health Care Plan.

For example, if the contribution rate of the Cooperating Fund is 50% of the rate applicable for the Southeastern Iron Workers Health Care Plan, then the Southeastern Iron Workers Health Care plan will credit one half (1/2) hour for each hour reciprocated. Similarly, if the contribution rate of the Cooperating Fund is double that of the Southeastern Iron Workers Health Care Plan, then two (2) hours will be credited for eligibility purposes under the under the Southeastern Iron Workers Health Care Plan for each hour worked in the Cooperating Fund for which contributions have been transferred.

WHEN BENEFIT COVERAGE BECOMES EFFECTIVE FOR EMPLOYEES AND DEPENDENTS

Benefit coverage for Plan A-1 or Plan B-1 becomes effective as of the date the Employee becomes eligible. **Whether an Employee is eligible for Plan A-1 or Plan B-1 depends on the current prevailing contribution rate of the Local Union which has jurisdiction for such Employee.** Benefit coverage with respect to eligible Dependents of Class 1 employees becomes effective on the later of the date the Employee becomes eligible or the date the dependent qualifies as an eligible Dependent. Please refer to the Definitions section for details on the individuals considered as Dependents under the Plan. In order to be covered by the Plan, it is necessary for you to provide properly completed enrollment forms including applicable marriage certificates, birth certificates, divorce decrees, proof of dependency or other documentation that may be considered necessary by the Administrative Manager. Payment for Covered Expenses will be made only with respect to Charges which are incurred while the Employee or eligible Dependent is eligible for benefits, except as may be specifically provided for under other provisions of this Plan.

TERMINATION OF ELIGIBILITY

An Employee's eligibility and benefit coverage will terminate on the earliest of the following dates:

1. The last day of the Benefit Quarter, if the Employee has failed to accumulate contributions for at least 375 hours of credited employment during the next Benefit Quarter's corresponding Qualifying Quarter and the Employee has not elected to continue coverage by either Self-Pay or COBRA;

2. The date that any required contribution is due and unpaid; or
3. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms; or
4. The effective date of any opt out or disenrollment of any Employee who requests such opt out or disenrollment in writing. An Employee may voluntarily elect to opt out of Medical (including Prescription Drug), Dental and/or Death Benefits. Coverage may be reinstated upon receipt of a written notice confirming the intent to opt back into coverage.

In the event of a termination of benefits, any accumulated hours will be forfeited and any Hour Bank account may be reduced to zero.

Benefits with respect to eligible Dependents will terminate on the earliest of the following dates:

1. The date of termination of the Employee's benefits under the Plan, except that, in the event of the Employee's death, benefits with respect to eligible Dependents will be continued, subject to the other terms of the Plan, during the remainder of the Benefit Quarter in which the Employee's death occurs and during any future Benefit Quarters for which the Employee would have been eligible based on accumulated hours prior to death, including hours in the Hour Bank;
2. The date the Plan is amended so as to terminate the benefits of all Dependents; or
3. The last day of the month in which the dependent ceases to meet the definition of an eligible Dependent under the Plan, except as specifically provided below; or
4. The effective date of any opt out or disenrollment of any Dependent(s) who requests such opt out or disenrollment in writing. A Dependent may voluntarily elect to opt out of Medical (including Prescription Drug), Dental and/or Death Benefits. For children under the age of majority, the disenrollment request must be signed by both parents and/or legal guardians. For a spouse, the disenrollment request must be signed by both the spouse and the Employee. Coverage may be reinstated upon receipt of a written notice confirming the intent to opt back into coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Federal law requires the Plan, in certain circumstances, to provide coverage for dependent children in cases of divorce. The Plan must provide this coverage only if the Plan is served a Qualified Medical Child Support Order (QMCSO). If the Plan is served with a Medical Child Support Order, the Plan will review the Order in order to determine whether it is a "Qualified" Order. The Plan will provide to you, upon written request, a detailed statement of the Plan's process for determining whether the Order is qualified and the Plan's requirements for a "Qualified" Order.

A Qualified Medical Child Support Order means any judgment, decree, or order including approval of a settlement agreement which:

1. Issues from a Court of competent jurisdiction pursuant to a States Domestic Relations Law;
2. Requires you to provide only the group health coverage available under the Plan for your children, even though you no longer have custody;
3. Clearly specifies your name and last known mailing address and the names and addresses of each child covered by the Order;
4. Provides a reasonable description of the coverage to be provided;

5. Specifies the length of time the Order applies and;
6. Identifies each plan affected by the Order.

These are the minimum requirements of a QMCSO. The Order must also meet other requirements of the Plan in order to be "Qualified". Please contact the Fund Office for more information.

NATIONAL MEDICAL CHILD SUPPORT ORDER (NMCSO)

The Plan will also comply with National Medical Child Support orders promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1988; provided that the order specifies a Plan Participant by name and mailing address, contains the name and address of each alternate recipient (or the address of an official of a state or political subdivision that may be substituted for the alternate recipient), describes the coverage to be provided, and does not provide that the Plan provide any other type of form of benefit other than those types and forms provided under the Plan, and otherwise complies with the requirements of a NMCSO.

EXTENDED ELIGIBILITY FOR INCAPABLE DEPENDENTS

Eligibility providing benefits for medical care expenses may be continued beyond the limiting age for an eligible Dependent child who is mentally or physically incapable of earning a living and who is dependent upon you for support and maintenance, provided that you furnish evidence of the Dependent's incapacitation at least 31 days before the Dependent reaches the limiting age.

Any benefits continued for such Dependent children will terminate under any of the conditions described above, or, in any event, when the Dependent ceases to be incapacitated, or at the end of the 31-day period after any requested proof of continued incapacity is not furnished.

REINSTATEMENT OF ELIGIBILITY

In the event that an Employee's eligibility terminates due to a failure to accumulate the required number of hours of contributions paid on his behalf, the Employee's eligibility will be reinstated as of the first day of any Benefit Quarter for which payment is remitted by an Employer for at least 375 **hours** in the corresponding Qualifying Quarter or following payment of at least **540 hours** in a period of six consecutive calendar months. If, however, the Employee has been without coverage for a period of 24 months or longer, the Employee must meet the requirements for Initial Eligibility.

In no event may hours be used in the application of this Reinstatement Provision that were used to provide Initial or Continuing Eligibility.

SELF-PAY

An Employee may continue eligibility for benefit coverage through Self-Pay if his eligibility would otherwise terminate due to insufficient hours paid if the Employee has a minimum of **225 hours** paid during a Qualifying Quarter or through a combination of paid hours and Hour Bank credits. If the Employee meets the 225 hour minimum requirement, he is eligible to Self-Pay the difference between his hours and the 375 hours required for Continuing Eligibility for the next Benefit Quarter.

If the Employee has fewer than 225 hours through hours paid and/or Hour Bank credits during a Qualifying Quarter, he will not be eligible to self-pay, but may otherwise be eligible for Continuation Coverage under COBRA. Self-pay cannot be accepted to establish Initial Eligibility or Reinstated Eligibility.

The amount of Self-Pay will be equal to the hourly rate of the current Employer Contribution multiplied by the hours needed to meet the 375 hour minimum for Continuing Eligibility.

The Administrative Manager will send a written notice advising the Employee that he is eligible to Self-Pay in order to continue eligibility for benefit coverage. 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 payable to the "Southeastern Iron Workers Health Care Plan" by check or money order. If the self-payment is not received by the date due, eligibility will automatically terminate in accordance with the Plan provisions (subject to the COBRA Continuation provision).

COBRA CONTINUATION COVERAGE

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- You do not work enough hours of employment or do not have enough hours in your

Hour Bank to maintain coverage; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse does not work enough hours of employment or does not have enough hours in his Hour Bank to maintain coverage;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee does not work enough hours of employment or does not have enough hours in his Hour Bank to maintain coverage;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is insufficient hours of employment, death of the employee, the employee's becoming eligible for Medicare benefits (under Part A, Part B or both), or commencement of a proceeding in bankruptcy with respect to the Employer, the Administrative Manager's Office will determine when a qualifying event has occurred and will notify the qualified beneficiaries of their COBRA rights within 30 days after such determination and the resulting loss of coverage.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN. 37070. Such notice must be in writing and must include the name(s) of

the individuals affected by the qualifying event, a description of the event and the date it occurred, and, if applicable, proof of the divorce or legal separation.

How is COBRA continuation coverage provided?
Once the Administrative Manager's Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Once an employee commences coverage under COBRA he is not eligible for the Plans Continuing Eligibility provisions. He must satisfy the Reinstatement Rules or Initial Eligibility requirements to continue eligibility under the Plan.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Written notice and a copy of the award of Social Security benefits must be provided to the Administrative Manager's Office within 60 days of the Social Security determination and before the end of the 18-month period of COBRA continuation coverage. If the SSA issues a determination, prior to the end of the 11-month extension, that the qualified beneficiary is no longer disabled, the qualified beneficiaries receiving the extended COBRA continuation coverage must notify the Administrative Manager's Office of such termination and provide it with a copy of the determination within 30 days of issuance.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Administrative Manager
Southern Benefit Administrators, Inc.
P.O. Box 1449
Goodlettsville, TN. 37070
TOLL-FREE 800.831.4914

ELIGIBILITY – RETIRED EMPLOYEES

ALL LOCALS

Eligibility for participation in the Retiree Plan (Plan R-1) is subject to the following requirements:

1. The Retiree must be retired from a participating Union's pension plan (documentation from the applicable pension plan confirming the pension effective date is required); and
2. The Retiree must have been an Eligible Employee under the Southeastern Iron Workers Health Care Plan for at least three (3) months immediately prior to retirement; and
3. The Retiree must have been an Eligible Employee under 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 of 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 of service credits in a participating Union's pension plan.

Retirees must first elect or reject COBRA coverage, prior to making self-payment under this provision. Retirees may continue coverage under another Group Medical Plan on a continuous basis prior to participating in this Plan. Retirees and/or their eligible spouses who elect to continue coverage under COBRA or another Group Medical Plan must elect this retiree coverage immediately upon termination of that coverage.

Retirees who qualify for this provision will be permitted to make self-payments until the age of 65, Medicare eligibility, or their termination date, whichever comes earlier, as set forth hereafter. Benefits for Dependents may be eligible to continue beyond the Retiree's termination if the Dependent spouse is under age 65, is otherwise not eligible for Medicare and continues plan participation. Coverage for such Dependents will terminate in accordance with the provisions stated below.

Retirees who are over age 65 when they retire, or are eligible for Medicare for reasons other than age, and who otherwise meet the eligibility requirements above, may elect to continue coverage for their non-Medicare eligible Dependents. Coverage for such Dependents will terminate in accordance with the provisions stated below.

If a Retiree 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 Administrative Office; such payment must be received by the Administrative Office no later than 30 days following the first day of the month for which he is self-paying. The monthly cost of coverage will be determined by the Board of Trustees and may be adjusted at the beginning of any month.

If a Retiree returns to work in Covered Employment and is already participating in the Retiree Medical Plan, the Retiree will be provided with contribution dollar credit towards the Retiree's self-payment required to maintain the Retiree's and/or spouse's eligibility in the Retiree Medical Plan. These

credits will be processed on a quarterly basis as shown below. Retiree contribution dollar credits in a Qualifying Quarter may not exceed the self-payment requirement for the corresponding Benefit Quarter and may not be carried over to a different Benefit Quarter. Although credits will be calculated and processed on a quarterly basis, the Retiree will continue to be required to self-pay monthly to the extent necessary to maintain eligibility in the Retiree Medical Plan.

QUALIFYING QUARTER(S)	BENEFIT QUARTER(S)
January, February, March	July, August, September
April, May, June	October, November, December
July, August, September	January, February, March
October, November, December	April, May, June

Upon a Retiree's return to work in Covered Employment for an extended period of time, the Retiree may elect to transfer at the beginning of a Benefit Quarter from the Retiree Medical Plan to Active Eligibility Status subject to attainment of sufficient hours credits as required by the Health Care Plan for Active Continuation of Eligibility (current minimum of 375 hours per Qualifying Quarter). To return to Active Eligibility Status, the Retiree is required to timely complete, sign and return to the Administrative Manager an appropriate election form. Absent timely election to return to Active Eligibility Status, the Health Care Plan will automatically credit the working Retiree with contribution dollar credit towards the Retiree's monthly self-payment requirement to maintain eligibility in the Retiree Medical Plan in the manner noted above in this notice. Please understand that a Retiree may not receive credits for the same contribution dollars/hours towards both the Retiree Medical Plan self-payment and towards Active Eligibility. The Retiree may only receive credit for one or the other, but not both. In order for a Retiree to elect to transfer to Active Eligibility Status, he should contact the Administrative Manager for the required election form. If a Retiree returns to Active Eligibility Status for a time period and subsequently "re-retires" and exhausts work hour eligibility credits, he will at that time be able to elect either COBRA continuation of coverage subject to Plan provisions or return to the Retiree Medical Plan. **If the Retiree wishes to remain in the Retiree Medical Plan, no action is required.**

TERMINATION OF ELIGIBILITY

Benefit coverage will terminate the first day of the month prior to the earliest of the following dates:

For the Retiree:

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

1. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms.
2. For Dependents:
3. The first day of the month in which the Dependent spouse attains age 65 or otherwise becomes entitled to Medicare (whether or not she applies for Medicare) [Dependent child(ren) may continue plan participation subsequent to this event as long as the Retiree continues participation.];
4. The first day of the month in which the he Retiree or Spouse becomes covered (as an Employee or as a Dependent) under any other group medical benefits plan;
5. The first day of the month in which the Retiree returns to work with a non-participating employer who engages in work similar to Employers who participate in the Plan;
6. The first day of the month in which the Retiree, if retired under a disability provision, is no longer receiving a disability pension;
7. The date the Dependent ceases to meet the definition of Dependent under the Plan (COBRA Continuation coverage provisions may apply);
8. The last day of the month following the date of the Retiree's death if there is no Dependent spouse who is continuing self-payments for benefit coverage (COBRA Continuation coverage provisions will apply);.
9. The first day of the month for which the Retiree fails to make Timely Self-Payments;
10. The date the retiree plan provision terminates; or
11. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms.

For the Surviving Spouse of a Retiree who dies or the spouse of a Retiree who reaches age 65 or becomes entitled to Medicare, benefit coverage for Dependents will end on the earliest of the following dates:

1. The first day of the month in which the Dependent spouse attains age 65 or otherwise becomes entitled to Medicare (whether or not she applies for Medicare) [Dependent child(ren) may continue plan participation subsequent to this event as long as the Retiree continues participation.];
2. The first day of the month in which the Spouse becomes covered (as an Employee or as a Dependent) under any group medical plan;
3. The first day of the month in which the Surviving Spouse remarries;
4. The first day of the month marking the end of 7 years of coverage following the Retiree's death;
5. The first day of the month marking the end of 7 years of coverage following the Retiree's attainment of age 65 or eligibility for Medicare;
6. The first day of the month for which the Spouse fails to make Timely Self-Payment; or
7. The date this 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 directly to the Administrative Office.

Retiree coverage does not include Death, Accidental Death and Dismemberment, nor Dental benefits.

COBRA Continuation of Coverage is not available after termination of Retiree Benefits (except in cases of divorce or, for Dependent Children, death of the Retiree or Dependent Spouse).

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.

If a participating Retiree or Dependent spouse subsequently terminates participation in the Retiree Plan for whatever reason (other than return to active status), he/she may not return to participation at a later date.

The Retiree Plan and these eligibility 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, Ornamental and Reinforcing 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 transferred, 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 membership from one Local Union to another local union, the Home Fund shall be the Health, Welfare or Insurance Fund on the jurisdiction of the new local union. Claims incurred by such an Employee shall be filed with the new Home Fund. If the employee is not eligible in this new Home Fund, but is eligible in the 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 Section 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 Section 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.

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, Ornamental and Reinforcing 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.

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 provide 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 Boards 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 timely file a 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 of 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 is 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.

Note: Certain capitalized terms such as Covered Services and Medically Necessary are defined in the "Definitions" section at the end of this booklet.

Your Health Care Plan is a comprehensive plan that provides coverage for In-Network benefits. If you choose to utilize an In-Network provider, which is one participating in the managed care network contracted by your Health Care Plan, you will receive the In-Network benefits and you will also have access to the discounted prices negotiated with these providers.

Non-network services are only payable if:

- Services are emergency or life-threatening in nature; or
- An In-Network provider was not available within 35 miles and the Non-Network provider is closer than the nearest In-Network provider (prior authorization should be obtained to verify coverage).

In order for a charge to be covered under this Plan it must be considered to be Medically Necessary and coverage or certification of services that are not Medically Necessary may be denied, whether a provider is In-Network or Non-Network.

Your Expenses

Under this Plan, there are times when you will have to pay for a portion of your benefit costs. Your expenses fall into these main categories:

Copays

When you have an office visit, you may be responsible for a copay that may be collected at the time of service and is a flat-dollar amount. Any copay amounts required are shown in your Schedule of Benefits.

Coinsurance

Your coinsurance amount is the percentage of charges that you are responsible for paying after application of any required deductibles and the Plan's payment. Your Schedule of Benefits lists the percentage that the Plan will pay and you are responsible for the remaining Coinsurance. For example, if the Schedule of Benefits indicates that the Plan pays 75%, then you will be responsible for paying the remaining 25%.

Deductibles

In certain cases there are deductible amounts that must be met before the Plan will begin to pay its percentage of covered charges. These amounts are referred to as deductibles. Your Plan has two types of deductibles:

Calendar Year Deductible – The amount of Covered Charges you must pay before the Plan begins to pay benefits (except for certain benefits which are specified in the Schedule of Benefits as paying with no deductible applied, such as In-Network Primary Care Office Visits). Amounts paid toward Copays do not accumulate toward satisfaction of deductible amounts.

Per Occurrence Deductibles – These deductibles apply each time certain services are incurred, such as emergency room visits, inpatient hospital admissions or outpatient surgery. Refer to your Schedule of Benefits for the specific Per Occurrence Deductibles in your Plan. These deductibles are applied in addition to the Calendar Year Deductible.

Non-Covered Expenses
You are fully responsible for payment for all non-covered expenses and for expenses incurred while not eligible for benefit coverage under the Health Care Plan. This also includes amounts in excess of any maximum benefit limitations shown in the Schedule of Benefits.

What the Plan Pays
The Schedule of Benefits outlines the percentage payable by the Plan for Covered Expenses. **Your Plan has an Out-of-Pocket Maximum**, this means that the Plan will pay 100% of covered charges once you reach that maximum for the remainder of the calendar year. Amounts you have paid toward your Deductibles, Copays and Coinsurance for both Medical and Prescription Drug Expenses apply toward the Out-of-Pocket Maximums. One maximum applies to Medical Expenses and another to Prescription Drug Expenses. Amounts you pay for non-covered charges (including most non-network charges), dental services or penalties for failure to pre-certify do not apply toward your Out-of-Pocket Maximum

PRE-ADMISSION CERTIFICATION and PRIOR AUTHORIZATION

Your Plan requires that all inpatient hospital admissions and outpatient surgical procedures, as well as other outpatient procedures such as advanced imaging (MRIs, CT Scans, PET Scans) be pre-approved for Medical Necessity and length of hospital confinement. This process is called Pre-Admission Certification (PAC) when Non-Network or Prior Authorization when In-Network. Failure to obtain PAC or Prior Authorization will result in a 10% reduction in the level of benefits that would have otherwise been payable by the Plan.

Please note that obtaining prior authorization is not a guarantee of payment and benefit coverage will still be subject to eligibility and the remaining provisions of the Plan at the time the claim is incurred.

If you or your Dependent use a Non-Network provider, you are responsible for the PAC process. You should request PAC prior to scheduling any non-emergency Hospital admission. For an admission due to pregnancy, you should contact the Review Organization by the end of the third month of pregnancy. If you or a Dependent are admitted due to emergency treatment, the Review Organization should be contacted within 48 hours after the admission. If your hospital stay is going to extend beyond the length originally approved during the PAC process, Continued Stay Review (CSR) must be notified prior to the end of the length of the originally approved stay.

Covered Expenses incurred will be reduced by 10% for Hospital charges made for each separate admission to the hospital:

- Unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of the admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charge listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any days in excess of the number of days certified through PAC or CSR; and
- Any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating (In-Network) Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under the Plan.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital or other health care facility services;
- Residential treatment;
- Nonemergency ambulance; or
- Transplant services.

If you use an In-Network Provider, the provider will complete the PAC process for you. Call the number on the back of your ID card or 1-800-768-4695 to complete the PAC process.

The term Covered Medical Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes eligible for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and Medically Necessary for the care and treatment of an Injury or Sickness, as determined by CIGNA. Any applicable Co-payments, Deductibles or Maximums are shown in the Schedules of Benefits.

COVERED MEDICAL EXPENSES

Covered Medical Expenses include, but are not limited to, the following:

1. charges made by a Hospital, on its own behalf, for semi-private Room and Board and other Medically Necessary services and supplies; except that for any day of Hospital confinement, Covered Expenses will not include that portion of charges for Room and Board which is more than the Room and Board limits shown in the Schedules of Benefits.
2. charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
3. charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
4. charges made by a free-standing surgical facility, on its own behalf, for medical care and treatment.
5. charges made by skilled nursing facility, a rehabilitation hospital or a sub-acute facility on its own behalf, for medical care and treatment; except that Covered Medical Expenses will not include that portion which is in excess of amount shown in the Schedules of Benefits.
6. charges made by a Physician for professional services.
7. charges made by a Nurse for professional nursing service.
8. charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; prosthetic appliances; and dressings.
9. charges made for blood, blood plasma and their administration.
10. charges made for preventive and wellness services, as defined under the Patient Protection and Affordable Care Act.
11. charges made for counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.
12. charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
13. charges made for services related to diagnosis and treatment of mental and nervous disorders.
14. charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.
15. charges made by a participating provider for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Injury or Sickness, or congenital defect. External prosthetic appliances shall include artificial arms and legs and terminal devices

such as hands or hooks. Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth.

16. charges for family planning services including medical history, physical examination, related laboratory tests; medical supervision in accordance with generally accepted medical practice, other medical services, information and counseling on contraception, implanted/injected contraceptives. Office visits, tests and counseling are subject to the preventive care maximumshown in the Schedules of Benefits.
17. charges made for home health care services when you:
    - require skilled care;
    - are unable to obtain the required care as an ambulatory outpatient; and
    - do not require confinement in a Hospital or other health care facility.
18. charges made due to terminal illness for the following Hospice care services:
    - by a Hospice facility for room and board and services and supplies, except that, for any day of confinement in a private room;
    - by a Hospice facility for services provided on an outpatient basis;
    - by a Physician for professional services;
    - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death if services provided as part of Hospice care;
    - for pain relief treatment, including drugs, medicines and medical supplies;
    - by another covered health care facility for:
        - part-time or intermittent nursing care by or under the supervision of a Nurse;
        - part-time or intermittent services of a health care professional who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies;
        - physical, occupational, or speech therapy;
        - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that suchcharges would have been payable under the policy if the person had remained or beenconfined in a Hospital or Hospice facility.
19. charges made for the purchase or rental of durable medical equipment which is ordered or prescribed by a provider and provided by a vendor approved by CIGNA. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.
20. braces, crutches or artificial limbs.
21. physiotherapy.
22. charges made by a participating provider for infertility services, limited to the diagnosis of infertility (but not the treatment of infertility).
23. charges made for short-term rehabilitative therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

    The following limitations apply to short-term rehabilitative therapy services:

    - Occupational therapy is provided only for purposes of training members to perform the activities of daily living.

- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

24. charges made for chiropractic care or services as follows:
    - charges for care are limited to the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function;
    - charges for office examinations including: patient history; physical examination; spinal x-rays; laboratory tests; and neuromuscular treatment and manipulation;
    - charges for lab work;
    - charges are limited to Medically Necessary care provided in an office setting.
25. charges made for human organ and tissue transplant services at designated facilities through the United States. Coverage is subject to the following conditions and limitations:
    - Organ transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Organ transplant services are only covered when they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.
    - Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.
    - To receive in-network benefits for all organ transplant services, other than cornea, kidney and autologous bone marrow/stem cell transplants, services must be received at a qualified or provisional CIGNA Lifesource Organ Transplant Network facility. The transplants that are covered at the in-network level at participating provider facilities, other than a CIGNA Lifesource Organ Transplant Network facility are cornea, kidney and autologous bone marrow/stem cell transplants.
26. charges made for reconstructive surgery following a mastectomy, if the eligible Participant chooses to have surgery, and in the manner chosen by the eligible Participant and Physician. Services and benefits include:
    - surgical services for reconstruction of the breast on which surgery was performed;
    - surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance, limited to one surgery per mastectomy;
    - postoperative breast prostheses;
      and
    - mastectomy bras and external prosthetic limited to the lowest cost alternative available that meets external prosthetic placement needs.
27. during all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.
28. Disease Management Training by a health professional when recommended by a Physician.
29. charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery. Reconstructive surgery for

correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by the Plan.

30. charges for routine patient care costs for approved clinical trials for treatment of cancer or other life threatening disease or condition, to the extent that such charges are required to be covered under the law.

MEDICAL EXPENSES NOT COVERED

Covered Medical Expenses will not include, and no payment will be made for expenses incurred for or in connection with:

1. charges that are not Medically Necessary, except as provided in the "Covered Medical Expenses" section of this booklet;
2. charges for services provided by Non-Network providers where either 1) the services were not emergency or life-threatening in nature; or 2) there was an In-Network provider available within 35 miles that could provide the same service;
3. cosmetic surgery or therapy unless coverage is provided under "Covered Expenses" section of this booklet. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve appearance or self-esteem.
4. eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
5. treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for room and board or Medically Necessary services and supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
6. medical and Hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the Plan;
7. procedures to reverse sterilization.
8. replacement of external prosthesis due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
9. treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
10. reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations, unless otherwise covered as a basic benefit.
11. transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
12. therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
13. treatment by acupuncture.
14. treatment for Substance Abuse.
15. cosmetic Surgery or Therapy. Cosmetic Surgery or Therapy is defined as surgery or therapy

performed to improve appearance or self-esteem.

16. medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass. The exception is 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 diagnosis of exogenous obesity (a condition usually caused by overeating), no benefits will be payable for expenses incurred.
17. court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the "Covered Medical Expenses" section of this certificate.
18. infertility services including infertility drugs, services other than tests and counseling, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
19. nonmedical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
20. consumable medical supplies, including but not limited to: bandages and other disposable medical supplies, skin preparations and test strips, except as provided under "Covered Medical Expenses."
21. private Hospital rooms and/or private duty nursing unless determined to be Medically Necessary.
22. routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.
23. membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
24. amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
25. genetic testing and therapy including germ line and somatic unless determined Medically Necessary for the purpose of making treatment decisions.
26. fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Plan’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
27. blood administration for the purpose of general improvement in physical condition.
28. costs of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
29. cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: (a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal

law can be dispensed only through a Physician's prescription, and are Medically Necessary as the primary source of nutrition.

30. personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
31. orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment for TMJ disorder is covered.
32. all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Covered Medical Expenses" section of this certificate.
33. expenses incurred for second surgical opinions in connection with:
    - i. cosmetic or dental surgical procedures not covered under the policy;
    - ii. minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;
    - iii. an opinion obtained more than 6 months after a surgeon has first recommended the elective surgical procedure;
    - iv. an opinion rendered by the Physician who performs the surgical procedure.
34. the following charges for Hospice care services:
    - i. services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
    - ii. any period when you or your Dependent is not under the care of a Physician;
    - iii. services and supplies not listed under Covered Medical Expenses;
    - iv. curative or life-prolonging procedures;
    - v. to the extent that any other benefits are payable for those expenses under the policy;
    - vi. services or supplies that are primarily to aid you or your Dependent in daily living;
35. the following durable medical equipment unless covered in connection with the services described in another section of this booklet:
    - i. hygienic or self-help items or equipment;
    - ii. items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
    - iii. environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
    - iv. institutional equipment, such as air fluidized beds and diathermy machines;
    - v. elastic stockings, garter belts, corsets, dentures and wigs;
    - vi. corrective orthopedic shoes and arch supports;
    - vii. equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;
    - viii. items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
    - ix. items which under normal use would constitute a fixture to real property, such as

ramps, railings, and grab bars.

36. charges for any of the following provided by a Chiropractor:
    i. services of a Chiropractor which are not within the scope of his practice, as defined by state law;
    ii. vitamin therapy;
    iii. maintenance or preventive treatment.
37. charges which would not have been made if the person had no insurance;
38. expenses for which no charge is made that the Employee is required to pay;
39. standby surgical fees or charges;
40. custodial services, education or training;
41. charges to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
42. charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and ½ of the amount otherwise payable for all other surgical procedures;
43. charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);
44. routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
45. speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
46. charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan;
47. charges in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit or any Injury or Sickness covered by Workers Compensation insurance;
48. experimental, investigational or unproven services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by the Plan, to be:
    i. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or
    ii. the subject of review or approval by an Institutional Review Board for the proposed use; or
    iii. the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
    iv. not demonstrated, through existing peer-reviewed literature, to be safe and

effective for treating or diagnosing the condition or illness for which its use is proposed.

49. charges made by any covered provider who is a member of your family or your Dependent's family;
50. an Injury or Sickness which is due to war, declared or undeclared;
51. expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure;
52. Injuries or Sickness incurred in the commission or attempted commission of an illegal act or crime or while in the custody of a law enforcement official or agency or a penal institution, unless such Injury or Sickness is as a result of being the victim of domestic violence or the result of a medical condition;
53. charges to the extent that billed charges exceed the Maximum Reimbursable Charges as described in the Definitions;
54. charges to the extent that payment is unlawful where the person resides when the expenses are incurred;
55. nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation;
56. medical treatment for a person age 65 or older, who is covered under this policy as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-participating provider;
57. medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider;
58. charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy;
59. 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;
60. to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
    i. a "no-fault" insurance law; or
    ii. an uninsured motorist insurance law;
61. or in connection with an elective abortion unless:
    i. the Physician certifies in writing that the pregnancy would endanger the life of the mother; or
    ii. the expenses are incurred to treat medical complications due to the abortion;
62. charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits.

PRESCRIPTION DRUG EXPENSES

HOW YOUR PRESCRIPTION DRUG BENEFITS WORK

Your prescription drug benefits are administered by CIGNA. To obtain benefits, you must have your prescriptions filled at a pharmacy that participates in the CIGNA network and you must present your ID card to the pharmacy when having the prescription filled. The CIGNA pharmacy network includes most national chains, as well as many independent pharmacies. For maintenance medications that are taken for extended periods of time, you can also utilize the CIGNA mail order pharmacy program, Tel-Drug, for additional savings on your 90-day prescriptions.

COVERED PRESCRIPTION DRUG EXPENSES

If you or any one of your Dependents, while eligible for benefits under this Plan, incurs expenses for charges made by a pharmacy for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, coverage for those expenses will be provided as shown in the Schedules of Benefits. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Amounts you pay toward Copays, Deductibles and Coinsurance for covered Prescription Drugs will apply towards satisfaction of the Maximum Out-of-Pocket amount shown in the Major Medical section of the Schedule of Benefits. Once you have reached your Maximum Out-of-Pocket amount, charges for covered Prescription Drugs will be paid by the Plan at 100% for the remainder of the Calendar Year.

LIMITATIONS

Each prescription order or refill shall be limited as follows:

1. Up to a consecutive 30-day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
2. Up to a consecutive 90-day supply at a mail order Participating Pharmacy, unless limited by the drug manufacturer’s packaging; or
3. To a dosage and /or dispensing limit as determined by the P&T Committee.

PRIOR AUTHORIZATION

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for a prescription requiring prior authorization, your Physician may call or complete the appropriate form and fax it to CIGNA. If the request is approved, your Physician will receive confirmation and your authorization will be processed in the claim system to allow you to have coverage for that prescription. The length of the authorization will depend on the diagnosis and drug or supply being dispensed and additional authorization may be required in the future. If the request is denied, you and your Physician will be notified that coverage is not authorized. If you disagree with a coverage decision, you may appeal that decision in writing according to the appeals provision of this Plan. If you have any specific questions regarding the prior authorization process, please contact Member Services at the toll-free number on your ID card.

STEP THERAPY

Certain Prescription Drugs have Step Therapy programs which require that you have tried and failed on a lower costing generic medication prior to the Plan covering a brand name drug. Examples of classifications of medications which have Step Therapy programs are medications for high cholesterol, depression, ADD/ADHD, and sleep disorders. If your physician determines that the generic alternative is not medically appropriate, prior authorization can be obtained to allow access to the brand name drug.

PRESCRIPTION DRUG EXPENSES NOT COVERED

Covered Prescription Expenses will not include, and no payment will be made for expenses incurred for or in connection with:

1. drugs available over the counter that do not require a prescription by federal or state law;
2. any drug that is a pharmaceutical alternative to an over the counter drug other than insulin;
3. non-sedating antihistamines;
4. H2 antagonists or proton pump inhibitors;
5. a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
6. injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
7. charges for experimental, investigational or unproven that are determined by the Plan, to be:
    a. not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal; or
    b. the subject of review or approval by an Institutional Review Board for the proposed use; or
    c. the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
    d. not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
8. prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
9. any fertility drug;
10. drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, decreased libido;
11. drugs used for the treatment of alcohol or substance abuse;
12. prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
13. drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;

14. diet pills or appetite suppressants (anorectics);
15. prescription smoking cessation products, except those considered as a Preventive and Wellness service, as defined by the Patient Protection and Affordable Care Act;
16. immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
17. drugs used to enhance athletic performance;
18. drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
19. prescriptions filled more than one year from the original date of issue.
20. drugs used for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit or any Injury or Sickness covered by Workers Compensation insurance;
21. Injuries or Sickness incurred in the commission or attempted commission of an illegal act or crime or while in the custody of a law enforcement official or agency or a penal institution, unless such Injury or Sickness is as a result of being the victim of domestic violence or the result of a medical condition;
22. charges to the extent that payment is unlawful where the person resides when the expenses are incurred;
23. charges that are not Medically Necessary, except as specifically provided in this section of the booklet;
24. charges to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
25. charges made by any covered provider who is a member of your family or your Dependent's family;
26. charges for or in connection with an Injury or sickness which is due to war, declared or undeclared;
27. expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure;
28. replacement of Prescription Drugs and Related Supplies due to loss or theft;
29. charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy;
30. 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;
31. charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits.

DENTAL BENEFIT EXPENSES

HOW YOUR DENTAL BENEFITS WORK

Your dental benefits are administered by Southern Benefit Administrators (SBA). Your plan is a Dental PPO that provides coverage for In-Network and Non-Network benefits. If you chose to utilize an In-Network provider, which is one participating in CIGNA's dental PPO network, you will receive the In-Network benefits. Utilizing In-Network benefits means that you will not have to pay as much money – not only will you receive the higher level of benefits, but you will also have access to the discounted prices negotiated with these providers.

Dental PPO – In-Network (Participating) and Non-Network (Non-Participating) Providers

Payment for a service delivered by a Participating Provider is the Contracted Fee, times the benefit percentage that applies to the class of service, as specified in the Schedule of Benefits. The covered person is responsible for the balance of the Contracted Fee.

Payment for a service delivered by a Non-Participating Provider is the Maximum Reimbursable Charge times the benefit percentage that applies to the class of service, as specified in the Schedule of Benefits. The covered person is responsible for the balance of the provider's actual charge.

COVERED DENTAL EXPENSES

A Covered Dental Expense is that portion of a Dentist's charge that is payable for a service that is incurred on or after a participant becomes eligible for benefits and is:

1. Ordered or prescribed by a Dentist;
2. Essential for the necessary care of teeth;
3. Within the scope of the coverage limitations; and
4. Started and completed while the patient is eligible for dental benefits under the Plan.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment. If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, CIGNA recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by CIGNA's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

SBA will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, SBA will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended (when charges exceed $500 -$1,000).

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. SBA may agree to cover expenses for a service not listed. To be considered, the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to SBA.

CLASS I SERVICES

Diagnostic and Preventive

1. Clinical oral examination – Only 2 per person per calendar year.
2. Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)
3. X-rays – Complete series – Only one per person, including panoramic film, in any 3 calendar years.
4. Bitewing x-rays – Only 2 charges per person per calendar year.
5. Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years.
6. Prophylaxis (Cleaning) – Only 2 per person per calendar year.
7. Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis. 2 Periodontal cleanings per year.
8. Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only one per person per calendar year.
9. Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old – Only one treatment per tooth in any 3 calendar years.
10. Space Maintainers, fixed unilateral – Limited to non-orthodontic treatment.

CLASS II SERVICES

Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

1. Amalgam Filling – One Surface
2. Composite/Resin Filling – One Surface
3. Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
4. Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.
5. Periodontal Scaling and Root Planing – Entire Mouth
6. Adjustments – Complete Denture
    a. Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.
7. Re-cement Bridge
8. Routine Extractions

9. Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
    a. Removal of Impacted Tooth, Soft Tissue
    b. Removal of Impacted Tooth, Partially Bony
    c. Removal of Impacted Tooth, Completely Bony
10. Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.
11. General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by SBA, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
12. I.V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by SBA, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

CLASS III SERVICES
Major Restorations, Dentures and Bridgework

1. High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam.
2. composite/resin, silicate, acrylic or plastic restoration.
3. Crowns
    a. Porcelain Fused to High Noble Metal
    b. Full Cast, High Noble Metal
    c. Three-Fourths Cast, Metallic
4. Fixed or Removable Appliances
    a. Complete (Full) Dentures, Upper or Lower
5. Partial Dentures
    a. Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
    b. Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
6. Bridge Pontics - Cast High Noble Metal
7. Bridge Pontics - Porcelain Fused to High Noble Metal
8. Bridge Pontics - Resin with High Noble Metal
9. Retainer Crowns - Resin with High Noble Metal
10. Retainer Crowns - Porcelain Fused to High Noble Metal
11. Retainer Crowns - Full Cast High Noble Metal

DENTAL EXPENSES NOT COVERED

Covered Dental Expenses will not include, and no payment will be made for expenses incurred for or in connection with:

1. charges for unnecessary care, treatment or surgery;
2. services performed solely for cosmetic reasons;
3. charges to the extent that billed charges exceed the Maximum Reimbursable Charges as described in the Definitions;
4. or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
5. standby surgical fees or charges;
6. replacement of a lost or stolen appliance;
7. replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while a person is eligible for these benefits;
8. any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
9. procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
10. porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
11. bite registrations; precision or semi-precision attachments; or splinting;
12. instruction for plaque control, oral hygiene and diet;
13. dental services that do not meet common dental standards;
14. services that are deemed to be medical services;
15. services and supplies received from a Hospital;
16. orthodontic treatment;
17. the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
18. Injuries or Sickness incurred in the commission or attempted commission of an illegal act or crime or while in the custody of a law enforcement official or agency or a penal institution, unless such Injury or Sickness is as a result of being the victim of domestic violence or the result of a medical condition;
19. charges made by any covered provider who is a member of your family or your Dependent’s family;
20. expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure;
21. charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan;
22. an Injury or Sickness arising out of, or in the course of, any employment for wage or profit; or any Injury or Sickness which is covered under any workers' compensation or similar law;
23. charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service- connected condition;
24. services or supplies received as a result of dental disease, defect or Injury due to an act of

war, declared or undeclared;

25. charges to the extent that payment is unlawful where the person resides when the expenses are incurred;
26. charges to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid; charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits.

In order to have benefits paid to you, you or your designated representative must follow the claims procedures as follows. Claims are processed and first level appeals are handled by SBA and second level appeals are determined by the Trustees.

APPLICATION FOR BENEFITS

Written notice of claim and proof of loss acceptable to the Plan must be submitted within 90 days after the expense or loss was incurred. You may get the required claim forms from your benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to SBA. For Hospital confinement, if possible, get your insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived. If you have a Benefit Identification Card, it should be presented at the time of admission. The card tells the Hospital to send its bills directly to CIGNA.

For Doctor's bills and other medical or dental expenses, the first medical or dental claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

Be sure to use your social security and account number when you file claim forms, or when you call SBA's office. Your account number is the 7-digit policy number shown on your benefit identification card. Prompt filing of any required claim forms results in faster payment of your claims.

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.

Claims should be filed at the following addresses:

Medical:	**Dental**:	**Pharmacy:**
Southern Benefit Administrators P.O. Box 1449 Goodlettsville, TN 37070	Southern Benefit Administrators P.O. Box 1449 Goodlettsville, TN 37070	Southern Benefit Administrators P.O. Box 1449 Goodlettsville, TN 37070

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 services rendered and the charge for those services.

Benefits for hospital charges and Physician's fees may be assigned to the Hospital or the 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 Plan to the extent of the payments.

No action at law or in equity shall be brought to recover benefits under this Plan prior to the expiration of sixty (60) days after written proof of loss upon which a claim is based and has been furnished as required above, or the completion of the claims review procedure hereafter provided, whichever is later. No action to recover life or dismemberment benefits shall be brought more than three (3) years after the expiration of the time within which proof of loss is required. No Employee or Dependent shall be entitled to benefits for any services rendered after termination of coverage.

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 prime carrier.

CLAIMS REVIEW PROCEDURE

In general there are four types of claims; Urgent Care, Pre-Service, Concurrent, or Post-Service.

1. An Urgent Care claim is one that generally includes those situations commonly treated as emergencies. If you file an Urgent Care claim, you shall be notified of the Plan's benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of your claim, unless you fail 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 you 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. You will 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 you 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. A Pre-Service claim is one that requires prior authorization in order to be covered. In the case of a claim involving Pre-Service, the Plan shall notify you of it's benefit determination no later than 15 days of the Plan's receipt of the claim, unless more time is needed due to matters beyond SBA's control, you will be notified no later than 15 days after receipt of the claim. The notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the claim. If more time is needed, because necessary information is missing, the notice will specify the needed information and you will be afforded forty-five (45) days after receiving the notice to provide the specified information. The determination period will be suspended on the date SBA sends such a notice of missing information, and the determination period will resume on the date you respond to the notice.

3. A Concurrent claim is for an ongoing course of treatment that has been approved and a request to extend the approval is being made. A request for approval must be made for a Concurrent claim at least 24 hours prior to the expiration of the approved period of time or number of treatments. SBA will notify you of the determination within 24 hours after receiving the request.

4. A Post-Service claim is one that is made after services have been rendered. In the case of a Post- Service claim, SBA will notify you of the Plan's benefit determination no later than 30 days of the Plan's receipt of the claim, unless more time is needed due to matters beyond SBA's control, you will be notified no later than 30 days after SBA has received the claim. The notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed, because necessary information is missing, the notice will specify the needed information and you will be afforded forty-five (45) days after receiving the notice to provide the specified information. The determination period will be suspended on the date SBA sends such a notice of missing information, and the determination period will resume on the date you respond to the notice.

If a Claim is Denied
If a claim is wholly or partially denied, we shall notify you of the adverse benefit determination within a reasonable period of time not to exceed 60 days after receipt of the claim, without regard to whether all information necessary to make a determination accompanies the filing.

The notice will include the following:
1. the specific reason or reasons for the adverse determination;

2. reference to the specific plan provision on which the determination is based;

3. 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 Relevant Information as defined;

4. a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a);

5. upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

CLAIMS APPEAL PROCEDURE

There is a two-step claims appeal procedure. To initiate an appeal, you must submit a request for an appeal in writing to SBA within 180 days of receipt of a denial notice. You should state the reason why you feel your request should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask SBA to register your appeal by telephone by calling 800-831-4914.

Written Level One Appeals should be submitted to the following addresses:

Medical:	**Dental**:	**Pharmacy:**
Southern Benefit Administrators	Southern Benefit Administrators	Southern Benefit Administrators
P.O. Box 1449	P.O. Box 1449	P.O. Box 1449
Goodlettsville, TN	Goodlettsville, TN	Goodlettsville, TN

LEVEL ONE APPEAL

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

You will receive a written response with a decision within 15 days after receipt of an appeal for a required Pre-Service or Concurrent care claim, within 30 days after receipt of an appeal for a Post-Service claim, and within 45 days after receipt of an appeal for a disability claim. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. SBA's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, SBA will respond orally with a decision within 72 hours, followed up in writing.

LEVEL TWO APPEAL

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal you must within 180 days after receipt of the determination of the level one appeal make a written request for a review to: Board of Trustees

Southeastern Iron Workers Health Care Plan c/o SBA.
P.O. Box 1449
Goodlettsville, TN 37070

If you fail to make a timely request for review, the last decision on the claim shall be final. If a timely request for review is made, you may submit written comments, documents, records and other information relating to the claim.

The Board of Trustees shall make a benefit determination on review no later than (i) the date of the first (1st) meeting of the Board of Trustees that immediately follows receipt by the Plan Office of a written request for review or (ii) if such written request for review was not received by the Plan Office more than thirty (30) days before such meeting, the date of the second (2nd) meeting of the Board of Trustees following the date the Fund Office received the written request for review. If special circumstances require a delay in the decision, the Board of Trustees shall, prior to commencement of the extension, send a written notice to you setting forth the special circumstances requiring an extension and the date by which the benefit determination is expected to be rendered, and the Board of Trustees shall issue its decision no later than the date of the third (3rd) meeting next following the date the Plan Office received the written request for review. The Plan Office shall notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

The Board of Trustees shall review any facts and information submitted by you, make a final decision, and notify you of (i) the decision in writing, which notice will specify the reason or reasons for the adverse determination; (ii) references to specific Plan or Trust Agreement provisions on which the benefit determination is based; (iii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (iv) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, and a statement of your right to bring an action under Section 502(a) of ERISA; (v) 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; and (vi) 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 that it will be provided free of charge upon request.

Your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

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 appeal 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, in any event, one (1) year following the Trustees' final decision on review.

EXTERNAL REVIEW OF AN ADVERSE BENEFIT DETERMINATION

Those claims involving Medical Judgment which have either been denied or otherwise not acted upon, as outlined herein, shall be eligible for external review, including only 1) claims for urgent

care that have not been acted upon within 72 hours of receipt of the claim/request; 2) other claims for which the Fund office fails to act within the time limits applicable to other pre-service and post-service claims, or where the claims procedure has not been followed by the Fund office; and 3) claims for which the internal review process (including Trustee review) has been exhausted.

Claims not eligible for external review shall include 1) claims relating to an individual's failure to meet the requirements for eligibility (e.g. insufficient hours worked, failure to self-pay, classification of employment, failure to meet the definition of eligible dependent, etc.); 2) claimsincurred while the individual is not eligible for benefits; 3)claims incurred for health care service that is not a covered service under the Plan; 4) claims for which the internal review process has not been exhausted, except as specifically stated above; 5) claims incurred for other than medical expenses; and 6) claims denials not involving Medical Judgment.

Standard External Review

Request for external review. The Fund will allow a claimant to file a request for an external review if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date fourmonths after the date of receipt of such a notice, then the request must be filed by the first day ofthe fifth month following the receipt of the notice. For example, if the date of receipt of the noticeis October 30, because there is no February 30, the request must be filed by March 1. If the lastfiling date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to thenext day that is not a Saturday, Sunday or Federal holiday.

Preliminary review. Within five business days following the date of receipt of the external review request, the Fund office will complete a preliminary review of the request to determine whether:

a. The claimant is or was covered under the Plan at the time the health care item or service wasrequested or, in the case of a retrospective review, was covered under the Plan at the time thehealth care item or service was provided;

b. The adverse benefit determination or the final adverse benefit determination does not relate tothe claimant's failure to meet the requirements for eligibility under the terms of the Plan;

c. The claimant has exhausted the Plan's internal appeal process in accordance with subsection 4hereof; and

d. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Fund office will issue a notification in writing to the claimant. If the request is complete but not eligible for externalreview, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Fund office will refer the review to an Independent Review Organization (IRO) approved by URAC (formerly the Utilization Review Accreditation Commission). To insure against bias, the Fund will rotate claims assignments among at least three such IROs.

Within five business days after the date of assignment of the IRO, the Fund office must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final adverse benefit determination. Failure to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

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

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

Expedited External Review

Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review at the time the claimant receives:

a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

b. A final adverse benefit determination, if the claimant has a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum

function, or if thefinal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has notbeen discharged from a facility.

Preliminary review. Immediately upon receipt of the request for expedited external review, the Fund office will determine whether the request meets the reviewability requirements set forth in above for an expedited external review. The Fund Office will immediately issue a notification in writing to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following receipt of the notification, whichever is later. If the request for expedited external review if found not to meet the qualifications to be considered as expedited, the claimant will be notified and the request will be treated as a standard external review, as described above.

Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Fund office will refer the review to an Independent Review Organization (IRO) approved by URAC (formerly the Utilization Review Accreditation Commission). To insure against bias, the Fund will rotate claims assignments among at least three such IROs. The Fund office will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

Definitions

"Adverse benefit determination" means any claims denial, or partial denial, as determined by the Fund office staff.

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

A claim denial involving "Medical Judgment" is a claim that involves medical judgment as determined by the external reviewer, including, but not limited to, those claims denials based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational.

Access to Plan Documents

At any time during these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Plan in making their decision, as requested by the claimant.

Arbitration

If a claim is denied on appeal, a remedy to resolve a claim is with binding arbitration administered under the American Arbitration Association Employee Benefit Claims 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 you receive 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 SBA, Inc. 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.

EMPLOYEE DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE IS SELF FUNDED

DEATH BENEFIT Plan A-1 and B-1)

The Death Benefit will be paid if you die while covered under this benefit.

Benefit Determination
The amount of benefit to be paid will be the Amount 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 Plan.

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.

No Conversion Privilege – there is no Conversion Privilege under this Plan.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (Plan A-1 and B-1)

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

To obtain a claim form and instructions on obtaining benefits contact the Administrative Manager.

Your Beneficiary is the party or parties named by you as shown on Plan records. 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 the Plan. Such change will take effect upon receipt of the signed form at the Administrative Office of the Plan.

Upon receipt of satisfactory Proof of Claim, both the Death Benefit and the Accidental Death and Dismemberment Benefit, if payable, will be paid 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 Plan may rely on an affidavit made by any individual listed above. If payment is made based on such an affidavit, the Plan 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 Plan will pay the benefit to his or her legal guardian. If there is no legal guardian, the Plan may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. The Plan 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 Plan to be equitably entitled to compensation because he or she has incurred expenses on behalf of your burial, the insurance company may pay to such individual the expenses incurred up to $500. Such payment, however, shall, not exceed the amount due under this benefit. The Plan 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 the Plan for Death benefits and Accidental Death and Dismemberment Benefits will never exceed the Amount of Insurance shown in the Schedule of Benefits Sections.

COORDINATION OF BENEFITS (COB)

Because of the growing number of Group health plans (private and government) and the increasing number of two-income families, more and more people are becoming covered under two group health plans. There is nothing wrong with this, provided that the benefits payable under all plans do not exceed the expenses incurred – that is, do not result in an "over-payment."

The coordination of benefits, or COB, provisions have been designed to control over-payments. The COB provisions in the Southeastern Iron Workers Health Care Plan are integrated with all other group health plans, but not with an individual's personal health insurance policies.

Under the COB provision, if you or your eligible dependent has coverage under another group health plan, the total benefits received by any one patient from all the plans combined may not amount to more than 100% of the allowable expenses. "Allowable expenses" are any necessary and reasonable expenses for medical service, treatment, or supplies that are at least partially covered by one of the plans under which the individual is covered. Payments will be reduced only the extent necessary to prevent an individual from making a profit on his group health coverage. You must report duplicate health coverage on your Claim Forms which you submit to secure reimbursement of the medical expenses.

This Plan utilizes a "non-duplication" or "maintenance of benefits" method for COB. This means that when this Plan pays after another plan, the amount the Plan will pay as secondary coverage will be limited to the lesser of 1) what the Plan would normally pay if the Plan were the primary coverage, or
2) the difference between what the Plan would pay if it were the primary coverage and the amount paid by the actual primary coverage.

TWO GROUP PLANS – WHICH PAYS FIRST

1. When duplicate coverage arises, and both plans contain a COB provision, the plan that insures the person incurring the expense as an employee is the "primary" plan and pays first.
2. If an individual is covered under two plans through two jobs, the plan which has covered the employee for the longer period of time is the primary plan and pays first.
3. The Plan has adopted the "Birthday Rule" for coordinating benefits with other group health plans. Under this method, if both the husband and wife are covered by group health benefits, the eligible dependent children will be covered first under the plan which covers the employee whose birthday falls earlier in the calendar year. The secondary plan will be that of the spouse with the later birthday, and benefits from that plan will be calculated based only on the unpaid balance of the claim. This rule applies only to eligible dependent children. If both you and your spouse have group health coverage, you should submit claims covering your children first to your plan if your birthday falls earlier in the year, or to your spouse's plan if his/her birthday falls earlier in the year than yours. For example, if your birthday is April 26, and your spouse's birthday is October 13, then claims for your eligible dependent children should be submitted first to your plan. The application of this rule has nothing to do with age, only to the date in the calendar year on which your birthday falls.
4. When another plan does not contain a COB provision, it will always be considered the

primary plan. Payment under the secondary plan is made after the benefits from the primary plan have been paid. Such payment will be limited to the amount necessary to reimburse the individual for not more than 100% of allowable expenses. However, in some cases, the combined benefits may not pay 100% of your bills since you will only receive up to the stated maximums in each plan.

MEDICARE COORDINATION OF BENEFITS

Coordination of benefits with Medicare is subject to regulations and guidelines published by the Federal Government.

1. **Medicare Secondary for Active Eligible Employee or Spouse Age 65 or Older** Any benefits for health care expenses which are payable for an Eligible Employee or Spouse who is eligible for Medicare will not have benefits coordinated with Medicare unless he or she has elected to have Medicare as primary coverage. This does not apply to an individual who is, or would be upon application, entitled to benefits as a result of end stage renal disease.
2. **Medicare Secondary for Disabled Covered Individual who is Under Age 65.** An Eligible Employee, Eligible Retiree, or Eligible Dependent, who is eligible for Medicare as a result of total and permanent disability, will not have such benefits under the Plan coordinated with Medicare unless he has elected to have Medicare as his primary coverage. This does not apply to an individual who is, or would be upon application, entitled to benefits as a result of end stage renal disease.
3. **End Stage Renal Disease ("ESRD") Beneficiary.** Benefits will be payable under the Plan without regard to an Eligible Employee's or Eligible Dependent's entitlement to Medicare if such person is entitled to Medicare as an ESRD beneficiary, and not more than 30 months have elapsed since the earliest of the following:
    a. The month in which the Eligible Employee or Eligible Dependent began a regular course of renal dialysis;
    b. The month in which the Eligible Employee or Eligible Dependent received a kidney transplant;
    c. The month in which the Eligible Employee or Eligible Dependent was admitted to a Hospital in anticipation of a kidney transplant that was performed within the next two months; or
    d. The second month before the month in which the kidney transplant was performed, if performed more than two months after Hospital admission.
4. **All Other Circumstances.** Under any circumstance other than discussed in 1, 2, and 3 above, the benefits will be reduced by the amount of benefits provided – or which would have been provided had the covered person been enrolled under all parts of Medicare – for those same expenses under Medicare.

SUBROGATION

In the event that an Employee receives any benefits (the "Benefits") under this Plan arising out of any loss, injury, or illness (the "Injury") for which the Employee has asserted or may assert any claim or right to recovery against a third party or parties or his or her or their insurer(s), except against any insurer on any policy of insurance issued to and in the name of such Employee, then any payment or payments by the Fund for such Benefits shall be made on the condition and with the agreement and understanding that the Fund shall receive restitution from the Employee to the extent of, but not exceeding, the amount or amounts received by the Employee (the "Recovery") from such third party

or parties or his or her or their insurer(s) (the "Responsible Party"), whether by way of settlement or in satisfaction of any judgments(s) or otherwise.

The Employee shall provide restitution to the Fund, starting with the first dollar that the Employee receives from the Responsible Party, no matter whether the Recovery is designated as actual or punitive damages, costs or expenses, medical expenses, pain and suffering, lost wages, workers' compensation, disability payments, loss of consortium, loss of work payments, emotional distress, or otherwise, and the Employee shall continue to make restitution to the Fund until the Fund has received full restitution for all Benefits related to the Injury; provided, however, that an Employee shall not be required to make restitution in excess of his or her Recovery.

The "make whole" doctrine is not applicable to the Fund's subrogation and restitution rights, and the Fund has the right to restitution even if an Employee has not been fully compensated for the Injury. Accordingly, an Employee shall make restitution to the Fund for all Benefits paid related to the Injury, such restitution to be paid out of any Recovery the Employee is able to obtain.

If it becomes necessary for the Employee to retain an attorney in order to obtain a Recovery or to recover Benefits paid by the Fund relating to the Injury, the amount to be restored to the Fund may, at the sole discretion of the Fund, be reduced by the Fund's *pro rata* share of those attorneys' fees and expenses.

If the Trustees retain an attorney to enforce the subrogation and restitution rights under this Section, then the Employee shall be liable for, in addition to all amounts outlined in the previous paragraphs, expenses involved, including the Fund's reasonable attorneys' fees and expenses. As a means of enforcing its subrogation and restitution rights under this Section, the Fund may, in addition to any other means allowed by law or equity, set off future Benefits to the Employee or lessen the reduction allowed by the Fund for the Employee's attorneys' fees and expenses incurred in obtaining the Recovery. However, this Section shall not limit the Fund's right to recover its attorneys' fees and expenses and shall be cumulative with all other rights the Fund may have to recover it attorneys' fees and expenses.

As security for all amounts due to the Fund under this Section, the Fund shall be subrogated to all of the claims, demands, actions, and rights of recovery of the Employee against the Responsible Party or his or her or their insurer(s) to the extent of any and all Benefits paid under this Plan. The Employee shall execute and deliver any instruments and documents requested by the Trustees and shall do whatever else the Trustees shall deem necessary to protect the Fund's rights. The Employee shall take no action to prejudice the Fund's rights to such restitution and subrogation. The Trustees may withhold any Benefits to which the Employee is entitled under this Plan until the Employee executes and delivers any such instruments and documents as may be requested by the Trustees.

Prior to the payments of Benefits under this Plan to an Employee or assignee of an Employee for injuries, expenses, or losses for which a third party is or may be liable in whole or in part, the Employee or assignee or both may be required to execute a written subrogation and restitution agreement in form and substance satisfactory to this Plan.

If a covered person is entitled to receive benefits from the Plan for injuries caused by a third party, the Plan has the right through subrogation and/or assignment to seek repayment in the event the

covered person recovers any portion of the benefits paid by the Plan by court action, settlement or otherwise. Should benefits be payable on behalf of a Dependent, then the Dependent, or the guardian of the Dependent, shall also execute the subrogation agreement. Upon refusal of any person required by the Plan to sign the subrogation agreement, the payment of claims may be withheld until all necessary documents required by the Plan are executed.

If the beneficiaries are represented by an attorney for injuries arising out of the incident giving rise to the claim, the attorney may be required to execute an agreement to the effect that all funds received on behalf of the beneficiary will first be applied to satisfy the subrogation lien, and in the event of a dispute over the amount required to discharge the lien, the sums will be held in escrow by said attorney until the dispute is resolved.

In the event any funds are received as settlement of claims made for personal injuries for which this Plan paid benefits, and payment is not made to the Plan on the subrogation claim to discharge it or reduce it, then the Trustees may deny or withhold payment of claims covered by the subrogation agreement until the subrogation claim is discharged or reduced to the extent of the funds so received.

The covered person agrees the Plan shall be subrogated and succeed to the rights of recovery the covered person has against any third party or insurer due to the covered person's injury, accident, or illness from the act or omission of any third party. The covered person authorizes the Plan to claim the right of first reimbursement even if the covered person is not made whole. The covered person and/or the beneficiary shall cooperate with the Plan and provide all documentation required by the Plan, as well as information and reports required by the Plan to protect the Fund. This includes prior notification of any settlement or disposition of the claim, and the filing of any lawsuit related to the claim. You will also provide the Plan with a copy of any insurance policies involved and such policies may be required to provide the initial coverage or claims payment, prior to invoking the Employee's rights to obtain benefits from the Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

MILITARY SERVICE (USERRA) LEAVE OF ABSENCE

Due to a change in the law, the maximum period of continuation coverage available to an Employee under the federal law known as "USERRA", during a uniformed services leave of absence, has been increased from 18 to 24 months from the date the eave begins. Continuation coverage under

USERRA will be administered in accordance with the Plan's administrative procedures, rules and timeframes for the election, payment and cancellation of COBRA continuation coverage, provided they do not conflict with USERRA. This means, for example, that if an Employee with continuation coverage rights under USERRA fails to elect continuation coverage within 60 days after his coverage would otherwise terminate or, if later, after he is notified of his right to elect continuation coverage, he and his Dependents will lose the right to receive continuation coverage under USERRA. The Plan may extend the 60-day election period if it determines that it is impossible or unreasonable for the Employee to make a timely election due to his uniformed services leave of absence. If an Employee is eligible for continuation coverage under USERRA and makes a timely election, the continuation coverage provided under the Plan will concurrently satisfy the Plan's obligations under COBRA and USERRA.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee works for a contributing Employer who employs at least 50 employees during the current or preceding calendar year, the Employee may be eligible to take a leave of absence under the Family and Medical Leave Act (FMLA). To qualify for such a leave, the Employee must have been employed by the same contributing Employer for a minimum of 1,250 hours within the 12-month period immediately preceding the commencement of the FMLA leave. If the Employee qualifies, he or she may take up to a total of 12 weeks of FMLA leave during any 12-month period, during which period the Employer is obligated to continue payments for coverage through the Health Care Plan and benefits will be continued subject to all other provisions of the Plan and Trust.

FMLA leave may be taken for any of the following reasons:

(a) birth or care of a newborn child;
(b) placement of a newly adopted child or foster child;
(c) care of a spouse, son, daughter or parent with a "serious health condition"; or
(d) a "serious health condition" that makes the Employee unable to perform his job.

A "serious health condition" generally means an illness, injury, impairment, or physical or mental condition involving:

(i) in-patient care in a hospital, hospice, or residential medical care facility;
(ii) any incapacity requiring absence from work, school, or other regular daily activities of more than three (3) calendar days that also involves continuing treatment by or under the supervision of a healthcare provider; or
(iii) continuing treatment by or under the supervision of a healthcare provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three days.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans and insurance issuers offering group health coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for: (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in

consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and Coinsurance.

OTHER PROVISIONS

1. **Not in Lieu of Worker's Compensation**

   This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance. None of the benefits provided under this Plan (except the life insurance) are paid when the accident or illness necessitating the hospitalization, loss of time or surgery is covered by the State Workers' Compensation Law or the Longshoremen and Harbor Workers' Compensation Law (Federal). Workers' Compensation cases provide for benefits pursuant to law and this Plan (except life insurance) has no application to them. Whenever the Plan honors any claim for benefits resulting from an injury or illness that is later found to be subject to the Workers' Compensation laws, the participant shall reimburse the Fund within sixty (60) days after written demand by the Plan Administrator. If the Plan is required to retain an attorney, the Plan shall seek the full amount due plus attorney's fees.

2. **Authority of Trustees to Interpret and Construe Plan**

   The Trustees shall have the right to make any and all determinations pursuant to the Plan. This includes, but is not limited to, the discretionary authority to determine eligibility for benefits, to determine the amount of benefits payable, to determine the meaning and applicability of Plan provisions, to construe Plan terms, and to promulgate rules for processing and reviewing claims. Any and all determinations of the Trustees shall be conclusive and binding upon all parties having dealings with the Plan. It is the intent of the Trustees to maintain sole and complete authority to construe the Plan terms, including the definition of all Plan terms and the summary of all terms in this Summary Plan Description. In the event you are dissatisfied with a decision of the Board of Trustees, you may appeal the decision as outlined in the Claim Appeal Section of this Summary Plan Description. You must use the appeal procedure before filing a lawsuit against the Fund. The decisions of the Board of Trustees are entitled to judicial deference.

3. **Plan Document**

   This Summary Plan Description is no more than a very brief and 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. All the provisions of the Plan are contained in the Plan Document adopted by the Board of Trustees. Since the Plan Document is complete in detail, it will govern the final interpretation of any specific provision. You may inspect a copy of the Plan Document 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.

   In the case of a conflict between the Plan and Trust Documents or the Collective Bargaining Agreement and this Summary Plan Description, the Plan and Trust Documents or Collective Bargaining Agreement shall control. This Summary Plan Description supersedes and replaces all previous Summary Plan Descriptions and Summary of Material Modifications.

4. **No Vested Benefits**
There are no vested benefits under this Plan.

5. **Authority of Trustees to Modify Benefits or Terminate Plan**
It is the intention of the Trustees to continue operation of the Plan. The Trustees reserve the right to modify or terminate the Plan at any time. This includes the right to modify the level of benefits, to change the amounts to be contributed toward the cost of providing benefits by the sponsors or by the participants, or to change the class or classes. The Plan may be modified or terminated by vote of the Board of Trustees. In the event of any modification of the Plan, the Board of Trustees will communicate such modification to the Plan participants. Amendment or termination of the Plan may terminate your right to receive benefits, may limit your benefits, and may increase the amount which you must contribute toward the cost of providing benefits, or may reduce the benefits to which you were previously entitled.

6. **Use of Assets upon Termination of Plan**
If the Plan is terminated, the assets will be used for sole and exclusive benefit of the participants and reasonable and necessary expenses.

7. **Conversion Benefits Not Provided**
The health benefits provided under the Plan are self-funded and provided out of the assets of the Fund, and as such are NOT subject to conversion to individual policies following the termination of coverage under the Plan.

8. **Law Applicable**
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 federal law or regulations, except as to matters governed by state law.

9. **Savings Clause**
Should any provision 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.

10. **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. The Trustees shall be the sole arbiters 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.

11. **Gender**
Except as the context may specifically require otherwise, use of masculine (feminine) gender shall be understood to include both masculine and feminine genders.

12. **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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The *Southeastern Iron Workers Health Care Plan* (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

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

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written or electronic).

The term "**Individually Identifiable Health Information**" means information that:

1. Is created or received by a health care provider, health plan, employer or health care clearinghouse;
2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
3. Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI to inspect and copy it and to provide you with an accounting of disclosures of PHI made by the Plan. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to the Southeastern Iron Workers Health Care Plan ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards. The Plan Sponsor will obtain an authorization from you if it intends to use or disclose your PHI for purposes unrelated to treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and Disclosures that Require your Written Authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

a. Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

The Plan may obtain your oral agreement or disagreement to a disclosure.

However, if you are not present, or the opportunity to agree or object to the disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Plan may, in the exercise of professional judgment, determine whether the disclosure is in your best interests, and, if so, disclose only PHI that is directly relevant to the person's involvement with your health care.

b. Uses and Disclosures for which Authorization or Opportunity to Agree or Object is not Required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

(a) When required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

(b) When permitted for purposes of public health activities, including disclosures to (i) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect and (ii) a person subject to the jurisdiction of the Food and Drug Administration (FDA) regarding an FDA-regulated product or activity for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity, including to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI also may be disclosed to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

(c) Except for reports of child abuse or neglect permitted by part (b) above, when required or authorized by law, or with your agreement, the Plan may disclose PHI about you to a government authority, including a social service or protective services agency, if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you

that such a disclosure has been or will be made unless (i) the Plan believes that informing you would place you at risk of serious harm or (ii) the Plan would be informing your personal representative, and the Plan believes that your personal representative is responsible for the abuse, neglect or other injury, and that informing such person would not be in your best interests. For the purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure generally may be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

(d) The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of: (i) the health care system, (ii) government benefit programs for which health information is relevant to beneficiary eligibility, (iii) entities subject to government regulatory programs for which health information is needed to determine compliance with program standards, or (iv) entities subject to civil rights laws for which health information is needed to determine compliance.

(e) The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection, and the time to object has expired and either no objections were raised or any objections were resolved in favor of disclosure by the court or tribunal.

(f) the Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes. The Plan may disclose PHI as required by law, including laws that require the reporting of certain types of wounds. Also, the Plan may disclose PHI in compliance with (i) a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer, (ii) a grand jury subpoena, or (iii) an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, provided certain conditions are satisfied. PHI may be disclosed for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose your PHI in response to a law enforcement official's request if you are, or are suspected to be, a victim of a crime. Further, the Plan may disclose your PHI if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Plan's premises.

(g) The Plan may disclose PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent

with applicable law, as necessary to carry out their duties with respect to the decedent.

(h) The Plan may use or disclose PHI for research, subject to certain conditions.

(i) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.

(j) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke an authorization at any time, provided your revocation is done in writing, except to the extent that the Plan has taken action in reliance upon the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Section 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for emergency treatment, the Plan must request that such health care provider not further use or disclose the information.

A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

The Plan may terminate its agreement to a restriction, if:

- You agree to or request the termination in writing;
- You orally agree to the termination and the oral agreement is documented; or

- The Plan informs you that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after the Plan has informed you of the termination.

If the Plan agrees to a restriction, it will document the restriction by maintaining a written or electronic record of the restriction. The record of the restriction will be retained for six years from the date of its creation or the date when it last was in effect, whichever is later.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070.*

2.2 <u>Right to Request Confidential Communications of PHI</u>

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc. P.O. Box 1449, Goodlettsville, TN 37070.*

2.3 <u>Right to Inspect and Copy PHI</u>

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set.

*"***Designated Record Set***"* means a group of records maintained by or for a health plan that is an enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan provides access to PHI, it will provide the access requested, including inspection or obtaining a copy, or both, of your PHI in a designated record set. The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable hard copy form or such other form or format as agreed to between you and the Plan. The Plan may provide you with a summary of the PHI requested, in lieu of providing access to the PHI or may provide an explanation of the PHI to which access has been provided in certain circumstances. The Plan will arrange with you for a convenient time and place to inspect or obtain a copy of the PHI, or mail a copy of the PHI at your request. If you request a copy of PHI or agree to a summary or explanation of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan denies access to PHI in whole or in part, the Plan will, to the extent possible, give you access to any other PHI requested, after excluding PHI as to which the Plan has grounds to deny access. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, if applicable, a statement of your review rights, including a description of how you may exercise those review rights and a description of how you may complain to the Plan or to the Secretary of the HHS. If you request review of a decision to deny access, the Plan will refer the request to a designated licensed health care professional for review. The reviewing official will determine, within a reasonable period of time, whether to deny the access requested. The Plan will promptly provide you with written notice of that determination.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc. P.O. Box 1449, Goodlettsville, TN 37070*

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

a. Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
b. Is not part of the designated record set;
c. Would not be available for your inspection under the Privacy Standards; or
d. Is accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply within that deadline provided that the Plan, within the original 60-day time period, gives you a written statement of the reasons for the delay and the

date by which it will complete its action on the request. If the Plan accepts the requested amendment, the Plan will make the appropriate amendment to the PHI or record that is the subject of the request by, at a minimum, identifying the records in the designated record set that are affected by the amendment and appending or otherwise providing a link to the location of the amendment. The Plan will timely inform you that the amendment is accepted and obtain your identification of and agreement to have the Plan notify the relevant persons with which the amendment needs to be shared as provided in the Privacy Standards.

If the request is denied in whole or part, the Plan must provide you with a written denial that (i) explains the basis for the denial, (ii) sets forth your right to submit a written statement disagreeing with the denial and how to file such a statement, (iii) states that, if you do not submit a statement of disagreement, you may request that the Plan provide your request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment, and includes a description of how you may complain to the Plan or to the Secretary of HHS. The Plan may reasonably limit the length of a statement of disagreement. Further, the Plan may prepare a written rebuttal to a statement of disagreement, which will be provided to you. The Plan must, as appropriate, identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link your request for an amendment, the Plan's denial of the request, your statement of disagreement, if any, and the Plan's rebuttal, if any, to the designated record set. If a statement of disagreement has been submitted, the Plan will include the above-referenced material, or, at the Plan's election, an accurate summary of such information, with any subsequent disclosure of the PHI to which the disagreement relates. If you do not submit a written statement of disagreement, the Plan must include your request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of the PHI only if requested by you.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070.* All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 <u>Right to Receive an Accounting of PHI Disclosures</u>

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date on which the accounting is requested. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

The accounting will include disclosures of PHI that occurred during the six years (or such shorter time period, if applicable) prior to the date of the request for an accounting, including disclosures

to or by business associates of the Plan. Except as otherwise provided below, for each disclosure, the accounting will include:

- The date of the disclosure;
- The name of the entity or person who received the PHI and, if known, the address of such entity or person;
- A brief description of the PHI disclosed; and
- A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or, in lieu of such statement, a copy of a written request for disclosure.

If during the period covered by the accounting, the Plan has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures, provide the above-referenced information for the first disclosure; the frequency, periodicity or number of the disclosures made during the accounting period; and the date of the last disclosure.

If during the period covered by the accounting, the Plan has made disclosures of PHI for a particular research purpose for 50 or more individuals, the accounting may, with respect to such disclosures for which your PHI may have been included, provide certain information as permitted by the Privacy Standards. If the Plan provides an accounting for such research disclosures, and if it is reasonably likely that your PHI was disclosed for such research activity, the Plan shall, at your request, assist in contacting the entity that sponsored the research and the researcher.

If the accounting cannot be provided within 60 days after receipt of the request, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070.*

2.6 <u>Right to Receive a Paper Copy of this Notice upon Request</u>

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070.*

2.7 <u>Right to a Personal Representative</u>

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person

will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

(a) a power of attorney for health care purposes, notarized by a notary public;
(b) a court order of appointment of the person as the conservator or guardian of the individual; or
(c) an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on Page 1 of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised Notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised Notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home address. In addition, the revised Notice will be maintained on any web site maintained by the Plan to provide information about its benefits.

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised Notice in which such material change is reflected.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

a) disclosures to or requests by a health care provider for treatment;
b) uses or disclosures made to the individual;

c) disclosures made to the Secretary of HHS;

d) uses or disclosures that are required by law;

e) uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and

f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

<u>Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary</u>

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070..*

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

<u>Section 5: Whom to Contact at the Plan for More Information</u>

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: *Administrative Manager, Southeastern Iron Workers Health Care Plan, c/o Southern Benefit Administrators, Inc., P.O. Box 1449, Goodlettsville, TN 37070.Phone (800) 831-4914.*

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in the Southeastern Iron Workers 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:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result 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 pre-existing 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 (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT INFORMATION TO HELP YOU IDENTIFY THIS PLAN

NAME OF PLAN. This Plan is known as the Southeastern Iron Workers Health Care Plan.

TYPE OF PLAN and IDENTIFICATION OF INSURANCE COMPANY. This Plan is a health care benefit plan, providing medical, prescription drug and dental benefits, as well as life and accidental death and dismemberment insurance benefits. The following chart explains whether a particular benefit is provided directly by the Plan or another entity and the name of any claims administrator or insurance company.

Benefit Type	***Type of Administration Claims Administrator***	***Source of Benefits and Type of Funding***
Comprehensive Medical Benefits	Contract Administration SBA	Self-funded from Plan assets and participant self-payments
Prescription Drug Benefits	Contract Administration CIGNA Healthcare	Self-funded from Plan assets and participant self-payments
Dental Benefits	Contract Administration SBA	Self-funded from Plan assets and participant self-payments
Employee Death and Accidental Death and Dismemberment	Contract Administration SBA	Self-funded from Plan Assets and participant self-payments

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

BOARD OF TRUSTEES

This Plan is maintained and administered by a Board of Trustees, which consists of an equal number of Employer and Union representatives. This Board has the primary responsibility for decisions regarding eligibility rules, type of benefits, administrative policies, management of Plan assets, and interpretation of Plan provisions.

As of October 1, 2015 the Trustees of this Plan are:

UNION TRUSTEES		**EMPLOYER TRUSTEES**	
Jack Jarrell	H. Wes Kendrick	David Tankersley	Paul Mette
John Becton	Thomas Graff	Alexander Bergel	Pat Saine
William J. Bradley	William McMillan	Jim Boykin	Dana Whitlow
Robert Duffield	Sean Mitchell	Lester Hensley	H. Preston Taylor

If you wish to contact the Board of Trustees, you may use the address and telephone number below:

Southeastern Iron Workers Health Care Plan
c/o SBA
P.O. Box 1449
Goodlettsville, TN. 37070
1 -800-831-4914
Fax 615 – 859-0324

PLAN ADMINISTRATOR - The Board of Trustees is the Plan Administrator. The Board has selected a professional employee benefits administration firm, SBA, Inc., to serve as the Administrative Manager of the Plan. The Administrative Manager maintains eligibility records, accounts for contributions, informs participants of Plan changes, and other routine administrative functions as directed by the Board of Trustees. You may contact the Administrative Manager at the above address or by calling 1-800-831-4914.

Additionally, the following professionals have been retained by the Board of Trustees to assist in the operation of the Plan:

Fund Attorney
The Venable Law Firm
7402 North 56th Street
Suite 380
Tampa, FL 33617

Fund Auditor
Steven D. Eisenberg, CPA, PA
13290 NW 4th Street
Suite 100
Sunrise, FL 33325

Fund Consultant
Withers Benefit Consultants,Inc.
P.O. Box 9
San Antonio, FL 33576

Fund Investment Consultant
The Javarone Group
777 S. Flagler Street
Suite 900
West Palm Beach, FL 33401

COLLECTIVE BARGAINING AGREEMENTS - This Plan is maintained pursuant to one or more Collective Bargaining Agreements. Copies of any or all of these Agreements shall be made available to you for your inspection at the Administrative Manager's Office of your Local Union Office during normal business hours. Further, should you so request, a copy of the Agreements shall be made available at your place of employment within 10 days of your request if you will advise your employer of your desire to examine the Agreements. You may obtain a copy of the Agreements for a reasonable charge by contacting the Administrative Manager's Office at the address or phone number listed.

PLAN SPONSORS - Employers who are obligated, through the Collective Bargaining Agreements, to contribute to the Plan are considered "Plan Sponsors." You are entitled to receive from the Plan Administrator, upon request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

SOURCE OF CONTRIBUTIONS - The primary source for the benefits provided under this Plan is employer contributions. The Collective Bargaining Agreement determines the amount of contribution. In certain instances, as described in this booklet, participants may make self-

contributions to the Plan in order to continue their eligibility for benefits. A portion of the Plan's assets is invested, which also produces additional Fund income.

TRUST FUND - All contributions and investment earnings are accumulated in a Trust Fund. All benefits are paid directly from the Trust Fund.

ACCOUNTING, PLAN AND REPORTING YEAR - Each 12-month period ending on January 31st constitutes a fiscal year for accounting purposes of all reports to the Department of Labor, to the Internal Revenue Service, and, where required, to any agency of those states in which contributing employers are located. The same 12-month period comprises a Plan Year within the meaning of ERISA.

PROCEDURE FOR OBTAINING ADDITIONAL PLAN DOCUMENTS - If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Fund Office. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

ELIGIBILITY FOR BENEFITS - Please see the Eligibility Rules section of this booklet.

EFFECTIVE DATE: The effective date of this Summary Plan Description is October 1, 2015.

AGENT FOR SERVICE OF LEGAL PROCESS - When legal disputes involving the Plan arise, any legal documents should be served upon:

The Venable Law Firm
7402 North 56th Street, Ste. 380
Tampa, Florida 33617
(813) 985-7122

Service of Legal process may also be made upon any Trustee or the Plan Administrator (Board of Trustees).

CONTINUATION OF PLAN - The Board of Trustees currently intends to continue the Family Health Plan described herein, but reserves the right, in its discretion, to amend, reduce or terminate the Plan at any time for the active participants, retirees, former participants and all dependants.

ACCUMULATION OF ASSETS AND FUNDING OF BENEFITS - All contributions from Participating Employers are made in accordance with Collective Bargaining Agreements between the Union and the Employer. The amounts of these contributions are set forth in the agreements. All benefits provided to Participants in the Plan, their spouses, and their beneficiaries are funded from employer and, in some instances, employee contributions and earnings on investments.

FACILITY OF PAYMENT- If the Trustees determine that a person entitled to benefits under the Plan is unable to care for his affairs because of illness, accident or other incapacity, any payment due may be paid to his legal guardian or other representative. Any such payment shall be made for the account of such incapacitated person, and shall to the extent thereof be a complete discharge of the obligations under this Plan to such person.

ERRONEOUS PAYMENT- If the Trustees determine that a claim has been erroneously paid as a result of a clerical error or on the basis of fraudulent or misleading statements made by the claimant, service provider, or any other entity, then the Trustees shall reserve the right to take necessary action to recover such payment.

Administrative Manager or Administrative Office
"Administrative Manager" or "Administrative Office" means the professional employee benefit administration firm selected by the Board of Trustees to maintain eligibility records, accounts for contributions, inform participants of Plan changes, and other routine administrative functions.

Actively at Work
The term "Actively at Work" or "Active Work" means 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" means a person designated by a Participant or by the terms of the Health Care Plan who is or may become entitled to a benefit thereunder.

Benefit Quarter
The term "Benefit Quarter" means the period of the Employee's eligibility for benefits, not the period in which payment is made on his behalf for the number of hours he works to become or remain eligible.

Child or Child/ren

The terms "Child" or "Children" shall mean a person under age 26 who is the:

1. Natural child of a participant, provided parental rights have not been abolished by a court or by adoption,
2. Adopted child of a participant (from the moment of placement in the home after assumption and retention of a Legal obligation for total or partial support of a child in anticipation of adoption of such child);
3. Step child, or child under legal guardianship, or
4. Child over whom the Employee or a spouse has legal custody, for whom the Employee or a spouse has full or joint parental responsibility and control and is approved by the Plan in writing as a Child, or
5. Alternate recipient according to the terms of a Qualified Medical Child Support Order.

` Qualified Medical Child Support Order means any judgment, decree, or order including approval of a settlement agreement which:

a. Issues from a Court of competent jurisdiction pursuant to a States Domestic Relations Law;
b. Requires an Employee to provide only the group health coverage available under the Plan for the Employee's children, even though you no longer have custody;
c. Clearly specifies the Employee's name and last known mailing address and the names and addresses of each child covered by the Order;
d. Provides a reasonable description of the coverage to be provided;

e. Specifies the length of time the Order applies and;
f. Identifies each plan affected by the Order.

The Plan will also comply with National Medical Child Support orders promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1988; provided that the order specifies a Plan Participant by name and mailing address, contains the name and address of each alternate recipient (or the address of an official of a state or political subdivision that may be substituted for the alternate recipient), describes the coverage to be provided, and does not provide that the Plan provide any other type of form of benefit other than those types and forms provided under the Plan, and otherwise complies with the requirements of a NMCSO.

6. Extended Eligibility for Incapable Dependents - Eligibility providing benefits for medical care expenses may be continued beyond the limiting age for an eligible Dependent child who is mentally or physically incapable of earning a living and who is dependent upon an Employee for support and maintenance, provided that the Employee furnishes evidence of the Dependent's incapacitation at least 31 days before the Dependent reaches the limiting age and upon written request no more frequently than annually.

However, this definition 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.

If both parents are Covered Employees under this Plan, a child may be included as a dependent of both parents. Benefits will be coordinated so that no more than 100% of eligible expenses will be paid.

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.

Any benefits continued for such Dependent children will terminate under any of the conditions described above, or, in any event, when the Dependent ceases to be incapacitated, or at the end of the 31-day period after any requested proof of continued incapacity is not furnished.

CIGNA

"CIGNA" means CIGNA Healthcare Company who provides Network OAP and PPO services for medical and dental, as well as prescription claims handling, and utilization management. The Trustees have contracted with CIGNA to provide these services for the Plan.

Covered Employment

"Covered Employment" means employment for which an Employer has paid a contribution to the Health Care Plan on an Employee's behalf.

Dependent

The term "Dependent" means:

1. An Employee's legal spouse, provided they are not legally separated, (the term “spouse” shall refer only to a person of the opposite sex who is a husband or wife. The term “spouse” shall exclude a common law spouse or spouse by civil union whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred. The term “marriage” means only a legal union between one man and one woman as husband and wife.
2. An Employee's unmarried Child/ren from birth to 26 years of age (Limiting Age),
3. An Employee's Incapacitated Child/ren as defined by the Plan, and
4. 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.

Employee

The term "Employee" means an:

1. 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.
2. Officer or salaried employee of the Union or the Southeastern Iron Workers District Council or the Mid-Atlantic Iron Workers District Council or the Joint Apprenticeship and Training Committee 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 contributions by the Collective Bargaining Agreement.
3. 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.
4. 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.
5. 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.
6. 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" or “Contributing Employer” means an:

1. 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 Health Care Plan with respect to Employees represented by the Union.

2. Employer who is not a member of, nor 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.
3. 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.
4. 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.
5. Association of one or more Employers which have Collective Bargaining Agreements with at least one of the Iron Workers Local Unions having jurisdiction over the Employer's work.
6. The 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.
7. 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.

Employer Contributions

The term "Employer Contribution(s)" or "Contribution(s)" means actual payment made by any Employer pursuant to a Collective Bargaining Agreement or other such agreement to this Plan.

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"): FMLA Leave cannot exceed 12 work weeks in a 12-month period and must be certified by an Employer as FMLA Leave in accordance with the FMLA and the Fund's policies and procedures.

Health Care Plan or Plan

The term "Health Care Plan" or "Plan" means the Southeastern Iron Workers Health Care Plan and the Rules and Regulations governing the eligibility of Employees for the benefits to be provided, as they may from time to time be amended.

HIPAA

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

Hospice

The term "Hospice" means 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.

Hospital
The term “Hospital” means:

1. an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
2. an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
3. an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Incapacitated Child/ren
Benefits are provided for Dependent Children 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:

1. 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
2. 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", as the term is used herein, means the Employee and/or his Dependents.

Injury
The term “Injury” means 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.

Joint Apprenticeship and Training Committee
The term "Joint Apprenticeship and Training Committee" means an apprenticeship or training program sponsored by an Employer and Union participating in the Plan.

Maximum Reimbursable Charge
The Maximum Reimbursable Charge is the lesser of:

1. the provider's normal charge for a similar service or supply; or
2. the Plan-selected percentile of all charges made by providers of such service or supply in the geographic area where it is received.

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may be considered. CIGNA uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually. For this Plan the 80th percentile is used to determine the Maximum Reimbursable Charge. Additional information about the Maximum Reimbursable Charge is available upon request.

Medically Necessary/Medical Necessity
"Medically Necessary" or "Medical Necessity" means health care services and supplies which are determined to be: (a) no more than required to meet the basic health needs of the eligible Participant; (b) consistent with the diagnosis of the condition for which they are required; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or their Physician; (e) rendered in the least intensive setting that is appropriate for the delivery of health care; and (f) of demonstrated medical value.

Network
The term "Network" refers to any Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), or similar organization contracted to provide health care services to the Plan and its Participants.

Nurse
The term "Nurse" means a professional who has the right to use the following professional designations: Registered Graduate Nurse (R.N.); Licensed Practical Nurse (L.P.N.); Licensed Vocational Nurse (L.V.N.).

Participant
The term "Participant" means 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.

Physician
The term "Physician" means 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. CIGNA has identified certain physicians as Cigna Care Network (CCN) Specialists and copayments for such physicians may be lower than non-CCN physicians.

Primary Care Physician (PCP)
“Primary Care Physician” means a General Practitioner, Internist, Pediatrician, or Gynecologist.

Qualifying Quarter
The term "Qualifying Quarter" means a calendar quarter of (1) January, February, and March, (2) April, May, and June, (3) July, August, and September, or (4) October, November, and December during which the Employer makes payment on behalf of the Employee for Covered Employment.

Related Supplies
Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Retiree
A former Employee who has retired from employment with his or her employer and has been awarded retirement from a pension plan affiliated with a Union participating in this Plan and whose employers are contracted to pay at a contribution rate level established by the Board of Trustees to allow participation in the retiree benefit plan.

Sickness
The term "Sickness" means a non-occupational disease, disorder or condition which requires treatment by a Physician. It includes both childbirth and pregnancy of an eligible spouse..

Trust Agreement
The term "Trust Agreement" means 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" means 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" means 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" means one of the Local Unions of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, including Locals 272, 387, 397, 402, 597, 709, 808, and 848 and their successors and assigns. The term may also include such other 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 this Trust Agreement under such terms and conditions as may be required by the Trustees.

USERRA

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