# SOUTHEASTERN IRON WORKERS HEALTH CARE PLAN

## SUMMARY PLAN DESCRIPTION


**AMENDED AND RESTATED**
**January 1, 2019**

## FUND OFFICE ADDRESS AND PHONE NUMBERS

SOUTHEASTERN IRON WORKERS
HEALTH CARE PLAN
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Local Phone Number: (615) 859-0131
Toll-Free Number: (800) 831-4914
Fax Number: (615) 859-0818

## PREFERRED PROVIDER ORGANIZATION

The Plan's preferred provider organization (PPO) is listed on your ID card. Generally, you must use the services of a participating PPO provider to receive medical benefits under the Plan (except in certain emergency situations). You may contact the PPO at the number listed on your ID card, or you may access the PPO's website to search for participating providers.

## PRE-ADMISSION CERTIFICATION

As outlined further in this booklet, all hospital inpatient admissions and outpatient surgical procedures must be pre-certified in order to be covered under the Plan. The number to be used for pre-certification is listed on your Plan ID card.

## PRESCRIPTION DRUG COVERAGE

In order to be covered under the Plan, prescription drugs must be purchased from a participating pharmacy. The contact information for the Plan's prescription benefits manager is listed on your Plan ID card. Be sure to present your card each time you purchase prescription drugs.

# SOUTHEASTERN IRON WORKERS
# HEALTH CARE PLAN

Dear Plan Participant:

The following pages contain a summary of the plan of benefits of the Southeastern Iron Workers Health Care Plan.

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

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

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

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

Best regards,

Your Board of Trustees

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# SOUTHEASTERN IRON WORKERS
# HEALTH CARE PLAN

## The Fund is Administered by:
## THE BOARD OF TRUSTEES

## The Trustees of the Fund are:

**UNION TRUSTEES:**

**MR. WILLIAM "BILL" J. BRADLEY**
Iron Workers Local 597
9616 Kentucky Street
Jacksonville, Florida 32218

**MR. ROBERT DUFFIELD**
Iron Workers Local 387
109 Selig Drive SW
Atlanta, Georgia 30336

**MR. DANIEL SEGOVIA**
Iron Workers Local 848
7326 Pepperdam Avenue
North Charleston, South Carolina 29418

**MR. GREGORY "JACK" JARRELL**
Iron Workers Local 397
P.O. Box 18
Mango, Florida 33550

**MR. ROBERT (BOBBY) KNOST**
Iron Workers Local 808
200 E. Landstreet Road
Orlando, Florida 32824

**MR. WILLIAM MCMILLAN**
Iron Workers Local 709
131 Westside Boulevard
Pooler, Georgia 31322

**MR. SEAN MITCHELL**
Iron Workers Local 402
1001 West 15th Street
Riviera Beach, Florida 33404

**MR. YOSVANY TORRES**
Miami Ironworkers Local 272
1201 N.E. 7th Avenue
Ft. Lauderdale, Florida 33304

**EMPLOYER TRUSTEES:**

**MR. ALEXANDER BERGEL**
ADF International Incorporated
9188 NW 44th Court
Coral Springs, Florida 33065

**MR. JIMBO BOYKIN**
Boykin Steel and Crane
P.O. Box 879
Jesup, Georgia 31598

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

**MR. LESTER HENSLEY**
Eagle Metal Products Incorporated
5409 Woods West Drive
Lake Worth, Florida 33463

**MR. PAUL METTE**
Mette Construction Incorporated
7065 Hundred Acre Drive
Cocoa, Florida 32927

**MR. STEVEN SCHELL**
Williams Enterprises of Georgia
Chief Financial Officer
1285 Hawthorne Avenue
Smyrna, Georgia 30080

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

**Administrative Services Are Provided By:**

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

**The Fund Attorney is:**

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

# SCHEDULES OF BENEFITS

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

## SCHEDULE OF BENEFITS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

### 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**

CALENDAR YEAR DEDUCTIBLE
- Per Individual . . . . . $500
- Per Family . . . . . .$1,000

EMERGENCY ROOM DEDUCTIBLE
- Per Occurrence . . . . . $200

MAXIMUM OUT-OF-POCKET EXPENSE
- 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

FUND PAYMENT PERCENTAGES
- In-Network Covered Preventive Services – deductible is waived . . . . . 100%
- In-Network Office Visits – after co-pays . . . . . 100%
- Other Covered In-Network charges – after deductibles . . . . . 80%
- Emergency (In-Network or Non-Network) – after deductibles . . . . . 80%
- In-Network and Emergency treatment after reaching Out-of-Pocket Maximum . . . . . 100%
- Charges Incurred with Quest Diagnostics and Labcorp – after deductibles . . . . . 100%
- Other Non-Network . . . . . .Not Covered

COPAYS
- Primary Care Physician (PCP) Office Visit . . . . . $30 Copay
- Chiropractor Office Visit . . . . . $25 Copay
- Specialist Office Visit . . . . . $40 Copay
- Urgent Care Visit . . . . . $30 Copay

**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 and Gynecologists only.

**PRESCRIPTION DRUG CARD BENEFITS – EMPLOYEES AND DEPENDENT COVERAGE**
(Provided Through Participating Network Pharmacies Only)

Calendar Year Deductible . . . . . None

Maximum Out-of-Pocket Expense
Per Individual . . . . . $1,000
Per Family . . . . . $2,000

| In-Network Copays | Retail Pharmacy | Tel-Drug Mail Order |
|---|---|---|
| Federally Mandated Preventive 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 | | |
| Specialty Drugs | 30 Days | 30 Days |
| Non-Specialty Drugs | 30 Days | 90 Days |

**Notes:**

- 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 the pharmacy benefit manager's formulary provisions, there are some drugs not covered by the Plan.
- A 90-day supply of non-specialty medications may be purchased at participating pharmacies that have agreed to participate in the program established for this purpose.

**DENTAL BENEFITS – EMPLOYEE AND DEPENDENT COVERAGE**

Maximum Benefit Payable Per Covered
Person Per Calendar Year . . . . . $1,500

Deductible . . . . . None

Fund Payment Percentage In-Network and Non-Network . . . . . 100%

**Notes:**

- Treatment of temporomandibular joint dysfunction is not covered by the Plan.
- The Maximum Benefit Payable per Calendar Year does not apply to routine exams and cleanings (limited to two per calendar year) and associated x-rays.
- The Maximum Benefit Payable per Calendar Year does not apply to Class I – Diagnostic and Preventive Services for individuals under age 19 (see pages 47 – 48 for a complete list of these services).

**VISION BENEFITS · EMPLOYEE AND DEPENDENT COVERAGE**

Maximum Benefit Payable per Covered Person per Calendar Year. . . . . $600

Deductible . . . . . None

Fund Payment Percentage . . . . . 100%

**Note:**

- Maximum Benefit Payable per Calendar Year does not apply to Essential Pediatric Vision Services as outlined in this booklet.

## SCHEDULE OF BENEFITS FOR RETIREES AND DEPENDENT SPOUSES

**MAJOR MEDICAL BENEFITS – RETIRED EMPLOYEE AND DEPENDENT SPOUSE**

CALENDAR YEAR DEDUCTIBLE
- Per individual . . . . . $500
- Per Family . . . . . $1,000

MAXIMUM OUT OF POCKET EXPENSE
- In Network Medical
  - Per Individual . . . . . $5,350
  - Per Family . . . . . $10,700
- Non-Network . . . . . Not Coverage

INPATIENT HOSPITAL ROOM & BOARD BENEFIT
- Daily Maximum Charge Allowed . . . . . Semi-Private

FUND PAYMENT PERCENTAGES
- In-Network Covered Preventive Services – deductible is waived . . . . . 100%
- In-Network Office Visits – after deductible . . . . . 80%
- Other Covered In-Network charges – after deductible . . . . . 80%
- Emergency (In-Network or Non-Network) – after deductible . . . . . 80%
- In-Network and Emergency treatment after reaching Out-of-Pocket Maximum . . . . . 100%
- Charges Incurred with Quest Diagnostics and Labcorp – after deductible. . . . . 100%
- Other Network . . . . . Not Covered

IN-NETWORK CHIROPRACTIC
- Office Visit Copay – Chiropractor . . . . . $25 Copay
- Maximum Covered Visits per Year . . . . . 10 Visits

**Note:**

- 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 – RETIRED EMPLOYEE AND DEPENDENT SPOUSE** (Provided Through Participating Network Pharmacies Only)

Calendar Year Deductible – Individual . . . . . $50

Maximum Out-of-Pocket Expense
- Per Individual . . . . . .$1,000
- Per Family . . . . . .$2,000

Fund Payment Percentage: Retail Pharmacy
- Federally Mandated Preventive Care Drugs . . . . . 100%
- Prior to Reaching Maximum Out-of-Pocket Maximum . . . . . 50%
- After Maximum Out-of-Pocket is Reached . . . . . 100%

Maximum Days Supply – Retail Pharmacy . . . . . 30 days

# CLAIM PROCEDURES

## HOW TO FILE YOUR CLAIMS

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

1. **Time Limit for Filing Claims** – Claims for benefits must be submitted to the Plan within 90 days after the expense is incurred. The Trustees may extend the 90 day deadline if they deem it reasonably necessary under the circumstances. However, in no event will any claim be covered if submitted more than twelve months after it is incurred.

2. When you receive services from a doctor, hospital or other medical care provider, you must furnish to that provider the information needed to file a claim. This information is found on your Fund I.D. card. Claims for vision and dental benefits as well as death and accidental death and dismemberment should be filed direct with the Fund office.

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

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

## PAYMENT OF CLAIMS BY FUND OFFICE

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

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

## PRE-APPROVAL OF A CLAIM

All inpatient hospital and facility admissions and advanced imaging procedures must be precertified. When seeking other types of health care services, you may wish to contact the Fund office prior to receiving treatment in order to assure that the treatment will be covered. You are especially encouraged to contact the Fund office prior to outpatient surgery or other serious medical treatment, if at all possible. The following rules apply to pre-approval of treatment:

1. **Approval of Medically Necessary Treatment** – As explained in this booklet, a charge must be Medically Necessary to be covered by the Plan. If there is any doubt about whether your expected treatment will be considered Medically Necessary under the Plan, you may contact the Fund office for an advance decision. As explained later in this booklet, you may appeal any adverse decision made by the Fund office regarding Medical Necessity.

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

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

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

As explained above, you may want to request pre-approval of treatment to ensure that it will be covered under the Plan. The Fund office staff will respond to all such requests in a timely manner, as follows:

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

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

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

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

2. **Non-Urgent Care Claims** – If proposed treatment is determined to be of a non-urgent nature, a decision on your request for pre-approval will be made and communicated to you within 15 days of receipt of your request. If additional information is necessary to make a decision on your claim, the Plan may require up to an additional 15 days to make a decision on your request. If an extension is required, you will be notified within 15 days of receipt of your request regarding the extension and a decision will be made as soon as possible. If the extension is required because it is necessary for you to provide additional information, you will be given at least 45 days to provide the requested information.

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

# DEFINITIONS

The following definitions of terms used in this booklet may be helpful in understanding the benefits provided under the Plan.

**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.

**COVERED EMPLOYMENT**

"Covered Employment" means employment for a participating employer that has paid a contribution to the Plan on the Employee's behalf.

**COVERED PERSON**

The term "Covered Person" means either an Eligible Employee, a Retiree or a Dependent, as those terms are defined in this section.

**DEPENDENT**

The term "Dependent" means:

1. An Employee's legal spouse, provided the two are not legally separated. The term "spouse" excludes 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.

2. An Employee's child/ren from birth to 26 years of age.

3. Child/ren whom the Plan is required to cover pursuant to a Court or Administrative Order, including a Qualified Child Support Medical Order (QCSMO), who is less than 26 years of age.

4. An Employee's unmarried child who is age 26 or older and who is mentally or physically incapable of earning a living as determined by the Office of Rehabilitation Services in the State Department of Education and who is dependent upon the Employee for support and maintenance, provided the Employee furnishes evidence of the Dependent's incapacitation at least 31 days before the Dependent reaches age 26 and upon written request thereafter no more frequently than annually.

As used in this definition, "child" means:

1. The natural child of an Employee, provided parental rights have not been abolished by a court or by adoption,

2. The adopted child of an Employee (from the moment of placement in the home after assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of such child);

3. The step child, or child under legal guardianship, of an Employee;

4. A child over whom the Employee or a Dependent spouse has legal custody, for whom the Employee or spouse has full or joint parental responsibility and control, and who is approved by the Plan in writing as a child; or

5. An alternate recipient according to the terms of a Qualified Medical Child Support Order.

This definition does not include 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 a child 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 Fund office proof acceptable to the Board of Trustees that any child meets or continues to meet any of the above categories.

Any benefits continued for incapacitated 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.

**ELIGIBLE EMPLOYEE**

The term "Eligible Employee" means an Employee who satisfies the rules of eligibility for active Employees as outlined in this booklet.

**EMERGENCY**

The term "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

**EMPLOYEE**

The term "Employee" means a person employed by a contributing employer, a person employed by the Board of Trustees, officers and employees of the Union and such other persons as the Trustees may determine, provided the required contributions are made to the Plan on behalf of such Employees under the terms of a collective bargaining agreement or a written participation agreement.

**HOSPICE**

The term "Hospice" means a licensed facility or program the primary purpose of which to provide counseling, medical services and sometimes room and board to terminally ill persons who have less than six 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 nursing service by Registered Graduate Nurses;

2. An institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and which is 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.

**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.

**MAXIMUM REIMBURSABLE CHARGE**

The term "Maximum Reimbursable Charge" means 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.

**MEDICALLY NECESSARY/MEDICAL NECESSITY**

The terms "Medically Necessary" and "Medical Necessity" mean health care services and supplies which are determined to be: (a) no more than required to meet the basic health needs of the Covered Person; (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.

**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.).

**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. Additionally, licensed chiropractors, licensed optometrists, licensed ophthalmologists and licensed nurse-midwives (with respect to maternity care) are included in the definition of a Physician.

**PRIMARY CARE PHYSICIAN (PCP)**

The term "Primary Care Physician" means a General Practitioner, Internist, Pediatrician, or Gynecologist.

**RELATED SUPPLIES**

The term "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**

The term "Retiree" means a former Employee who satisfies the eligibility rules for retired employees as outlined in this booklet.

**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 a Dependent spouse.

## USUAL, CUSTOMARY AND REASONABLE EXPENSE

The term "Usual, Customary and Reasonable Expense" means the lesser of:

1. The PPO contracted charge; or

2. A level of charges that does not exceed the prevailing range of charges generally made by providers in the locality for like or comparable services or supplies. The term "locality" means a geographic area that includes a cross-section of persons or entities regularly furnishing the type of treatment, services, or supplies for which the charge is made. In determining whether charges are Usual, Customary, and Reasonable, due consideration will be given to the condition being treated and any medical complications or unusual circumstances that may require additional time, skill, or experience.

## ELIGIBILITY – ACTIVE EMPLOYEES

You will become eligible for coverage under the Plan if you 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 your behalf. This section explains the rules for how you can first gain and then continue eligibility under the Plan, when your dependents become eligible, as well as what happens if your eligibility should terminate.

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

You will initially qualify for 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 your behalf during any eleven consecutive calendar months,

### CONTINUING ELIGIBILITY

Once you have met the above qualification for Initial Eligibility, ongoing coverage will be determined based on Qualifying Quarters and the corresponding Benefit Quarters. If payment is made on your behalf for a minimum of 375 Hours of Covered Employment in a Qualifying Quarter, you 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 |
|---|---|
| January, February, March | July, August, September |
| April, May, June | October, November, December |
| July, August, September | January, February, March |
| October, November, December | April, May, June |

### HOUR BANK

The purpose of an Hour Bank is to assist you in retaining your benefits during short periods of illness or seasonably low periods of employment. After establishing initial eligibility, all hours paid on your behalf in excess of 400 hours during a Qualifying Quarter will be credited to your Hour Bank. The maximum number of hours that may be accumulated in your Hour Bank at any one time is 750 hours. If you do 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 your Hour Bank to continue coverage for the next Benefit Quarter. If at any time you are not actively at Work or available for Active Work in the jurisdiction of the Plan, your Hour Bank will be cancelled and any remaining hours will be forfeited.

### SELF-PAYMENTS

You may continue your coverage under the Plan through self-payments if your eligibility would otherwise terminate due to having insufficient hours worked, provided you are credited with at least one

hour of work for which contributions are paid to the Plan in the applicable Qualifying Quarter, either through current hours worked or accumulated Hour Bank hours. If you meet this minimum requirement, you will be eligible to self-pay the difference between the hours credited and the minimum 375 hours required for Continuing Eligibility for the Benefit Quarter.

If you have less than one hour credited through hours paid and/or Hour Bank credits during a Qualifying Quarter, you will not be eligible to self-pay but may otherwise be eligible for Continuation Coverage under COBRA. Self-payments cannot be accepted to establish Initial Eligibility or Reinstated Eligibility.

The amount of the self-payment will be equal to the current hourly employer contribution rate multiplied by the hours needed to meet the 375 hour minimum for Continuing Eligibility.

The Fund office will send a written notice advising you that you are eligible to self-pay in order to continue eligibility. You will have 30 days from the date of the written notification in which to remit the required amount of self-pay to the Fund office payable to the "Southeastern Iron Workers Health Care Plan" by check or money order. If your self-payment is not received by the date due, your eligibility will automatically terminate in accordance with Plan provisions (subject to the COBRA Continuation provision).

Regardless of the above, if your self-payment is received after the due date otherwise specified above, it will be accepted, and coverage under the Plan will be granted, subject to the following provisions:

1. Your self-payment must be received in the Fund office no later than 45 days after the due date; and

2. A late self-payment will be allowed on a one-time basis only.

Self-payment is not available if you are not available for work with a contributing employer.

**RECIPROCAL HOURS**

From time to time, the Plan receives transfers of contributions under the terms of the Iron Workers International Reciprocal Health and Welfare Agreement or other "money follows the man" reciprocal agreements. In those instances where contributions are transferred, the number of hours credited for Initial Eligibility, Continuing Eligibility, Reinstatement of Eligibility and Hour Bank purposes will be equal to the number of hours worked under the transferring fund.

**WHEN BENEFIT COVERAGE BECOMES EFFECTIVE**

Your coverage becomes effective as of the date you satisfy the requirement for Initial Eligibility. Coverage for your Dependents becomes effective on the later of the date you become eligible or the date your 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 Fund office.

## TERMINATION OF ELIGIBILITY

Your eligibility and benefit coverage will terminate on the earliest of the following dates:

1. The first day of the Benefit Quarter for which you have failed to accumulate contributions for at least 375 hours of Covered Employment in the corresponding Benefit Quarter and you have not elected to continue coverage by either Self-Pay or COBRA;

2. The date that any required contribution is due and unpaid;

3. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms;

4. The effective date of any opt out or disenrollment if you request such opt out or disenrollment in writing. You may voluntarily elect to opt out of Medical (including Prescription Drug), Dental, Vision, and/or Death Benefits. Coverage may be reinstated upon receipt of a written notice confirming your intent to opt back into coverage;

5. The date you cease to be employed by, or available for work with, a contributing employer in a category of work covered by an applicable collective bargaining agreement. However, this provision will not be applicable to disabled employees, retired employees, or employees who are working for, or available for work with, a contributing employer of a reciprocating local union. Such termination will be immediate upon receipt of written notification of your status in the Fund Office. If you are working at the trade for a non-contributing employer, you will be deemed to be unavailable for work with a contributing employer. An employee terminated under this provision will not be eligible to make self-payments to continue coverage, other than COBRA payments if otherwise applicable; or

6. The date determined by the Board of Trustees that occurs as a result of the cessation of participation in the Southeastern Iron Workers Health Care Plan by your local union on behalf of its members who participate in the Plan.

In the event of a termination of benefits, any accumulated hours will be forfeited and any Hour Bank account will 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 your benefits under the Plan, except that, in the event of your death, benefits with respect your eligible Dependents will be continued, subject to the other terms of the Plan, during the remainder of the Benefit Quarter in which your death occurs and during any future Benefit Quarters for which you would have been eligible based on accumulated hours prior to your death, including hours in your Hour Bank;

2. The date the Plan is amended so as to terminate the benefits of all Dependents;

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;

4. The date that you or your Dependent spouse request in writing that your spouse's coverage under the Plan be terminated, provided that coverage may only be terminated prospectively (or if no date is specified, the date the written request is received); or

5. The effective date of any opt out or disenrollment of any Dependent(s). You may voluntarily elect to opt out of any, or all, of the coverages provided by this Plan. This refusal of coverage can apply to Medical, Dental, and Vision Benefits. For children under the age of majority, the election must be signed by both parents and/or legal guardians. The election for a Dependent spouse requires both you and your spouse to sign. For a Dependent child over the age of majority, both you and your Dependent child are required to sign. Coverage may be reinstated upon receipt of a written notice signed by you and your spouse confirming the intent to opt back into coverage.

**EXTENDED ELIGIBILITY FOR INCAPABLE DEPENDENT CHILDREN**

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

Any benefits continued for your Dependent children will terminate under any of the conditions described above, or, in any event, when your 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 your eligibility terminates due to a failure to accumulate the required number of hours of contributions paid on your behalf, your 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, you have been without coverage for a period of 24 months or longer, you must once again 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.

**ENTRY INTO THE ARMED FORCES**

If you, the Employee, are inducted or enlist or are otherwise called to active duty in the uniformed services of the United States of America you will be entitled to credit or the right to make self-contributions for continued coverage as set forth below:

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

2. For active uniformed service of 31 days or more – All benefits for you and your Dependents will be terminated on the date you enter uniformed service for a period of service of 31 days or more, except as follows:

   (a) You may choose to continue coverage through the use of any accumulated hours worked and Hour Bank hours, if available.

   You may elect to use your accumulated eligibility to continue coverage under the Plan, or may elect to defer the use of your eligibility until your reemployment as described below, or may elect to use any portion of your accumulated eligibility and defer usage of the remainder. Failure to affirmatively elect continued coverage under this paragraph will result in an automatic deferral of the use of your accumulated eligibility.

   (b) Upon termination of coverage as otherwise outlined in this section, and following any extension of coverage under paragraph (a) above, if applicable, you may elect to continue coverage for the period of active uniformed service, not to exceed 24 months, by making COBRA self-contributions in the amount and under the terms outlined in this booklet. In order to be entitled to make such self-contributions, you must notify the Fund office in writing within 60 days following the date on which your coverage would otherwise terminate.

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

If you have chosen to use accumulated eligibility credits as outlined under paragraph 2.(a) above and, as a result, have insufficient eligibility accumulated to your credit to continue your coverage under the Fund upon reemployment, you will be required to make monthly payments to the Fund in order to regain and continue your coverage. Monthly payments will be required until you have worked sufficient hours to satisfy the requirements for continuing eligibility.

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

# ELIGIBILITY – RETIRED EMPLOYEES

## REQUIREMENTS FOR PARTICIPATION

Participation as a Retiree is subject to the following requirements:

1. You 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. You must have been an Eligible Employee under the Southeastern Iron Workers Health Care Plan for at least three months immediately prior to retirement; and

3. You 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 your retirement, and you:

   (a) Were at least age 55 but under age 65 on the date of retirement, and have retired with at least five years of service credits earned in a participating union's pension plan; or

   (b) Were at least age 50 but under age 55 on the date of retirement or complete withdrawal from Covered Employment anywhere as an ironworker and have earned at least 30 years of service credits in a participating union's pension plan.

You must first elect or reject COBRA coverage prior to making self-payments under this provision. You may continue coverage under another group medical plan on a continuous basis prior to participating in this Plan. If you or your Dependent spouse elect to continue coverage under COBRA or another group medical plan, you must elect this Retiree coverage immediately upon termination of that coverage.

If you qualify for this provision you will be permitted to make self-payments until the age of 65, Medicare eligibility, or your termination date, whichever comes earlier, as set forth below. Benefits for Dependents may continue beyond your termination if your Dependent spouse is under age 65, is otherwise not eligible for Medicare and continues Plan participation. Coverage for your Dependents will terminate in accordance with the provisions outlined below.

If you are over age 65 when you retire, or are eligible for Medicare for reasons other than age, and you otherwise meet the eligibility requirements above, you may elect to continue coverage for your non-Medicare eligible Dependents. Coverage for those Dependents will terminate in accordance with the provisions outlined below.

## COMMENCEMENT OF RETIREMENT BENEFITS

No benefits will become effective until application is made in advance of the month they are to be effective. Applications must be made directly to the Fund office. If you elect to self-pay in accordance with these provisions, you must make a timely self-payment, equal to the monthly cost of coverage, directly to the Fund office. Your payment must be received by the Fund office no later than 30 days following the first day of the month for which you are 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 you qualify under this provision, you will be permitted to make self-payments until the age of 65, Medicare eligibility, or your termination date, whichever comes earlier. Dependents are eligible to continue eligibility beyond your termination if your Dependent spouse is under age 65, is otherwise not eligible for Medicare and continues to make Retiree self-payments at the rate determined by the Trustees. Coverage for your Dependents will terminate in accordance with the provisions outlined below.

**RETURN TO COVERED EMPLOYMENT AFTER COMMENCEMENT OF RETIREE BENEFITS**

If you return to work in Covered Employment and are already participating as a Retiree, you will be provided with contribution dollar credits towards your self-payment required to maintain your and/or your spouse's eligibility. 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, you will continue to be required to self-pay monthly to the extent necessary to maintain eligibility as a Retiree.

| 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 your return to Covered Employment for a period of time sufficient to satisfy the Continuing Eligibility requirement for Active Employees, you will once again be classified as an active Eligible Employee for all purposes of the Plan. This reclassification will be automatic, and no application for active status will be required. Should you later fail to satisfy the ongoing eligibility requirements for active coverage, you will be entitled to continue coverage through COBRA self-contributions, or you may opt to participate once again as a Retiree or may defer participation under this provision until your COBRA self-contribution rights are fully or partially exhausted. The Fund office will notify you of your right to elect COBRA continuation coverage and you must notify the Fund office of your election to once again participate as a Retiree. Coverage under the Fund must be continuous in order for you to once again participate under this provision.

**TERMINATION OF RETIREE ELIGIBILITY**

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

For you:

1. The first day of the month in which you attain age 65 or otherwise become entitled to Medicare (whether or not you apply for Medicare);

2. The first day of the month in which you become covered (as an employee or as a dependent) under any other group medical benefits plan;

3. The first day of the-month in which you return 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 you, if retired on a disability pension, are no longer receiving a disability pension;

5. The first day of the month for which your fail to make a timely self-payment;

6. The date this Retiree provision terminates; or

7. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms.

For your Dependents:

1. The first day of the month in which your 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 you continue participation;

2. The first day of the month in which you or your Dependent spouse become covered (as an employee or as a dependent) under any other group medical benefits plan;

3. The first day of the month in which you return to work with a non-participating employer who engages in work similar to employers who participate in the Plan;

4. The first day of the month in which you, if retired on a disability pension, are no longer receiving/ a disability pension;

5. The date your Dependent ceases to meet the definition of Dependent under the Plan (COBRA Continuation coverage provisions may apply);

6. The last day of the month following the date of your death if there is no Dependent spouse who is continuing self-payments for benefit coverage (COBRA Continuation coverage provisions will apply);

7. The first day of the month for which you fail to make a timely self-payment;

8. The date the Retiree provision terminates; or

9. The date the Plan is cancelled, terminated or discontinued in accordance with the respective terms.

For your surviving Dependent spouse if you die, attain age 65 or become 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 your 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 you continue participation;

2. The first day of the month in which your spouse becomes covered (as an employee or as a dependent) under any group medical plan;

3. The first day of the month in which your surviving spouse remarries;

4. The first day of the month marking the end of eight years of coverage following your death;

5. The first day of the month marking the end of eight years of coverage following your attainment of age 65 or eligibility for Medicare;

6. The first day of the month for which your spouse fails to make a timely self-payment; or

7. The date this Plan or this provision terminates.

COBRA Continuation of Coverage is not available after termination of Retiree Benefits (except in cases of divorce or, for Dependent children, your death or that of your Dependent spouse).

Timely self-payments means payments received by the Fund office no later than 30 days following the first day of the month when payments are due.

If you or your Dependent spouse subsequently terminate participation under this provision for whatever reason (other than return to active status), you or your spouse may not return to participation at a later date.

This Retiree provision and these eligibility rules may be changed, modified, amended or terminated at any time in order to maintain the Plan's financial stability and actuarial soundness. The granting of medical coverage for retired employees and their spouses is neither a vested nor a contractual right.

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

## INTRODUCTION

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

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

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

## WHAT IS COBRA CONTINUATION COVERAGE?

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

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

1. Your hours of employment are reduced; or

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

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

1. Your spouse dies;

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

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

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

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

1. The parent-employee dies;

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

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

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

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

**WHEN IS COBRA COVERAGE AVAILABLE?**

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

**YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS**

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

**HOW IS COBRA COVERAGE PROVIDED?**

Once the Fund office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

## HOW LONG DOES COBRA COVERAGE LAST?

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

### Disability Extension of 18-Month Period of Continuation Coverage

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

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

### Maximum Period of 24 Months for Service in the Armed Forces

As described on pages 17 and 18, if you enter active duty in the Uniformed Services of the United States of America for a period of 31 days or more, the maximum period of COBRA coverage which you may elect is 24 months, provided you notify the Fund office in writing within 60 days of your entry into active uniformed service.

### Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the employee or former employee dies or gets divorced or legally separated or the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## PROCEDURE FOR OBTAINING CONTINUATION COVERAGE

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

## TYPE OF COVERAGE EXTENDED

Medical, Prescription Drug, Dental and Vision Benefits may be continued by Eligible Employees and Dependents. The benefits that are available during the continuation coverage period will be the same as those being provided under the Plan to similarly situated participants with respect to whom a qualifying event has not occurred.

## CANCELLATION OF COBRA COVERAGE

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

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

2. The Plan terminates;

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

4. You become covered by Medicare.

## ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund office at the address listed below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable

Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/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**

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

**PLAN CONTACT INFORMATION**

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

Southeastern Iron Workers Health Care Plan
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131
Toll-Free: (800) 831-4914

# EMPLOYEE DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
## (FOR ACTIVE ELIGIBLE EMPLOYEES ONLY)

### GENERAL PROVISIONS FOR THE DEATH BENEFIT

Upon satisfactory proof of the death of an active Eligible Employee from any cause, at any time or place, the plan will pay a Death Benefit in the amount set forth in the Schedule of Benefits.

### GENERAL PROVISIONS FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If an active Eligible Employee sustains accidental bodily Injuries while covered under the Fund and if the Injuries result in any of the losses named below within 90 days after the date of the accident, the benefit outlined below will be payable. The Accidental Death Benefit is payable in addition to the Death Benefit outlined above.

| Loss | Amount Payable |
|---|---|
| Loss of Life or of More Than One Member | The Principal Sum |
| Loss of One Member | One-Half of the Principal Sum |
| Maximum -All Losses – Any One Accident | The Principal Sum |

Loss of a member means:

1. The loss of a hand or foot by complete severance at or above the wrist or ankle joint; or

2. The irrecoverable loss of the entire sight of an eye.

### PAYMENT OF BENEFITS

Benefits paid due to the death of an active Eligible Employee will be paid to the beneficiary designated in accordance with the following provisions. Benefits for dismemberment will be paid direct to the Eligible Employee.

### BENEFICIARY

You may designate or change your beneficiary from time to time by filing a written and signed request on a form satisfactory to the Trustees. Consent of the beneficiary will not be required to change your beneficiary.

Unless specifically provided otherwise, if more than one beneficiary is designated, all surviving beneficiaries will share equally. If at the time of death there is no designated beneficiary with respect to all or any part of the benefits, or if the designated beneficiary is deceased, the benefits will be paid at the option of the Trustees to the first of the following classes of persons who survive you:

1. Your surviving spouse,

2. Your child or children in equal shares,

3. Your parents in equal shares,

4. Your brothers and/or sisters in equal shares, or

5. 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.

If your 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 Fund office may require to establish the validity of the claim.

**FACILITY OF PAYMENT**

If an individual appears to the Plan to be entitled to compensation because he or she has incurred expenses on behalf of your burial, the Plan may pay to such individual the expenses incurred up to $500. Such payment, however, will 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 in one lump sum.

**ASSIGNMENT**

The Death Benefits provided by the Plan are not assignable.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT EXCLUSIONS**

No Accidental Death or Dismemberment Benefit is payable if death or any loss is caused directly or indirectly, wholly or partly, by:

1. Bodily or mental illness or disease of any kind;

2. Ptomaine 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.

# MAJOR MEDICAL BENEFITS
## (FOR ALL COVERED PERSONS)

Major Medical Benefits become payable when you incur Covered Medical Expenses in excess of the deductible. Benefits are provided as described below.

**PRECERTIFICATION/PREAUTHORIZATION**

All Inpatient Hospital admissions and outpatient surgical procedures must be preapproved for Medical Necessity and length of hospital confinement. Failure to obtain authorization will result in a 10% reduction in the level of benefits that would have otherwise been payable by the Plan.

You should request preauthorization 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 preauthorization process, continued stay review must be notified prior to the end of the length of the originally approved stay.

Covered Medical Expenses incurred will be reduced by 10% for Hospital charges made for each separate admission to the Hospital unless preauthorization 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 Medical Expenses for which benefits would otherwise be payable under this Plan will not include:

1. Hospital charges for bed and board, for treatment listed above for which preauthorization was performed, for any days in excess of the number of days precertified; and

2. Any Hospital charges for treatment for which preauthorization was requested, but which was not certified as Medically Necessary.

Services that require prior authorization include, but are not limited to:

1. Inpatient Hospital or other health care facility services;

2. Residential treatment·

3. Nonemergency ambulance; or

4. Transplant services.

Instructions for precertification can be found on your Fund ID card.

## BENEFITS LIMITED TO NETWORK PROVIDERS

Benefits under the Plan are generally limited to services provided by in-network providers. However, the following types of charges will be covered under the Plan at the in-network level of benefits:

- Emergency treatment; and
- Services incurred with an out-of-network pathologist, radiologist, anesthesiologist or laboratory when you are treated by an in-network provider and, if applicable, at an in-network facility.

## CALENDAR YEAR DEDUCTIBLE

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

## EMERGENCY ROOM DEDUCTIBLE

The Emergency Room Deductible is the amount of Covered Medical Expenses you must pay for each visit to a Hospital emergency room before the Plan begins to pay benefits. The Emergency Room Deductible is in addition to the Calendar Year Deductible.

## 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. Copay amounts are shown in the Schedule of Benefits.

## MAXIMUM OUT-OF-POCKET EXPENSE

The Out-of-Pocket Maximum is designed to ensure that the amounts required to be paid by you for Covered Medical Expenses in each calendar year are limited to a manageable level. The amounts required to be paid by you above the benefit percentages paid by the Plan are applied toward the Out-of-Pocket Maximum.

## COVERED MEDICAL EXPENSES

Covered Medical Expenses are limited to the Maximum Reimbursable Charges for the services listed below that are Medically Necessary for the treatment of an Injury or a Sickness or other listed covered condition and which are ordered by a Physician:

1. Charges made by a Hospital, on its own behalf, for semi-private room and board and other Medically Necessary services and supplies. Covered Medical Expenses will not include that portion of charges for room and board which is more than the room and board limit shown in the Schedules of Benefits.

2. Charges for licensed ground ambulance service only 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.

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 counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.

11. Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

12. Charges made for services related to diagnosis and treatment of mental and nervous disorders.

13. 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.

14. 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.

15. 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.

16. Charges made for home health care services when you:

    (a) require skilled care;

    (b) are unable to obtain the required care as an ambulatory outpatient; and

    (c) do not require confinement in a Hospital or other health care facility.

17. Charges made due to terminal illness for the following Hospice care services:

    (a) by a Hospice facility for room and board and services and supplies, except for any day of confinement in a private room;

    (b) by a Hospice facility for services provided on an outpatient basis;

    (c) by a Physician for professional services;

    (d) 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 are provided as part of Hospice care;

    (e) for pain relief treatment, including drugs, medicines and medical supplies;

    (f) by another covered health care facility for:

        (1) part-time or intermittent nursing care by or under the supervision of a Nurse;

        (2) part-time or intermittent services of a health care professional who is licensed or otherwise authorized under applicable state law to deliver medical services and supplies;

        (3) physical, occupational, or speech therapy;

        (4) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been payable by the Plan if the person had remained or been confined in a Hospital or Hospice facility.

18. 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 the Plan. 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.

19. Braces, crutches and artificial limbs.

20. Physiotherapy.

21. Charges made by a participating provider for infertility services, limited to the diagnosis of infertility (but not the treatment of infertility).

22. Charges made for short-term rehabilitative therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac 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:

    (a) Occupational therapy is provided only for purposes of training the Covered Person to perform the activities of daily living.

(b) Speech therapy is not covered when (1) used to improve speech skills that have not fully developed; (2) considered custodial or educational; (3) intended to maintain speech communication; or (4) not restorative in nature.

23. Charges made for chiropractic care or services as follows:

(a) 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;

(b) Charges for office examinations including: patient history; physical examination; spinal x-rays; laboratory tests; and neuromuscular treatment and manipulation;

(c) Charges for lab work;

(d) Charges are limited to Medically Necessary care provided in an office setting.

24. Charges made for human organ and tissue transplant services at designated facilities throughout the United States. Coverage is subject to the following conditions and limitations:

(a) 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.

(b) 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.

(c) To receive in-network benefits for all organ transplant services, services must be received at a network approved organ transplant facility.

25. Charges made for reconstructive surgery following a mastectomy, if the Covered Person chooses to have surgery, and in the manner chosen by the Covered Person and Physician. Services and benefits include:

(a) 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;

(b) postoperative breast prostheses; and

(c) mastectomy bras and external prosthetics limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

26. Disease management training by a health professional when recommended by a Physician.

27. 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 the 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.

28. 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.

29. Expenses incurred in connection with pain management, including required drug screening in connection with such pain management, but only if such pain management and drug screening are performed by an in-network provider.

30. Recommended preventive services as required by the Affordable Care Act. Covered services are periodically updated by the Department of Health and Human Services. For a current list of covered services, visit www.healthcare.gov/coverage/preventive-care benefits/, or you may contact the Fund office to determine what services are covered.

31. Services that are otherwise covered hereunder when rendered by a nurse practitioner or a licensed clinical social worker.

**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.

2. Charges for services provided by non-network providers where either the services were not emergency or life-threatening in nature or 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 the Covered Medical Expenses. 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 Medical Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follow 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, including neonatal care and any other post-birth care, for the infant child of a Dependent child of an Employee, unless that child is otherwise eligible for benefits under the Plan. This exclusion will not limit coverage for maternity benefits, including delivery and post-partum care, for the mother of such infant child.

7. Procedures to reverse sterilization.

8. Replacement of external prostheses due to wear and tear, loss, theft or destruction; or for any bio-mechanical 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 license, and court ordered, forensic or custodial evaluations.

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. 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.

16. Court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the Covered Medical Expenses.

17. 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.

18. 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.

19. Consumable medical supplies, including but not limited to: bandages and other disposable medical supplies, skin preparations and test strips, except as provided under the Covered Medical Expenses.

20. Private Hospital rooms and/or private duty nursing unless determined to be Medically Necessary.

21. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.

22. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs, except as otherwise covered as a recommended preventive service.

23. 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.

24. Genetic testing and therapy including germ line and somatic unless determined to be Medically Necessary for the purpose of making treatment decisions.

25. 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.

26. Blood administration for the purpose of general improvement in physical condition.

27. Costs of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

28. 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.

29. 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 or other covered condition.

30. 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.

31. All noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided under the Covered Medical Expenses.

32. Expenses incurred for second surgical opinions in connection with:

    (a) cosmetic or dental surgical procedures not covered under the Plan;

    (b) minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;

    (c) an opinion obtained more than 6 months after a surgeon has first recommended the elective surgical procedure; or

    (d) an opinion rendered by the Physician who performs the surgical procedure.

33. The following charges for Hospice care services:

    (a) services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's house;

    (b) any period when the Covered Person is not under the care of a Physician;

    (c) services and supplies not listed under the Covered Medical Expenses;

    (d) curative or life-prolonging procedures;

    (e) to the extent that any other benefits are payable for those expenses under the Plan;

    (f) services or supplies that are primarily to aid the Covered Person's daily living;

34. The following durable medical equipment unless covered in connection with the services described in another section of this booklet:

    (a) hygienic or self-help items or equipment;

    (b) 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;

    (c) environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;

(d) institutional equipment, such as air fluidized beds and diathermy machines;

(e) elastic stockings, garter belts, corsets, dentures and wigs;

(f) corrective orthopedic shoes and arch supports;

(g) equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;

(h) 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;

(i) items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

35. Charges for any of following provided by a chiropractor:

(a) services of a chiropractor which are not within the scope of his practice, as defined by state law;

(b) vitamin therapy; or

(c) maintenance or preventive treatment.

36. Standby surgical fees or charges.

37. Custodial services, education or training.

38. Charges to the extent that the Covered Person is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

39. 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.

40. Charges made by an assistant surgeon or a co-surgeon in excess of 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).

41. 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.

42. Speech therapy, if such therapy: (a) is 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.

43. Charges which the Covered Person is not obligated to pay or for which he is not billed or which would not have been billed had he not been covered under this Plan.

44. 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.

45. 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:

    (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 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 Ill 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 it is proposed.

46. Charges made by any provider who is a member of the Covered Person's family.

47. An Injury or Sickness which is due to war, declared or undeclared.

48. Expenses incurred outside the United States or Canada, unless the Covered Person is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

49. 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 an act of domestic violence or the result of a medical condition.

50. Charges to the extent that billed charges exceed the Maximum Reimbursable Charges as described in the Definitions.

51. Charges to the extent that payment is unlawful where the person resides when the expenses are incurred.

52. Medical treatment for a person age 65 or older who is covered under this Plan as a Retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-participating provider.

53. Medical treatment when payment is denied by a plan providing primary coverage to the Covered Person because treatment was received from a non-participating provider.

54. 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.

55. 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:

    (a) a "no-fault" insurance law; or

    (b) an uninsured motorist insurance law.

56. Charges incurred in connection with an elective abortion unless:

    (a) the Physician certifies in writing that the pregnancy would endanger the life of the mother; or

    (b) the expenses are incurred to treat medical complications due to the abortion.

57. Charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits.

58. Charges incurred for transportation by air ambulance, regardless of the circumstances.

59. Charges incurred due to injuries sustained while participating in a riot or civil insurrection, or if caused during a Covered Person's violation of local, state, or federal criminal law, including either felonies or misdemeanors for which the person is charged. In the event the person is found not guilty or all criminal charges are dismissed, the person may re-apply for payment of benefits and provide proof of the not guilty determination or of all charges being dismissed. This exclusion will not apply to acts of domestic violence.

60. Charges for opiod replacement therapy (including suboxone).

61. Charges that exceed the Usual, Customary and Reasonable Expense.

# PRESCRIPTION DRUG CARD BENEFITS
## (FOR ALL COVERED PERSONS)

Prescription Drug Card Benefits are administered a prescription benefits manager (PBM) as listed on your Fund ID card. To obtain benefits, you must have your prescriptions filled at a pharmacy that participates in the PBM's network and you must present your ID card to the pharmacy when having the prescription filled. The 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 PBM's mail order pharmacy program.

### COVERED PRESCRIPTION DRUG EXPENSES

If you or your Dependent, while eligible for benefits under the Plan, incur 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 Dependent by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Amounts you pay toward Copays for covered Prescription Drugs will apply towards satisfaction of the Maximum Out-of-Pocket amount shown in the Schedules 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 is 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. The dispensing limit as listed in the Schedules of Benefits.

### 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 should contact the PBM as listed on your Fund ID card. 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 provisions 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 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 drug 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 PBM.

6. Injectable infertility drugs and any injectable drugs that require Physician supervision and which 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 drugs 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;

   (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 or 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 as covered under the recommended preventive services.

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 an act 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.

24. Charges to the extent that the Covered Person 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 provider who is a member of the Covered Person'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 the Covered Person 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 the Covered Person is not obligated to pay or for which he is not billed or would not have been billed in the absence of this coverage.

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.

32. Charges incurred for the purchase of brand name drugs when a generic equivalent drug is available, regardless of any prohibitions or restrictions indicated by the prescribing Physician.

# DENTAL BENEFITS
## (FOR ACTIVE ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS)

The Plan provides Dental Benefits through a dental preferred provider network (PPO). You do not have to receive covered dental expenses from a network provider, but please bear in mind that the charges made by participating providers are discounted through the PPO.

### 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 you become eligible for benefits and is:

1. Ordered or prescribed by a Dentist (D.D.S. or D.M.D.);

2. Essential for the necessary care of teeth;

3. Within the scope of the coverage limitations; and

4. Started and completed while you are eligible for Dental Benefits under the Plan.

### Alternate Benefit Provision

If more than one type of 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 you request or accept a more costly covered service, you are responsible for expenses that exceed the amount covered for the least costly service. You should seek 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 a preauthorization of service and is not required;

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

### COVERED SERVICES

### CLASS I SERVICES

### Diagnostic and Preventive

1. Clinical oral examination – Only 2 per person per calendar year.

2. Palliative (emergency) treatment of dental pain and 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 dentures. 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, and

(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 Necessary, 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 Necessary, 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 Covered 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,

(b) Full cast, high noble, metal, and

(c) Three fourths cast, metallic.

4. Fixed or removable appliances – Complete full dentures, upper or lower.

5. Partial Dentures:

(a) lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth), and

(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.

12. Implants – implants and accompanying prostheses.

**CLASS IV SERVICES**

**Orthodontia**

**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. 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.

4. 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. 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 an act of domestic violence or the result of a medical condition.

17. Charges made by any covered provider who is a member of the Covered Person's family.

18. Expenses incurred outside the United States or Canada, unless the Covered Person is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

19. Charges which the Covered Person is not obligated to pay or for which he is not billed or which he would not have been billed in the absence of this coverage.

20. 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.

21. 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.

22. Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared.

23. Charges to the extent that payment is unlawful where the person resides when the expenses are incurred.

24. Charges to the extent that the Covered Person is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

25. Charges incurred prior to the effective date of these benefits or after the termination date of eligibility for benefits.

# VISION BENEFITS
## (FOR ACTIVE ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS)

Vision Benefits will be payable when you incur Covered Vision Expenses, as outlined below, while covered under this benefit, and subject to the provisions outlined in the Schedule of Benefits.

### COVERED VISION EXPENSES

1. Routine eye exam performed by an optometrist of ophthalmologist. A routine eye exam may include tests for visual acuity, color vision and field of vision.

2. Eyeglass lenses, contact lenses and frames. The eyeglasses or contact lenses must be prescribed by an optometrist or ophthalmologist.

### ESSENTIAL PEDIATRIC VISION SERVICES

Benefits are payable for the following services and supplies when rendered to a Covered Person under 19 years of age (through the end of the calendar month in which the individual attains age 19):

1. One routine vision examination per calendar year when rendered by a Doctor or Optometry (O.D.) or a Physician; and

2. One pair of eyeglasses or contact lenses per calendar year, limited to the minimum necessary to correct vision to its optimal level (i.e. no coverage is provided for upgrades such as coatings, progressive lenses, sunglasses, designer frames, etc.).

These Covered Pediatric Services do not duplicate the Covered Vision Expenses outlined above nor increase the frequency of any covered services, but provided additional coverage, when necessary, for charges otherwise covered under this Vision Benefit that exceed the maximum calendar year benefit listed in the Schedule of Benefits.

### LIMITATIONS

Benefits are not provided for:

1. Any medical or surgical treatment of the eye.

2. Non-prescription sunglasses or safety lenses or goggles.

3. Orthoptics, vision training or aniseikonia.

## CLAIMS REVIEW AND APPEAL PROCEDURE

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

**An Urgent Care claim** is one that generally includes those situations commonly treated as emergencies. If an Urgent Care claim is filed by or on behalf of a Covered Person, notification of the Plan's benefit determination will be made as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of such claim, unless such Urgent Care claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Fund office will provide such notification as soon as possible, but not later than 24 hours after receipt of the claim, or the specific information necessary to complete the claim. A reasonable amount of time will be allowed, taking into account the circumstances, but not less than 48 hours to provide the specified information. Notification of the Plan's benefit determination will be provided as soon as possible, but in no case later 48 hours after the earlier of receipt of the specified information or the end of the period afforded the claimant to provide the specified additional information.

**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 Fund office will provide notification of benefit determination no later than 15 days after receipt of the claim, unless more time is needed due to matters beyond the Plan's control. Initial notification will be provided no later than 15 days after receipt of the claim. That 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 45 days will be afforded after receiving the notice to provide the specified information. The determination period will be suspended on the date the Plan sends such a notice of missing information, and the determination period will resume on the date a response to the notice is received.

**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. The Plan will provide notification of the determination within 24 hours after receiving the request.

**A Post-Service claim** is one that is made after services have been rendered. In a case of a Post-Service claim, the Plan will provide notification of the Plan's benefit determination no later than 30 days after the Plan's receipt of the claim, unless more time is needed due to matters beyond the Plan's control. The Plan will provide notification no later than 30 days after the Plan 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 45 days will be afforded after receiving the notice to provide the specified information. The determination period will be suspended on the date the Plan sends such a notice of missing information, and the determination period will resume on the date a response to the notice is received.

## IF A CLAIM IS DENIED

If a claim is wholly or partially denied, notification of the adverse benefit determination will be provided with 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 specified reason or reasons for the adverse determination;

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

3. A statement that the claimant is entitled to received, 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); and

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 (with a possible third step of External Review). To initiate an appeal, a request for an appeal must be submitted to the Fund office in writing within 180 days of receipt of a denial notice. The request for an appeal should state the reason the request should be approved and include any information supporting the appeal.

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

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

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

**Level One Appeal**

Written Level One Appeals should be submitted to the Fund office.

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

A written response will be provided 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, written notification of the right to request an extension of up to 15 days and to specify any additional information needed to complete the review will be provided.

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

**Level Two Appeal**

If dissatisfied with a level one appeal decision, a second review may be requested. Initiation of a level two appeal must be made by a written request for a review within 180 days after receipt of the determination of the level one appeal and must be submitted to the Fund office.

In the absence of a timely request for review, the last decision on the claim will be final. A timely request for review may include submission of written comments, documents, records and other information relating to the claim.

The Board of Trustees will make a benefit determination on review no later than (i) the date of the first meeting of the Board of Trustees that immediately follows receipt by the Fund office of a written request for review, or (ii) if such written request for review was not received by the Fund office more than thirty (30) days before such meeting, the date of the second 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 will, prior to commencement of the extension, send a written notice 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 will issue its decision no later than the date of the third meeting next following the date the Fund Office received the written request for review. The Fund office will provide notification of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

The Board of Trustees will review any facts and information submitted, make a final decision, and provide notification of the decision in writing, which notice will include (i) the reason or reasons for the adverse determination; (ii) reference to specific Plan or Trust Agreement provisions on which the benefit determination is based; (iii) a statement of entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; (iv) a statement describing any voluntary appeal procedures offered by the Plan and the right to obtain information about such procedures, and a statement of the 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.

**External Review of an Adverse Benefit Determination**

1. Claims Subject to Review. Those claims involving Medical Judgment which have either been denied or otherwise not acted upon, as outlined herein, will be eligible for external review, including only:

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

   (b) Other claims for which the 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

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

2. Claims not subject to Review. Claims not eligible for external review include:

   (a) Claims relating to 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.);

   (b) Claims incurred while the individual is not eligible for benefits;

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

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

   (e) Claims incurred for other than medical expenses; and

   (f) Claims denials not involving Medical Judgment.

3. Standard External Review.

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

(a) **Request for external review**. The Fund will allow a claimant to file a request for an external review if the request is filed within 4 months after the date of the receipt of a notice of an adverse benefit determination or final adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

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

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

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

(3) The claimant has exhausted the Plan's internal appeal process; and

(4) 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 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.

(c) **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.

(1) 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 interna1 adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

(2) 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.

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

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

4. **Expedited External Review**.

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

(1) 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 claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(2) 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 the final 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 not been discharged from a facility.

(b) **Preliminary review**. Immediately upon receipt of the request for expedited external review, the Fund office will determine whether the request meets the reviewability requirement for standard external review. The Fund office will immediately send a notice that meets the requirements set forth for standard external review to the claimant of its eligibility determination.

(c) **Referral to independent review organization**. Upon a determination that a request is eligible for external review following the preliminary review, the Fund office will assign an IRO for standard review. 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.

(d) **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

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

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

3. 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 requirement 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

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 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 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 fact was not supported by the evidence.

## 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 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, of 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 provisions, if you or your eligible Dependent have coverage under another group health plan, the total benefits received by any one patient from all the plans combined may not amount to more that 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 to 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 (i) what the Plan would normally pay if the Plan were the primary coverage, or (ii) 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 spouses 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 Employees 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, or 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 Dependent's entitlement to Medicare if such person is entitled to Medicare as an ESRD beneficiary, and not more that 30 months has elapsed since the earliest of the following:

   (a) The month in which the Eligible Employee or Dependent began a regular course of renal dialysis;

   (b) The month in which the Eligible Employee or Dependent received a kidney transplant;

   (c) The month in which the Eligible Employee or 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 a Covered Person receives any benefits (the "Benefits") under this Plan arising out of any loss, injury, or illness (the "Injury") for which the Covered Person 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 Covered Person, 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 Covered Person to the extent of, but not exceeding, the amount or amounts received by the Covered Person (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 judgment(s) or otherwise.

The Covered Person shall provide restitution to the Fund, starting with the first dollar that the Covered Person 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 Covered Person shall continue to make restitution to the Fund until the Fund has received full restitution for all benefits related 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 a Covered Person has not been fully compensated for the Injury. Accordingly, a Covered Person shall make restitution to the Fund for all benefits paid related to the Injury, such restitution to be paid out of any recovery the Covered Person is able to obtain.

If it becomes necessary for the Covered Person 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 attorney's fees and expenses.

If the Trustees retain an attorney to enforce these subrogation and restitution rights, then the Covered Person shall be liable for, in addition to all amounts outlined in the previous paragraphs, expenses involved, including the Fund's reasonable attorney's fees and expenses. As a means of enforcing its subrogation and restitution rights, the Fund may, in addition to any other means allowed by law or equity, set off future benefits to the Covered Person or lessen the reduction allowed by the Fund for the Covered Person's attorneys' fees and expenses incurred in obtaining the Recovery. However, this provision 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 its attorneys' fees and expenses.

As security for all amounts due to the Fund under this provision, the Fund shall be subrogated to all of the claims, demands, actions and rights of recovery of the Covered Person 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 Covered Person 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 Covered Person shall take no action to prejudice the Fund's rights to such restitution and subrogation. The Trustees may withhold any Benefits to which the Covered Person is entitled under this Plan until the Covered Person executes and delivers any such instruments and documents as may be requested by the Trustees.

Prior to the payment of Benefits under this Plan to a Covered Person or assignee of a Covered Person for Injuries, expenses, or losses for which a third party is or may be liable in whole or in part, the Covered Person 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 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. The Covered Person must 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 Covered Person's rights to obtain benefits from the Plan.

# MISCELLANEOUS INFORMATION

## THE TRUSTEES INTERPRET THE PLAN

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

## THE PLAN MY BE CHANGED

The Trustees have the authority to change the Plan.

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

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

## DISCRETIONARY PAYMENT OF CLAIMS TO MEDICAL PROVIDERS

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

## NON-ASSIGNMENT OF CLAIMS, ERISA RIGHTS OR OTHER RIGHTS

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

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

## NO THIRD PARTY BENEFICIARY

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

## NO CONVERSION PRIVILEGE

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

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

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

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

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

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

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

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

# RIGHTS OF PLAN PARTICIPANTS

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

## RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

## CONTINUE GROUP HEALTH PLAN COVERAGE

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

## PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

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

## ENFORCE YOUR RIGHTS

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

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

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

**ASSISTANCE WITH YOUR QUESTIONS**

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

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

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

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

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

## TYPE OF PLAN

This plan provides death, accidental death and dismemberment, hospital, medical, prescription drug, vision and dental benefits.

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

## NAME AND ADDRESS OF THE PLAN ADMINISTRATOR AS DEFINED BY ERISA

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

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

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

Board of Trustees
Southeastern Iron Workers
Health Care Plan
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

## TYPE OF ADMINISTRATION

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

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

## COLLECTIVE BARGAINING AGREEMENTS

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

## PLAN SPONSORS

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

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

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

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

## SOURCE OF CONTRIBUTIONS

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

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

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

## FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS

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

## CIRCUMSTANCES THAT MAY RESULT IN LOSS OF ELIGIBILITY OR BENEFITS

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

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

## AGENT FOR SERVICE OF LEGAL PROCESS

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

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

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

## PLAN IDENTIFICATION NUMBERS:

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

Employer Identification Number (EIN)
assigned by the Internal Revenue Service. . . . . 63-0334002
Plan Number . . . . . 501

## FISCAL YEAR

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