MCASF LOCAL 725
HEALTH AND WELFARE PLAN

PLAN DOCUMENT

Amended and Restated Effective January 1, 2025

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INTRODUCTION

This document is the sixth amended and restated Plan Document FOR THE MCASF LOCAL 725 HEALTH AND WELFARE TRUST FUND, formerly known as the ACRA LOCAL 725 HEALTH AND WELFARE TRUST FUND, and is a continuation of the Plan adopted effective the first day of May, 1958, and subsequently amended and restated. The purpose of this Plan is to provide health and welfare benefits to eligible Participants and their dependents. This document sets forth the rules and regulations concerning eligibility and amount of benefits that will be payable to and/or on behalf of eligible Participants and dependents from the Trust Fund. The Plan is hereby amended and restated effective January 1, 2025 except to the extent an earlier effective date is expressly provided with respect to a particular provision hereof.

ARTICLE 1
DEFINITIONS

1.1 The term "Administrator" or "Fund Administrator" shall mean the Board of Trustees for the Fund, or the MCASF Local 725 Service Corporation, a non-profit entity the Board of Trustees has established and delegated to it certain duties and tasks related to the administration of the Plan. The MCASF Local 725 Service Corporation is designated a fiduciary by the Board of Trustees.

1.2 The term "Association" or "MCASF" shall mean the Mechanical Contractors Association of South Florida and its successors and assigns.

1.3 The term "Bargaining Unit Alumni" shall mean a Union member who had been a Bargaining Unit Employee and Participant in this Plan who thereafter transitions with contiguous service to employment with a Contributing Employer that is not the type of covered work associated with the tools in the trade and craft of the Industry of the Fund.

1.4 The term "Bargaining Unit Employee" shall mean any employee who is a member of the Union and/or for whom the Union is the bargaining representative and who performs the duties and functions that are included with the trade and craft of the Industry of the Fund.

1.5 The term "Beneficiary" shall mean a person designated by a Participant or by terms of the Plan who is or may become entitled to a benefit.

1.6 The term "Benefit" or "Benefits" shall mean those classes of benefits provided by the Plan.

1.7 The term "Collective Bargaining Agreement" shall mean any written contract for Labor between an Employer and the Union, or the Association and Union, or other participating union that provides for Contributions to the Trust Fund for this Plan together with any renewal, modification, amendment or continuation thereof or successor agreement thereto, as approved by the Trustees as a basis for participating in the Trust Fund and this Plan. The term shall also include any written contract for labor between the Union and an Employer covering a period of time before the date the Employer became a Contributing Employer, and shall also include any written agreement for labor or otherwise by which an Employer becomes obligated to make Contributions to the Trust Fund for this Plan, including without limitation by virtue of any Reciprocal Agreement with any other Health and Welfare Fund or other agreement executed by and/or approved by the Trustees.

1.8 The term "Contributions" or "Employer Contributions" shall mean the payment required to be paid by an Employer to the Trust Fund, in amounts and in a manner set forth in the Collective Bargaining Agreement, Participation Agreement, or other written agreement in effect from time to time. No Contributions shall be made on behalf of sole proprietors, partners or principals of non-incorporated Employers.

1.9 The term "Coverage" shall mean coverage for the Benefits provided under the Plan as determined by the Trustees.

1.10 The term "Covered Employment" shall mean any employment during which the Employee has been employed by an Employer who makes or is required to make Contributions with respect to such employment to the Fund under the terms of a Collective Bargaining Agreement or other written agreement.

1.11 The term "Dependent" shall mean a Participant's Spouse and/or Child(ren), if any, who is eligible for Coverage under the Plan. For purposes of this definition:

(a) "Spouse" shall mean a person who is married to a Participant and whose marriage is lawfully recognized and was validly entered into, including two individuals of the same sex who are legally married. Persons shall cease being a Spouse upon entry of a formal decree of dissolution of marriage.

A Spouse will be a Dependent under this Plan provided the Spouse resides with the Participant. If the Participant and Spouse have resided apart for a period of six months or more, a Spouse is presumed to no longer be a Dependent under the Plan. A Participant may be required to submit documentation to the Trustees that the Spouse remains dependent upon the Participant for support, which such determination shall be made by the Trustees in their sole discretion.

(b) "Child" or "Children" shall mean a person who qualifies under **a**, **b**, or **c** below:

a. Any person up until the end of the calendar year in which he/she turns age 26 and is either:
   i. A Participant's biological child;
   ii. A Participant's adopted child, meaning the Participant has obtained physical and legal custody of the child through the adoption process;
   iii. A Participant's step-child, meaning the child of the Participant's Spouse who is financially dependent on the Participant and Participant's Spouse, and for whom the Participant and Participant's Spouse have physical custody at least 50% of the time;
   iv. Any other child for whom the Participant has been awarded physical custody and/or granted legal guardianship by a court of competent jurisdiction.

b. Consistent with ERISA Section 609(a), a child can also be eligible for Coverage if a court-ordered Qualified Medical Child Support Order requires that the Participant to provide medical coverage to the child as an alternate recipient under the Plan.

(c) Ineligible Dependents. The following individuals are not eligible for Coverage as a Dependent under the Plan:

a. Spouses of dependents;
b. Spouses with a waiver of spousal participation because the spouse has other health coverage available;
c. An adult dependent child who signs a waiver of coverage;
d. An individual who no longer meets the requirements of a Dependent under this Section 1.11 and the terms of the Plan;
e. A separated spouse who resides apart from the Participant for a period of six months or longer, and the Participant fails to provide information establishing the separated spouse remains dependent upon the Participant for support;
f. Stepchild(ren) whose parent no longer lives with the Participant.

1.12 The term "Employee" shall mean:

(a) Any person on whose behalf contributions are made to the Trust Fund for this Plan pursuant to a Collective Bargaining Agreement, Participation Agreement, Reciprocal Agreement, or other written agreement;

(b) Any person who has performed work for a Contributing Employer, is not presently employed by a Contributing Employer in a collective bargaining unit represented by the Union, but remains available for the performance of collective bargaining unit work for a Contributing Employer;

(c) The corporate officers, superintendents, supervisors or other Non-Bargaining Unit Employees of an Employer working 1,000 hours or more in a plan year on whose behalf the Employer contributes pursuant to a written agreement on terms agreed to by the Trustees, except those individuals covered by other health plans to which the Employer contributes on their behalf;

(d) Bargaining Unit Alumni on whose behalf the Employer contributes pursuant to a written agreement on terms agreed to by the Trustees;

(e) Employees of allied entities to the Plan (including the Union, Association, ACRA-Local 725 Joint Apprenticeship and Training Committee Trust Fund, and MCASF Local 725 Service Corporation) for whom contributions are made to the Trust Fund pursuant to a written agreement on terms agreed to by the Trustees; and/or

(f) Persons who are or become eligible for participation in the Plan by virtue of a duly adopted Resolution of the Board of Trustees upon such conditions of eligibility as set forth in such Resolution and who are not prohibited from such participation by any applicable law including without limitation the Internal Revenue Code of 1986, as amended, Section 302(c)(5) of the Labor Management Relations Act of 1947, 29 USC Section 186(E)(5) as amended and the Employee Retirement Income Security of 1974 of 1974, Public Law 93-406, as amended, or Section 416 of the Code.

The term "Employee" shall not include any partner, sole proprietor, or principal of any non-incorporated employer.

1.13 The term "Employer" or "Contributing Employer" shall mean:

(a) Any corporation, individual, partnership, or business association which has presently in force or hereafter executes or enters into a Collective Bargaining Agreement with the Union, or is otherwise bound to or becomes bound to a Collective Bargaining Agreement with the Union, or who performs work in any Jurisdiction of the Fund and for whose Employees the Union is the recognized collective bargaining agent, or is obligated to make Contributions on behalf of Employees to the Trust Fund contemplated by the Trust Agreement by virtue of any Reciprocal Agreement or other written agreement executed by Trustees;

(b) The Union;

(c) The Association;

(d) The ACRA Local 725 Joint Apprenticeship and Training Committee Trust Fund;

(e) The MCASF Local 725 Service Corporation;

(f) Any Employer of an Employee on whose behalf contributions are required to be submitted to the Trust Fund.

1.14 The term "Hospital" shall mean a facility properly licensed pursuant to any state or agency of the state responsible for licensing hospitals and that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent. A Hospital does not include: an ambulatory surgical center, a skilled nursing facility, a stand-along birth center, a convalescent, rest or nursing home, or a facility which primarily provides custodial care, educational, or rehabilitative therapies.

1.15 The term "Hour Worked" shall mean:

(a) Generally - Any hour of Covered Employment for which a person is paid, or entitled to payment, by an Employer: (1) for the performance of duties; (2) for reasons other than the performance of duties (including vacations, holidays, illness, jury duty, military duty, or leave of absence); or (3) as the result of backpay being awarded, or agreed to, by an Employer (irrespective of mitigation of damages).

(b) Exclusions – Hours Worked shall not include hours for which the person is paid, or entitled to payment, if no duties are performed and if such payment is made or due

solely for the purpose of complying with workers compensation, unemployment compensation, or disability insurance laws, or if such payment solely reimburses the person for medical or medically related expenses incurred by the person.

(c) Limitations – Hours Worked for reasons other than the performance of duties, such as vacations, holidays, illness, jury duty, military duty, leave of absence, or backpay, is limited to a maximum of five hundred and one (501) hours per Plan Year on account of any single, continuous period during which no duties are performed.

(d) Other Federal Law – Nothing in this section shall be construed as denying a person credit for an Hour Worked if credit is otherwise required by law. Furthermore, the nature and extent of such credit shall be determined under the law.

(e) Determination of Hours Worked – Hours Worked shall be ascertained from the most accurate records available, including records of hours, work shifts, days or weeks for which payment is made or owing, as reported to the Board of Trustees. If records are not available which reflect services performed on an hourly basis, then the number of work shifts, days or weeks of service shall be converted to an hourly basis in accordance with Department of Labor Regulations 29 CFR Sections 2530.200b-2(b) and (c), which are incorporated herein by reference.

1.16 The term "Industry of the Fund" shall mean the pipefitting and/or HVAC/R service industry and the type of work normally performed by a member of United Association Local 725 of Miami, Florida, as described and covered in the Collective Bargaining Agreement between the Union and the Association herein, or any other work to which a trade employee of a Contributing Employer has been assigned, referred or is capable of performing by virtue of his skills and training as a tradesman in the trade governed by the Collective Bargaining Agreement, whether or not collectively bargained.

1.17 The term "Injury" shall mean a bodily injury sustained accidentally by external means.

1.18 The term "Jurisdiction of the Fund" shall mean the territorial jurisdiction of the Collective Bargaining Agreement between the Union and the Association.

1.19 The term "Medically Necessary" shall mean that a Physician, exercising prudent clinical judgment, provided a Service to a Participant or Beneficiary for the purpose of preventing, evaluating, diagnosing, or treating and illness, injury, disease, or its symptoms, and the Service was: (1) in accordance with the generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Participant's or Beneficiary's illness injury or disease; and (3) not primarily for the Participant's or Beneficiary's convenience, or that of the Participant's or Beneficiary's Physician or other health care provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Participant's or Beneficiary's illness.

1.20 The term "Non-Bargaining Unit Employee" shall mean all employees of an Employer other than those Bargaining Unit Employees whose job is covered by the Union, which may include shareholders, corporate officers, directors, supervisors, or management personnel who are compensated on a basis other than the hourly basis required by the Collective Bargaining Agreement to which the Employer is bound; provided however, that compensation at a higher hourly rate than provided in the Collective Bargaining Agreement shall not, by itself, render an Employee a Non-Bargaining Unit Employee.

1.21 The term "Owner/Operator" shall mean a Bargaining Unit Employee who was a Participant in this Plan and other Plans sponsored by the Union and MCASF for at least a period of two consecutive years, and who thereafter enters into business as an owner of a Contributing Employer and who continues to perform bargaining unit work. An Owner/Operator must work for an incorporated company or limited liability company.

1.22 The term "Participant" shall mean a person who is eligible for Coverage under the Plan pursuant to Article 2 and/or who is receiving any Benefit under the Plan. "Participant" can include an Employee, Beneficiary, Dependent, or Retiree.

1.23 The term "Participation Agreement" shall mean any written agreement pursuant to which Contributions are paid or payable to this Fund on behalf of the Employees who are not covered under a Collective Bargaining Agreement.

1.24 The term "Physician" shall mean any individual who is properly licensed by the State of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

1.25 The terms "Plan" or "Health and Welfare Plan" shall mean this Plan document, and the program, method, rules and procedures for the payment of Benefits from the Trust Fund, which may be amended from time to time by the Trustees.

1.26 The term "Plan Year" shall mean for all Plan Years beginning after December 31, 1998, the twelve (12) month period beginning with January 1 and ending the following December 31. Plan Years for years prior to December 31, 1998 are detailed in prior Plan documents.

1.27 The term "Pregnancy" shall mean pregnancy and resulting childbirth, miscarriages, or complications and is treated the same as any other disability or illness.

1.28 The term "Reasonable and Customary" shall mean those charges for Services rendered to a Participant or Beneficiary, which are Medically Necessary, or negotiated as a covered Service, and: (1) do not exceed the actual amount billed by the provider of the Service; (2) are limited to the customary charges based upon distribution of charges billed by providers of Services within a professionally recognized medical specialty and within a geographic area covered by the Plan; and (3) are reasonable with respect to customary charges of comparable complexity and difficulty.

1.29 The term "Reciprocal Agreement" shall mean any written agreement between the Trustees of this Health and Welfare Fund and another health and welfare fund providing a basis for portability and/or transfer and/or allocation of credits and/or Contributions as defined in this Plan and/or the plan of the Board of Trustees with whom the agreement is entered into on behalf of Employees for the purpose or providing Benefits hereunder or thereunder.

1.30 The term "Retirement" or "Retire" shall mean the separation of service and complete withdrawal from any further employment and work in the Jurisdiction of the Fund after having reached the age of 55. A person who is retired is a "Retiree" for purposes of the Supplemental Self-Pay and Retiree Subsidy rules of the Plan, but is still deemed an active Participant under this Plan if eligible for Coverage under any provisions of the Plan.

1.31 The term "Services" may include, as appropriate, medical treatments, procedures, medications, devices, equipment, facilities, personnel, and/or other instrumentalities and methodologies of care provided to Participants in the Plan.

1.32 The term "Sickness" shall mean a disease, disorder or condition which, requires treatment by a physician, and which is not an occupational related condition. Sickness also includes childbirth, pregnancy or related condition.

1.33 The term "Totally Disabled" shall mean that the Trustees, in their sole and absolute discretion, find on the basis of medical evidence that an Employee Participant (who was actively employed by a Contributing Employer immediately prior to his or her disability) has been totally disabled by bodily injury or a physical or mental condition so as to be prevented from engaging in the performance of Work and is under a physician's care. However, no Participant shall be deemed to be Totally Disabled if the disability was contracted, suffered, or incurred while engaging in a felonious enterprise or as the result of an intentional self-inflicted injury.

1.34 The term "Trust Agreement" shall mean the Trust Agreement governing the Fund that was originally adopted simultaneously with this Plan, together with any amendments, modifications, or restatements thereof as the Trustees may have in the past and from time to time in the future adopt and promulgate.

1.35 The term "Trustees" or "Board of Trustees" shall mean the persons acting as Employer Trustees and Union Trustees under the terms of the Trust Agreement.

1.36 The terms "Trust Fund" or "Health and Welfare Fund" or "Fund" shall mean the MCASF LOCAL 725 HEALTH AND WELFARE TRUST FUND, and the entire assets thereof including all funds received in the forms of Employer Contributions, together with all contracts, any Contributions received from other trust funds, all investments made and held by the Trustees, all income, increments, earnings and profits therefrom and all other property or funds received and held by the Fund.

1.37 The terms "Union" or "Participating Union" shall mean the United Association Local 725 of Miami, Florida, A.F.L.-C.I.O., and its successors and assigns, or any other union which

is accepted by the Trustees in writing for participation in the Trust Fund and Plan for the purpose of providing participation in this Plan for Employees represented by the Participating Union for the purpose of Collective Bargaining, including by Reciprocal Agreement, where both the Participating Union and an Employer become bound to the Trust Agreement.

1.38 The term "Work" shall mean the actual expenditure of time and energy by an Employee for a Contributing Employer, performing each and every duty pertaining to his job in the place where and the manner in which such job is normally performed.

ARTICLE 2
ELIGIBILITY

2.1 Initial Eligibility and Participation. A Bargaining Unit Employee will become a Participant and be eligible for health coverage under the Plan on the first day of the month in which the Fund has received four hundred (400) hours of Contributions on behalf of the Employee by Contributing Employers during any five (5) consecutive calendar month period, unless otherwise authorized by the Trustees for a particular Employee or group of Employees.

2.2 Other Employees. Other types of employees of Contributing Employers can participate in the Plan as follows:

(a) Owner/Operators. An Owner/Operator can participate in the Plan if contributions are submitted to the Plan on such individual's behalf at the R1 Journeyman rate for at least a minimum of forty (40) hours per work, fifty-two (52) weeks a year (which cannot be less than 173.33 hours per month), but in no event shall the Owner/Operator report and contribute less than the actual numbers of hours of work he or she performs during a given workweek. The minimum contribution hours (40 weekly or 173.33 monthly) are required regardless of holidays, vacation, illness or lesser work hours. Participation shall be effective for the Owner/Operator on the first day of the month in which contributions are first received by the Plan for such individual. The Owner/Operator shall not accrue Hour Bank hours or be entitled to Participant Self-Pay for continuing eligibility. Participation shall immediately cease if the Employer fails to timely submit the required Contributions on behalf of the Owner/Operator. Additionally, within 12-months of becoming an Owner/Operator, the Owner/Operator's company must employ at least one apprentice or journeyman who performing covered work in order for the Owner/Operator to continue participation.

(b) Bargaining Unit Alumni. Bargaining Unit Alumni can participate if they are subject to a Bargaining Unit Alumni participation agreement and contributions are submitted to the Plan on the employee's behalf at the R1 Journeyman rate for a minimum of 173.33 hours per month and 2,080 hours per year (or for such actual hours worked, if greater). Participation commences on the first day of the month in which contributions are first received by the Plan for such employee. Bargaining Unit Alumni shall not accrue Hour Bank hours or be entitled to Participant Self-Pay for continuing eligibility, but are permitted to utilize the retiree subsidy pursuant to Section 2.11. Participation shall immediately cease if the Employer fails to timely submit the required Contributions on behalf of the Bargaining Unit Alumni.

(c) Non-Bargaining Unit Employees. Other Non-Bargaining Unit Employees of Contributing Employers may participate if they are subject to a participation agreement and provided such employees work at least 1,000 hour per year and contributions are submitted to the Plan on the employee's behalf at the R1 Journeyman rate for a minimum of 173.33 hours per month and 2,080 hours per year (or for such actual hours worked, if greater). Participation commences on the first day of the month in which contributions are first received by the Plan for such employee. Non-Bargaining Unit

Employees shall not accrue Hour Bank hours or be entitled to Participant Self-Pay for continuing eligibility. Participation shall immediately cease if the Employer fails to timely submit the required Contributions on behalf of the Non-Bargaining Unit Employees. Unless otherwise subject to prior grandfathered agreements with the Trustees, Employers who seek to provide health coverage for a Non-Bargaining Unit Employee must contribute to the Fund on behalf of all of such Employer's Non-Bargaining Unit Employees, and the Employer may elect an initial waiting period not to exceed ninety (90) days from the date such Non-Bargaining Unit Employee is hired before participation commences, which is applied uniformly to all Non-Bargaining Unit Employees.

(d) Allied Entities. Employees of allied entities to the Plan (including the Union, Association, ACRA-Local 725 Joint Apprenticeship and Training Committee Trust Fund, and MCASF Local 725 Service Corporation) can participate in the Plan if they are subject to a participation agreement and contributions are submitted to the Plan on the employee's behalf at the R1 Journeyman rate for a minimum of 173.33 hours per month and 2,080 hours per year (or for such actual hours worked, if greater). Participation commences on the first day of the month in which contributions are first received by the Plan for such employee. These allied Employees shall not accrue Hour Bank hours or be entitled to Participant Self-Pay for continuing eligibility. Participation shall immediately cease if the Employer fails to timely submit the required Contributions on behalf of the allied Employees.

(e) Apprentices. Second year apprentices who are attending training with the ACRA-Local 725 Joint Apprenticeship and Training Committee Trust Fund will become a Participant and eligible for health coverage under the Plan on the first day of the month in which the Fund receives one or more hours of Contributions on behalf of such apprentice.

2.3 Continuing Eligibility.

(a) Effective September 1, 2018, once an Employee becomes a Participant and meets the initial eligibility requirements of Section 2.1, such Coverage shall continue on a month-to-month basis ("Continuing Eligibility") provided the Participant is credited with at least 100 or more hours in each subsequent calendar month as provided in Section 2.3(b). The associated month of coverage will generally be the second month following the month in which such hours are worked. For example, if a Participant works 100 hours in November and contributions for those hours are received by the Plan during December, the Participant is eligible for coverage during January. If the Participant worked 100 hours in December and those contributions are paid timely the following January, the Participant is eligible for health coverage during February.

(b) For purposes of Section 2.3(a), the 100 hours required each month to maintain Continuing Eligibility can be satisfied by a combination of one or more of the following:

a. Contributions from a Contributing Employer;

b. Withdrawal of Hour Bank hours as provided in Section 2.4;

c. Participant Self-Pay Contributions as provided in Section 2.5; and/or

d. Disability Credits as provided in Section 2.7.

For purposes of the eligibility provisions in the Plan, "hours" and/or "hours of Contributions" received on behalf of an Employee pursuant to a Reciprocal Agreement shall be credited to such Employee based upon the ratio that the per hour contribution received from the Reciprocating Fund, Plan or Trust ("Reciprocal Rate") bears to the per hour contribution rate payable to this Plan under the applicable Collective Bargaining Agreement. If the per hour Reciprocal Rate exceeds the rate payable to this Plan, then the excess shall be credited to the Hour Bank of said Participant, pursuant to Section 2.4 hereof.

2.4 Hour Bank

(a) Hours of contributions paid on behalf of a Participant by a Contributing Employer in excess of one hundred (100) hours per month will be credited to the Participant's individual Hour Bank, subject to the limitations in Sections 2.4(b). Hours of contributions earned during an Employee's Initial Eligibility Period in Section 2.1 do not accumulate toward Hour Bank credit. Additionally, Owner/Operators, Bargaining Unit Alumni, and Non-Bargaining Unit Employees shall not have any hours of contributions credited towards an Hour Bank when performing employment consistent with Section 2.2.

(b) Effective April 1, 1993, the maximum accumulation of Hour Bank hours per Participant is limited to one thousand (1,000) hours at any time, unless otherwise grandfathered pursuant to the rules of the prior Plan document. From October 1, 1992 through March 31, 1993, a Participant's maximum accumulation of Hour Bank hours was permitted to be twelve hundred (1,200) Hour Bank hours. For any Participants who accumulated up to the twelve hundred (1,200) Hour Bank hours during that time period, and who subsequently used any Hour Bank hours for continuing coverage, their maximum accumulation of Hour Bank hours shall be reduced by the amount of Hour Bank hours used, and their total accumulation shall not thereafter exceed one thousand (1,000) Hour Bank hours.

EXAMPLE: A Participant accumulates twelve hundred (1,200) Hour Bank hours during the period of October 1, 1992 through March 31, 1993. From April 1, 1993 to June 30, 1993, the Participant uses one hundred (100) Hour Bank hours. The Participant's total Hour Bank accumulation is one thousand, one hundred (1,100) hours and the Participant cannot accumulate any additional Hour Bank hours. Between July

1, 1993 and September 30, 1993, the Participant uses an additional two hundred (200) Hour Bank hours, thereby reducing his individual Hour Bank total accumulation to nine hundred (900) hours. The Participant may thereafter only accumulate an additional one hundred (100) Hour Bank hours, such that his individual Hour Bank shall not exceed a maximum of one thousand (1,000) hours. Hour Bank hours will be credited when necessary as hours worked in determining an Employee's Coverage.

(c) Hour Bank hours may be withdrawn by a Participant to meet the Continuing Eligibility requirements of 100 hours worked per month as provided in Section 2.3, subject to the following restrictions:

a. Hour Bank hours may not be used to meet the Continuing Eligibility requirements if a Participant begins working for a non-signatory employer in the Industry and Jurisdiction of the Fund who does not submit contributions to the Plan (i.e., begins working in non-covered employment). In the event of such non-covered employment, the Participant's Hour Bank hours shall be forfeited and reduced to zero.

b. The ability to utilize and withdraw accrued Hour Bank hours for a Participant's Continuing Eligibility is terminated upon a Participant's retirement on or after age 65. However, if the Participant has a Spouse and/or other eligible Dependent at the time of the Participant's retirement on or after age 65, the Participant's remaining Hour Bank hours can be used for Continuing Eligibility as to those individuals only until the Spouse either turns age 65, the Dependent(s) cease to meet the Plan's eligibility requirements, or the Hour Bank coverage is exhausted, whichever occurs first.

(d) Hour Bank hours can be frozen and remain available for future use in the following circumstances:

a. A Participant's Hour Bank hours can be frozen if the Participant is called to active military duty and requests in writing to the Fund Office that the Hour Bank be frozen and made available to the Participant upon his or her honorable discharge from active military duty and return to work with a Contributing Employer. The Plan shall otherwise comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) with respect to military service.

b. A Participant/Bargaining Unit Employee whose employment status changes such that the Participant becomes an Owner/Operator for whom Contributions are being submitted to the Fund on the basis of 40-hours per week, 52-weeks per year as provided in Section 2.2, can have his or her existing Hour Bank hours frozen upon written request to the Fund Office prior to such changed employment status. The frozen Hour Bank can be utilized later for Continuing Eligibility only if and when the Participant returns to covered employment with a Contributing Employer as a Bargaining Unit Employee prior to turning 65

years old.

c. A Participant who leaves the Industry of the Fund to work in another type of employment will have his Hour Bank frozen for a period of up to 18-months from the last date of employment within the Industry and Jurisdiction of the Fund. If the individual returns to work in the Industry and Jurisdiction of the Fund within 18-months, the individual shall have access to his Hour Bank and can begin participating again in the Plan under the Continuing Eligibility requirements as provided in Section 2.3. If the individual does not return to work within the Industry and Jurisdiction of the Fund within that 18-month period, the individual's Hour Bank will be forfeited and reduced to zero. In such event, the individual must reestablish the initial eligibility requirements of Section 2.1 before he can become a Participant in the Plan again.

2.5 **Participant Self-Pay Coverage.** If a Participant does not work at least 100 hours in a particular month (due to reasons other than retirement) and does not have sufficient hours in the Hour Bank to cover the hour deficiency for Continuing Eligibility, the Participant may elect to continue coverage by utilizing Participant Self-Pay Coverage as provided herein:

(a) Only Bargaining Unit Participants are able to elect the Participant Self-Pay Coverage; Spouses and Dependents cannot elect Participant Self-Pay Coverage. An election for Participant Self-Pay Coverage shall be made prior to the termination of the last coverage available to the Participant under the Plan. The written election shall be in form and substance as may be required from time to time by the Board of Trustees.

(b) The amount of the Participant Self-Pay payment is based on the full cost of coverage for health benefits for the given month, which is determined by the Board of Trustees from time to time, and must be paid (received by the Fund Office) by the 25th of the month immediately preceding the month in which coverage is sought. The premium for the initial period of coverage shall be made simultaneously with the election of Participant Self-Pay Coverage, and shall include all amounts which might be due related to the last day of coverage under which the Participant was covered through the last day of the calendar month for which the initial payment is made. Failure to pay the premium when due will result in automatic termination of Participant Self-Pay Coverage for the Participant and all Dependents, and the Board of Trustees will send a Notice of Cancellation of Participant Self-Pay Coverage.

(c) The amount of the Participant Self-Pay payment may be impacted by the application of any remaining Hour Bank hours for a given month. For example, if a Participant is eligible for Coverage and worked 70 hours in January and has 10 hours in the Hour Bank, the Participant is able to make a Participant Self-Pay payment to account for the 20-hour shortfall (100-hours-needed minus 70-hours-worked minus-10-Hour-Bank-hours) in order to maintain Continuing Eligibility. The 70-hours worked and 10-Hour-Bank-hours would be calculated at the rate of the CBA-contribution rate, and subtracted from the total cost of coverage for the month

(d) A Participant cannot utilize Participant Self-Pay Coverage for more than six months out of any calendar year. Additionally, a Participant cannot utilize Participant Self-Pay Coverage if the reason the Participant did not work 100 hours in a given month is because the Participant was working for a non-signatory employer in the Industry and Jurisdiction of the Fund who does not contribute to the Fund.

(e) A Participant who exhausts or fails to elect Participant Self-Pay Coverage may experience a "qualifying event" under COBRA, and may be entitled to COBRA Continuation Coverage as provided in Article 6.

2.6 Supplemental Self-Pay Coverage

(a) If a Participant retires as provided in Section 1.30 and neither the Participant or the Participant's Spouse is eligible for Medicare because they are not yet age 65, such retiree may elect to continue active Coverage by using Supplemental Self-Pay Coverage as provided for in this Section 2.6, so long as said Retiree was covered under the Plan by virtue of Employer Contributions being paid on the retiree's behalf for a period of not less than five (5) continuous years preceding retirement. Supplemental Self-Pay Coverage is available only after the Retiree has used and exhausted all other health coverage available under this Plan, including coverage based on Employer Contributions, Hour Bank hours, and COBRA Continuation Coverage.

(b) An election for Supplemental Self-Pay Coverage shall be made in writing within 30-days after termination of the last coverage available to the Participant under the Plan. The written election shall be in form and substance as may be required from time to time by the Board of Trustees.

(c) A Retiree's Supplemental Self-Pay Coverage shall be the same coverage as provided under the Plan, except that Supplemental Self-Pay Coverage shall not include Life Insurance Coverage, Accidental Death or Dismemberment Coverage, or Loss of Time Benefits, and shall not provide any coverage for Dependents unless the Participant specifically elects coverage for the eligible Dependents. The maximum duration of Supplemental Self-Pay Coverage is 11 months from the commencement date of such coverage, or when the Participant and/or the Participant's Spouse becomes eligible for Medicare, whichever occurs first.

(d) The amount of the monthly premium for Supplemental Self-Pay Coverage shall be the full cost of coverage as determined from time-to-time by the Board of Trustees and must be paid as a condition precedent to any coverage under this Section 2.6, including for any eligible Dependents. The Supplemental Self-Pay payment must be paid (received by the Fund Office) by the 25th of the month immediately preceding the month in which coverage is sought. The premium for the initial period of coverage shall be made simultaneously with the election of Supplemental Self-Pay Coverage, and shall include all amounts which might be due related to the last day of coverage under which the Participant was covered through the last day of the calendar month

for which the initial payment is made. Failure to pay the premium when due will result in automatic termination of Supplemental Self-Pay Coverage for the retiree and all Dependents, and the Board of Trustees will send a Notice of Cancellation of Supplemental Self-Pay Coverage.

2.7 Disability Credits for Eligibility. A Participant who becomes Totally Disabled for a minimum of twenty (20) consecutive days within a particular month can be credited with 100 hours of employment for each month of disability for purposes of meeting the Plan's Continuing Eligibility requirements. This credit will be provided only upon the approval of and a determination by the Board of Trustees that the Participant is Totally Disabled. A Participant must notify the Fund Office within 90-days of the disability and provide copies of documentation establishing the Participant's disability. The Plan has the right to request medical reports and other records from a health care provider, or to have a Participant evaluated by a physician, to ensure the Participant is Totally Disabled for purposes of receiving disability credits. If approved, the maximum credit for disability hours is limited to six consecutive months per disability.

2.8 Termination of Eligibility. A Participant is no longer eligible for health Coverage under the Plan when one of the following circumstances occurs:

(a) Insufficient Contributions. If a Participant fails to work a minimum of 100 hours for Continuing Eligibility as provided in Section 2.2 and has exhausted his Hour Bank and any ability for Participant Self-Pay Contributions, then eligibility for Coverage will terminate for such Participant and his Dependents as of the last day on which the Participant was most recently covered under Continuing Eligibility, unless such coverage is otherwise extended by the Participant pursuant to Article 6 (COBRA).

(b) Retirement on or after age 55. If a Participant retires on or after age 55 and prior to age 65, and has exhausted his Hour Bank, then eligibility for Coverage will terminate for such Participant and his Dependents as of the last day on which the Participant was most recently covered under Continuing Eligibility, unless such coverage is otherwise extended by the Participant pursuant to Article 6 (COBRA) and Section 2.6 (Supplemental Self-Pay Coverage).

(c) Retirement on or after age 65. Eligibility for Coverage will terminate on the first day of the month following the date of a Participant's retirement on or after age 65.

(d) Non-Covered Employment. Eligibility for Coverage will terminate immediately if a Participant begins working for a non-signatory employer in the Industry of the Fund who does not submit contributions to the Plan (i.e., begins working in non-covered employment). No Hour Bank hours or Participant Self-Pay are available in the event of such non-covered employment.

2.9 Reinstatement.

(a) An Employee who was previously covered by the Plan and eligible for benefits, but whose Coverage has been terminated for a period of at least 12 consecutive months,

shall become eligible for Coverage again only upon meeting the initial eligibility requirements provided in Section 2.1.

(b) An Employee who was previously covered by the Plan and eligible for benefits, but whose Coverage has been terminated for a period of less than 12 consecutive months, shall become eligible for Coverage again if such Employee works at least 100 hours in one month for a Contributing Employer and contributions are received by the Plan on such Employee's behalf. Coverage shall be reinstated for such Employee on the first day of the second month following the month in which such hours are worked.

2.10 Military Leave. The Plan adheres to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If a Participant is called to active military duty during Covered Employment, Coverage will continue under the Plan for up to 30 days from the start of active service. Pursuant to USERRA, if active military service lasts more than 30 days, a Participant can continue Coverage by making self-contributions to the Plan until the earlier of 24 consecutive months after the Plan's coverage ends or the end of the period during which the Participant is eligible to apply for re-employment in accordance with the terms of USERRA. The cost of continuation coverage under USERRA is the same as the cost for COBRA Continuation Coverage as provided in Section 6.6. The procedures for electing coverage under USERRA are also the same procedures as for COBRA, except that coverage may last for only up to 24 months. Dependents do not have a separate right to choose to continue coverage under USERRA, but can continue coverage under COBRA if the Participant is receiving USERRA coverage.

2.11 Retiree Subsidy

(a) Generally. Since July 16, 1997, the Plan has allocated $0.25 from each hour of Contributions received for certain work classifications to account for a retiree subsidy. A Participant who becomes a Retiree under this Plan may be eligible to receive a retiree subsidy to help fund the cost of ongoing active coverage through COBRA Coverage (Article 6) and/or Supplemental Self-Pay Coverage (Section 2.7) provided following requirements are met:

a. The Retiree had worked in the GF, F, R1, R2, R5, MESJ, MES2 job classifications (as described in the Collective Bargaining Agreement) and/or as a Bargaining Unit Alumni, or was reported upon by a Contributing Employer pursuant to an appropriate reporting form, for the entire 60-consecutive calendar month period preceding retirement; or

b. For that same 60-consecutive month period preceding retirement, the Retiree had coverage resulting from a combination of:

i. Having performed work as described in the GF, F, R1, R2, R5, MESJ, and MES2 job classifications or as a Bargaining Unit Alumni;
ii. Having expended available Hour Bank hours;
iii. Having made Participant Self-Pay Contributions;

iv. Having made COBRA Coverage payments; and/or
v. Having made Supplemental Self-Pay Contributions.

(b) Amount and Reimbursement Procedures. If eligible, the retiree subsidy benefit provides reimbursement of up to $500.00 per month (effective January 1, 2025) to the Retiree for ongoing health coverage costs for a period of up to a total of 72 consecutive months, and may be utilized as provided in 2.11(c) and 2.11(d). All Retirees and Spouses, as applicable, are required to submit documentation to the Fund Office detailing the applicable coverage and corresponding payments that have been made for ongoing health coverage.

(c) Use Prior to Age 65. If the Retiree retires before reaching age 65, the Retiree can utilize the monthly retiree subsidy to obtain reimbursement towards the cost of COBRA Coverage (up to 18 months) and/or Supplemental Self-Pay (11 months), if applicable, and towards any other health coverage the Retiree obtains, including exchange insurance products (i.e., Outside Coverage). The retiree subsidy will be provided monthly until the Retiree reaches the age of 65, at which point the retiree must enroll in Medicare Parts A and B in order to continue utilizing the retiree subsidy. Thereafter, the remaining months of the retiree subsidy can be used for reimbursement of a portion of the premium costs for the Retiree's individual Medicare Supplemental Insurance Policy or a Medicare Advantage Plan.

(d) Use After Age 65. If the Retiree retires at or after reaching age 65, or retired prior to age 65 and has since turned age 65, the monthly retiree subsidy can be used only for reimbursement of a portion of the premium costs for the Retiree's individual Medicare Supplemental Insurance Policy or a Medicare Advantage Plan. If a married Retiree retires at or after reaching age 65, and the Retiree's Spouse has not yet reached age 65, the monthly retiree subsidy can be applied towards the Retiree's Medicare Supplemental Insurance Coverage or Medicare Advantage Plan, or towards the Spouse's COBRA Coverage and/or Supplemental Self-Pay.

(e) Death and Impact on Spouse. If a Participant dies after reaching age 55 but prior to retirement, the Participant's surviving Spouse (regardless of age) is eligible to receive a monthly retiree subsidy for up to 72 months (as of January 1, 2025) provided the Participant met the requirements of Section 2.11(a) at the time of his or her death as if it were the date of retirement. If the surviving Spouse is less than age 65, he or she can utilize the retiree subsidy to obtain reimbursement towards the cost of coverage as indicated in Section 2.11(c).

(f) Amendment. The retiree subsidy is a use-it-or-lose-it benefit. The provisions regarding the retiree subsidy may be amended or completely eliminated at any time in the sole discretion of the Board of Trustees.

2.12 Dependent Eligibility

(c) An eligible Dependent will become eligible for Coverage on the same day that the Participant becomes eligible for Coverage under the Plan provided the Dependent already exists at the time participation commences. A Participant must submit requested documentation to the Fund Office regarding Dependent's enrollment.

(d) If a Participant obtains a Spouse and/or Child by marriage, birth, or adoption after having already been eligible for Coverage, the Participant must provide written notice to the Fund Office within 30 days of acquiring such dependent. If timely notice is received, a Spouse's coverage will begin as of the date of the marriage, and a Child's coverage will begin as of the date of the birth, adoption, or such other date that qualified the Child as a Dependent under the Plan. If notice is not provided within 30 days of acquiring such dependent, the dependent will not be eligible for Coverage until the first day of the month following the month in which the Fund Office receives notice and enrollment forms for such eligible dependent.

(e) A Dependent's Coverage will automatically terminate as a result of the following:

a. The date on which the Participant's Coverage is terminated in accordance with the Plan, subject to the following:

1. If a Participant dies while covered under the Plan, the Participant's Dependent can utilize the Participant's existing Hour Bank credits to maintain Dependent eligibility at no cost to the Dependent until the date the Participant would not have been eligible had the Participant lived and not earned any additional hours of Contributions;

2. If the Participant has a Spouse and/or other eligible Dependent as the time of the Participant's retirement, the Participant's remaining Hour Bank hours can be used for Continuing Eligibility as to those Dependent(s) until the Spouse either turns age 65, the Dependent(s) cease to meet the Plan's eligibility requirements, or the Hour Bank coverage is exhausted, whichever occurs first.

b. The date a Dependent enters active service with the armed forces of any country;

c. For a Dependent Spouse, the date of divorce of the Spouse from the Participant, or the first day of the month following the six month period during which the Participant and Spouse have lived apart and the Participant has not otherwise established the Spouse as being financially dependent on the Participant as provided in Section 1.11(a);

d. For a Dependent Child, the first day of the calendar year following the year in which the Dependent Child turns age 26, subject to any COBRA Continuation Coverage available as described Article 6;

e. The date a Dependent otherwise ceases to meet the definition for an eligible Dependent under Section 1.10;

f. The date Coverage for Dependents is terminated under this Plan.

ARTICLE 3
PLAN BENEFITS

3.1 Medical Coverage

(a) Medical Benefits. The Plan provides self-insured medical benefits, including hospitalization, for Participants and their eligible Dependents. The benefits are administered by Blue Cross Blue Shield of Florida (BCBSF) and are described in a Schedule of Benefits and related materials provided by BCBSF (the "BCBSF Documents"). All amendments and notices regarding changes to such Schedule of Benefits will be provided to Participants and Dependents as legally required.

(b) Covered Health Services. Subject to the requirements and limitations that may exist in the BCBSF Documents, including the application of deductibles or copays, the Plan provides coverage for the following types of health services, the amount of which is dependent upon whether the services were provided in an In-Network or Out-of-Network facility:

a. Primary care visit to treat an injury or illness
b. Specialist visit
c. Allergy injections
d. Advanced imaging services
e. Outpatient therapies and spinal manipulation
f. Preventative care/screening/immunization
g. Virtual visits by a designated virtual care provider
h. Routine Colonoscopy
i. Mammograms
j. Urgent care
k. Emergency room facility
l. Physician services at hospital and ER
m. Ambulance/emergency medical transportation
n. Convenient care centers and urgent care centers
o. Pregnancy related services
p. Independent clinical lab
q. Independent diagnostic testing facility
r. Outpatient hospital facility (diagnostic)
s. Ambulatory surgical center
t. Outpatient hospital facility (surgical)

(c) Preventative Services. In accordance with the Patient Protection and Affordable Care Act (ACA), required preventative services and essential health benefits are covered at 100% under the Plan (no copay or deductible required), but only when services are provided by an In-Network provider.

(f) Deductible and Pricing Amounts. For those health care services that are not covered 100% under the Plan or as required by law, the following pricing terms apply:

Benefit Description	In-Network	Out of Network
Individual Deductible (DED) per Plan Year (Jan. – Dec.) **Note:** The Individual DED will be waived by BCBSF for health care services rendered by any Independent Clinical Laboratory.	$500	
Family Deductible (DED) per Plan Year	$1,500	
Hospital Per Admission Deductible (PAD)	$0	$300 In addition to the DED and applicable *Coinsurance
Emergency Room Per Visit Deductible (PVD) if not admitted	$300	$300
Amount Payable by the Plan	80% of the Allowed Amount	60% of the Allowed Amount
Individual Out-of-Pocket Maximum per Plan Year for Medical Benefits	$3,600	Not Applicable
Family Out-of-Pocket Maximum per Plan Year for Medical Benefits	$7,200	Not Applicable
Note: Out-of-Pocket Maximums do not include any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount.		

(g) Benefit Exclusions. Pursuant to the exclusion and/or limitations set forth in the BCBSF Documents, the following health care services are not covered or paid for by the Plan:

a. Services received prior to a Participant's effective date of Coverage in the Plan, or after the date a Participant's Coverage terminates;

b. Services not specifically listed in the BCBSF Documents for covered services unless such services are specifically required to be required by applicable law;

c. Services a Participant or Dependent renders to himself or herself or those rendered by a physician or other health care provider related to the Participant by blood or marriage;

d. Services that are not Medically Necessary as determined by Blue Cross Blue Shield of Florida or the Fund. The ordering of a service by a health care provider does not in itself make such service Medically Necessary or a covered service;

e. Experimental or investigational services, except as otherwise covered under the Bone Marrow Transplant provision provided in the BCBSF Documents;

f. Services to treat an injury resulting from an accident related to a Participant's or Dependent's job or employment, except for services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual;

g. Services rendered at no charge;

h. Services to diagnose or treat a condition that directly or indirectly resulted from or is connected with:

    i. War or an action of war, whether declared or not;
    ii. The Participant's or Dependent's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot or rebellion;
    iii. The Participant or Dependent engaging in illegal activities; or
    iv. Services received at military or governmental facilities to treat a condition arising out of the Participant's service in the armed forces, reserves and/or National Guard.

i. Court-ordered care or treatment, unless otherwise covered;

j. Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust or similar person or group that is not the Plan;

k. Services that are not patient-specific, as determined solely by BCBSF;

l. Abortion by choice, that is not medically necessary;

m. Arch supports;

n. Assisted Reproductive Therapy (infertility treatments);

o. Autopsy;

p. Cell and/or gene therapy except as specifically authorized by the Plan;

q. Complementary or alternative medicine (e.g., self-help training, homeopathic medicine and counseling, aromatherapy, traditional Oriental medicine etc.)

r. Complications of Non-Covered Services (e.g., complication of cosmetic surgery);

s. Costs related to telephone consultations with physicians or other administrative requirements for appointments;

t. Custodial care for daily living (e.g., rest homes, home maid services, etc.);

u. Dental care (see Section 3.3);

v. Certain drugs (see Section 3.2);

w. Food and food products unless covered as an Enteral Formula;

x. Foot care in the absence of disease (e.g., bunion, toenails, corns, etc.);

y. Genetic screening and evaluation;

z. Hearing aids;

aa. Immunizations unless otherwise covered by the Plan or by law;

bb. Maternity services for a Participant or Dependent who becomes pregnant as a gestational surrogate;

cc. Mental health services, including diagnostic evaluation, psychiatric treatment, individual therapy, and/or group therapy, including inpatient, outpatient, and partial hospitalization services;

dd. Occupational therapy;

ee. Motor vehicle accidents, including any costs incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage;

ff. Oral surgery if the primary purpose is to improve the appearance or self-perception of the individual;

gg. Orthomolecular therapy, including nutrients, vitamins, and food supplements;

hh. Oversight of a medical laboratory by a physical or other health care provider;

ii. Personal comfort, hygiene or convenience items that are not Medically Necessary and not directly related to the treatment of a condition, such as beauty and barber services, guest meals and accommodation, travel expenses, physical fitness equipment, and massages, unless otherwise covered;

jj. Private duty nursing care;

kk. Rehabilitative therapies on inpatient or outpatient basis, excuse those that are specifically covered such as for cardiac, speech, spinal manipulation;

ll. Reversal of voluntary, surgically-induced sterility;

mm. Self-inflicted injuries or sickness that are not incurred as a result of a documented medical condition;

nn. Sexual reassignment, modification, or gender affirming care;

oo. Sports related devices used to affect performance primarily in sports-related activities;

pp. Substance dependency care and treatment;

qq. Training and educational programs or materials (e.g. for pain management and vocational rehabilitation) unless covered under diabetes outpatient self management category;

rr. Travel or vacation expenses even if prescribed by a provider;

ss. Volunteer services;

tt. Weight control services (e.g., including weight control/loss programs, appetite suppressants and other medications, dietary regiments, exercise programs, etc.);

uu. Wigs and/or cranial prosthesis;

vv. Any Service or Services which are not within, are in excess of, and/or in addition to Reasonable and Customary Charges (as defined in Section 1.28).

3.2 Prescription Drug Coverage.

(a) Pharmacy Benefits. The Plan provides self-insured prescription drug benefits for Participants and their eligible Dependents. The Plan contracts with A & A Services, LLC, d/b/a Sav-Rx Prescription Services of Fremont, NE ("Sav-Rx") to manage and administer the prescription drug plan that utilizes the Sav-Rx formulary. Prior authorizations may be required in order for certain drugs to be covered as further dictated by the Plan and Sav-Rx. Drugs are available to Participants and their

Dependents at certain retail pharmacies as well as the Sav-Rx mail order and specialty networks.

(b) Covered Drugs. Pursuant and subject to the Sav-Rx documents and any changes to its prescription drug management requirements, the Plan covers those drugs that have been prescribed for use by the Food and Drug Administration and are proven safe, effective, and accepted for the treatment of the specific medical condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full-length articles in respected national professional medical journals. Covered drugs include certain brand name drugs, generic equivalents, and biosimilars. Any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication is covered, provided the drug is recognized for treatment of the Participant's or his Dependent's particular cancer in a Standard Reference Compendium or is recommended for treatment of the Participant's or his Dependent's particular cancer in medical literature. Additionally, the following drugs and drug classes are covered by the Plan, or covered with certain limitations as further detailed by Sav-Rx:

a. Insulin;
b. Insulin syringes and pen needles;
c. Tubeless insulin pump;
d. Tubeless insulin pump supplies;
e. Other syringes;
f. Vitamins and prenatal vitamins with a prescription;
g. Tretinoin.

(c) ACA Covered Drugs: The following drugs are covered by the Plan 100% if required by the Affordable Care Act, however a Participant is required to pay the difference in cost for utilizing brand products that have a generic equivalent:

a. Oral contraceptives (e.g., combination, progestin-only, extended cycle, Plan B, Ella);
b. Prescription non-oral contraceptives (e.g., patch, ring, injection, implant, IUD, cervical cap, diaphragm);
c. Over the counter ("OTC") non-oral contraceptives if FDA-approved and prescribed by health care provider;
d. Generic aspirin for men and women aged 50 – 59;
e. Generic aspirin for women of childbearing age at risk for preeclampsia;
f. Oral fluoride as prescribed through age five;
g. Generic OTC folic acid supplements for women to age 55;
h. Iron supplement drops as prescribed through age one;
i. Vitamin D for age 65 and older;
j. Erythromycin omphalic ointment as prescribed through age one;
k. Routine childhood and adult immunizations;
l. Herpes zoster (shingles) – male and female age 50 and over;
m. Influenza

n. Prescription tobacco cessation products;
o. OTC tobacco cessation products;
p. Breast cancer chemopreventative (e.g., tamoxifen, raloxifene);
q. Colorectal cancer screening tests (e.g., colonoscopy prep – PEG solution, GoLYTELY);
r. Pre-exposure prophylaxis (PrEP) antiretroviral therapy to prevent HIV;
s. Clinically managed statins (select generics) Simvastatin, Pravastatin, Lovastatin;
t. Brand statins (covered at applicable copay)
u. Other generic statins (covered at applicable copay)

(d) Prior Authorizations. Pursuant and subject to the Sav-Rx documents and any changes its prescription drug management requirements, the following drug classes are covered provided a prior authorization is granted and no limitations apply:

a. Diabetic testing machines;
b. Continue glucose monitor and supplies;
c. Injectables;
d. Specialty injectables;
e. Transplant;
f. Growth hormones;
g. Erectile Dysfunction Daily Dose (for benign prostatic hyperplasia use only).

(e) Copayments. Participants are responsible for paying a copay on drugs, whether received at retail, mail order, or specialty as detailed below:

Channel	Day Supply	Copay for Generic	Copay for Preferred	Copay for Non-Preferred	Copay for Brand instead of Generic Option*
Retail – 30 day	1-30	$15	$35	$65	$65 + difference in cost
Retail – 60 day	31-60	$30	$70	$130	$130 + difference in cost
Retail – 90 day	61-90	$45	$105	$195	$195 + difference in cost
Mail – 90 day	90	$30	$70	$130	$130 + difference in cost
Specialty – 30 day	30	$15	$35	$65	$65 + difference in cost
Specialty – 60 day (select meds)	31-60	$30	$70	$130	$130 + difference in cost
Specialty – 90 day (select meds)	61-90	$45	$105	$195	$195 + difference in cost

* Cost difference not charged to the Participant if prescriber provides a clinical justification for utilizing brand name medication over generic.

(f) Accumulators. There is no deductible for the prescription benefit coverage under the Plan. The maximum out-of-pocket per Plan Year for prescription drug coverage is $900 per individual and $1,800 per family. If a Participant and/or Dependent chooses to utilize a brand medication instead of an available generic equivalent (and the prescriber has not provided a clinical justification for brand name use), the difference in cost associated with the brand medication will operate as a penalty and will not apply toward that Participant's individual or family out-of-pocket maximum.

(g) Exclusions. The Plan does not cover the following drug classes under the prescription drug benefit program:

a. Insulin pump and supplies (part of the Plan's medical benefits);
b. Non-routine immunizations;
c. Travel vaccines;
d. Fertility treatments;
e. Abortifacients, unless such drug is used for a medically necessary purpose, in which case a Participant submit a drug reimbursement request to the Plan;
f. OTC male condoms;
g. Mental health drugs, unless such drugs are used for a non-mental health diagnosis subject to prior authorization;
h. CNS stimulants (e.g., attention deficit, narcolepsy), unless such drug is utilized for a non-mental health diagnosis subject to prior authorization;
i. Weight loss drugs;
j. Cosmetic drugs;
k. Erective dysfunction on demand;
l. Sexual dysfunction drugs;
m. Gender affirming care;
n. Any non-prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products or health foods, other than those required to be provided under the Affordable Care Act or otherwise specifically determined as covered under the Plan;
o. Complementary or alternative medicine, including but not limited to homeopathic medicine;
p. Drugs prescribed for uses other than the FDA's approved label indications;
q. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for continuation of growth hormone therapy will not be covered except for conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment

3.3 Dental and Orthodontia Benefits. The Plan contracts with Blue Cross Blue Shield of Florida (Florida Combined Life) to provide fully insured dental and orthodontia benefits to Participants and their eligible Dependents.

(a) Dental. The maximum dental benefit per individual is $2,500 per Plan Year. All charges for services are paid in accordance with the prevailing schedule under the BCBSF arrangement. The Plan covers 70% of the cost of dental services including:

a. Periodic oral evaluations;
b. Comprehensive oral evaluations;
c. Bitewing X-rays;
d. Cleanings – adult/child;
e. Fluoride Treatment – child;
f. Office visits;
g. Space maintainers – fixed – unilateral;
h. X-rays – intraoral/complete series;
i. Sealant – per tooth;
j. Amalgam restorations (silver fillings);
k. Resin based restorations – anterior;
l. Extractions – routine and surgical;
m. Root canal molar;
n. Periodontal scaling & root planning – per quad;
o. Osseous surgery – 4 or more contiguous teeth;
p. Crowns – porcelain fused to noble metal;
q. Complete dentures;
r. Pontic – porcelain fused to noble metal;
s. Partial dentures;
t. Surgical placement of implant body – endosteal implant;
u. Implant supported porcelain fused to metal crown (titanium high noble metal)

(b) Orthodontia The Plan also covers orthodontia services at 70% of service cost, with a $1,000 per person maximum per lifetime.

(c) Other Terms. There are no deductibles for dental or orthodontic services, nor are there waiting periods. Rollovers from other dental plans are not available to Participants and their eligible Dependents. All information regarding dental and orthodontia coverage and benefits is set forth in the BCBSF documentation. Claims and appeals for dental and orthodontia benefits will be governed solely by the procedures set forth in the BCBSF documents for such benefits, and not by the provisions of Article 7.

3.4 Life Insurance. The Plan provides for and administers a self-funded life insurance benefit for certain Participants as follows:

(a) If a Participant dies prior to retiring and while eligible for Coverage under the Plan, the Participant's Beneficiary will be entitled to a lump sum life insurance benefit of $30,000.00. In order to be entitled to the life benefit, a claim form and a death certificate must be submitted by the Beneficiary and received by the Fund Office within one year of the Participant's death. Notwithstanding the foregoing, if the Participant's death is caused by an accident, the benefit paid shall be governed pursuant to Section 3.5(b) herein.

(b) If a Participant retires and is or becomes permanently Totally Disabled before age 60, a $30,000.00 life insurance benefit will be available on the Participant's death for a period of up to 10 years or until the Participant reaches age 65, whichever occurs first. This benefit will remain in place for the aforementioned time period even if the Participant retires prior to turning age 65. For example, if a Participant becomes permanently Totally Disabled at age 56 and retires on disability status before age 60, and then dies at age 62, the Participant's Beneficiary will be entitled to receive the life insurance benefit. If the Participant does not die until age 65 or after, the Beneficiary will not receive the life insurance benefit. Any claims for life benefits under this subsection must be submitted to and received by the Fund Office within a year of the Participant's death, and must include a death certificate and proof of the Participant's disability.

(c) If a Participant has not named a Beneficiary under the Plan, or the named Beneficiary does not survive the Participant, the life insurance benefits will be paid in the following order: (1) to the Participant's Spouse, if living; (2) to the Participant's surviving children, in equal shares; (3) to the Participant's parents, in equal shares; or (4) to the Participant's estate.

(d) Benefits will not be paid under this Section 3.4 if the death or disability is caused by:

a. A disability that occurred prior to the Participant's Coverage in the Plan;
b. Suicide or self-inflicted injuries;
c. Voluntary taking of (1) a prescription drug in a manner other than as prescribed by a physician, (2) any other federally- or state-regulated substance in an unlawful manner, (3) non-prescription medicine, in a manner other than as indicated in the printed instructions, or (4) poison;
d. Voluntary use of a hallucinogen or substance causing intoxication
e. Voluntary use of alcohol resulting in intoxication above the legal limit;
f. Operating a vehicle while intoxicated above the legal limit or while under the influence of hallucinogen or substance causing intoxication;
g. Voluntarily inhaling gas or taking poison
h. Committing or attempting to commit a crime
i. Participating in a riot or suffered during a war or act of war;
j. Disability that is incurred while serving in the armed services;
k. Death or disability from car racing, motorcycle racing, boat racing, flying a plane, or participating in extreme activities such as bungee jumping, sky diving, or scuba diving.

3.5 Accidental Death & Dismemberment (AD&D). The Plan provides for and administers a self-funded AD&D benefit for Employee Participants as follows:

(a) Accident Defined. For purposes of this Section 3.5, an "accident" is deemed to be an event that is not caused by any of the circumstances listed in Section 3.5(d), and typically involves vehicular accidents, fire, accidental falls, accidents that take place on public or commercial transportation, or accidental drownings. The Trustees have the sole discretion to determine whether an accident occurred for purposes of the benefits under Section 3.4, and may request additional information from the Participant to establish the factual background supporting such accident. Accidents that occur during a Participant's employment that are covered by workers compensation are not deemed "accidents" for purposes of this Section 3.5.

(b) Fatal Accidents. If a Participant dies prior to retiring and while eligible for Coverage under the Plan, the Participant's Beneficiary will be entitled to receive a benefit in the total amount of $60,000.00 if the Participant's death is caused by an accident and the Participant dies within 365 days of such accident. A Beneficiary's receipt of the $60,000 benefit under this Section 3.5(a) is in lieu of, and not in addition to, the life insurance benefit provided in Section 3.4(a). In order to be entitled to the $60,000.00 benefit, a claim form and death certificate must be submitted by the Beneficiary and received by the Fund Office within one year of the Participant's death.

(c) Nonfatal Accidents. The Plan will also pay an AD&D benefit to a Participant of up to $60,000 if a non-retired Participant who is eligible for Coverage under the Plan suffers a bodily injury or injuries in an accident such that the Participant is deemed dismembered under the Plan.

a. A Participant is deemed dismembered if one or more of the following injuries occur as a result of an accident:

i. Loss of a hand, by actual severance at or above the wrist joint;
ii. Loss of a foot, by actual severance at or above the ankle joint;
iii. Loss of an eye involving the irrecoverable and complete loss of site in the eye;
iv. Loss of speech or hearing that is deemed total, permanent, and irrevocable which requires the loss has been present for 12 consecutive months;
v. Loss of thumb and index finger of the same hand, by actual severance of the entire digits (complete severance through or above the metacarpophalangeal joint above digits);
vi. Third-degree burns caused by direct contact with chemical, fire, steam, water or heat (except sunburns);
vii. Quadriplegia – entire and irrecoverable paralysis of both upper and lower limbs (a limb means the entire arm or leg);
viii. Paraplegia – entire and irrecoverable paralysis of both lower limbs;

ix. Hemiplegia – entire and irrecoverable paralysis of the upper and lower limbs on one side of the body;
x. Uniplegia – entire and irrecoverable paralysis of one limb.

b. The amount of benefit is payable as follows:

i. The full principal sum of $60,000 is payable for the following injuries:
1. Loss of both hands, both feet, or both eyes;
2. Loss of both hearing and speech;
3. Quadriplegia;
4. Third-degree burns covering 75% or more of the body.

ii. Half the principal sum (or $30,000) is payable for the following injuries:
1. Loss of one hand, loss of one foot, or loss of one eye
2. Loss of either hearing or speech;
3. Paraplegia or hemiplegia
4. Third-degree burns covering 50 – 74% of the body.

iii. One quarter of the principal sum ($15,000) is payable for the following injuries:
1. Loss of the thumb and index finger of the same hand;
2. Uniplegia.

iv. No more than the full principal sum ($60,000) is payable for all losses listed above resulting from one accident.

c. In order to be entitled to an AD&D benefit hereunder, a claim form and information describing the accident must be submitted by the Participant and received by the Fund Office within 90-days of the accident. The Trustees have the right to request additional information and documentation as necessary to substantiate a claim.

(d) Exclusions. Benefits will not be paid under this Section 3.5 if the death or injury is caused by:

a. Injury that occurred prior to the Participant's Coverage in the Plan;
b. Death caused by illness, including mental illness;
c. Suicide or self-inflicted injuries;
d. Voluntary taking of (1) a prescription drug in a manner other than as prescribed by a physician, (2) any other federally- or state-regulated substance in an unlawful manner, (3) non-prescription medicine, in a manner other than as indicated in the printed instructions, or (4) poison;
e. Voluntary use of a hallucinogen or substance causing intoxication;
f. Voluntary use of alcohol resulting in intoxication above the legal limit;
g. Operating a vehicle while intoxicated above the legal limit or while under the influence of hallucinogen or substance causing intoxication;

h. Voluntarily inhaling gas or taking poison
i. Committing or attempting to commit a crime
j. Participating in a riot or suffered during a war or act of war
k. Injuries while serving in the armed services
l. Death or injury from car racing, motorcycle racing, boat racing, flying a plane, or participating in extreme activities such as bungee jumping, sky diving, or scuba diving.

3.6 Medicare Eligibility and Coverage. Participants who turn age 65 are eligible for Medicare. Under certain circumstances, Participants can become eligible for Medicare before age 65 if they are disabled or have chronic End-Stage Renal Disease (ESRD). A Participant who turns age 65 or who becomes eligible for Medicare due to ESRD must notify the Fund Office of such developments. Participants should apply for Medicare Parts A (hospitalization benefits) as soon as they are eligible. Participants must enroll in Part B (medical insurance benefits) upon retiring from active employment. Participants will be considered to be insured under Parts A and B of Medicare whether or not they have registered for Part A or enrolled in Part B. Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable as further stated in Section 9.6.

ARTICLE 4
THIRD PARTY CLAIMS AND RIGHT OF FIRST DOLLAR REIMBURSEMENT

4.1 Generally. This Article 4 pertains to claims for first dollar right of reimbursement, which involves cases where a Participant is injured or develops an illness that results in a claim by the Participant or Dependent against another person or third-party (a "Third-Party Injury"). Third-Party Injuries can be compensated in whole or in part by workers' compensation or employer liability laws, through no-fault automobile insurance or automobile liability insurance, or by claims against, or a legal obligation on the part of, a third-party by the Participant or Dependent. If the Plan has paid Benefits to or on behalf of a Participant or Dependent for a Third-Party Injury, the following rules apply:

(a) To the extent Benefits are paid by the Plan to or on behalf of a Participant or Dependent arising out of a Third-Party Injury where the third party may be liable or from which recovery is sought from the third party, the Plan is entitled to first dollar reimbursement from any recovery awarded to the Participant or Dependent through a lawsuit, settlement, or otherwise from any third party (including without limitation any insurance carrier), up to the full amount of benefits that were paid by the Plan on behalf of the Participant or Dependent for such Third-Party Injury (i.e., the Plan's lien amount). The Participant or Dependent must repay to the Plan all benefits paid on his or her behalf out of any recovery received from a third party and/or applicable insurer for such Third-Party Injury. The Plan's lien and right of reimbursement applies to any amounts recovered by the Participant or Dependent, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Plan.

(b) To the extent benefits are paid by the Plan to or on behalf of a Participant or Dependent arising out of a Third-Party Injury where the third party may be liable or from which recovery is sought from the third party, the Plan is subrogated to any claims the Participant or Dependent may have against the third party who caused the injury. The Plan shall also be entitled to assert and shall be subrogated to all rights, remedies, and claims of a Participant or Dependent to the same extent such person has or may have against any third party for such injury or illness including, without limitation to pursue and collect from all other sources of payment for, contribution to, and/or reimbursement of the expenditures paid by the Plan as benefits to or on behalf of said Participant or Dependent. The rights described in this Subsection 4.1(b) shall include the independent right to file and prosecute claims administratively and/or by filing litigation in the name of, on behalf of, or in lieu of the Participant or Dependent, or, at the sole option of the Plan, to require the Participant or Dependent to initiate, prosecute, join and cooperate with the Plan in all efforts to seek and obtain recovery from all sources which may be obligated to pay and or contribute to such expenditures by contract, statutory law, common law or equity, including, without limitation filing, prosecuting and appearing in and at all judicial and/or quasi-judicial actions and/or proceedings which the Plan, in its absolute discretion may deem necessary or desirable to assist or facilitate such recovery.

(c) The Plan's right of subrogation and reimbursement applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for this or her losses and/or expenses related to the Third-Party Injury, as the Plan's right to subrogation and reimbursement applies to any full or partial recovery and notwithstanding any "Make Whole" doctrine. The Plan does not have responsibility for, and is not required to give any credit for, the injured Participant's or Dependent's attorneys fees, and shall therefore not be subject to any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine".

4.2 Conditions to Payment of Benefits. If a Participant or Dependent sustains a Third-Party Injury, or is being denied workers compensation due to a dispute over whether the claim is work-related, the Plan will advance benefits related to such injury (if such benefits are otherwise properly payable under the terms and conditions of the Plan), provided the following conditions are met:

(a) As soon as reasonably possible, the Participant or Dependent must notify the Fund Office that he or she has a Third-Party Injury and/or is initiating a claim or legal action against any third party that relates to a health benefit under the Plan (including claims for money from an uninsured motorist liability policy, homeowner's insurance policy, or private accident insurance). The Participant or Dependent shall also notify the Plan of the name and address of any applicable insurance carrier.

(b) The Participant or Dependent must complete all paperwork deemed necessary by the Plan to protect the Plan's subrogation interests, which may include the signing of a separate subrogation and reimbursement agreement. Notwithstanding the foregoing, the Plan's rights of reimbursement and subrogation as stated in Section 4.1 remain enforceable even if a Participant or Dependent fails to comply with documentation requirements.

(c) The Participant or Dependent must fully cooperate with the Plan in doing what is necessary to assist Plan with the enforcement of the Plan's rights of subrogation and reimbursement under this Article 4.

(d) In consideration of the Plan's advancement of benefits in this context, no settlement may be made by a Participant or Dependent, nor release given, for claims arising out of such person's Third-Party Injury without prior written consent of the Fund.

4.3 Failure to Comply. If the Participant or Dependent fails to execute and/or deliver any agreement or document requested by the Plan under Article 4, or fails to comply or cooperate with the Plan's enforcement of this Article 4, the Plan may deny coverage for benefits associated with the Third-Party Injury. Additionally, the Plan may immediately seek recovery of all benefit amounts paid on behalf of the Participant or Dependent for the Third-Party Injury by any available means, including legal action. The Plan shall also have the right to offset any future benefit payments that would otherwise be payable to or on behalf of the Participant or Dependent up to an amount of the Plan's lien for first dollar right of reimbursement. These offset benefits will be permanently forfeited by the Participant or Dependent and such person will be legally responsible for any unpaid amounts to the Plan. If it becomes necessary for the Plan to enforce its rights by

initiating any action against the Participant or Dependent, the Participant or Dependent agrees to pay the Plan's attorney's fees and costs associated with such action regardless of the action's outcome. The Plan shall be entitled to enforce its entitlement to attorney's fees and costs by way of an equitable restitution, constructive trust, or any other equitable remedy.

ARTICLE 5
LOSS OF TIME BENEFITS

5.1 Generally. If an eligible Participant becomes Totally Disabled due to a non-occupational bodily injury or sickness, such Participant is eligible for "Loss of Time" benefits from the Plan provided the Participant is unable to work in any capacity. Loss of Time benefits are not available to Spouses or Dependents.

5.2 Application and Proof. In order to receive Loss of Time benefits, a disabled Participant must provide written notice and proof of disability to the Fund Office within 90-days after the disability occurs. The Plan has the right to request medical reports and other records from a health care provider, or to have a Participant evaluated by a physician, to ensure the Participant is and remains Totally Disabled for purposes of Loss of Time benefits. The Loss of Time benefit payments will not become payable until the first day of the week following the date the application is processed by the Fund Office, provided benefits can be paid retroactively to the first week following the date of the disability in the Trustees' discretion.

5.3 Amount of Loss of Time Benefits. Loss of Time benefits are paid weekly for a period of up to 26 weeks. The amount of the weekly benefit is based on CBA job classification as follows:

(a) $500 per week – General Forman, Foreman, R5, R1, and MESJ.

(b) $360 per week – R2 and A5;

(c) $250 per week – R3, R4, MES2, MES3, Apprentice 2, 3, 4 & MAT.

The weekly amount may be prorated in the event a Participant is disabled for less than a complete five-day week.

5.4 Termination of Loss of Time Benefits. Loss of Time benefits will terminate on the earlier of the following:

(a) The expiration of the 26 week period referenced in Section 5.3; or

(b) The date the Participant is no longer deemed Totally Disabled for purposes of Loss of Time benefits and is capable of returning to work in any capacity. Participants must advise the Fund Office if the Participant's disability status changes.

5.5 Trustee Discretion. A Participant's entitlement to Loss of Time benefits shall be determined by the Trustees in their sole discretion. The Trustees have the right to amend the provisions pertaining to Loss of Time benefits, including the amount and duration of the same, in their sole discretion.

5.6 Claims Procedures. For claims involving Loss of Time benefits, the Plan will review and determine the claim as a Disability Claim under the procedures of Article 7, however Loss of time benefits are not subject to external review.

5.7 Exclusions. Loss of Time benefits will not be paid under this Article 5 if the injury or sickness is caused by:

a. Injury or sickness that occurred prior to the Participant's Coverage in the Plan;
b. Self-inflicted injuries;
c. Injury or sickness caused by a drug overdose;
d. Injury while driving under the influence of alcohol or other substances or drugs;
e. Injury from voluntarily inhaling gas or taking poison;
f. Injury while committing a crime;
g. Injury while participating in a riot or suffered during a war;
h. Injuries while serving in the armed services;
i. Injury from car racing, motorcycle racing, boat racing, flying a plane, or participating in extreme activities such as bungee jumping, sky diving, or scuba diving.

5.8 Occupational Injuries. An eligible Participant who has an occupational injury that has been denied by the Workers Compensation insurer and who is challenging that decision in a workers' compensation claim may request benefits in writing to the Plan. The Plan may, in its discretion after review, allow payment of benefits provided that the participant agrees to reimburse the Plan for all benefits paid from any recovery of any type received by participant.

ARTICLE 6
COBRA CONTINUATION COVERAGE

6.1 COBRA Continuation Coverage.

Participants and their Dependents have the right under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to make payments to extend health care coverage temporarily ("COBRA Continuation Coverage") after coverage would otherwise end under the Plan due to a Qualifying Event. A Qualifying Event includes one or more of the following:

(a) Termination of a Participant's employment for any reason other than "gross misconduct";

(b) Reduction of hours of work such that a Participant's hours are insufficient to maintain continuing eligibility under the Plan (and the Participant has exhausted any applicable Hour Bank or desired Participant Self-Pay coverage);

(c) Participant's death;

(d) Participant or the eligible Dependent's entitlement to health care coverage under Medicare Part A, Part B, or both;

(e) Participant's divorce to a Spouse; and/or

(f) A Child's loss of dependent status under the Plan.

Upon the occurrence of a Qualifying Event, a Qualified Beneficiary may elect COBRA Continuation Coverage as further provided in this Article 6 and applicable federal law. A Qualified Beneficiary for purposes of COBRA is a Participant, Spouse, and/or a Participant's Dependent(s) who are covered by the Plan on the day before the Qualifying Event occurs. Spouses who become married, or children who become born or adopted during the period of COBRA Continuation Coverage are also Qualified Beneficiaries if properly enrolled in the Plan.

6.2 Description of Continuation Coverage. COBRA Continuation Coverage is identical to the medical, prescription drug, and dental coverage that was previously provided under the Plan for such Qualified Beneficiary. COBRA Continuation Coverage does not provide ongoing coverage for life insurance benefits, AD&D benefits, or disability coverage under the Plan.

6.3 Periods of COBRA Continuation Coverage. COBRA Continuation Coverage can be elected only after a Participant has exhausted all of his or her applicable Hour Bank and Participant Self-Pay coverage under Article 2. COBRA Continuation Coverage will then be provided as follows:

(a) 18-Month Coverage. If the Qualifying Event is the loss of the Participant's employment (including retirement) or the reduction of the Participant's hours of

employment, COBRA Continuation Coverage will generally last for up to a total of eighteen (18) months from the date of loss of coverage.

(b) 29-Month Coverage. If COBRA Continuation Coverage is provided under Section 6.3(a) and the Qualified Beneficiary is disabled as determined by the Social Security Administration and such disability occurred during or before the first 60 days of the 18-month period of COBRA Continuation Coverage, such coverage can be further extended for all eligible family members until the earlier of 29-months from the date of the Qualifying Event or the first of the month that begins 30 days after the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

In order to extend coverage under this subsection 6.3(b), the Fund Office must receive written notification and a copy of the Social Security Administration's disability determination within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA Continuation Coverage. If the Social Security Administration later determines that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary or Participant must notify the Fund Administrator in writing within 30 days of the date of notice from the Social Security Administration.

(c) 36-Month Coverage. COBRA Continuation Coverage may continue for up to 36 months if a Participant's spouse and/or dependent(s) lose coverage because of the Participant's death, divorce, entitlement to health care coverage under Medicare Part A, Part B, or both, or a child's loss of dependent status under the Plan.

Additionally, if a family experiences a second Qualifying Event as listed in this subsection 6.3(c) during the first 18 months of already receiving COBRA Continuation Coverage, the COBRA Continuation Coverage can be extended for a maximum of 36 months from the date of the initial Qualifying Event, provided notice and proof of the second Qualifying Even is given within 60 days to the Fund Administrator. The extension is available only if the second Disqualifying Event would have caused a Participant's spouse and/or dependent child(ren) to lose coverage under the Plan had the first Qualifying Event not occurred.

(d) Calculation of Monthly Maximum Period. The calculation of the monthly maximum period shall be measured from the date of the Qualifying Event notwithstanding the date of the election for COBRA Continuation Coverage. However, if a Qualifying Event occurs during the period of time a Participant is receiving coverage under the Plan by virtue of Hour Bank or Participant Self-Pay coverage, and such individual elects COBRA Continuation Coverage, the maximum monthly duration of such coverage shall be measured from the date of the exhaustion of the Hour Bank or Participant Self-Pay coverage (unless said period is terminated earlier by other provisions hereof).

(e) Armed Forces. The Plan adheres to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If a Participant is

called to active military duty during Covered Employment, coverage will continue under the Plan for up to 30 days from in active service. Pursuant to USERRA, if active military service lasts more than 30 days, a Participant can continue coverage by making self-contributions to the Plan until the earlier of 24 consecutive months after the Plan's coverage ends or the end of the period during which the Participant is eligible to apply for re-employment in accordance with the terms of USERRA. The cost of continuation coverage under USERRA is the same as the cost for COBRA Continuation Coverage. The procedures for electing coverage under USERRA are also the same procedures as for COBRA, except that coverage may last for only up to 24 months. Dependents do not have a separate right to choose to continue coverage under USERRA, but can continue coverage under COBRA if the Participant is receiving USERRA coverage.

6.4 COBRA Notices.

(a) By the Plan. Within the first 90-days of coverage under the Plan, the Plan will provide notice to each Participant and Dependent of the Plan's COBRA Continuation Coverage and the rights and manner of election of the same. Additionally, the Plan shall provide notice to any Qualified Beneficiary of such person's rights under COBRA within 14-days of the Plan receiving notice that a Qualifying Event has occurred. Any written notification to a Qualified Beneficiary who is the Spouse of a Participant shall constitute notification to all other Qualified Beneficiaries residing with such Spouse at the time the notification is made.

(b) By the Participant/Qualified Beneficiary. A Participant or Qualified Beneficiary must give written notice to the Fund Office within 60 days after a Qualifying Event occurs. This notice must include the name and social security number of the Participant, the name of the Qualified Beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the Qualifying Event (for example, the date of a divorce), and the date on which the Qualifying Event occurred. If timely notice is not provided, the right to COBRA Continuation Coverage is forfeited.

Further, failure to timely notify the Plan of a divorce or a child losing eligibility gives the Plan the right to hold the Participant and his or her spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Fund may suspend the payment of future benefits until such amount has been recovered.

(c) By the Employer. An Employer of a Participant must notify the Plan within 30-days of the occurrence of any Qualifying Event affecting one if its Participant Employees. Failure of the Employer to give this notice shall entitle the Plan to recoup from the Employer all costs, damages, penalties, and liabilities which the Plan incurs as a result thereof. In addition to the foregoing, the Employer shall be liable for the full amount of the benefits and payments which the Plan makes to any Qualified Beneficiary or Participant prior to the time the Plan received notice from the Employer of a Qualifying Event. Failure to make payment of same within five (5) days demand by the Plan shall

constitute a delinquency under the Trust entitling the Trust Fund to endorse all remedies for delinquent Contributions under the Trust Agreement and Collective Bargaining Agreement including, without limitation, court costs, interest, attorneys fees, penal ties, and liquidated damages.

6.5 Election of COBRA Continuation Coverage.

(a) Time Within Which Election Must be Made. A Participant or Qualified Beneficiary must elect COBRA Continuation Coverage within sixty (60) days of termination of Coverage under the Plan by reason of a Qualifying Event or, if later, sixty (60) days after the Notice described in Section 6.4(a) above from the Plan of the Participant's and/or Qualified Beneficiary's rights to COBRA Continuation Coverage hereunder.

(b) Manner of Making Election. An election of COBRA Continuation Coverage hereunder shall be made in writing in the same manner as set forth in Section 6.4(b) above with respect to notices to the Plan. Said election must be accompanied by the payment of the COBRA Premium as provided in Section 6.6.

(c) Effect of Election Upon Other Beneficiaries. Unless an election specifically states otherwise, any election by a Participant, if the Qualifying Event is termination or reduction or hours of employment, shall be deemed to include an election of COBRA Continuation Coverage on behalf of any other Qualified Beneficiary who would lose coverage under the Plan due to the said Qualifying Event; provided however, that a Participant can elect not to cover any of his or her Qualified Beneficiaries.

(d) Revocation of Waiver. In the event a Qualified Beneficiary waives COBRA Continuation Coverage, such Qualified Beneficiary may revoke such waiver at any time before the end of the election period described in Subsection 6.5(a) hereof. If a Qualified Beneficiary revokes the waiver of COBRA Continuation Coverage, such revocation shall be considered to be made on the date that such revocation is mailed or sent to the Plan Administrator. A revocation of such waiver of COBRA Continuation Coverage shall entitle the individual to obtain such coverage only from the date of such revocation respectively through the balance of the period of coverage provided in Section 6.3 measured from the date of the Qualifying Event.

6.6 Self-Payment Premium.

(a) Amount of Premium. Qualified Beneficiaries must pay for COBRA Continuation Coverage in an amount determined by the Trustees based on the cost of coverage for a Plan Year for similarly situated beneficiaries of the Plan for whom a Qualifying Event has not occurred as determined in a manner consistent with Section 604 of ERISA ("COBRA Premium"). Such COBRA Premium shall not be more than 102% percent (or 150% in the case of any month of 29-Month Coverage described in Section 6.3(b)) of the cost incurred by the Plan in providing coverage for the Plan Year in which the COBRA Continuation Coverage is provided.

(b) Payment of Premium. The party electing COBRA Continuation Coverage must timely pay the COBRA Premium in monthly installments unless a different interval is required or permitted. If a timely election is made after the occurrence of the Qualifying Event, payment of the amount of the first COBRA Premium (hereinafter called the "Initial Payment") for the Period of Coverage which preceded the election must be made within forty-five (45) days of the postmark date of notice of the timely election provided that the payment is made in full for the entire period of coverage through the date of payment of Initial Payment and all subsequent accruing premium payments have also been timely made. The Initial Payment may be pro-rated, if appropriate, based on the date of the Qualifying Event within a particular month. Subject to the grace period set forth below, all other payments of COBRA Premium must be made promptly on the first date of each month throughout the duration of the COBRA Continuation Coverage. A thirty (30) day grace period shall apply to all payments of the COBRA Premium except for the Initial Payment.

In the event any COBRA Premium is not received by the Plan on its due date and within the Grace Period provided above, COBRA Continuation Coverage shall be immediately terminated for such Qualified Beneficiary with respect to whom such premium was not promptly paid, unless due to a unique circumstance as determined by the Trustees in their sole discretion. Payment shall mean actual receipt by the Plan at the Fund Office. If COBRA Continuation Coverage is terminated due to nonpayment, the Qualified Beneficiary will not be given a second chance to reinstate coverage.

6.7 Early Termination of COBRA. The period of COBRA Continuation Coverage will terminate on any of the dates provided below if the date is earlier than the maximum periods of coverage set forth in Section 6.3:

(a) The date in which the Plan terminates with respect to every Participant and Benefits are afforded under the Plan;

(b) The first day of the period for which a Qualified Beneficiary fails to make a timely self-payment premium under Section 6.5 to maintain COBRA Continuation Coverage;

(c) The date on which the Qualified Beneficiary first becomes covered under any other group health plan (as an employee or otherwise) that does not exclude pre-existing conditions to which the Qualified Beneficiary may be subject,;

(d) The date on which the Qualified Beneficiary first becomes entitled to Medicare coverage; or

(e) The last day of the month in which the Social Security Administration determines that the Qualified Beneficiary is no longer disabled, if applicable.

COBRA Continuation Coverage shall immediately cease without notice on the date of occurrence of any of the above-described events, however the Fund Office will provide written notice when practical after such coverage ends. In the event of early termination of COBRA Continuation

Coverage, there shall be no refund of any premium paid. There shall be no right of reinstatement to COBRA Continuation Coverage after early termination.

ARTICLE 7
CLAIMS, NOTICES, AND APPEAL PROCEDURES

7.1 **Submission of Claims and Notices.** All claims, notices, and inquiries regarding benefits, elections (or revocations of election), re-employment, verification, advance determinations of prohibited work, notices of mailing address, notices of appeal, and all other inquiries and matters concerning the Plan and its provision of benefits shall be submitted to the Board of Trustees addressed at the Fund Office:

MCASF 725 Health and Welfare Plan
c/o Benefit Services
15800 Pines Blvd., Suite 201
Pembroke Pines, Florida 33027

All inquiries shall be promptly answered by the Plan within a reasonable time. Many claims for health benefits are submitted directly from the provider to the Fund Office. If they are not, claims for benefits must be made in writing on forms filed at the above Fund Office and under the rules determined by the Trustees.

Written notice of a claim for benefits, along with proof of the claim and any charges incurred, must be submitted within 90-days of the occurrence of the claim (if reasonably possible). In no event will a claim submitted more than twelve (12) months after the date of occurrence be accepted or payable by the Plan. The Plan may ask for additional documentation and/or information to support a claim, notice, or inquiry prior to making a determination regarding the same. Participants must complete "Annual Family Statements" as required by the Fund in order for claims to be processed. The Annual Family Statement will be mailed to each Participant once per year or at such times as determined necessary by the Board of Trustees.

7.2 **Trustee Discretion.** The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or governmental regulation, and subject to the review procedures established herein and by applicable law, shall be final and conclusive.

7.3 **Types of Claims.** For purposes of the procedures set forth herein, benefit claims are classified as being one of four types:

(a) An Urgent Claim is a claim where the care requested could seriously jeopardize the life or the health of the claimant, or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the individuals' medical condition, the individual would be subjected to severe pain that could not be adequately managed without the care of requested treatment;

(b) A Pre-service Claim is a claim in which the benefit being sought must be requested in advance, and an approval given by the Plan, before the benefit is covered;

(c) A Claim for Payment is a claim for benefits that a claimant wants the Plan to pay for that has already been incurred;

(d) A Disability Claim is a claim for weekly sickness and injury disability benefits a non-occupational injury or disease as is available under the terms of the Plan.

Claims and appeals for dental and orthodontia benefits will be governed solely by the procedures set forth in the BCBSF documents for such benefits, and not by the provisions of this Article 7.

7.4 Review Period for Claims.

(a) An Urgent Claim will be reviewed and determined within 72 hours from receipt of the claim by the Plan. However, if more information is needed for the Plan to decide the claim, the claimant will be notified within 24 hours of submitting the claim what additional information is needed, and the claimant will have 48 hours to provide that information. A decision on the claim will be made within 48 hours of receiving such additional information.

(b) A Pre-service Claim will be reviewed and determined within 15 days from receipt of the claim by the Plan. The Plan may utilize an additional 15 days to review the Claim if additional time is necessary. If more information is requested from the claimant, the claimant will have 45 days to provide such additional information, and the Plan's review window is tolled while awaiting requested information from the claimant.

(c) A Claim for Payment will be reviewed and determined within 30 days from receipt of the claim by the Plan. The Plan may utilize an additional 15 days to review the Claim if additional time is necessary. If more information is requested from the claimant, the claimant will have 45 days to provide such additional information, and the Plan's review window is tolled while awaiting requested information from the claimant.

(d) A Disability Claim will be reviewed and determined within 45 days from receipt of the claim by the Plan. The Plan may utilize up to two additional 30-day periods if necessary to review the claim. If more information is requested from the claimant, the claimant will have 45 days to provide such additional information, and the Plan's review window is tolled while awaiting requested information from the claimant.

7.5 Adverse Benefit Determination. If any claim for benefits is denied, suspended, or terminated, in whole or in part, by the Plan, then the claimant shall be furnished with a Notice of Denial, Suspension or Termination (also known as an Adverse Benefit Determination). The Notice shall be provided in writing or electronically and shall set forth:

(a) the specific reasons for the denial, suspension or termination;

(b) the specific provisions or Plan provisions on which the decision was based;

(c) if applicable, a description of any additional material or information necessary for the claimant to perfect the claim, along with an explanation of why such material or information is necessary;

(d) a description of the Plan's review procedures and the applicable time limits for such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

(e) a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

(f) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) in the case involving urgent care, a description of the expedited review process applicable to such claims;

(h) in the case of an adverse benefit determination with respect to disability benefits, a discussion of the decision, including an explanation of the basis for disagreeing with or not following any views presented by a health care professional or medical or vacation expert who opinioned regarding the claim or the claimant's injuries.

7.6 Additional Evidence. Before the Plan can issue an initial benefit determination based on a new or additional rationale, or new or additional evidence considered or relied upon by the Plan or at the direction of the Plan, the claimant must be provided, free of charge, with the rationale or new or additional evidence. The rationale or new or additional evidence must be provided as soon as possible and sufficiently in advance of the date on which the initial benefit determination is required to be provided under Section 7.4 to give claimant a reasonable opportunity to respond prior to that date.

7.7 Internal Appeals.

(a) Generally

a. A claimant may appeal any adverse benefit determination received pursuant to Section 7.5 within 180-days of receipt of the determination. The claimant must submit a written appeal to the Trustees setting forth the issues to consider related to the benefit denial, along with any additional comments the claimant may have.

b. All appeals must be timely submitted or else the claimant waives his or her right to have the benefit claim subsequently reviewed on internal appeal, by external review, or in a court of law.

c. Reviews on appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

d. A claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

e. The Plan will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal appeal. The Plan will continue to provide coverage pending the outcome of an internal appeal.

(b) Notice of Decision on Internal Appeal. The notice of decision on appeal shall be provided to the claimant in writing or electronically and shall set forth:

a. The specific reasons for the denial;

b. the specific provisions or Plan provisions on which the decision was based;

c. A statement that the claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;

d. a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

e. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

f. in the case of an adverse benefit determination with respect to disability benefits, a discussion of the decision, including an explanation of the basis for disagreeing with or not following any views presented by a health care professional or medical or vacation expert who opinioned regarding the claim or the claimant's injuries;

g. A description of the external review process, including information regarding

how to initiate the external review process;

h. A statement of the claimant's right to bring a civil action after a further denial on appeal or external appeal and the time limitations for bringing such action, if applicable; and

i. The availability of possible assistance with the internal claims and appeals and external review processes from the Employee Benefits Security Administration or U.S. Department of Labor Office.

(c) Timing of Decisions on Appeal. Final decisions on appeal shall be made by the Board of Trustees in writing and shall be made by the date of their next regular meeting that immediately follows the date the Notice of Appeal is received. If the Notice of Appeal is received less than 30-days before the next board meeting, the Trustees may make their decision by the second meeting following the receipt of the appeal request. If special circumstances exist requiring additional time to make a decision on the appeal, then the decision may be made no later than the third meeting following receipt of the appeal request. In the event the Trustees need an extension due to such special circumstances, the Trustees will notify the claimant in writing before the extension begins, describing the special circumstances and the date by which the Trustees will make a determination. The Trustees' decision on the appeal will be communicated to the claimant in writing within five (5) days of the meeting at which the decision was made for Claims for Payment and Disability Claims. If an appeal is denied, in whole or in part, then the decision shall set forth the specific reasons for the decision, with specific references to those Plan provisions or other criterion upon which the decision is based. The claimant shall be promptly provided with a copy of this decision and if requested, will receive access and copies of all documents, materials, and procedures relevant to the claim. The decision of the Board of Trustees shall be final and binding.

Notwithstanding the foregoing, appeals of Adverse Benefit Decisions pertaining to an Urgent Claim will be decided within 72 hours of receipt by the Plan of the appeal. Pre-Service claims will be decided within 30 days of receipt by the Plan of the appeal. Appeals of disability claims will generally be decided within 45 days of receipt by the Plan of the appeal, unless circumstances require additional time due to matters beyond the Plan's control.

7.8 External Review.

(a) Generally. Pursuant to 45 CFR § 147.136(d), a claimant may be able to request an external review after a denial of an appeal under Section 7.7 herein. The external review process applies to any final internal adverse benefit determination that involves (1) medical judgment, including but not limited to, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or experimental or investigational treatment (excluding, however, determinations that involve only contractual or legal interpretation without the use of medical judgment), or (2) a recission of coverage (whether or not the recission has any effect on any particular

benefits at that time. Loss of Time benefits are not subject to external review. A denial, reduction, or termination of benefits based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan are also no eligible for external review.

(b) Request for External Review. Any request for an external review must be filed within four months after the date of the claimant's receipt of the final adverse benefit determination of an internal appeal under Section 7.7.

(c) Preliminary Review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
- 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 (e.g., whether a person worked sufficient hours during the eligibility period);
- The claimant has exhausted the Plan's internal appeal process; and
- The claimant provided all of the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, such 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 also describe the information or materials needed to make the request complete. The Plan will allow the claimant to perfect an incomplete request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(d) Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) to conduct the external review. The IRO must provide the Plan with a response to the request for an external review within 30 days for a standard review or seven (7) days for cases meeting expedited review criteria. The IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits. The assigned IRO will:

a. Utilize legal experts where appropriate to make coverage determinations under the Plan;

b. Timely notify the claimant in writing of the request's eligibility and acceptance for external review;

c. Within five business days after the date of assignment of the IRO, the Plan will provide the assigned IRO with the documents and any other information considered in making the final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will 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 final adverse benefit determination;

d. Within 10 business days following the date of receipt of notice from the IRO that it has received the request for external review, the claimant may submit, in writing, additional information for the IRO to consider. The IRO may, but is not required to, accept and consider additional information submitted after ten business days;

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

f. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided by the Plan and the claimant, to the extent the information or documents are available and the IRO considers them appropriate, the assigned IRO will consider the following:

    i. The claimant's medical records;
    ii. The attending health care professional's recommendation;
    iii. Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating provider;
    iv. The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
    v. Appropriate practice guidelines, which must include applicable

evidence based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

g. The assigned IRO will provide written notice of the final external review decision within 45 days after it receives the request for the external review and will deliver the notice of final external review decision to the claimant and the Plan within one business day after making the decision. The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the claimant;

vi. A statement that judicial review may be available to the claimant; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

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

(f) Expedited External Review. A claimant may make a request for an expedited external review with the Plan if the claimant receives:

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

b. A final internal adverse benefit determination and the claimant has a medical condition where the timeframe 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 internal 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.

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above and will immediately send the claimant a notice of its eligibility determination. Upon a determination that a request is eligible for external review, the Plan will assign an IRO and provide or transmit all necessary documents and information considered in making the final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. The assigned IRO will 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 will provide written confirmation of the decision to the claimant and the Plan.

7.9 Limitations of Actions. No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Administrator, the Trustees, or any of them, unless all of the required internal claim and appeal procedures of the Plan have been followed and exhausted, nor can such action be brought unless brought within one year following the date of the Notice of Decision on an internal review under Section 7.7. In the event a claimant does not bring any action within such year, he waives his right to any further review of an adverse determination in a court of law. If a claimant pursues external review of an internal adverse benefit determination pursuant to Section 7.8, the one year deadline for bringing an action in a court of law shall toll from the date the Plan receives notice of the external review request until such date the Plan receives written notice from the assigned Independent Review Organization (IRO) regarding its final external review decision pursuant to 29 CFR § 2560.503-1(c)(3)(ii).

7.10 Right to Reimbursement. A Participant must immediately notify the Fund Office if the Participant leaves the Industry, becomes self-employed, and/or begins working for a Non-Contributing Employer. A Participant must also immediately notify the Fund Office if the Participant's Spouse and/or Dependent no longer meet the eligibility requirements under the Plan (e.g., such as a divorce or loss of physical and legal custody of a dependent). If the Fund has paid benefits on behalf of a Participant, Spouse, or Dependent who is no longer eligible to receive such benefits, the Fund is entitled to seek reimbursement from the Participant, Spouse, and/or Dependent of the amounts paid on their behalf.

ARTICLE 8
HIPAA PROVISIONS

8.1 Protected Health Information. The Plan and its Trustees adhere to the privacy practices and regulations adopted by the Department of Health and Human Services at 45 CF § 164. Accordingly, Protected Health Information ("PHI") as defined in 45 CFR § 164.501 will be treated confidentially and not disclosed by the Plan, except as specifically permitted herein and in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its corresponding regulations. To the extent possible, any PHI that is individually identifiable health information (i.e., name, address, birth date, social security number, etc.) will be deidentified. PHI will be utilized only for Plan administration.

8.2 Request, Use and Disclosure of PHI by Trustees. The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

(a) To make or obtain payment for care received by eligible Participants;

(b) To facilitate treatment which involves the provisions, coordination or management of health care or related services;

(c) To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to eligible Participants;

(d) In connection with judicial or administration proceedings in response to an order of a court or administration tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process;

(e) If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes;

(f) To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.

(g) For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action;

(h) To prevent or lessen a serious and imminent threat to an eligible Participant's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct;

(i) For specified government functions under 45 CFR Part 164;

(j) To the extent necessary to comply with laws related to workers' compensation or similar programs.

8.3 Trustee Duties Regarding PHI. The Trustees, as Plan Sponsor, agree to the following regarding the disclosure of any PHI:

(a) The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law;

(b) The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees;

(c) The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees;

(d) The Trustees will report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services or its designee for the purpose of determining the Plan's compliance with HIPAA;

(f) When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

8.4 Electronic Protected Health Information. In compliance with the HIPAA Security Regulations, the Plan Sponsor will:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI ("ePHI") that it creates, receives, maintains or transmits on behalf of the group health plan;

(b) Ensure that there is adequate separation as between the Plan and Trustees such that ePHI will be used only for Plan administrative purposes with reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontract, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect ePHI; and

(d) Report to the Plan any security incident of which it becomes aware concerning ePHI.

ARTICLE 9
COORDINATION OF BENEFITS

9.1 Application. This Article 9 applies to situations where a Participant (included Spouses and Dependents) are covered by more than one health care plan or insurance plan. Generally, if a Participant has coverage under more than one plan, benefits will be coordinated between the various plans. In any calendar year, this Plan will pay either its regular benefits in full, or pay a reduced amount which, when added together with the benefits payable by the "Other Plan", will equal 100% of the "Allowable Expenses" incurred as provided herein. Participants must notify the Fund Office if there is duplication of coverage under any other health plan, program, or policy that the Participant, Spouse, or Dependents may have. If this information is not received by the Fund Office, claims may be denied and the Participant will be responsible for payment of any expenses related to denied claims.

9.2 Definitions. For purposes of this Article 9, the following definitions apply:

(a) "Allowable Expenses" means part or all of necessary, reasonable and customary charges a Participant or Dependent incurs during a calendar year while eligible for benefits under this Plan. Expenses or services that are excluded or limited in this Plan (e.g., see Section 3.1(g)) will not be considered an Allowable Expense.

(b) "Other Plan" means any plan providing benefits or services for or by reason of medical care or treatment, which are provided by:

a. Any group or non-group health insurance, group-type self-insurance, or HMO plan;

b. Any group plan issued by any Blue Cross and/or Blue Shield organizations;

c. Any other plan, program, or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits coordination of benefits;

d. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other arrangement of benefits for individuals of a group;

e. Any coverage under governmental programs (including Medicare), and any coverage required or provided by any statute.

9.3 Individual Policy Coordination. If a Participant or any of his eligible Dependents has purchased or acquired an individual policy of health care benefit coverage, such individual policy will be primary and will pay benefits first before this Plan. This Plan will coordinate with the individual policy and pay benefits as the secondary carrier up to a maximum of 100% of the Allowable Expenses.

9.4 Group Plan Coordination. For all cases other than those described in Section 9.3, the following order of coordination of benefits will be used to determine the amount of benefits payable under this Plan and the amounts to be paid by any Other Plans:

(a) A plan without coordination of benefits pays its benefits before a plan that contains coordination of benefits.

(b) A plan that covers a person other than as a dependent pays its benefits before a plan, which covers the person as a dependent.

(c) A spouse who has declined available coverage from their employer, regardless of any premium contribution for that coverage, shall be subject to coordination on the same basis as if the spouse had elected such coverage.

(d) For claims on behalf of dependent children:

a. The plan from the employer of the dependent child would pay first;

b. The plan from the employer of the spouse of the dependent child would pay second;

c. The plan which covers the parent whose birthday (month and day) falls first in the calendar year pays third;

d. The plan of the parent whose birthday falls later in the year pays fourth;

e. If both parents have the same birthday, the plan covering the parent for the longer period of time pays first.

(e) If one plan uses the male-female rule and the other plan coordinates benefits as in Section 9.4(c) above, the male/female rule plan pays its benefits first. In the male/female rule plan, the plan which covers a person as a dependent of a male employee will pay its benefits before a plan which covers the person of a dependent of a female employee; except that in the case of a dependent child of separated or divorced parents:

a. If there is a court decree, which established financial responsibility for medical expenses, the plan covering the dependent children of the parent who has that legal responsibility will be primary.

b. If there is not a court decree establishing such financial responsibility, the plan that covers the parent with custody will be primary.

c. If there is not a court decree establishing such financial responsibility and the parent with custody has remarried, the order of benefit coordination will be:

i. the plan of the parent with custody;

ii. the plan of the stepparent with custody;

iii. the plan of the parent without custody.

Notwithstanding anything to the contrary herein, all Participants and Dependents under this Plan are required to comply with the reasonable requirements of any applicable Other Plan's coverage as a condition precedent to this Plan being required to make payments not paid by the Other Plan where the Other Plan is primary.

9.5 FSA/HSA/HRA. If the "Other Plan" includes a Flexible Spending Account (FSA), Health Savings Account (HSA), or a Health Reimbursement Account (HRA), the following order of benefits will apply:

(a) FSA: Apply COB to the other employer or individual coverage first, other than an FSA. This Plan then pays second. An FSA can be used to pay any deductible or out of pocket expense remaining, usually by submitting the amount due for reimbursement from the FSA administrator. An FSA may qualify as a health plan for purposes of COB if the individual had no other coverage, but this Plan will still pay first before the FSA.

(b) HSA: There should not be any coordination of benefits because an HSA participant cannot have any other coverage.

(c) HRA: Apply COB to the other employer or individual coverage. The HRA could be the individual's Other Plan if their employer does not offer other insurance coverage, or is an arrangement they have in addition to a health plan. If the individual has other coverage and an HRA, the HRA can be used to pay deductible or out of pocket expense remaining after coordination either by the individual submitting a request for reimbursement to the HRA, or submitting the amount due for direct payment by the HRA.

9.6 Medicare Coordination. Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable. When a Participant becomes covered under Medicare and continues to be eligible under the terms of this Plan, coverage under this Plan shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. The Plan will pay benefits before Medicare only for:

(a) An actively employed Participant who is age 65 or older;

(b) An actively employed Participant's Spouse who is age 65 or older;

(c) The first 30 months of treatment for End-Stage Renal Disease (ESRD) received by any Participant or Dependent beginning with the earlier of: (i) the month in which the individual became entitled to Medicare Part A ESRD benefits; or (ii) the first month in which the individual would have been entitled to Medicare Part A ESRD benefits if a timely application had been made.

(d) Any Participant or Dependent who is less than age 65 and is receiving Medicare benefits because of a disability.

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary. If the Plan was primary prior to ESRD entitlement, then the Plan's coverage will remain primary for the ESRD coordination period.

ARTICLE 10
MISCELLANEOUS

10.1 Construction. The terms and conditions of this Plan shall be construed subject to the purposes and provisions of the Trust Agreement establishing the Trust Fund, and subject to ERISA, the Internal Revenue Code and all other applicable laws. The Board of Trustees is vested with sole and exclusive authority to interpret the provisions of the Plan including, without limitation, payment of benefits hereunder, and all such reasonable interpretations and rulings by the Board of Trustees shall be binding and conclusive upon all parties.

10.2 Standard of Proof. The Board of Trustees shall be the sole judge of the standards of proof required in any case. Subject to the external review procedures in Section 7.8 herein, the decisions of the Board of Trustees shall be final and binding on the Participants and Beneficiaries, the Associations, the Employers, the Union, and all other persons.

With respect to any and all determinations and decisions required and/or permitted to be made by the Board of Trustees pursuant to the terms of this Plan, including, without limitation, determinations of eligibility for benefits, termination of eligibility, disability status, medical, physical, and/or health conditions of any person, the Board of Trustees shall be entitled to rely upon, accept, and base its decisions or determinations upon, the opinion of any expert engaged by the Board of Trustees to review and evaluate such matters, including, without limitation, any licensed health care professional (including, without limitation, a licensed nurse, nurse practitioner, medical doctor, chiropractor or other physician, as the term "physician" is defined herein (hereafter collectively called "Referred Physician")), notwithstanding the fact that, the opinion of such Referred Physician may be contrary or otherwise inconsistent with the opinion and/or evaluation expressed by the treating physician or other expert for said individual. It is specifically the right of the Board of Trustees to not grant special deference, weight or authority to the opinion or evaluation of the treating physician of any individual and the Board of Trustees is not required to afford the opinion or evaluation of such treating physician of any individual over the opinion and/or evaluation of any Referred Physician to which the Board of Trustees has submitted the matter for evaluation and opinion.

10.3 Benefits Not Assignable.

(a) This Plan shall be considered a Spendthrift Trust under Florida law, except as provided hereunder, and the right of any person under this Plan shall not be subject to assignment, alienation or voluntary or involuntary transfer, and to the fullest extent permitted by law, shall not be subject to attachment, execution, garnishment, sequestration or other legal or equitable process. In the event any person attempts to assign, transfer or dispose of such right, or if an attempt is made to subject said right to such process, such assignment, transfer or disposition shall be null and void.

(b) Notwithstanding the provisions of subparagraph 9.3(a) above, benefits payable for expenses incurred in connection with a specified period of disability, hospital care or surgical or medical treatment, resulting from one injury or period of sickness may be

assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable.

(c) The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payments and the Plan will not be required to see to the application of the payment.

10.4 Qualified Medical Support Orders

(a) Assignment of Benefits Upon Divorce. The prohibition against assignment, alienation and transfer of benefits provided in Section 9.3 shall not apply to a Medical Child Support Order that is determined to be a "Qualified Medical Child Support Order" as defined in Section 609(a) of ERISA.

(b) Filing of Claims. Each and every claim for Benefits under a Medical Child Support Order shall be filed, in writing, with the Board of Trustees along with a copy of the Medical Child Support Order on which the claim is based.

(c) Definitions.

a. "Qualified Medical Child Support Order (QMCSO)" means a medical child support order: (1) which creates or recognizes the existence of an Alternate Recipient's right to, receive Benefits for which a Participant or Beneficiary is eligible under a group health plan; and, (2) clearly specifies:

i. The name and last known mailing address (if any) of the Participant and each Alternate Recipient covered by the order;

ii. A reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined;

iii. The period to which such order applies;

iv. The plan to which such order applies; and

v. Specifically does not require a plan to provide any type of form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993).

b. "Medical Child Support Order" means any judgment, decree, or order

(including approval of a settlement agreement) issued by a court of competent jurisdiction which:

i. provides for Child Support with respect to a child Participant under a Group Health Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan; or

ii. enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 1822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

c. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Participant.

(d) Procedures. Upon receipt of a medical child support order, the following procedures will be used by the Plan to determine whether or not it is a Qualified Medical Child Support Order pursuant to the terms of ERISA:

a. The Participant, any potential alternate recipients, and/or their designated representatives will be notified in writing within 30-days of receipt that the order has been received by the Plan and has been referred to legal counsel for determination of its status, such notice to include a provision permitting an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to the order and a copy of the Plan's procedures for determining the qualified status of the order.

b. The order will be referred to the Fund's legal counsel for review and a determination within a reasonable period of time as to whether the order is qualified as a QMCSO in accordance with Section 9.4(c).

c. After determining the qualification of the order, the Participant and alternate recipients and/or their designated representatives will be notified in writing. If the order is qualified and acceptable as a QMCSO, the alternate recipients and/or their designated representative will be informed of the alternate recipient's health benefits and of the Plan's procedures to provide benefits.

d. If the Fund's legal counsel determines that an order is not a QMSCO, legal counsel may suggest necessary modifications. During this interim period, the Fund may either provide coverage or wait and provide retroactive coverage once the QMCSO is approved.

e. The Plan may adopt additional written procedures to supplement these provisions for determining whether a medical child support order constitutes a

QMSCO, and for administration of distributions under QMSCOs.

f. The Board of Trustees may file an interpleader action to assist in its determination whether an order is a "Qualified" Medical Child Support Order. The professional fees and costs of an interpleader action may be deducted from the sums deposited with the Court.

(e) Disenrollment. Once an alternate recipient is enrolled in the Fund pursuant to a QMCSO, the Plan cannot disenroll or eliminate coverage unless the Plan is provided with written evidence that the Court or Administrative Order is no longer in effect or that the alternate recipient will be enrolled in comparable health insurance through another insurer effective no later than the date of the disenrolling. Notwithstanding the foregoing, the Plan may disenroll an alternate recipient at the same time and under the same conditions as it can disenroll other Dependents of Participants under the Plan.

(f) National Medical Support Notice. The Plan shall comply with the applicable requirements for a National Medical Support Notice pursuant to Section 609(a)(5)(C) of ERISA and the requirements of 29 CFR § 2590.609-2.

10.5 Interpleader. In the event of any controversy under and/or regarding the Trust and Plan including, without limitation, questions or controversies of whatever character, arising in any manner or between any persons or entities in connection with the Plan or the operation thereof, or which are related to any claim for any benefit by any participant or any other person, the Board of Trustees may file an interpleader action or any action for judicial determination declaratory judgment in any court of competent jurisdiction to determine the rights, duties, and/or obligations of the Plan, Trust, and Participant beneficiary, and/or Trustees. The court costs and all professional fees and costs of an interpleader action may be deducted from the sums deposited with the Court or disbursed pursuant to the Order of such Court.

10.6 Incorporation by Reference. This Plan is maintained for the exclusive purpose of providing benefits to Participants and Beneficiaries hereof, and is intended to satisfy all the requirements of Section 302(c)(5) of the National Labor Relations Act of 1947, ERISA and the Internal Revenue Code. In the event any requirements of such laws have been omitted, they shall be deemed to be incorporated herein by reference.

10.7 Rescission of Coverage. If health care coverage has been provided under the Plan as a result of fraud or misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent (including but not limited to failing to inform the Plan of a divorce or other event which makes a Dependent ineligible for coverage under the Plan), the Plan will rescind coverage (i.e., retroactively cancel coverage). A thirty day notice of rescission will be provided. In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly or severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this Section 10.07 limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the right of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment.

10.8 Payment of Trust and Plan Expenses. All expenses incurred with respect to preparation of Trust and/or Plan documents, design, administration, operation, and compliance of the Trust and Plan with all applicable legal requirements, including, without limitation, amendments to the Trust, Plan, and/or related documents, and compliance with applicable law, as such law may be enacted, amended or modified (including, without limitation, by action or decision of any court having applicability to the Trust and/or Plan) from time to time, shall and are hereby declared and determined to be, activities and expenses undertaken and incurred by the Board of Trustees in their capacity as fiduciaries to the Trust and the Plan (and not in any other capacity), in accordance with ERISA and Department of Labor Field Assistance Bulletin 2002-2 and shall be expenses paid for by the Trust.

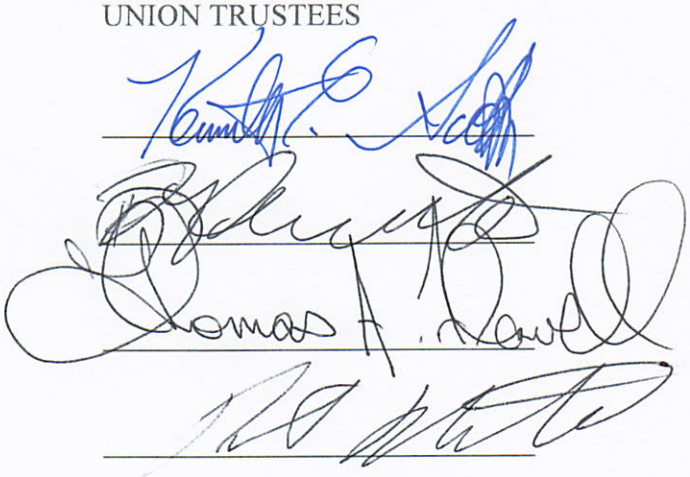
10.9 Plan Amendments. The Trustees reserve the right to amend, alter, or terminate any or all coverages hereunder or the terms of this Plan, for any or all classes of Participants or Dependents, at any time, prospectively or retroactively, provided that such amendment complies with the Internal Revenue Code, ERISA, all other applicable laws, and the purposes as set forth in the Trust Agreement. Additionally, and not by way of limitation, the Board of Trustees may amend this Plan when it is deemed necessary to maintain its tax exempt status, or to preserve compliance with the Internal Revenue Code, ERISA, and all other applicable laws. A copy of each amendment to this Plan shall be made available to the Union, the Association, the Employers, and the Participants, upon request.

10.10 Termination of the Plan. In the event of termination of the Plan, the Board of Trustees shall follow the procedures contained in the Trust Agreement, ERISA, the Internal Revenue Code, and all other applicable laws in terminating the Plan. In the event there are any funds remaining after paying benefits earned by the Participants, then such remaining funds shall not revert to the Employers.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Board of Trustees of the MCASF Local 725 Health and Welfare Trust Fund hereby adopt this Amended and Restated MCASF Local 725 Health and Welfare Plan to be effective January 1, 2025.

UNION TRUSTEES



EMPLOYER TRUSTEES