MCASF Local 725
Health & Welfare Plan

SUMMARY PLAN DESCRIPTION

JULY 1, 2021

Introduction

Dear Participant,

As Trustees of the MCASF Local 725 Health and Welfare Fund (formerly the ACRA Local 725 Health and Welfare Fund) (the "Fund"), we are pleased to provide you with this updated Summary Plan Description ("SPD") for the MCASF Local 725 Health and Welfare Plan (the "Plan"), which summarizes the eligibility rules and benefits of the Plan.

The Plan offers a comprehensive benefit program designed to protect you and your covered dependents. Whether you are beginning a new job, having a child or adopting one, getting married or divorced, battling an illness or disability, looking forward to retirement, or are already retired, the Plan offers health coverage that is designed to help meet the needs of you and your family.

As a participant in the Plan, you may qualify for a wide range of benefits. The Trustees have enlisted the services of Blue Cross Blue Shield of Florida ("BCBSF") to provide the network of benefits to participants in order to obtain discounts for the Plan and its participants. However, the eligibility rules of the Plan determine for which, if any, benefits you are eligible. The level of benefit coverage provided to you depends on whether you are an active employee or a retired employee. Please read this booklet carefully so that you will know what benefits you and your family members are entitled to, and what you must do to qualify for benefits and how to file a claim.

The Trustees have established the MCASF Local 725 Service Corporation (the "Service Corporation") to assist with administering these benefits. The Service Corporation operates the Fund Office, and does business under the name of "Benefit Services".

This SPD has been prepared for active and retired employees of the Plan and their dependents. The Board of Trustees has the sole discretion and authority to make final determinations regarding any application for benefits, interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under the Plan will only be paid if and when the Board of Trustees, or persons to whom such decision-making authority has been delegated by the Trustees, in their sole discretion, decide the participant or beneficiary is entitled to benefits under the terms of the Plan. The Trustees' decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If the Plan makes inadvertent, mistaken, excessive, erroneous, or fraudulent payment of benefits, the Trustees or their representative will have the right to recover these types of payments. The Trustees reserve the right to change, modify, or discontinue all or part of the benefits in this SPD at any time by action or amendment.

This SPD replaces and supersedes all prior summary plan descriptions that have been issued. However, this SPD is only a summary of the provisions of the Plan. We have attempted to make this SPD as complete as possible, but there may be provisions contained in the master Plan Document that are not set out in the summary contained in this SPD. If there is any discrepancy between the provisions in the SPD and the Plan Document, the Plan Document will prevail.

If there is something that you do not understand about the Plan or if you need specific information about your individual eligibility or benefits, please feel free to contact the Fund Office, which is located at 15800 Pines Boulevard, Suite 201, Pembroke Pines, Florida 33027 and is open during normal business hours Monday through Friday (except holidays). The Fund Office can be reached by telephoning (754) 777-7735. The Fund Office and the Board of Trustees will make every effort to assist you with any matter related to the Plan.

Sincerely,

Board of Trustees
MCASF LOCAL 725 HEALTH AND WELFARE FUND

NOTE:

This benefit plan is self-funded. This means that all the benefits provided under the Plan are paid for through the contributions that are made on your behalf under the terms of the collective bargaining agreement between your employer and Local 725. You are encouraged to report any instance of fraud, billing errors or other abuse, as the contributions to the Plan go further when only the appropriate benefits are paid. The self-funded status also should encourage everyone to make smart health care choices.

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Eligibility Rules

As an employee, you become eligible for benefits under the Plan when an employer makes sufficient contributions to the Plan on your behalf because you perform work for that employer that is covered by a collective bargaining agreement between Local 725 and the employer. There is no option to decline coverage. If you are working outside of the Local 725 jurisdiction, health fund contributions on your behalf may be forwarded to the Plan through reciprocity to be credited to you so you can continue your coverage. Additionally, office employees of signatory contractors who are approved by the Trustees may qualify for participation in the Plan.

Initial Eligibility

You are initially eligible for benefits on the first day of the month in which the Plan has received accumulated contributions on your behalf of 400 or more hours during a five (5) consecutive month period. For example, if you work 150 hours in January and the contributions are received by the Plan in February, you work 150 hours in February and the contributions are received by the Plan in March, and you work 150 hours in March and the contributions are received in April, you will become initially eligible for benefits effective April 1.

The Fund Office will request certain information from you before you can be officially eligible for coverage. Your eligibility start date may be affected if you do not timely submit the requested information and documentation to the Fund Office.

Continuation of Eligibility

Once you are eligible for benefits, your ongoing eligibility is based on hours worked each month. Effective September 1, 2018, you are eligible for a future month of health coverage if you work at least 100 hours in a calendar month and contributions for those hours are received timely by the Plan. For example, if you worked 100 hours in November 2019 and contributions for those hours are received by the Plan during December, you would be eligible for health coverage during January 2020. If you worked 100 hours in December 2019 and those contributions are paid timely in January 2020, you would be eligible for health coverage during February 2020. Because the Fund office needs to receive and process the contributions sent in by your employer on your behalf, there is a lag month between each month in which you fulfill the eligibility requirements and the month during which you receive coverage.

The 100 hours required each month to be eligible can be satisfied by one or a combination of the following:

(1) Contributions from your employer;
(2) Withdrawal of Hour Bank hours (discussed below);
(3) Participant Self-Pay contributions (discussed below); or
(4) Disability credits (discussed below).

Hour Bank

After you become eligible for benefits, you have the opportunity to earn Hour Bank credits that can be used for continuing eligibility if you do not work the required 100 hours during a month to meet the continuing eligibility requirements. These Hour Bank credits are merely accounting entries, and you do not have any ownership or entitlement to them or their value, except as described in this section.

During any month in which you work more than 100 hours, the excess hours will be credited to your individual Hour Bank, up to a total maximum of 1,000 hours (or 1,200 hours for certain grandfathered participants). Hours of contributions earned during your initial eligibility period do not accumulate toward Hour Bank credit. In the event you fail to work 100 hours in a month, you can draw on your Hour Bank credits to meet the 100-hour requirement for continuing eligibility.

You may <u>not</u> withdraw hours from your Hour Bank to meet the continuing eligibility requirements if you begin working for a non-signatory employer who does not contribute to the Plan in the trade and geographic area covered by the collective bargaining agreement. In such instance, the hours in your Hour Bank will be reduced to zero.

Upon retirement at age 65, credits and eligibility earned in your Hour Bank are terminated. However, if you have a spouse and/or other eligible dependent at the time of your retirement, your Hour Bank can be used for continuing eligibility as to those individuals until your spouse either turns age 65, your dependent(s) cease to meet the Plan's eligibility requirements, or the Hour Bank coverage is exhausted, whichever occurs first. If you retire prior to age 65, you can expend any remaining Hour Bank coverage until it is exhausted or you reach age 65, whichever occurs first.

Disability Eligibility

If you become totally disabled for a minimum of 20 consecutive days within a particular month, upon approval by the Board of Trustees you will be credited with 100 hours of employment for each calendar month of proven disability. The maximum credit for disability hours is limited to six consecutive months.

Participant Self-Pay Eligibility

If you are already eligible for benefits and work less than 100 hours in a particular month, you may be able to utilize Participant Self-Pay in order to maintain your continuing eligibility, provided you do not have sufficient hours in your Hour Bank to meet the 100 hour threshold for continuing eligibility. Participant Self-Pay allows you to make up the difference between the number of hours worked together with any available Hour Bank hours, and the 100-hour requirement needed to maintain eligibility by submitting your own self-payment to the Plan. 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 by the 25th of the month immediately preceding the month in which coverage is sought.

For example, if you are currently eligible for benefits and worked 70 hours in January and have 10 hours in your Hour Bank, you are 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 your eligibility. If the monthly cost of coverage is $1,100, you would be responsible for paying $552 to remain eligible, after application of the 70 hours worked and the 10 hours from your Hour Bank (80 hours multiplied by the current $6.85 CBA-contribution rate ($548), subtracted from the cost of coverage of $1,100). This payment must be made on or before February 25, as the hours worked in January provide coverage for March.

Note that you cannot utilize Participant Self-Pay for more than 6 months out of each calendar year. You also cannot utilize Participant Self-Pay if the reason you did not work 100 hours for continuing eligibility in a particular month is because you were working for a non-signatory employer in the trade and geographic area covered by the collective bargaining agreement who does not contribute to the Plan.

Only participants are able to elect Participant Self-Pay Eligibility. Spouses and dependents cannot independently elect this type of coverage.

Termination of Eligibility

Your eligibility for benefits can terminate for several reasons:

- Not enough hours have been worked and contributed on your behalf to continue your eligibility and you have exhausted both your Hour Bank and any ability for Participant Self-Pay contribution;
- You retire;
- You enter active military service (subject to the provisions of USERRA as described on page 21);
- The Plan terminates; or
- For a dependent, the day that individual ceases to meet the Plan's definition of a dependent.

In addition, your eligibility will terminate immediately if you work for an employer in the heating, ventilation, air conditioning, refrigeration and piping systems industry that is not signed to a collective bargaining agreement requiring a contribution obligation to the Plan. You are required to notify the Fund Office immediately if you leave the industry or become self-employed. Failure to do so may result in a loss of benefits, and/or an obligation to reimburse the Plan for benefits paid on your behalf.

When your eligibility ends after use of any eligible Hour Bank balance, no benefits will be paid for claims incurred after the termination date.

Supplemental Self-Pay Eligibility

If you are **retired** and neither you or your spouse are eligible for Medicare, and you have worked for a contributing employer for at least five continuous years immediately preceding retirement and have used and exhausted all coverage available under the Plan, including Hour Bank coverage and COBRA continuation coverage (see page 15), you can continue your health coverage by electing Supplemental Self-Pay Eligibility. This election must be made in writing within 30 days after termination of the last coverage available to you under the Plan.

The coverage provided under Supplemental Self-Pay Eligibility is the same coverage as provided under the Plan except that it does not include life insurance coverage, accidental death or dismemberment coverage, or short-term disability coverage. The premium for Supplemental Self-Pay coverage is the full cost of coverage, which is determined by the Board of Trustees from time to time and must be paid in advance to receive coverage and/or paying any benefits. You can also elect to cover your spouse and dependents as part of Supplemental Self-Pay Eligibility coverage so long as the required notice is given and premiums are paid. The maximum duration of Supplemental Self-Pay coverage is 11 months from the commencement date of such coverage.

Reinstatement

If your eligibility is terminated and you are not covered for 12 or more consecutive months, you must meet the initial eligibility requirements again to become a participant in the Plan and become eligible for benefits. If your eligibility has been terminated for less than 12 consecutive months, you only need to work 100 hours in one month to be considered eligible for benefits again.

Schedule of Benefits

Deductible and Coinsurance Amounts

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	$4,500	Not Applicable
Family Out-of-Pocket Maximum per Plan Year	$9,000	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.		

Office and Preventive Health Services

Benefit Description	**In Network** (What the Plan covers)	**Out of Network** (What the Plan covers)
Primary care visit to treat an injury or illness	You will pay a $45 Copayment per visit*	60% of the Allowed Amount after DED
Specialist visit	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Allergy injections (rendered by primary care physician or other specialist)	You will pay a $5 Copay*	60% of the Allowed Amount after DED
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) rendered by:		
Primary Care Physician	You will pay a $45 Copay*	60% of the Allowed Amount after DED
Specialist Physician	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Outpatient Therapies and Spinal Manipulation rendered by:		
Primary Care Physician	You will pay a $45 copay*	60% of the Allowed Amount after DED
Specialist Physician	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED

Benefit Description	In Network (What the Plan covers)	Out of Network (What the Plan covers)
Preventative care/screening/immunization	100% of the Allowed Amount	50% of the Allowed Amount
Virtual Visits by a designated Virtual Care Provider		
General Medicine and Urgent Care	You will pay a $45 copay*	Not Covered
Specialized Care	80% of the Allowed Amount after DED	Not Covered
Routine Colonoscopy Note: Routine Colonoscopy covered at age 50 and over once every 5 years.	100% of the Allowed Amount	60% of the Allowed Amount
Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Urgent Care	You will pay a $45 Copayment per visit*	60% of the Allowed Amount after DED
*These Services are subject to the Copayment only.		
Note: A Covered Plan Participant should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, a Covered Plan Participant may access the PPO Provider directory on the website www.floridablue.com or contact the local BCBSF office.		

Other Services

Benefit Description	**In Network** (What the Plan covers)	**Out of Network** (What the Plan covers)
Emergency Room Facility	80% of the Allowed Amount after applicable PVD	80% of the Allowed Amount after applicable PVD
Physician Services at Hospital and ER	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED
Ambulance/emergency medical transportation	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED
Convenient Care Centers and Urgent Care Centers	$45 Copay	60% of the Allowed Amount after DED
Mental health, behavioral health, or substance abuse services	Not covered	Not covered
Pregnancy – office visits and childbirth/delivery facility services	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Pregnancy – Childbirth/delivery professional services	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED

Outpatient Diagnostic Services	**In Network** (What the Plan covers)	**Out of Network** (What the Plan covers)
Independent Clinical Lab	80%	60%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
All other diagnostic Services (e.g., X-rays)	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Outpatient Hospital Facility	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED

Outpatient Surgical Services	**In Network** (What the Plan covers)	**Out of Network** (What the Plan covers)
Ambulatory Surgical Center Facility (per visit); Radiologist, Anesthesiologists, and Pathologists; and Other health care professional services rendered	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Outpatient Hospital Facility	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED

Pharmacy

	Participating Pharmacy (Your responsibility)	**Non-Participating Pharmacy** (Your responsibility)
Generic Drugs as provided in the Plan's formulary	$15 copay per prescription at retail; $30 per Prescription by mail	50% of the Non-Participating Pharmacy Allowance
Preferred brand drugs	$35 copay per prescription at retail; $70 per Prescription by mail	50% of the Non-Participating Pharmacy Allowance
Non-preferred brand drugs	$65 copay per prescription at retail; $130 per Prescription by mail	50% of the Non-Participating Pharmacy Allowance
Specialty Drugs	Subject to the cost share based on applicable drug tier	Subject to the cost share based on applicable drug tier

Dependent Coverage

As an active participant, your dependents can be eligible for coverage under the Plan in accordance with the following rules:

Eligible Dependents

- **Your legal spouse** is covered if you are married and reside together. A spouse will be presumed to no longer be a dependent under this Plan if you and your spouse reside apart for a period of six months or more. In this case you may be required to submit documentation to the Trustees that your spouse is still dependent upon you for support. The Trustees will determine, in their sole discretion, whether the spouse is still a dependent.

- **Your children** are covered through the end of the calendar year in which they turn age 26, including:

    - **Biological children**
    - **Adopted children** are eligible for coverage as of the date he or she is formally placed in your custody through the adoption process, such that you have physical and legal custody of the child.
    - **Stepchildren** are eligible for coverage the day you marry their legal guardian.
    - **Children** for whom you have been awarded physical custody and/or granted legal guardianship.

- **Qualified Medical Child Support Order child(ren**) are eligible for coverage if they are recognized as having the right to enrollment for the group health plan, even though the child does not reside with you or live within the service area of the health insurance carrier.

Ineligible Dependents

- Spouses of your dependents
- Spouses with a waiver of spousal participation, if a spouse has an employer-sponsored Health Savings Account (HSA).
- Adult Dependent Child who signs a waiver of coverage
- Dependent who no longer meets the requirements of a dependent under the terms of the Plan.
- Separated Spouse who resides apart from you for a period of six months or more. You may be required to submit documentation to the Trustees that your spouse is still dependent upon you for support. The Trustees will determine, in their sole discretion, whether the spouse is still a dependent.
- Stepchild(ren) whose parent no longer lives with you

Commencement of Dependent Health Coverage

Your dependents become eligible for benefits on the same day that you become eligible for benefits under the Plan if your dependents already exist at the time you become eligible. In order for your dependents to receive plan coverage, you must submit requested documentation, and list them as dependents on an enrollment form which you can receive from the Fund Office upon request.

In the event you acquire an eligible dependent either by marriage, birth, or adoption after you are already eligible for benefits under the Plan, you must provide notice to the Fund Office within 30 days of acquiring such eligible dependent. If such timely notice is received, the dependent's coverage will be effective as of the date you acquired such dependent. If notice is not provided within 30 days, the dependent shall not be eligible for coverage until the date notice of the dependent's existence was received by the Fund Office. Again, in order for your dependents to receive plan coverage, you must submit requested documentation, and list them as dependents on an enrollment form which you can receive from the Fund Office upon request.

Dependent Coverage After Your Death

If you die while covered under the Plan, your dependent's eligibility will continue at no cost to them until the date you would no longer have been eligible had you lived and not earned any additional hours of contributions. Your dependent can utilize your remaining Hour Bank credits as needed.

Continuation of Coverage for Dependents

If a previously-covered dependent later becomes ineligible, such individual will be eligible for COBRA continuation coverage as further provided herein.

Qualified Medical Child Support Orders

In general, a Qualified Medical Child Support Order (QMCSO) is a court order that requires a participant to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. A QMCSO may require the Plan to provide coverage to an alternate recipient who might not otherwise be eligible for coverage, but may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by Law.

This Plan provides benefits according to the requirements of any QMCSO, as defined by ERISA section 609(a). The Fund Office will promptly notify affected participants and alternate recipients if a QMCSO is received. Within a reasonable time after receipt of such an order, the Trustees will determine whether the order is qualified and notify each affected participant and alternate recipient of his or her qualifying procedures and the Trustee's determination.

COBRA Continuation Coverage

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents ("Qualified Beneficiaries") have the right to make payments to extend coverage temporarily after coverage would otherwise end under the Plan due to a "qualifying event."

Qualifying events include the following that result in a loss of coverage:

- Termination of your employment or a reduction of your hours of work;
- Your death;
- Your entitlement to health care coverage under Medicare (eligibility for and enrollment in coverage under Part A, Part B, or both);
- Your divorce and/or;
- Your child's loss of dependent status under the Plan.

Qualified Beneficiaries include you, your spouse, and your dependent child(ren) who are covered by the Plan on the day before your qualifying event. Spouses and children born, adopted or placed for adoption during the period of COBRA continuation coverage are also Qualified Beneficiaries and have the same rights as a spouse or dependents who are covered by the Plan on the day before the event that triggered COBRA continuation coverage, provided they are properly enrolled.

You may elect COBRA continuation coverage after you have exhausted all of your Hour Bank coverage.

COBRA Benefits

COBRA continuation coverage will be identical to any medical, prescription drug, dental, vision, or hearing coverage you had under the Plan. You will <u>not</u> be eligible to continue coverage for life insurance coverage, accidental death and dismemberment coverage, or disability coverage.

Periods of COBRA Coverage

- **18-Month Coverage**: If one of the following qualifying events occurs and your Plan coverage ends as a result of that event, you and/or your dependents are entitled to elect and receive COBRA continuation coverage for up to 18-months by making timely self-payments:
    - You experience a reduction in hours causing you to lose your eligibility; or

- You have a loss of employment (which includes retirement), unless your employment ends because of gross misconduct

- **29-Month Coverage**: A special extension of the initial 18-month continuation period is available for disabled individuals under COBRA continuation coverage.

  If the Social Security Administration determines that you or your covered dependent (who is a Qualified Beneficiary) is disabled at any time during or before the first 60 days of an 18-month period of COBRA continuation coverage, and you notify and provide a copy of the Social Security Administration's disability determination to the Fund Administrator in writing, the 18-month period will be extended for all of your 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 you are no longer disabled.

  The Fund Administrator must receive your 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 you or your dependent is no longer disabled, you or your dependent must notify the Fund Administrator in writing within 30 days of the date of the notice from the Social Security Administration.

- **36-Month Coverage:** COBRA coverage may continue for up to 36 months if your dependents lose coverage because of one of the following qualifying events:
  - Your death;
  - Your entitlement to health care coverage under Medicare (eligibility for and enrollment in coverage under Part A, Part B, or both);
  - Your divorce; and/or
  - Your child's loss of dependent status under the Plan.

  In addition, if your family experiences a second qualifying event (of the four events listed above) while receiving COBRA continuation coverage during the first 18 months of coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for up to a maximum of 36 months from the date of the initial qualifying event, provided notice and proof of the second qualifying event is properly given to the Plan.

  The extension is available only if the event would have caused your spouse or dependent child(ren) to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Notification Responsibility

- **Employer**: The Plan offers COBRA continuation coverage to Qualified Beneficiaries only after the Fund Administrator is notified that a qualifying event has occurred. Under the law, your Employer is required to notify the Fund Administrator within 30 days of the date of your death, the termination of your employment or a reduction in your hours causing you to lose your eligibility, or your becoming entitled to Medicare. However, because Employers contributing to multiemployer Plans may not be aware of these events, we urge you or a family member to notify the Fund Administrator of any and all qualifying events as soon as they occur.

- **Member:** For other qualifying events (your divorce from your spouse, or your dependent child's loss of dependent status), you must notify the Fund Administrator, in writing, within 60 days of the date on which the qualifying event occurs.

  If you are providing notice of a Social Security Administration determination of disability, you must send your notice to the Fund Administrator no later than 60 days after the date of the disability determination by the Social Security Administration. In addition, you must send notice to the Fund Administrator no later than the end of the first 18 months of continuation coverage.

  If you are providing notice of a Social Security Administration determination to the Fund Administrator that you or a dependent is no longer disabled, you must send your notice to the Fund Administrator no later than 60 days after the date of the determination by the Social Security Administration that you or your dependent is no longer disabled.

  You should send the notice to:

  MCASF Local 725 Health and Welfare Plan
  15800 Pines Boulevard, Suite 201
  Pembroke Pines, Florida 33027

  Include your name, the names of covered family members, an explanation of the reason for the notice (including, if relevant, the type of qualifying event and the date of the qualifying event) and the address(es) where the Fund Administrator should send election notices and/or correspondence related to COBRA continuation coverage. A Qualified Beneficiary should keep copies of any notices sent to the Fund Administrator.

  If you do not notify the Fund Administrator in a timely manner, you will lose your right to choose COBRA continuation coverage.

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

- **The Plan:** Within 14 days from the date you notify the Fund Administrator of your divorce or your dependent child's loss of eligibility, the Fund Administrator will send a COBRA election notice and COBRA election form to you and/or any of your dependents who lose coverage due to the qualifying event. The Plan notice will inform you of your right to elect COBRA continuation coverage, the due dates for returning the election form and the amount of the COBRA self-payment, as well as other necessary information. If any other qualifying event occurs, the Fund Administrator will notify each Qualified Beneficiary of his or her COBRA rights within 30 days.

  If you are not eligible for COBRA continuation coverage, the Fund Administrator will send you notice of your ineligibility within the same timeframes noted above after the Fund Administrator receives notice of a qualifying event.

Electing COBRA Coverage

Once you receive a COBRA notice from the Fund Administrator, you have 60 days to respond if you want to choose COBRA continuation coverage. You may choose COBRA on behalf of yourself and your family members or they can each choose their own COBRA coverage.

You or your dependents must complete the election form and send it back to the Fund Administrator to choose COBRA continuation coverage. The following rules apply to the election of COBRA continuation coverage:

- If you choose COBRA continuation coverage for yourself and your dependents, your election is binding on your dependents. You can elect not to cover your dependents.

- The person choosing COBRA continuation coverage has 60 days after the Fund Administrator sends the election notice to him or her or 60 days after the qualifying event, whichever is later, to return the completed form. The Fund Administrator will consider the official election date of COBRA continuation coverage to be the date on which you postmark the election form to the Fund Administrator. A person also has the right to waive a previous election and make a new election within the 60-day period.

- If you and/or your dependents do not mail the election form back to the Fund Administrator within the allowable period, the Fund Administrator will consider you and/or your dependents to have waived your right to COBRA continuation coverage.

- If you choose COBRA continuation coverage, the Plan will provide coverage that is identical to the health coverage provided to participants and their dependents (excluding life insurance coverage, accidental death and dismemberment coverage, or disability coverage). Any dependent who was not covered under the Plan on the day before coverage ended, is not eligible for COBRA continuation coverage. However, you may add newly acquired dependents during the continuation period by notifying the Fund Administrator within 30 days after acquiring the new dependent through marriage, birth, adoption, or placement for adoption, and by paying the required premium.

COBRA Self-Payments

Under the Plan, Qualified Beneficiaries who choose COBRA continuation coverage must pay for COBRA continuation coverage. The Fund Administrator will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to elect COBRA coverage. The Trustees determine the cost of COBRA continuation coverage on a yearly basis; however, it will not exceed 102 percent of the cost incurred by the Plan to provide the coverage. The Trustees also determine the cost for extended disability coverage (from the 19th month through the 29th month); however, such extended coverage will not exceed 150 percent of the cost to provide the coverage.

The following rules apply to your self-payments for COBRA continuation coverage:

- You must make COBRA continuation coverage self-payments on a monthly basis, unless a different interval is required or permitted by the Plan. Monthly payments are due on the first day of the month in which coverage is sought.
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- The Trustees determine the amount of the monthly self-payments. The amounts are subject to change, but not more often than once a year, unless substantial changes are made in the benefits.

- You and/or your dependents who choose COBRA continuation coverage must make the initial self-payment for coverage no later than 45 days after the postmark date of the signed election form you sent to the Fund Administrator.

- Although monthly payments are due on the first day of every month, a Qualified Beneficiary is given a grace period of 30 days to make each monthly payment. Continuation coverage is provided for each month as long as you make payment for that month before the end of the grace period for that payment. However, if a Qualified Beneficiary pays a monthly payment later than the first day of the month, but before the end of the grace period for the month, coverage under the Plan may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

- If you do not make a self-payment within the grace period, COBRA continuation coverage for all family members for whom you are making the payment will end and cannot be reinstated.

Termination of COBRA Coverage

COBRA continuation coverage ends on the earliest of the following dates:

- The first day of the period for which you or your dependent(s) fail to make a timely self-payment;

- The day on which the Trustees discontinue the Plan;

- The day you or your dependent becomes entitled to Medicare coverage, after you elect COBRA coverage;

- The day you or your dependent becomes entitled to coverage under another group health plan that does not exclude pre-existing conditions to which you or your dependent may be subject, after you elect COBRA coverage;

- The last day of the month in which the Social Security Administration determines that you or your dependent is no longer disabled, if applicable; or

- The last day of the 18-, 29-, or 36-month period, whichever is applicable, after COBRA continuation coverage began.

If your COBRA continuation coverage ends before the end of the maximum COBRA continuation coverage period, the Fund Administrator will send you a written notice as soon as practical after the Fund Administrator determines that your COBRA continuation coverage will end.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are provided on page 59 of this SPD and are available through EBSA's website at www.dol.gov/ebsa/.

Military Leave (USERRA)

If You Take a Military Leave (Active Members)

If you are called to active military duty, you can request in writing that your Hour Bank reserves be frozen until you are honorably discharged from active duty and return to work as required.

Under the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, if you are in active service as a Uniformed Service member for up to 30 days, your Plan coverage will continue at no cost to you for up to 30 days.

If your military service lasts more than 30 days, you may continue your coverage by making any required self-contributions to the Fund until the earlier of 24 consecutive months after your Plan health coverage ends or the end of the period during which you are eligible to apply for re-employment in accordance with the terms of USERRA.

Uniformed Service includes service in the:

- United States Armed Forces;
- Army National Guard;
- Air National Guard;
- Commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

Service means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Full-time National Guard duty;
- Inactive duty training; and
- Reserve duty.

It also includes any period that:

- A person is absent from a position of employment so he/she can be examined in order to determine his/her ability to perform such a duty; and
- A person is absent from employment to perform official Uniformed Service funeral honors duty.

You must give your employer and the Fund Administrator advance notice of your military service, unless you are unable to do so because of military necessity, or advance notice is impossible or unreasonable under the circumstances. While dependents have a separate right to choose COBRA continuation coverage, they do not have a separate right to choose to continue their coverage under USERRA.

How USERRA Works with COBRA

Coverage under USERRA will run concurrently with COBRA continuation coverage. Your cost of continuation coverage under USERRA will be the same cost as COBRA continuation coverage. The procedures for electing coverage under USERRA are the same procedures described for COBRA, except:

- Only you can make an election for USERRA coverage on behalf of your dependents; and
- Coverage may last for only up to 24 months.

Your coverage under USERRA continues until the earlier of the end of the period during which you are eligible to apply for re-employment in accordance with USERRA, or 24 consecutive months after your Plan Health coverage would have otherwise ended.

However, your coverage ends at midnight on the earliest of the day:

- Your coverage would otherwise end as described directly above;
- You lose your rights under USERRA (for instance, for a dishonorable discharge);
- Your self-contribution is due to the Fund but is not paid; or
- You again become covered under the Plan.

If you do not choose to continue coverage under USERRA, your coverage will end 31 days after the day you enter active military service. Your dependents will then have the opportunity to choose COBRA continuation coverage.

Your Re-employment Rights

When you are discharged from military service, you may apply for re-employment with your former employer in accordance with USERRA. You have the right to choose reinstatement in any health insurance coverage offered by that employer. According to USERRA guidelines, once you are discharged or released from military service, re-employment and reinstatement deadlines are based on your length of military service. For instance, if you served for:

- 30 days or less, you have one workday after discharge to return to work for a Contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a Contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a Contributing Employer.

If you are hospitalized or recovering from an illness or injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to work for a Contributing Employer, for up to a maximum of five years.

If your employer reports your return to work to the Fund Administrator during the USERRA-required timeframe, your eligibility and your dependents' eligibility will be reinstated on the day you return to work.

Benefit Exclusions and Limitations

The Plan will not provide coverage for certain expenses incurred for the treatment of a sickness or injury that is not considered a covered Health Care Service. The following general exclusions are not considered covered Health Care Services and will not be paid by the Plan:

- Any Health Care Service received prior to a Covered Plan Participant's Effective Date or after the date a Covered Plan Participant's overage terminates, unless coverage is extended in accordance with the Extension of Benefits section;

- Any Health Care Service not specifically listed in the Covered Services section or in any Endorsement attached hereto, un less such Services are specifically required to be covered by applicable law;

- Any Health Care Service a Covered Person renders to him or herself or those rendered by a Physician or other health care Provider related to the Covered Person by blood or marriage;

- Any Health Care Service that is not Medically Necessary as determined by Blue Cross Blue Shield of Florida or MCASF Local 725 Health and Welfare Fund. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a covered Service;

- Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision described in the Transplant Services category of the "Covered Services" section;

- Health Care Services to treat an injury resulting from an accident related to a Covered Plan Participant'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;

- Any Health Care Service rendered at no charge;

- Any Health Care Service to diagnose or treat a Condition that directly or indirectly, resulted from or is in connection with:

    - War or an action of war, whether declared or not;

    - The Covered Plan Participant's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion;

    - The Covered Plan Participant's engaging in illegal activities; or

- Services received at military or government facilities to treat a Condition arising out of the Covered Plan Participant's service in the armed forces, reserves and/or National Guard;

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

- Any Health Care Service 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;

- Health Care Services that are not patient-specific, as determined solely by BCBSF

Expenses for the following Health Care Services are also excluded. These exclusions are in addition to any exclusion specified above and in the Covered Services section:

- **Abortion**, by choice; not Medically Necessary.

- **Arch Supports**, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devises/appliances regardless of intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

- **Assisted Reproductive Therapy (infertility)** including, but not limited to, associated Services, supplies and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting; donor semen and related costs including collection and preparation; and infertility treatment medication.

- **Autopsy** or postmortem examination Services, unless specifically requested by MCASF Local 725 Health and Welfare Fund or BCBSF.

- **Complementary or Alternative Medicine** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies; traditional Oriental medicine including acupuncture; naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, Rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies (including CBD and medical marijuana).

- **Complications of Non-Covered Services**, including the diagnosis or treatment of any Condition that is a complication of a non-covered Health Care Service (e.g., Health Care Services to treat a complication of cosmetic surgery are not covered).

- **Cosmetic Services**, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery subsection), including without limitation: cosmetic surgery and procedure or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A) and hair implants/transplants.

- **Costs** related to telephone consultations except with existing primary care physician, failure to keep a scheduled appointment, or completion of any form and/or medical information.

- **Custodial Care**, any Service of a Custodial nature, including and without limitation: Health Care Services primarily to assist the Covered Plan Participant in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; and respite care.

- **Dental Care**, or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to Accidental Dental Care, child Cleft Lip and Cleft Palate Treatment Services.

- **Drugs**:

    - Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been 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. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Covered Plan Participant's particular cancer in a Standard Reference Compendium, or is recommended for treatment of the Covered Plan Participant's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

- All drugs dispensed to, or purchased by, and Covered Plan Participant from a pharmacy. This exclusion does not apply to drugs dispensed to a Covered Plan Participant when:
    - The Covered Plan Participant is an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility or a Hospice facility;
    - The Covered Plan Participant is in the outpatient department of a Hospital;
    - Dispensed to the Covered Plan Participant's Physician for administration to the Covered Plan Participant in the Physician's office and prior coverage authorization has been obtained (if required).
    - The Covered Plan Participant is receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills BCBSF for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit; and
    - Defined by, and covered under, a BCBSF Pharmacy Program Endorsement.
- 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, except as described in the Preventive Health Services category of the "Covered Services" section.
- Any drug that is indicated and used for sexual dysfunctional (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction drugs excluded under this paragraph.
- Any Prescription Drug that a Plan Participant administers to him or herself as recommended by a physician, except when indicated as covered in the "Covered Services" section of this Evidence of Coverage.
- Blood or blood products used to treat hemophilia, except when provided to a Covered Plan Participant for:
    - Emergency stabilization;
    - During a covered inpatient stay, or
    - When proximity related to a surgical procedure.

- The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia drugs excluded under this exclusion.

- Drugs that require prior coverage authorization when prior coverage authorization is not obtained.

- 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. (See the Covered Services section for additional information.)

- **Food and Food Products** prescribed or not, except as covered in the Enteral Formulas category of the "Covered Services" section.

- **Foot Care (routine)**, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to, treatment of bunions, flat feet, fallen arches, and chronic foot strain, trimming of toenails, corns, or calluses.

- **Genetic screening**, including the evaluation of genes of a Covered Plan Participant to determine if they are carriers of an abnormal gene that puts them at risk for a Condition, except as provided under the Preventive Health Services category of the "Covered Services" section.

- **Hearing Aids** (external or implantable) and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

- **Immunizations** except those covered under the Preventive Health Services category of the "Covered Services" section.

- **Maternity Services** rendered to a Covered Plan Participant who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expense for prenatal, intra-partum, and post-partum maternity/obstetrical care and Health Care Services rendered to the Covered Plan Participant acting as a Gestational Surrogate.

- **Mental Health Services** including diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy provided to you by a Physician, Psychologist, or Mental Health Professional for the treatment of a Mental and Nervous Disorder, including inpatient, outpatient, and Partial hospitalization services.

- **Occupational Therapy** including services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition.

- **Motor Vehicle Accidents** including any costs the Covered Plan Participant incurs 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.

- **Oral Surgery** the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the Covered Services section.

- **Orthomolecular Therapy**, including nutrients, vitamins, and food supplements.

- **Oversight of a medical laboratory** by a Physician or other health care Provider. "Oversight" as used in this exclusion shall, include, but is not limited to, the oversight of:

    - The laboratory to assure timeliness, reliability, and/or usefulness of test results;

    - The calibration of laboratory machines or testing of laboratory equipment;

    - The preparation, review or up0dating of any protocol or procedure created or reviewed by a Physician or other health car4e Provider in connection with the operation of the laboratory; and

    - Laboratory equipment or laboratory personnel for any reason.

- **Personal Comfort, Hygiene or Convenience Items** and services deemed to be no Medically Necessary and not directly related to the treatment of the Covered Plan Participant including, but not limited to: beauty and barber services; clothing including support hose; radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses; other than Medically Necessary Ambulance services; motel/hotel accommodations; air conditioners' humidifiers; or Physical fitness equipment; and massages except as covered in the Covered Services Section of this Evidence of Coverage.

- **Private Duty Nursing Care** rendered at any location.

- **Rehabilitative Therapies** provided to a Covered Plan Participant on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility Home Health Care, and Outpatient Cardiac, Physical, Speech, Massage Therapies and Spinal Manipulation Services categories of the Covered Services section.

- **Reversal of Voluntary, Surgically-Induced Sterility**, including the reversal of tubal ligations and vasectomies.

- **Sexual Reassignment, or Modification Services**, including but not limited to any Health Care Service related to such treatment, such as psychiatric Services.

- **Smoking Cessation Programs**, including any Service to eliminate or reduce the dependency on, or addition to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

- **Sports-Related** devices and Services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

- **Substance Dependency Care and Treatment** including Health Care Services (inpatient and outpatient or any combination thereof) provided by a Physician, Psychologist or Mental Health Professional.

- **Training and Educational Programs**, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self Management category of the Covered Services section.

- **Travel** or vacation expenses even if prescribed or ordered by a Provider.

- **Volunteer Services** or Services which would normally be provided free of charge to a Covered Plan Participant and any charges associated with Deductible, Coinsurance, or Copayment (if applicable) requirements which are waived by a health care Provider.

- **Weight Control Services** including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to, weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise program; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict the ability to assimilate food.

- **Wigs** and/or cranial prosthesis.

Preventive Care Benefits

In accordance with the Affordable Care Act (ACA), the following preventive services are covered at 100% under the Plan, but only when the services are delivered by an in-network provider. This means you do not have to pay a copayment or coinsurance, or meet a deductible.

Covered Preventive Services for Adults	Covered Preventive Services for Women, Including Pregnant Women

• **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
• **Alcohol Misuse** screening and counseling
• **Aspirin** use for men and women of certain ages
• **Blood Pressure** screening for all adults
• **Cholesterol** screening for adults of certain ages or at higher risk
• **Colorectal Cancer** screening for adults over 50
• **Depression** screening for adults
• **Type 2 Diabetes** screening for adults with high blood pressure
• **Diet** counseling for adults at higher risk for chronic disease
• **HIV** screening for all adults at higher risk
• **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  ○ Hepatitis A
  ○ Hepatitis B
  ○ Herpes Zoster
  ○ Human Papillomavirus
  ○ Influenza
  ○ Measles, Mumps, Rubella
  ○ Meningococcal
  ○ Pneumococcal
  ○ Tetanus, Diphtheria, Pertussis
  ○ Varicella
• **Obesity** screening and counseling for all adults
• **Sexually Transmitted Infection**
	• **Anemia** screening on a routine basis for pregnant women
	• **Bacteriuria** urinary tract or other infection screening for pregnant women
	• **BRCA** counseling about genetic testing for women at higher risk
	• **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
	• **Breast Cancer Chemoprevention** counseling for women at higher risk
	• **Breast Feeding** interventions to support and promote breast feeding including purchase or rental of a standard model breast pump (manual or electric) with a prescription from your doctor. Upgrades or additional supplies for the breast pump are not covered by the plan.
	• **Cervical Cancer** screening for sexually active women
	• **Chlamydia Infection** screening for younger women and other women at higher risk
	• **Folic Acid** supplements for women who may become pregnant
	• **Gonorrhea** screening for all women at higher risk
	• **Hepatitis B** screening for pregnant women at their first prenatal visit
	• **Osteoporosis** screening for women over age 60 depending on risk factors
	• **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
	• **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
	• **Syphilis** screening for all pregnant women or

(STI) prevention counseling for adults at higher risk • **Tobacco Use** screening for all adults and cessation interventions for tobacco users • **Syphilis** screening for all adults at higher risk	other women at increased risk • **Full range of FDA-approved contraceptive methods** including, but not limited to, barrier methods, hormonal methods, intrauterine devices, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Contraceptive methods that are generally available OTC are only included if the method is both FDA-approved and prescribed for a woman by her health care provider. • **Domestic and interpersonal violence** screening and counseling annually • **Human Immunodeficiency Virus(HIV)** screening and counseling for sexually active women • **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • **Human Papillomavirus (HPV) DNA Test**: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older • **Sexually Transmitted Infections (STI)** counseling annually for sexually active women • **At least one annual well-woman preventive care visit**, including preconception and prenatal care

Covered Preventive Services for Children	

• **Alcohol and Drug Use** assessments for adolescents
• **Autism** screening for children at 18 and 24 months
• **Behavioral** assessments for children of all ages
• **Cervical Dysplasia** screening for sexually active females
• **Congenital Hypothyroidism** screening for newborns
• **Developmental** screening for children under age 3, and surveillance throughout childhood
• **Dyslipidemia** screening for children at higher risk of lipid disorders
• **Fluoride Chemoprevention** supplements for children without fluoride in their water source
• **Gonorrhea** preventive medication for the eyes of all newborns
• **Hearing** screening for all newborns
• **Height, Weight and Body Mass Index** measurements for children
• **Hematocrit or Hemoglobin** screening for children
• **Hemoglobinopathies** or sickle cell screening for newborns
• **HIV** screening for adolescents at higher risk
• **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  ○ Diphtheria, Tetanus, Pertussis
  ○ Haemophilus influenzae type b
  ○ Hepatitis A
  ○ Hepatitis B
  ○ Human Papillomavirus
  ○ Inactivated Poliovirus
  ○ Influenza
  ○ Measles, Mumps, Rubella
  ○ Meningococcal
  ○ Pneumococcal
  ○ Rotavirus
  ○ Varicella
	• **Iron** supplements for children ages 6 to 12 months at risk for anemia
	• **Lead** screening for children at risk of exposure
	• **Medical History** for all children throughout development
	• **Obesity** screening and counseling
	• **Oral Health** risk assessment for young children
	• **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
	• **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
	• **Tuberculin** testing for children at higher risk of tuberculosis
	• **Vision** screening for all children

These provisions also apply:

- Flu Immunization: Once per calendar year
- Pap Smear & Pelvic Exam: Once per calendar year
- Mammogram Screening: Once per calendar year over age 40
- Flexible Sigmoidoscopy: Once every 4 years over age 50
- Colonoscopy: Once every 10 years over age 50

The following colorectal cancer screening tests are determined to be medically necessary preventive services based on recommendations from the American Cancer Society and the American College of Gastroenterology for members aged 50 years and older when these tests are recommended by their physician:

- Sigmoidoscopy (considered medically necessary every 4 years for persons at average risk)
- Double contrast barium enema (DCBE) (considered medically necessary every 5 years for persons at average risk)
- Colonoscopy (considered medically necessary every 10 years for persons at average risk)

In addition, the Plan considers screening with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT), either alone or in conjunction with sigmoidoscopy, to be medically necessary preventive services for members beginning at age 50 years.

Colorectal cancer screening beginning at age 40 is considered a medically necessary preventive service for persons with a single first-degree relative (sibling, child, or parent) with a history of colorectal cancer or an adenomatous polyp.

Dental Benefits

The Plan also contracts with Blue Cross Blue Shield of Florida to provide dental benefits to participants and their dependents. The coverage provided is summarized as follows:

	What the Plan Covers	Maximum Benefits
Dental Services: • Periodic Oral Evaluations; • Comprehensive Oral Evaluations; • Bitewing X-rays; • Cleanings – Adult/Child; • Fluoride Treatment - Child; • Office Visits; • Space Maintainers – fixed – unilateral; • X-Rays – Intraoral/Complete Series; • Sealant – per tooth; • Amalgam Restorations (Silver Fillings); • Resin Based Restorations – Anterior; • Extractions – Routine and Surgical; • Root Canal Molar; • Periodontal Scaling & Root Planing – per quad; • Osseous Surgery – 4 or more contiguous teeth; • Crowns – Porcelain fused to noble metal; • Complete Dentures; • Pontic – Porcelain fused to noble metal; • Partial Dentures; • Surgical Placement of implant body – endosteal implant; • Implant supported porcelain fused to metal crown (titanium high noble metal)	70% of service cost	$2,500 per person, per Plan Year
Orthodontia Services	70% of service cost	$1,000 per person, per lifetime

Deductibles are not required for dental or orthodontic services, nor are there waiting periods. Rollovers from other dental plans are not available.

Life Insurance and Accidental Death & Dismemberment (AD&D)

The Plan provides for and administers a self-funded life insurance benefit and AD&D benefit for certain participants as follows:

Life Insurance

If you die prior to retiring and while eligible for coverage under the Plan, your beneficiary will be entitled to a life insurance benefit in the amount of $30,000. The life insurance benefit is paid in a lump sum and your beneficiary must submit a claim form and a death certificate to the Fund Office within one year of your death in order to be entitled to the life benefit. Your beneficiary should nevertheless endeavor to notify the Fund Office of your death as soon as possible.

If you retire and are or become totally and permanently disabled and your disability occurs before you turn age 60, you are entitled to the $30,000 life insurance benefit for a period of up to 10 years or until you reach age 65, whichever occurs first. This benefit will remain in place for the aforementioned period of time even if you retire prior to turning age 65. For example, if you become totally and permanently disabled at age 56 and have retired on disability status before age 60, and then you die at age 62, your beneficiary will be entitled to receive the life insurance benefit. If you do not die until age 65, your beneficiary will not receive the life insurance benefit. Proof of your disability must be provided to the Fund Office in order for the benefit to be effective.

AD&D

If you die prior to retirement and while you are eligible for coverage under the Plan, your beneficiary will be entitled to receive an AD&D benefit in the amount of $60,000 if your death is caused by an accident and you die within 365 days of such accident. This benefit is paid to your beneficiary and includes the life insurance benefit referenced in the above section, provided your beneficiary submits a claim to the Fund Office within a year of your death and provides proof of such accident and subsequent death.

The Plan also pays a benefit if, while you are eligible for coverage under the Plan and prior to your retirement, you suffer a bodily injury or injuries in an accident such that you are considered dismembered under the terms of the Plan (e.g., loss of arm or leg, loss of vision).

NOTE: There are certain exceptions to when the AD&D and/or life benefit is not payable, such as accidents or deaths caused by bungee jumping, sky diving, drinking and driving, drug overdoses, suicide or attempted suicide, and car, motorcycle, or boat racing.

Below is illustrative chart summarizing the above-referenced benefits:

	Life Insurance	**AD&D**
Active Participants	$30,000	Up to $60,000
Nondisabled Retirees	None	None
Disabled Retirees	$30,000 for a period of 10 years from your date of disability before age 60 or until you turn age 65, whichever occurs first	Up to $60,000 for a period of 10 years from your date of disability or when you turn age 65, whichever occurs first

Beneficiaries

If you do not name a beneficiary, or the beneficiary does not survive you, the Plan will pay the above benefits in the following order:

1. Your spouse, if living;
2. Your surviving children, in equal shares;
3. Your parents in equal shares; or
4. To your estate.

Payment of Claims and Appeals

The Fund Office processes all claims for benefits. Written notice of a claim for benefits, along with proof of the claim and any charges incurred, must be submitted to the Fund Office within 90-days of the occurrence of the claim (if reasonably possible):

MCASF Local 725 Service Corporation
15800 Pines Blvd., Suite 201
Pembroke Pines, FL 33027

In no event will a claim submitted more than 12-months after the date of occurrence be accepted or payable by the Plan. If you have a question or concern about the payment of a claim or eligibility for benefits, contact the Fund Office.

Annual Family Statement

Each year you must complete an "Annual Family Statement" to enable the Fund Office to process claims accurately on behalf of you and your dependents. It is an important tool used by the Fund Auditor regarding coordination of benefits (COB) with other insurance providers. If you do not timely provide complete or accurate information on the Annual Family Statement, the Fund Office will not be able to process your claims and they will be denied. The Annual Family Statement will be mailed to each participant once per year, or at such times as determined necessary by the Trustees.

Statement of Claim

You will need to submit a "Statement of Claim" if we receive a claim for you or one of your dependents as a result of an accident. This is done to ensure that benefits are not paid from the Welfare Fund when workers' compensation, automobile insurance, homeowners' insurance or another third party is responsible.

Claims Decision and Appeal Procedure

If you have a claim under the Plan, there are two levels of decision that can be made on your claim. The first is the Initial Claim Determination. This is the initial claim determination by the Plan that the benefit you are seeking is covered, or will be paid, by the Plan. The second decision is the Determination on Review, also called the Appeal. If you receive an Initial Claim Determination that you disagree with, you may appeal and request a Determination on Review by the Plan. The following procedures are used to determine claims and appeals.

- **Submit Claim on Form**: Your claim must be filed on a form provided by the Fund Office. The form must be completed, signed by you and filed at the Fund Office. In addition, the Trustees may require further information.

- **Determining Claims, Time for a Decision**: After you have filed a claim for your benefits, you will be told whether or not you will receive the benefits. If more time is

needed to examine your request, you must be told within the initial time period that additional time is needed, and the date by which a decision will be made on your claim. However, the request for an extension may only be for a limited amount of time, depending on the type of claim involved. If your claim is denied, the Plan must notify you in writing, and explain in detail why it was denied, and what Plan provisions, rules or procedures the decision was based on.

Claims are determined as quickly as possible, but will typically be decided according to the type of claim involved. Claims are classified as being one of four types: 1) Urgent Claims; 2) Pre-service Claims; 3) Claims for Payment; and 4) Disability Claims. The four types of claims are defined below:

- An **Urgent Claim** is a claim where the care requested could seriously jeopardize the life or 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 individual's medical condition, the individual would be subjected to severe pain that could not be adequately managed without the care of requested treatment.

- 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.

- A **Claim for Payment** is a claim for benefits that a claimant wants the Plan to pay for that has already been incurred.

- A **Disability Claim** is a claim for weekly sickness and injury disability benefits for eligible members as a result of a non-occupational injury or disease as is available under the terms of the Welfare Plan.

The amount of time that the Plan has to decide each type of claim, including any available extension, and the time period for a review on an appeal are set out in the table below:

	CLAIM TYPE			
	Urgent Claim	**Pre-service Claim**	**Claim for Payment**	**Disability Claim**
Initial Claim Determination	72 hours from receipt of claim by the Plan	15 days from receipt of the claim by the Plan	30 days from receipt of the claim	45 days from receipt of the claim by the Plan
Additional Time for Initial Determination	If more information is needed to decide the claim, you will be notified within 24 hours of submitting the claim what additional information is needed, and you will have at least 48 hours to submit the additional information. A decision will be made within 48 hours of receiving that information.	Up to 15 additional days, if the Plan notifies you that additional time is necessary. If more information is needed from you, you will have at least 45 days to submit the needed information.	Up to 15 additional days, if the Plan notifies you that additional time is necessary. If more information is needed from you, you will have at least 45 days to submit the needed information.	Up to two additional 30-day period, if requested by the Plan. If more information is needed from you, you will have at least 45 days to submit the needed information.
Determination On Review (or Appeal)	72 hours from receipt of request for review by the Plan	30 days from receipt of the request for review by the Plan	At the next meeting of the Trustees following receipt of the request for review, unless the request is received less than 30 days from the next Board meeting, in which case the decision is due by the second meeting following submission of the request for review.	At the next meeting of the Trustees following receipt of the request for review, unless the request is received less than 30 days from the next Board meeting, in which case the decision is due by the second meeting following submission of the request for review.
Extension of Time for Determination on Review (Appeal)	N/A	N/A	To the next (not later than the 3rd) meeting of the Trustees	To the next (not later than the 3rd) meeting of the Trustees

If you submit an Urgent Claim and the Plan needs more information to decide the claim, you will be notified within 24 hours of submitting the claim that additional information is needed, and you will have at least 48 hours to submit the additional information. A decision will be made within 48 hours of receiving the additional specified information, or the time you are given to submit the information.

Pre-service Claims will usually be decided within 15 days of the Plan receiving the claim. Payment claims will usually be decided within 30 days of the Plan receiving your claim. The Plan can extend the time for a decision for an additional 15 days if necessary, and if it advises you in writing that additional time is required. If more information is required from you, you will have at least 45 days to submit the additional information.

If the Plan decides to reduce or terminate benefits that are being provided for an ongoing course of treatment with a provider, this will be considered an Initial Claim Determination. The Plan will provide you sufficient advance notice of the reduction or termination of the benefits associated with that treatment so that you will be able to appeal the determination and receive a decision on review regarding the change in benefits before the change becomes effective.

The Plan provides an expedited review process if your claim involves an Urgent Claim that has been initially denied by the Plan and you wish to obtain a decision on review. You may request an expedited appeal of the denial of benefits from the Fund Office orally or in writing, and information regarding the initial benefit determination and the Plan's determination on review will be communicated to you by telephone, facsimile or other similarly expeditious available method.

If you submit a claim for Weekly Injury and Sickness Benefits, the Plan will review your request according to these provisions. The administrative staff of the Plan will review your claim within 45 days of receiving the complete request. The Plan will send you either a written decision on your claim or a notice that the Plan is extending the period of time to decide your claim for an additional 30 days. Before the end of this extension period, the Plan will either send you a written decision on your claim or provide you notice that the Plan is extending the period to decide your claim for a second 30 days. If the Plan notifies you that it is extending the period of time to decide your claim for the second 30 days and that extension is the result of you not having provided additional information that the Plan has requested, the extension period will not begin to run until you have provided the information.

Denial of Initial Claim

The denial notice will contain specific reference to the Plan provisions on which the denial is based, will describe any additional material or information necessary to complete your claim and, will state why such material or information is necessary.

If your claim has been denied, completely or in part, you have 180 days within which to request a review on appeal of the claim determination by the Plan. Your request must be in writing. You have the right to review pertinent documents and records in the Fund Office, to receive copies at no cost to you, appear before the Trustees and submit comments in writing.

Review on Appeal

If you request a review of a denied claim, the review will be conducted either by a person or committee designated by the Trustees, or directly by the Trustees themselves. The Trustees or their designee may consult with experts, including physicians familiar with the type treatment involved in your claim, about the issues raised by your appeal.

Claims for Urgent Claims will be decided within 72 hours of receipt by the Plan of your appeal. Preservice claims will be decided within 30 days of receipt by the Plan of your appeal. Urgent claim appeals may be decided on an expedited basis if requested and to the extent possible.

For all other claims, the Trustees will make a decision by the date of their next regular meeting that immediately follows the date your request for review on appeal is received. If your complete written request 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 your request. If special circumstances exist requiring additional time to make a decision on your appeal, then the decision may be made not later than the third meeting following receipt of your request. In the event the Trustees need an extension due to special circumstances, the Trustees will notify you in writing before the extension begins, describing the special circumstances and the date by which they will make a determination.

Notice of the Decision on Appeal

The Trustees' decision of its Determination on Review will be communicated to you within five days of the meeting at which the decision was made for Payment Claims and Disability Claims. The decision will include the specific reason for the decision, and will refer to the specific plan provisions, rules, protocols or other criterion that the decision is based upon. If the Determination on Review is for an Urgent Claim or Pre-service Claim, you will receive notice of the decision with the time for deciding as listed in the Table above. You may receive, at no cost to you, access to and copies of all documents, materials and procedures relevant to the claim.

Right to Obtain Review after Appeal

If you disagree with the final review decision, you may appeal your claim to a state or federal court, or you may choose to submit the appeal to binding arbitration as an alternative to going to court pursuant to a voluntary agreement with the Plan. If you choose to arbitrate, you may obtain an arbitration agreement from the Fund Office.

Instructions For Requesting An External Review by an IRO

You or your designated representative may request an external review. External review will be performed by an independent review organization (IRO). The IRO must provide the Plan with a response to your request for an external review within 30 days for a standard review or seven days for cases meeting expedited review criteria. The IRO's decision must include:

- A description of the patient's condition;
- The principal reasons for the decision; and
- An explanation of the clinical rationale for the decision.

If the IRO determines that the service should be covered by the Plan, the Plan must pay for the service according to the terms of the Plan Document. If the IRO determines that the service should not be covered by the Plan, the Plan does not have to pay for the service.

1. **Filing a Request for External Review**

   - You, your beneficiary, or the authorized representative of you or your beneficiary (all together referred to as "claimant") may file a request for an external review if the request is filed within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination (denial of appeal). If the date of receipt does not have a corresponding date that is four months later due to such date of receipt being the end of the month, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

2. **Preliminary review**

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

   - You or your dependent (the claimant) is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   - The adverse benefit determination or the final adverse benefit determination related to a failure to meet the requirements for eligibility under the terms of the Plan (e.g., whether you worked sufficient hours during the eligibility period);
   - The Plan's internal appeal process was exhausted unless exhaustion is not required as set out in this procedure; and
   - The claimant provided all the information and forms required to process an external review.

   Within one business day after completion of the preliminary review, the Plan will issue a written notification. 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. You or the claimant will be allowed 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.

3. **Referral to Independent Review Organization**

The Plan will assign an Independent Review Organization (IRO) accredited by URAC or similar nationally-recognized accrediting organization to conduct the external review and will take action against bias and to ensure independence by contracting with at least three IROs and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits. If you would like information regarding the IROs with which the Fund contracts, you may contact the Fund Office.

4. **The External Review Process**

The assigned IRO will:

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

- Timely notify you or the claimant in writing of the request's eligibility and acceptance for external review;

- 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 adverse benefit determination or 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 adverse benefit determination or final internal adverse benefit determination;

- Within 10 business days following the date of receipt of notice from the IRO that it has received the request for external review, you or 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;

- Upon receipt of any information from you or 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 adverse benefit determination or 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 adverse benefit determination or 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;

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim anew and will 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 Fund and you or the claimant, to the extent the information or documents are available and the IRO considers them appropriate, the assigned IRO will consider the following:
  - The claimant's medical records;
  - The attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating provider;
  - 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;
  - 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;
  - 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
  - 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.

- 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:
  - 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);
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - 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;

- 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;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including a phone number, for an applicable office of health insurance consumer assistance or ombudsman.

5. **Reversal of Plan's Decision**

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

6. **Expedited External Review**

You or your dependent (the claimant) or representative may make a request for an expedited external review with the Plan if the claimant receives:

- 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

- 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 adverse benefit determination or 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.

Sole Authority on Plan Benefits

In carrying out their respective responsibilities under the Plan, the Trustees, who act as the Fund Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan, this Summary Plan Description and other documents governing the Plan, and to interpret any facts relevant to a benefit determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

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 claim procedures and claim appeal procedures of the Plan have been followed and exhausted, nor can such action be brought unless brought within two years from the expiration of the time within which proof of loss is required to be furnished or within the maximum time permitted under the applicable provisions of ERISA.

This provision, permitting court action, will not be deemed to extend or reinstitute any claim or cause of action that has expired under the time limits set forth in the Trust Agreement, or in any Plan document or regulations of the Trustees or under any statute if such time limit has already expired.

Coordination of Benefits

If you have coverage under more than one plan, this Plan enables you to receive the most benefits available, while preventing payment of benefits greater than the actual amount of expenses incurred for a sickness or injury. This is accomplished by coordinating benefits offered by this Plan, and other plans. It also ensures that the appropriate plan pays its benefits first. If both you and any of your dependents are covered by this Plan as an employee, or you or any of your dependents are covered by any other health benefit plan in addition to this one, then benefits will be coordinated between the various plans. This is accomplished through specific procedures adopted by the Plan called Coordination of Benefits ("COB")

In any calendar year, this Plan will pay either its regular benefits in full or a reduced amount which, when added together with the benefits payable by "Other Plans" (as defined below), will equal 100 percent of the Allowable Expenses incurred.

"Allowable Expenses" means part or all of necessary, reasonable and customary charges you incur during a calendar year while eligible for benefits under this Plan. However, expenses or services described in the "**Benefit Exclusions and Limitations**" section will not be considered an Allowable Expense.

"Other Plan" means any plan providing benefits or services for or by reason of medical care or treatment, which are provided by group insurance or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis. Dental benefits will not be subject to these COB rules, unless you or an eligible dependent is eligible for these benefits under this Plan.

Specifically, the term "Other Plan" refers to any plan providing benefits or services for actual expenses, and which are provided by:

1. Group, blanket or franchise insurance coverage

2. Group Blue Cross or group Blue Shield coverage and other group prepayment coverage

3. 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

4. Any coverage under governmental programs, and any coverage required or provided by any statute

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:

1. 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.

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

3. 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.

In the event that you or any of your eligible dependents have purchased or acquired an individual policy for health care benefit coverage, the individual policy will be primary and will pay benefits first. This Plan will coordinate with the individual policy and pay benefits as the secondary carrier up to a maximum of 100 percent of the Allowable Expenses.

In all other cases, 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:

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

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

3. 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.

4. For claims on behalf of dependent children:
   - The plan from the employer of the dependent child would pay first
   - The plan from the employer of the spouse of the dependent child would pay second
   - The plan which covers the parent whose birthday (month and day) falls first in the calendar year pays third
   - The plan of the parent whose birthday falls later in the year pays fourth
   - If both parents have the same birthday, the plan covering the parent for the longer period of time pays first

5. If one plan uses the male-female rule and the other plan coordinates benefits as in (3.) 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

Right of First Dollar Reimbursement, Subrogation, and Assignment

Reimbursement and Subrogation

If you are injured or develop an illness that results in a claim by you against another person's insurance proceeds or other monetary benefits, the Plan's right of first reimbursement and subrogation may apply. In the event that benefits are paid by this Plan on account of an injury or a sickness covered by:

- Workers' compensation or employer liability laws;
- No-fault automobile insurance, or automobile liability insurance; or
- Circumstances that create a claim against, or a legal obligation on the part of a third-party to compensate you because of your injury or illness,

The Plan has the right to recover and be reimbursed **first** for all benefits paid on behalf of a person covered by the Plan from any money received as a result of the injury or illness, regardless of the source. This right to be reimbursed first also applies when you have claimed that the injury or sickness is caused by a work injury, automobile accident, or the liability of someone else. If you receive a recovery from someone for an injury or sickness, the Plan has the right to claim an equitable remedy (a constructive trust) over the proceeds to the extent of any benefits paid.

The Plan's recovery includes, but is not limited to, proceeds of court judgments, administrative or agency orders, arbitration awards, settlements, any and all monies for any other source however characterized, or any other payments. No settlement may be made by a covered person or release given for claims arising out of the covered person's loss, injury or illness without prior written consent of the Fund. In consideration for the Plan's advancement of benefits in this context, the responsible person(s) agrees to the terms set forth herein.

In connection with the above paragraphs, the Plan will be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Plan. The Plan will recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any member, whether under comparative negligence or otherwise. The Plan will receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the covered person, payment of attorney's fees and/or expenses. The Plan's right to full reimbursement will not be subject to reduction for reasons including the covered person's failure to recover the perceived full or actual value of his or her claim for whatever reason. Further, the Plan's right of recovery will be a prior lien against any proceeds recovered by the member or covered person, which right will not be defeated nor reduced by application of any so-called "Make Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

You are encouraged to notify the Plan promptly and early in any proceeding when you have a claim against another party or for insurance benefits maintained by you. This includes claims

made for money from an uninsured motorist liability policy, homeowner's insurance policy and private accident insurance.

The Plan is also subrogated to your right of recovery against a potentially responsible party or insurer, in addition to being entitled to be reimbursed first out of any recovery. You are required to cooperate with the Plan in enforcing its right to subrogation. The Plan may pursue a claim or cause of action in its own name or in your name against such third party, or intervene in or continue an action already instituted. In the event you make any settlement of or recovery upon any such claim, the Plan has the right to be reimbursed first from the proceeds of the recovery for all benefits paid or payable to you or on your behalf, regardless of the source.

No participant hereunder will incur any expenses on behalf of the Plan in pursuit of the Plan's right hereunder, specifically no court costs nor attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right will not be defeated by any so called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."

The covered person will complete all paperwork deemed necessary by the Plan to protect its subrogation interests, including the signing of any subrogation and reimbursement agreement requested by the Plan (although none is required for the Plan to enforce or pursue its rights). Failure to do so entitles the Plan to deny coverage for the subject loss, injury or illness. The covered person will do nothing to impair or negate the Plan's right of subrogation and will fully cooperate with the Plan. If the covered person performs any act or fails to act or otherwise compromises the Plan's rights, the Plan may immediately seek recovery of all benefit amounts paid by any available means, including legal action. The Plan will also have the right to offset any future benefit payments that would otherwise be payable to or on behalf of the covered person, to the extent of its lien. These offset benefits will be permanently forfeited by the covered person and the covered person will be legally responsible for any unpaid amounts.

The covered person assigns to the Plan any and all claims, demands and contractual rights the covered person has or may have against Responsible Person(s) arising from or related in any way to the covered person's loss, injury or illness. The covered person agrees that the Plan is substituted in the place of the covered person against such Responsible Person(s) to the extent of the amount paid by the Plan as a result of such loss, injury or illness. This entitles the Plan to make claim or file suit in the name of the covered person. The covered person agrees that the Plan will hold a lien against any amounts the covered person receives, will receive or has available from any source as a result of the loss, injury or illness to the extent of benefits paid by the Plan. The covered person agrees that the Plan may at any time notify or otherwise communicate with the Responsible Person(s) and the covered person's attorney and release information relative to the loss, injury or illness. The covered person agrees to promptly make claims against the Responsible Person(s), and, if necessary, to commence and prosecute a lawsuit against such Responsible Person(s) with all due diligence.

Recoupment

If the Plan provides any form of benefit to you and/or your dependent(s) and, for whatever reason, such benefit is not required under the terms of the Plan or was otherwise mistakenly paid, the Plan will have the right to offset future benefits to the extent of the overpayment. This provision does not limit the Plan's right to recover such amount by any other lawful means.

Assignment of Benefits

Benefits may be assigned by you or on your behalf to the provider of covered services or supplies as permitted by the Trustees.

Facility of Payment

If payment of any benefit under this Plan cannot be paid to you, your assignee or beneficiary, due to your incompetence or disappearance, the Trustees may make payment of the benefits due to the designated beneficiary, or to your relatives by blood or by marriage, or to the person(s) or organization(s) caring for or providing services or supplies to you or to your legal representative at such time and in such amounts as the Trustees may determine. Payments made under this section will constitute full and final discharge of all obligations of this Plan to the extent of such payments. In any case, this Plan reserves the right to make benefit payments directly to the health care provider.

Mistaken Payments / Right of Recovery

If the Plan makes mistaken or excessive payment of benefits, the Trustees, or their representative, have the right to recover the payments. The Trustees may, after notice to the participant who has received a mistaken or excessive payment, offset future claims by the amount to be recovered, including, at the Plan's option, to recoup benefits subject to the Plan's right of first dollar reimbursement.

Retiree Subsidy

Upon retirement you may be eligible to receive a subsidy to help fund your retiree healthcare if you have worked in the GF, F, R1, R2, R5, MESJ and MES2 job classifications or are a bargaining unit alumni on whose behalf a $0.25 hourly contribution is remitted to the Plan as part of the collective bargaining agreement's hourly contribution rate. This portion of the contribution rate funds retiree subsidies, and you shall be eligible to receive a retiree subsidy benefit, provided you:

- worked in one of the seven classifications above, or have been reported upon pursuant to an appropriate reporting form, for the entire 60 consecutive calendar months preceding retirement; or

- for that same 60 consecutive month period preceding retirement, had coverage resulting from a combination of:

    - having performed work as described in the initial paragraph above;
    - having expended available Hour Bank Hours (see page 6);
    - having made Participant Self-Pay contributions (see page 6);
    - having made COBRA continuation coverage payments; and/or
    - having made Supplemental Self Pay contributions (see page 7);

  and

- if you retire on or after age 65, you have enrolled in Medicare Parts A and B.

If eligible, the retiree subsidy benefit provides reimbursement to you for up to $425.00 per month (subject to change at the discretion of the Trustees) for a period of up to a total of 60 consecutive months as provided below. The retiree subsidy is a use-it-or-lose-it benefit:

Retirees Under Age 65

If you retire before reaching age 65, you will receive a monthly subsidy for a period of up to 60 months. During this period you can utilize the retiree subsidy to obtain reimbursement towards the cost of COBRA Coverage (18 months) and/or Supplemental Self-Pay (11 months), if applicable, or towards any other health care coverage you obtain, including exchange insurance products ("Outside Coverage"). The monthly subsidy will be provided until you reach age 65 and have enrolled in Medicare Parts A and B. At that point, the remaining months of the retiree subsidy would be used for reimbursement of a portion of the premium costs for your individual Medicare Supplemental Insurance Policy or a Medicare Advantage Plan.

If upon retirement you elect first to obtain Outside Coverage, you will not be permitted to later elect COBRA Coverage and/or Supplemental Self-Pay if the initial time periods for electing COBRA Coverage and/or Supplemental Self-Pay after your retirement have passed (see pgs. 4, 16).

If you die after reaching age 55 but prior to retirement, your widow or widower (regardless of age) is eligible to receive a monthly subsidy for up to 60 months. If your widow or widower is less than age 65, he or she can utilize the retiree subsidy to obtain reimbursement as indicated in the box immediately above. If your widow or widower is age 65 or older upon your death, then the subsidy will be applied for a period of up to 60 consecutive months per the terms specified in the box immediately below.

Retirees Over Age 65

If you retire at or after reaching age 65, or you retired prior to age 65 and have now reached age 65, you will receive a monthly subsidy for a period of up to a total of 60 months, or the amount of months remaining if you retired before age 65. The subsidy can only be used for reimbursement of a portion of the premium costs for your individual Medicare Supplemental Insurance Policy or a Medicare Advantage Plan.

If you retire at or after reaching age 65, and your spouse has not yet reached age 65, you may have the subsidy applied towards your own Medicare Supplemental Insurance Coverage or Medicare Advantage Plan, or to your spouse's COBRA Coverage and/or Supplemental Self-Pay.

NOTE: The retiree subsidy is paid to you as a reimbursement for the costs you incur to pay for the health coverages referenced above. You are required to submit documentation to the Fund Office detailing your coverage and the corresponding payments you have made, and if eligible for the retiree subsidy, the Plan will reimburse you up to $425 per month for those costs.

Medicare

Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare consists of four parts:

- **Medicare Part A (Original Medicare):** The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part A of Medicare. While it primarily covers hospital care, Medicare Part A also provides coverage for other things like skilled nursing facility care, nursing home care (as long as custodial care is not the only care you need), hospice care, and home health services. Under certain circumstances, you may automatically be enrolled in Medicare Part A and a Medicare card will be sent to you in the mail.

- **Medicare Part B:** The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part B of Medicare. Primarily, Medicare Part B covers services like doctor visits, lab tests and surgeries, and supplies like wheelchairs and walkers, which are considered medically necessary to treat a disease or condition. Under certain circumstances, you may automatically be enrolled in Medicare Part B and a Medicare card will be sent to you in the mail.

- **Medicare Advantage Plans:** The third part are "Medicare Advantage Plans" and is the managed care program under Medicare. Participation is not automatic; you have to enroll in a Medicare Advantage plan to become eligible for that coverage. A Medicare Advantage plan is offered by a private company that contracts with Medicare to provide you with all of your Medicare Part A and Part B benefits—and most of them offer prescription drug coverage, as well. If you enroll in a Medicare Advantage plan, Medicare services are covered through the plan and are not paid for under Original Medicare.

- **Medicare Part D:** The fourth part is prescription drug coverage, which is commonly referred to as Part D of Medicare. Medicare offers prescription drug coverage to everyone with Medicare. However, to get Medicare drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, a widow, or have chronic End-Stage Renal Disease (ESRD). Even if you do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare.

Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You must enroll in Part B upon retiring from active employment, and you will be required to

pay a monthly premium for Part B of Medicare. Depending on the Medicare Advantage plan that you enroll in, you may be required to pay a monthly premium, and other out-of-pocket costs may also apply.

If one of your dependents becomes eligible for Medicare while you are still working, it is essential that they have both Part A and B in effect when you retire. The Plan will pay benefits as if Medicare paid first, or was primary, even if it is not in place.

The Plan will pay its benefits before Medicare ONLY for:

- An actively employed participant who is age 65 or older;
- An actively employed member's dependent spouse who is age 65 or older;
- The first 30 months of treatment for End-Stage Renal Disease received by any covered person;
- Any person covered under the benefit program for active members, who is less than age 65 years of age and who is receiving Medicare benefits because of disability.

When the rules above do not apply, the Plan will pay its benefits only after Medicare has paid its benefits.

Important: Medicare benefits will be taken into account for any individual while he/she is eligible for Medicare whether or not he/she is enrolled for Medicare.

If you receive treatment at a hospital operated by the Veterans Administration for an illness or injury while on Medicare, which is not related to military service, the medical benefits paid by the Plan, if any, will be the amount you would have received had the service been provided in a non-governmental facility.

The Plan will pay the percent payable under the schedule of coverage for covered expenses, which are not or would not be paid by Medicare (subject to the Limiting Charge Amount established by Medicare guidelines), after the Plan's deductible has been met.

Loss of Time (Short Term Disability)

If you are already eligible for benefits as an active participant under the Plan and you become totally disabled due to a non-occupational bodily injury or sickness, you are eligible for "Loss of Time" benefits from the Plan if you are unable to work.

In order to receive a Loss of Time benefit, you must provide notice and proof to the Plan within 90-days of your disability that prevents you from working. The Plan has the right to require a report from your physician, or to obtain in independent medical exam to validate eligibility, or continued eligibility for benefits.

Loss of Time benefits are weekly benefits (or a prorated portion of a week if you are disabled for less than a complete five-day week) consisting of a weekly benefit amount (subject to change) for a period of up to 26 weeks for a non-occupational injury or illness. Benefits are determined by your position classification under the CBA as follows:

$500 per week – General Forman, Forman, R5, R1, and MESJ;

$360 per week – R2, and A5;

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

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 Loss of Time 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.

Plan Information

The following information is provided to help you identify this Plan and the people who are involved in its operations:

Name of Plan

This Plan is known as the MCASF Local 725 Health and Welfare Plan (previously the ACRA Local 725 Health and Welfare Plan).

Identification Numbers

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The Employee Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 59-6150964.

Plan Year

The Plan Year begins on January 1 and ends on December 31.

Type of Plan

This Plan is welfare benefit plan maintained for the purpose of providing medical benefits in the event of injury or sickness and other welfare benefits. The complete terms of the self-insured benefits are set forth in the Plan.

Eligibility

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

Plan Sponsor and Administrator

The Board of Trustees is the Plan Sponsor and Fund Administrator, and is responsible for the operation of this Plan. The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Association and Local Union who have entered into working agreements that relate to this Plan.

The Board of Trustees utilizes the services of the MCASF Local 725 Service Corporation to act as Plan Manager:

MCASF Local 725 Service Corporation
15800 Pines Blvd., Suite 201
Pembroke Pines, FL 33027
Phone: 754-777-7735

The above office is the Fund Office. The MCASF Local 725 Service Corporation also does business as Benefit Services.

Name and Business Address of Trustees

Union Trustees	Employer Trustees
Mr. Kenneth E. Scott, Jr. United Association LU 725 13185 NW 45th Ave. Opa Locka, FL 33054	Mr. Ed Llosent Airtech Air Conditioning, Inc. 7805 NW 55th St. Miami, FL 33166
Mr. Thomas Flavell United Association LU 725 13185 NW 45th Ave. Opa Locka, FL 33054	Ms. Julie Dietrich Mechanical Contractors Association of South Florida 160 W. Camino Real #132 Boca Raton, FL 33432
Mr. Bob Heslekrants United Association LU 725 13185 NW 45th Ave. Opa Locka, FL 33054	Mr. Chris Figueras Evo Air Conditioning 13083 SW 133 Court Miami, FL 33186
Mr. Ralph Castro United Association LU 725 13185 NW 45th Ave. Opa Locka, FL 33054	Mr. Carlos Borja Weathertrol Maintenance Corp. 7250 N.E. Fourth Ave. Miami, FL 33138

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Trustees at the Fund Office or upon any individual Trustee. Legal process can also be served upon Plan's legal counsel at the following address:

William Cumming, Esq.
Laura H. Lindsay, Esq.
c/o Hessian & McKasy, PA
3700 RBC Plaza
60 South Sixth Street
Minneapolis, MN 55402

Note that arbitration is available instead of a court action.

Plan Funding

The benefits of the Plan are provided through employer contributions. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provision of the collective bargaining agreement and other working

agreements. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of employees working under the collective bargaining agreement or working agreement.

The Plan is self-insured, meaning benefits are paid for from contributions received from employers on your behalf. The Fund is not an insurance company and because it is not "in the business of insurance," it is not subject to state laws regarding health insurance.

Trust Fund

All assets are held in trust by the Trustees for the purpose of providing benefits to covered employees and defraying reasonable administrative expenses. The Fund's assets and reserves are invested in savings accounts and federal securities in numerous banks. All benefits are paid directly from the Trust Fund.

Plan Termination

The Trustees may terminate this Plan at any time. Upon termination, the rights of the Plan Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Participants.

Plan Amendments

The Plan may be amended from time to time – either to revise the benefits or to bring the Plan into compliance with changes in the laws. If the Plan is amended, you will be provided with written notification explaining the change(s). Any update to this booklet or its inserts will be sent to you in writing at the last address you furnished to the Fund. You are responsible for keeping the Plan Manager informed of any change in your address.

Interpretation of the Plan

The Trustees of the Plan may only interpret this Plan by their official actions at a duly called meeting of the Board of Trustees. The Trustees' decisions should receive judicial deference to the extent that they do not constitute an abuse of discretion.

The Trustees have the sole responsibility for interpreting, changing or waiving any part of the obligations, rights or benefits set forth in the Plan. The Fund Administrator has broad discretion to determine eligibility for benefits and interpret Plan language. No individual Trustee(s), employer, employer association, union or union official has the authority to make any such interpretation, promise or commitment on behalf of the Plan or to bind the Plan in any way, except when participating in an official action of the Trustees.

Statement of ERISA Rights

As a participant in the MCASF Local 725 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, all documents governing the Plan, including insurance contracts, your Collective Bargaining Agreement and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts, your Collective Bargaining Agreement and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (the Fund Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, which the Fund Administrator is required by law to furnish to each participant annually.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event (you or your dependents may have to pay for such coverage; review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights); and
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan,

You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when: (1) You lose coverage under the Plan; (2) You become entitled to elect COBRA continuation coverage; or (3) Your COBRA continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a health benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights; For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator.

If you have a claim for benefits has been denied or ignored, in whole or in part, you may file suit in a state or federal court, depending on the type of claim. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries misused the Plan's money, or if you believe you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA: By calling (866) 444-3272; or visiting the website of the EBSA at www.dol.gov/ebsa.

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Benefit Services
SERVING LOCAL UNION 725 & MCASF
15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

MCASF LOCAL 725 HEALTH AND WELFARE PLAN

SUMMARY OF MATERIAL MODIFICATION

This notice is a Summary of Material Modifications ("Summary" or "SMM"), as required by Section 104(b) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and is intended to notify you of an important change that has been made to the MCASF Local 725 Health and Welfare Plan ("Plan"). You should take the time to read this Summary carefully and should keep it with your Summary Plan Description booklet ("SPD") for future reference.

Please note that in the event of any conflict between this Summary, the SPD and the Plan, the terms of the Plan Document will govern, unless expressly stated to the contrary herein. If you have any questions about these changes and/or any other information provided herein, please call the Plan's Administrative Manager, the MCASF Local 725 Service Corporation, at (754) 777-7735.

EXCLUSION FOR CELLULAR AND GENE THERAPY

Effective January 2, 2024, the Board of Trustees of the Plan approved excluding coverage for all FDA-approved Cellular and Gene Therapy Products, a list of which is published and amended from time to time by the FDA. All future additions to the FDA-approved list of Cellular and Gene Therapy Products will also be excluded from coverage under both the medical benefits and the pharmacy benefits. These products are generally not medically necessary for most participants in the Plan and their exclusion will help further the Trustees' goal to provide cost-effective health care to all Participants.

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CALENDAR YEAR MAXIMUM OUT OF POCKET EXPENSE

Previously the Maximum Out of Pocket expense was combined for Medical & Prescription at $4,500 per calendar year, per individual and $9,000 per calendar year, per family. This maximum could be hit regardless of the ration of claims for medical care versus pharmacy benefits. Effective January 1, 2024, the Maximum Out of Pocket expense will be split between Medical and Prescription benefits as follows: (1) the Medical Maximum Out of Pocket expense will change to $3,200 per calendar year, per individual and $7,200 per calendar year, per family; and (2) the Prescription Maximum Out of Pocket expense will change to $900 per calendar year, per individual and $1,800 per calendar year, per family.

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