ACRA LOCAL UNION NO. 725

HEALTH AND WELFARE FUND

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BOARD OF TRUSTEES

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James Taylor
Ralph Marinello
Richard Folkman

MANAGEMENT
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Wayne Masur, P.E.
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LEGAL COUNSEL
Michael Storace, P.A.

FUND CONTRACT ADMINISTRATOR
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FUND AUDITOR
Steven I. Gordon, CPA

FUND CONSULTANT
Core Management Resources, Inc.

FUND SPECIAL CONSULTANT
George Meyers (Retirees)
Seitlin Benefits (Medical & Prescription Drugs)

TRUSTEES OF THE A.C.R.A. LOCAL 725
HEALTH AND WELFARE TRUST FUND
OF DADE, BROWARD AND
MONROE COUNTIES, FLORIDA
688 Walnut Street, Suite 103
Macon, Georgia 31202
(912) 741-3521
(888) 741-2673

TO ALL PARTICIPANTS:

As you all know, on October 1, 1983, the Trustees of your Plan elected to undertake a program of "self-insurance" due to the constant increases in health insurance premiums. The program has been successful in helping to stabilize costs to the program while providing excellent benefits to the participants.

This new booklet restates "as of November 1, 2007 and thereafter" the existing benefits, plus includes new provisions which comply with new legal requirements of which the Trustees and their Advisors feel will help to continue to stabilize costs while at the same time eliminate possible costs abuse. It includes new provisions effective through November 1, 2007. Please pay particular attention to the Surgical Expense section, and the Major Medical Expense section. We urge you to read the booklet carefully and to contact the Fund Administrator should you have questions. In keeping with this objective the Trustees contracted with Blue Cross and Blue Shield of Florida to take advantage of the excellent discounts aloud by their Preferred Provider Network for hospital, medical and surgical services. This change became effective November 1, 2007.

Although every effort has been made to accurately describe the Plan, this document is merely a summary of the Plan Document provisions. It attempts to explain the provisions in brief, simple language, in order to make it as understandable as possible. Nonetheless, the terms and provision of the Plan Documents prevail over this document. There are a number of definitions and provisions of the Plan Documents which are not included in this document. Moreover, certain of the provisions in this document are merely summaries of extensive, specific, and detailed provisions of the Plan Documents. Therefore, **in the case of any discrepancy, inconsistency, ambiguity or vagueness between this Summary Plan Description and the actual Plan Documents, the terms and provisions of the Plan Documents will prevail. Your right to obtain information regarding the Plan Documents is contained in Part II.**

PART I
INFORMATION REQUIRED BY THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974

1. The Plan is administered and maintained by the Joint Board of Trustees at the following address:

Board of Trustees

A.C.R.A. Local No. 725 Health and Welfare Trust Fund of Dade, Broward and Monroe Counties, Florida.

c/o **Core Management Resources**
515 Mulberry Street, Suite 300
Macon, Georgia 31202
(912) 741-3521 or 1-888-741-2673

2. The Plan is a Health and Welfare Plan. It provides accidental death and dismemberment insurance, weekly disability benefits and hospital, surgical, medical, major medical, certain life insurance and death benefits.

3. The names and addresses of the Trustees are listed below:

Labor
Kenneth E. Scott, Jr.
Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

Ralph Marinello
Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

James Taylor
ACRA Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

Richard Folkman
Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

Management
William Ansley
Direct Digital Concepts
7275 N.W. 74th Street
Miami, Florida 33166

Wayne Masur, P.E.
2680 Hunter Court
Miami, Florida 33331

Herbert Dell
Hill York Sales & Service Corp.
10650 N.W. 6th Court
Miami, Florida 33168

Ed Llosent
Airtech Air Conditioning, Inc.
7805 NW 55th St.
Miami, Florida 33166

4. The Employee Identification Number (EIN) issued to the Board of Trustees by the Internal Revenue Service is 59-6150964 and the Plan number (PN) is 501

5. The date of the end of the Plan Year is December 31.

6. Core Management Resources, P.O. Box 840, Macon, Georgia 31202-0840, has been designated as the agent for the service of legal process.

7. Funding Medium.
Benefits are provided from the Employer Contribution provisions of the Collective Bargaining Agreement (see Section 8 below) and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

8. Contributions Source.
All contributions to the Plan are made by employers in accordance with their collective bargaining agreement negotiated between A.C.R.A. and the United Association Local 725. See the section entitled Statement of ERISA Rights in Part II if you wish to obtain additional information about the Collective Bargaining Agreement.

9. Investment of Fund Assets.
The Fund's assets and reserves are invested in savings accounts, federal securities in numerous banks, and other investments. The investments are managed by Sawgrass Asset Management as Investment Manager. See the Section entitled Statement of ERISA Rights in Part II if you wish to obtain additional information concerning the Fund's investment assets and checking accounts.

10. Eligibility:
The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualifications, ineligibility, or denial or loss of any benefits are fully described in the General Provisions and "Termination of Insurance" sections of this booklet.

11. Type of Plan:
The A.C.R.A. Local No. 725 Health and Welfare Trust Fund is a Medical Plan providing hospital, surgical, medical, dental, loss of time and other related health benefits. The Plan also provides Life Insurance and Accidental Death and Dismemberment Insurance protection through a policy issued by Aetna Life Insurance company. All health care benefits are self-funded out of contributions and assets of the Fund.

12. Administration of the Plan:
The Board of Trustees are responsible for the overall administration of the Plan. For purposes of main-

taining the necessary records and the handling of day-to-day business affairs of the Plan, the Trustees have retained the services of Core Management Resources.

13. Plan Sponsors:
The Union and Employers participating in the Plan are the Plan Sponsors. A complete list of participating employers may be obtained by written request to the Plan Administrator.

14. Plan Documents:
The Plan, the Trust Agreement, the contract with Aetna Life Insurance Company, and all amendments and resolutions entered into by the Board of Trustees constitute the Plan.

15. Collective Bargaining Agreements:
The United Association Local No. 725 has executed a collective Bargaining Agreement requiring Employers to make contributions into the Fund. Copies of this Agreement may be secured from the Union at the Address listed below:

Local Union No. 725 of the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada.

13185 N.W. 45th Avenue
Opa Locka, Florida 33054

16. Termination of the Plan:
It is the intention of the Union and the Employers that this Plan shall be continued indefinitely. If the Plan were to be terminated by the Trustees the assets of the Trust Fund, after the payment of all expenses would be used to provide benefits for eligible participants until exhausted.

17. The Fund Contract Administrator:
Core Management Resources
P.O. Box 840
Macon, Georgia 31202-0840

18. The Fund Auditor:
Steven I. Gordon, CPA
4600 W. Commercial Blvd
Suite 5
Tamarac, FL 33319

19. The Fund Legal Counsel:
Michael Storace, Esq.
4800 LeJeune Road
Coral Gables, Florida 33146

20. The Fund Consultant:
Core Management Resources
P.O. Box 840
Macon, Georgia 31202-0840

21. The Fund's Investment Manager:
Those funds not immediately needed to pay benefits and expenses are invested by Sawgrass Asset Management.

22. Procedures for Filing Claims:
Your Trustees have attempted to provide you with prompt and efficient Claim Service. By following the steps shown below when filing a claim, prompt service will be assured.

Secure a claim from your Administrator (Address shown below)

Complete your portion of the form by filling in all information requested and signing your name on the line specified.

Have your doctor complete his portion of the form.

Forward your completed form, with all itemized bills attached, to:

i) Core Management Resources
P.O. Box 840
Macon, Georgia 31202-0840

a) For Class III Retiree Medical Benefits
All Dental Benefits
Weekly Disability Benefits
Life and AD&D Benefits

b) Blue Cross and Blue Shield of Florida
P.O. Box 45287
Jacksonville, Florida 32232-9837
For Medical Benefits and Prescription Drug Benefits

c) No legal action may be brought prior to:

d) Ninety (90) days after proof of claim has been sent in accordance with the above requirements and no legal action will be brought after two years following the date proof of claim is required, or

e) The time provided in item 23(f) below written notice of a claim, including sufficient information to identify the covered person, must be sent to the Plan within twenty (20) days after the occurrence of any event for which claim is made. The Plan will furnish forms for filing proof of claim. However, if the Plan does not furnish such forms within fifteen (15) days after receiving notice of claim, the covered person will be considered to have compiled with the requirements for proof of claim by sending written proof of the occurrence, character and extent of the claim within 90 days after the occurrence of the event for which the claim is made.

23. Claim Review and Claim Appeal Procedures:

a) If a claim is denied or partly denied, you will be notified in writing and given the opportunity for a review.

b) The written denial will give:

1) Specific reason(s) for denial.

2) A description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed.

3) An explanation of the Plan's Claim Review Procedure.

c) If your claim is not acted on within a reasonable time, you may proceed to that appeal procedure stage, described in paragraph d below, as if the claim has been denied.

d) Appeal Procedure:

1) Where a claim has been denied or partly denied after review, you may appeal the denial and have a review.

2) Within sixty (60) days after you receive written notice your claim has been denied, you or your representative may make a written request for review to the Board of Trustees in care of:

i) Core Management Resources
P.O. Box 840, Macon, Georgia 31202-0840

a) For Retiree Class III Medical Benefit
Dental Benefits
Weekly Disability Benefits

ii) Blue Cross and Blue Shield of Florida
P.O. Box 45287
Jacksonville, FL 32232-9837
For Medical Benefits

b) The written request for review must briefly describe the ground on which the request for review is sought.

3.) You may review pertinent documents relating to the denial and you may submit issues and comments in writing.

e) Decision on Appeal: A decision will be made promptly and delivered to you by the Board of Trustees not later than sixty (60) days [one hundred twenty (120) days in special circumstances which required additional time] after receipt of your request for appeal. The decision on appeal will be in writing and will include specific reasons for the decision.

f) Exhaustion of claims review and appeal procedure - No action in law or in equity shall be brought to contest a denial, suspension or termination of benefits until the claimant has complied with the review and approved procedures unless the Board of Trustees fails to render a decision within 120 days after receipt of the Notice of Appeal. In no case, however, shall any action be brought unless instituted within one (1) year from the time the claimant received notice of denial, suspension or termination.

24. Reliance on this document:
Although every effort has been made to accurately describe the Plan, this document is merely a summary of the Plan Document provisions. It attempts to explain the provisions in brief, simple language, in order to make it as understandable as possible.

Nonetheless, the terms and provisions of the Plan Documents prevail over this document. There are a number of definitions and provisions of the Plan Documents which are not included in this document. Moreover, certain of the provisions in this document are merely summaries of extensive, specific, and detailed provisions of the Plan Documents. Therefore, in case of any discrepancy, inconsistency, ambiguity or vagueness between this Summary Plan Description and the actual Plan Documents, the terms and provisions of the Plan Documents shall prevail. Your right to obtain information regarding the Plan Documents is contained in Part II.

25. Amendment of the Plan:
The Trustees reserve the right to alter the plan and benefits and any rules and regulations of this plan at any time in accordance with the terms of the agreement and declaration of trust. Such amendments and alterations include, without limitation the right to eliminate totally and/or reduce any benefits, rights, elections or other privileges or prerogatives of any beneficiary under this plan, unless such termination and/or reduction is specifically prohibited by law.

26. Change of Trustees:
Upon the death, resignation, and/or removal of any Trustee, the following provisions shall apply:

(a) Resignation. A Trustee may resign, and become and remain fully discharged from all further duty or responsibility hereunder upon giving thirty (30) days written Notice in the manner set forth in paragraph (c) below.

(b) Removal. A Union Trustee may be removed from office at any time by action of the Union, and upon the Union providing Notice in the manner set forth in paragraph (c) below. An Employer Trustee may be removed at any time by action of ACRA and upon ACRA providing Notice in the manner set forth in paragraph (c) below.

(c) Notice of Resignation by Trustee and Appointment of new Trustee. Any Notice regarding any resignation, death, or removal of any Trustee and/or Appointment of Successor and/or New Trustee shall be provided to ACRA, the Union, the Administrative Manager, and Legal Counsel for the Trust. To the extent any applicable law may require that such Notice be provided to any Participant and/or Beneficiaries, then such Notice shall be deemed to have been provided to, and enforceable against such Participant and/or Beneficiary in accordance with Paragraph 27 hereof. Such Notice shall:

(1) state the date on which it is to take effect, which in the case of resignation of a Trustee, may not be earlier than thirty (30) days from date of deliver, unless an earlier date is accepted by all parties entitled to receive such notice; and,

(2) in the case of appointment of a new or successor Trustee, provide the full name, mailing address

thereof, and such additional information as the Trust may reasonably require.

27. Representation: The following rules and procedures shall apply with respect to all notices, notifications, reports or other matters requiring any communication to and/or action by the parties set forth below:

(a) Except as to those notices specifically required to be given personally to any Beneficiary, Participant, Employer, or Contributing Employer by any applicable Federal Law, all notices, information, accountings, reports or other notifications of any type whatsoever, required to be given, issued, or delivered to any Participant, Beneficiary, Settlor, Employer, and/or Contributing Employer of the Trust (including those required by any section or provision of the laws of Florida or any other state not pre-empted by Federal Law) shall be deemed to have been given to and enforceable against the parties to be notified when delivered to the respective Representatives ("Representatives") designated as follows:

(i) To Participants and/or Beneficiaries - by written notice to the Union

(ii) To Settlors, Employers, and/or Contributing Employers - by written notice to ACRA

(iii) Rules of Interpretation: For all purposes of the Paragraph 27 the term:

(a) "Participant" and/or "Beneficiary" shall include any person entitled to and/or accruing a Benefit from the Trust, including under a Participation Agreement, which right, entitlement, and/or accrual has not been totally terminated. [See Florida Statutes Section 736.0306.]

(b) "Settlor" shall include any member of ACRA and any person, party, or entity who and/or which has, at any time, been represented, directly or indirectly, by ACRA, bound to any agreement regarding contributions to the Trust, and/or contributed property of any kind to the Trust.

(c) Except as to notices, information, accountings, reports, approvals, waivers, consents, ratifications, confirmations, elections, and/or other actions required by any applicable Federal Law to be specifically provided to, or given by, any person or entity for whom a Representative is designated in paragraph (a) above, all approvals, disapprovals, waivers, consents, ratifications, confirmations, and/or other actions permitted or required by the laws of the State of Florida or by any other state, which are permitted or required by the laws of the State of Florida or by any other state, which are given, declined, taken, not taken, or otherwise exercised or not exercised by the Representative named in Sub-paragraph (a), above shall bind the party so represented."

PART II
STATEMENT OF ERISA RIGHTS

As a participant in the A.C.R.A. Local No. 725 Health and Welfare Trust Fund of Dade, Broward and Monroe Counties, Florida, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, a list of participating employers and employee organizations sponsoring the plan and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. Upon written request, you may receive information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address.

b) Obtain copies of all Plan Documents and certain other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, call "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 excising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a

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

If you have questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor Management Service Administration, Department of Labor.

PART III
ELIGIBILITY PROVISIONS

1. GENERAL CONDITIONS OF ELIGIBILITY

The following Rules and eligibility for benefits under the Plan based on these Rules, are strictly conditioned upon the Employee working for, or being available for full time employment with an Employer having a Collective Bargaining Agreement which obligates the Employer to make contributions to this fund, and upon such Employer being in full compliance with the terms of such Collective Bargaining Agreement.

2. WHO IS ELIGIBLE:

(a) Class 1 - Eligible Employees - All active full-time employees of contributing Employers whose employment is the subject of a Collective Bargaining Agreement by and between the Employers and ACRA - Local Union 725 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada AFL-CIO.

(b) Class 2 - Eligibility for Permanently and Totally Disabled Persons under age 65 and their Dependents.

If you have been covered under the plan for a minimum of three years and if, while so covered and before attaining age 65, you are certified as permanently and totally disabled by a physician(s), and if the disability is not covered under any Workers Compensation Legislation, you and your dependents will continue to be covered until the last day of the Calendar month preceding the month in which you or your dependents attain age 65, but only for those benefits listed in the Schedule of Benefits applicable to Class 2.

(c) Class 3 - Eligibility for Retirees and their Eligible Spouses age 65 and over.

To qualify for the benefits as a Retiree the following requirements must be met:

(1) You must be at least 65 years of age.

(2) Your must have been covered under the Plan as an eligible active participant immediately prior to your retirement under the terms of ACRA Local 725 Pension Trust Fund for a period of 60 consecutive months.

(3) You must not receive any financial gain from employment in the Pipefitting, Air Conditioning, Heating and Refrigeration Trade as an employee, officer, partner or owner.

(4) You must be receiving benefits under the terms of the Social Security Act.

(d) **Special Note:** If you collect early, normal, or late retirement benefits under the ACRA-Local 725 Pension Plan, and then become employed in the jurisdiction of a reciprocating union, but pursuant to the provision of the ACRA-Local 725 Pension Plan, elect to continue receiving Pension benefits, then just as you are not entitled to earn any additional pension credit, or increase in monthly pension benefit level in the ACRA-Level 725 Pension Plan, you will not be entitled to receive active employee benefits from ACRA-Local 725 Health & Welfare Plan. You must elect to be covered in the Health & Welfare Plan of the Local in the jurisdiction you have been working.

Effective January 1, 2007 a retired participant age 62 or over who is collecting early, normal or later retirement benefits under ACRA Local 725 Pension Plan may elect to return to employment with a contributing employer signatory to the Collective Bargaining Agreement with ACRA Local Union 725 and not cause an interruption of his monthly pension benefits. You should contact Local Union 725 regarding this provision.

(e) DEFINITION OF ELIGIBLE DEPENDENT:

Your dependents or your spouse and each unmarried child who has not attained his 19th birthday, or 25th birthday if attending an accredited school or college on a full-time basis. If an unmarried child is incapable of self-sustaining employment because of a physical handicap or mental retardation and he is dependent upon you for support, his coverage will be continued provided (1) his incapability commenced before the attainment of the age limit shown above, and (2) proof of dependent child's incapability is furnished to the Plan Administrator no later than 31 days after attainment of the age limit. Proof of the continued existence of such incapability may be requested by the Trustees from time to time.

"Child includes stepchild, adopted child and foster child, provided such child is primary dependent upon the employee for support and maintenance.

A dependent who is hospitalized on the date he would otherwise become covered will not be covered until he has been finally discharged from the hospital. However, if a newborn dependent child incurs charges for services over and above the usual costs of nursery charges for routine well baby care because of sickness, injury, congenital defects or premature birth, coverage begins from birth.

Effective date of coverage under this Plan means the effective date of coverage for each beneficiary. Each beneficiary's effective date will be determined individually. The effective date of coverage for each member of a family will be determined individually. Thus where an employee is already covered and acquires a new dependent (such as a spouse or by adoption) the effective date of coverage for the new dependent will be deemed to be the date on which the new dependent became covered under the Plan rather than the date on which the employee became covered under the Plan.

DEPENDENTS OF DECEASED EMPLOYEES: Benefits for Dependents of a Deceased Covered Employee will continue until such Deceased Covered Employees "Earned Eligibility" is exhausted, unless entitled to COBRA Coverage (see Section II of Part III).

(f) NON-BARGAINING UNIT EMPLOYEES:

(a) Non-Bargaining Unit Employee is a shareholder, officer, director or any person employed by or performs work for an employer who received compensation in whole or in part for duties and/or functions are not included in the trade or craft and/or who are compensated on a basis other than the hourly basis as described in the Collective Bargaining Agreement to which the Employer is bound; provided, however, that compensation at a higher hourly rate than provided in the Collective Bargaining Agreement, shall not, by itself, render an employee a Non-Bargaining Unit Employee.

(1) The term "Non-Bargaining Unit Employee" does not include those employees who are permitted under the terms of the Collective Bargaining Agreement to perform work described under the Collective Bargaining Agreement and for whom employers are required to pay contributions to the Health & Welfare Plan on the basis of not less than 40 hours per week, 52 weeks a year pursuant to the terms of the Collective Bargaining Agreement.

(a) The Collective Bargaining Agreement requires that in order for any shareholder or other owner/employee of an Employer to perform any work covered by, or described under the Collective Bargaining Agreement, (i.e. "work with the tools"), either part time or full time, the Employer must:

(i) Pay contributions to the Health & Welfare Fund on behalf of said person at the rate provided in the Collective Bargaining Agreement:

(ii) On the basis of **not less than** 40 hours per week, 52 weeks per year.

If the owner/employee works with the tools less than 40 hours per week, contributions must nonetheless be paid for 40 hours in that week. If the owner/employee works with the tools more than 40 hours per week, contributions must be paid for the full number of hours worked with the tools during that week. These individuals are considered part of the bargaining unit.

(b) Some employees may perform exclusively "other" work. Other types of work may include services of corporate officer, supervisor, clerical personnel, sale, management, or any other services not covered by the Collective Bargaining Agreement. Such an individual is not considered to be part of the bargaining unit [for which contributions are required to be paid on his behalf in the manner set forth in paragraph (a) above] only if that individual no longer is eligible, or permitted to perform bargaining unit work under the terms of the Collective Bargaining Agreement. This provision applies to all persons such as shareholders, officers, owner, salespersons, clerks, etc. Such an individual must be covered under a participation Agreement in order to be covered. Such persons will be considered Non-Bargaining Unit Employees, for whom the rules set forth in paragraph two (2) and three (3) below apply.

(2) A Non-Bargaining Unit Employee may not participate in the plan unless all the following requirements are satisfied:

a) Only full time Non-Bargaining Unit Employees (i.e. those who normally work more than 20 hours per week for the employer) may be covered under a Participation Agreement and

i) Such employee has been a participant in the plan as a Bargaining Unit Employee at some time in the past, or

ii) The employer elects to cover all of such Employer's Non-Bargaining Unit Employees (including those who did formerly participate as a Bargaining Unit Employee and those who did not so participate); provided, however, that the Employer may elect an initial waiting period which must expire prior to coverage of new Non-Bargaining Unit Employees, not to exceed ninety (90) days, for the date such Non-Bargaining Unit Employees become employed by the employer in any capacity (including as a bargaining unit employee) which is applied uniformly to all Non-Bargaining Unit Employees,

(3) Eligibility for benefits for Non-Bargaining Unit Employees shall commence and shall terminate in accordance with the Rules or Participation to Bargaining Unit Employee's eligibility benefits.

These rules provide (among other things) that eligibility for a Non-Bargaining Unit Employee shall commence immediately upon;

a) (i) Becoming named in a Participation Agreement approved by the Trust Fund and

(ii) The employer making contributions to the Health and Welfare Trust Fund on behalf of such employees on the basis of a minimum of 40 hour per week, 52 weeks per year, providing and keeping in full force a bond for such contributions in the amount required by the Collective Bargaining Agreement for such employee and executing a Participation Agreement as required under the rules for Non-Bargaining unit Employees.

b) Shall terminate immediately upon the termination of the Participation Agreement as provided therein, and/or as provided in paragraph 4 (d)(ii) of the Rules of Participation.

c) Shall also be determined by the additional rules set forth in the Rules of Participation.

(4)Determination of approval or non-approval of a Participation Agreement is a matter that is totally within the discretion of the Board of Trustees and shall be based on such criteria as the Trustees may establish from time to time, including without limitation, circumstances as applicable to each particular employer and employee which shall include such factors as the prior contribution delinquency experiences of such employer and/or employee.

(5)Non-Bargaining Unit Employees are not allowed to make self-contributions or earn Hour Bank Credit. Hour Bank Credit earned immediately prior to the employee's commencement of participation as a Non-Bargaining Unit Employee shall be frozen and held in suspense. If no contributions are again made to the Plan on behalf of the employee as a Bargaining Unit Employee within 30 days of termination of work as a Non-Bargaining Unit Employee his Hour Bank Credit shall be terminated permanently.

(6)Notices required to be given to you or your covered dependent or beneficiaries by the Participation Agreement, Rules of Participation, Federal law or State Law not Pre-empted by Federal Law shall be deemed to have been given to and enforceable against the parties when delivered to United Association Local Union 725 as your representative. Action taken by United Association Local Union 725 in your behalf shall be binding on you, your dependents or beneficiaries. Such notices required to be given to your Employer shall be deemed to have been given and enforceable against the Employer if written notice is given to Air Conditioning Refrigeration Association ("ACRA") as their designated representative.

(7)The rules of Participation are extensive and complex. A complete copy of the rules should be obtained from Core Management Resources.

3. WHEN YOU BECOME COVERED:

Initial Eligibility

After December 31, 1992: Each Employee will become covered under the Plan on the first day of the Benefit Quarter after you have accumulated contributions of 400 or more employment hours during a five (5) consecutive month period.

4. CONTINUING COVERAGE:

Once covered you will continue for the coverage until the end of the then current Coverage Period.

After December 31, 1992: To continue eligibility during succeeding Benefit Quarters, contributions for a minimum of 300 employment hours must be credited to the Fund on your behalf during the Eligibility Quarter applicable to each Benefit Quarter as set forth in the following table:

300 Hours Worked During Eligibility Quarter

(1)January, February, March
(2)April, May, June
(3)July, August, September
(4)October, November, December

Provide Benefit Coverage During This Benefit Quarter

(1)June, July, August
(2)September, October, November
(3)December, January, February
(4)March, April, May

(c) The number of employment hours required under paragraphs (a) or (b) above may be satisfied by one, or a combination of two or more of the following:

(i) Contributions from Contributing Employers, or

(ii) Disability credits, or

(iii) withdrawal of Hour Bank Hours.

5A. DEFINITIONS OF ELIGIBILITY AND BENEFIT QUARTERS

(a) "Eligibility Quarter" means

(i) After December 31, 1992, the periods described below:

ELIGIBILITY QUARTER ONE: January, February, March

ELIGIBILITY QUARTER TWO: April, May, June

ELIGIBILITY QUARTER THREE: July, August, September

ELIGIBILITY QUARTER FOUR: October, November, December

(b) "Benefit Quarter" means:

(i) After December 31, 1992, the periods described below:

BENEFIT PERIOD ONE: June, July, August

BENEFIT PERIOD TWO: September, October, November

BENEFIT PERIOD THREE: December, January, February

BENEFIT PERIOD FOUR: March, April, May

5B. GENERAL DEFINITIONS:

(a) "Covered Person" means and Eligible Employee [see Part III(2a)] and an "Eligible Dependent" [see part III2, (e)].

(b) "Beneficiary" includes all Covered Persons.

(c) Earned Eligibility shall mean eligibility earned in accordance with the provisions of paragraph.

(d) The term "Physician" as used herein shall mean a licensed doctor of medicine (MD), doctor of osteopathy (DO), and doctor of dental surgery (DDS). Other holders of a certificate of license authorizing such licensee to perform medical care or surgical services shall satisfy the term "Physician" provided that such care or service is under supervision or referral of an MD or DO.

(e) The term "spouse" shall mean the one who is married to a covered employee and which marriage is recognized under the laws of the State of Florida. Persons shall cease being a spouse upon the entry into a legal separation or a formal decree of dissolution of marriage.

(f) A licensed chiropractor or podiatrist practicing within the scope of their chiropractic or podiatric license shall be considered eligible service providers.

6. DISABILITY CREDITS:

For each month of proven disability up to six consecutive calendar months, contributions representing 100 employment hours will be credited automatically on your behalf by the fund. A month of proven disability is a calendar month during which you supply medical evidence satisfactory to the Trustees that you were totally disabled during a minimum of twenty consecutive days.

7. HOUR BANK:

After December 31, 1992:

During ay Eligibility Quarter (except for your Initial Eligibility Period) all hours of contributions in excess of four hundred (400) hours will be credited to your individual Hour Bank; except that the Hour Bank will not exceed one thousand (1,000) such hours at any one time. Hours of contributions earned during your Initial Eligibility Period do not accumulate toward Hour Bank Credit.

(b) Hour Bank hours may be withdrawn for Continuing Eligibility only if you are available for "full time" employment with a Contributing Employer to ACRA Local 725's Fringe Benefit Funds.

(i) If you become unavailable for full time employment with a contributing Employer of ACRA Local 725, coverage by virtue of withdrawal of Hour Bank hours shall immediately terminate and no further Benefits shall be payable by virtue of withdrawal of Hour Bank hours until the Employee again satisfies the requirements for Initial Eligibility.

(ii) Not withstanding paragraph (i) above if you work in the jurisdiction and in the industry covered by ACRA Local 725's Collective Bargaining Agreement for an Employer solely for maintenance of his property, you must provide written notice of said employment within 30 days after commencing such work and may not lose your right to use your Hour Bank to continue eligibility under the Plan. In such case your Hour Bank will be frozen for a period of 18 months from the date of such employment. You will lose your Hour Bank if you do not return to work for a Contributing Employer within this 18 month period.

(iii) Armed Forces Exemption: Up to 1,000 hours of your Hour Bank will be reinstated for persons satisfying the condition of Section 10(f)(iii)

8. REINSTATEMENT:

After December 31, 1992: If you loose your coverage under the Plan for a period greater than 8 consecutive quarters then you must satisfy the Initial Eligibility Rules (item 3, part III) to again be eligible. If your loss of coverage under the Plan is for a period less than 8 consecutive quarters then you must only satisfy the Continuing Coverage requirements (item 4, part III) to again be eligible. Each employee previously insured under the plan, whose coverage has been terminated because of entry into the Armed Services, shall again become eligible for the insurance on the date of re-employment with a Contributing Employer, provided that such re-employment occurs within ninety (90) days after discharge from the armed Services or within ninety (90) days after release from the hospital, if hospitalized at the time of discharge from the Armed Services.

9. EFFECTIVE DATE OF YOUR COVERAGE:

You will become covered on the date you become eligible. However, if you are not at active work due to disability on the date you would otherwise become covered or your coverage would increase, you will not become covered or increase your coverage until the date you subsequently return to active full-time work.

10. TERMINATION DATE OF COVERAGE:

Coverage will terminate on the date of:

(a) Termination of the Plan;

(b) Your entry into Armed Services; but subject to the provision of Section 10(f)3(iii) below

(c) The last day of the Benefit Quarter if, (i) after as of any the 1st day of next Benefit Quarter you have been credited with less than 300 employment hours during the applicable Eligibility Quarter, Dependent Coverage will terminate simultaneously.

(d) If termination of an employee's coverage is due to his death, the coverage for his dependents will be continued until the end of the coverage period such employee had earned coverage at the date of his death.

(e) The coverage under the Plan of a retiree and the coverage of your eligible dependent spouse will terminate on the last day of any calendar month in which you become gainfully employed. You will be considered gainfully employed if you receive any wages, salaries, or commissions from any employer which causes your benefits under the terms of the Social Security Act to be reduced.

(f) As of March 1, 1988, eligibility for Health and Welfare Benefits is immediately terminated if an individual is unavailable for full time employment by contributing employers. A "Contributing Employer" is generally one who is required or permitted to make Contributions to the Health and Welfare Trust Fund pursuant to a collective bargaining agreement with Local Union 725. (The detailed definition of "Contributing Employer" in the Trust Agreement governs.) The following rules apply:

(1) The term "Unavailable for full time employment by contributing employers" includes, performing work in the craft covered by the ACRA-Local 725 Collective Bargaining Agreement for Non-Contributing Employers which are "Trade Employers." This includes all types of work covered by the ACRA Local 725 collective bargaining agreement or which could be performed by virtue of skills and training to perform such work, within the geographic area covered by the Health and Welfare Plan.

(2) A "Trade Employer" is a contractor as defined in the ACRA Local 725 Collective Bargaining Agreement or any party other than a Contributing Employer as defined in the Trust Agreement which at any time offers service of a nature described in subparagraph 1 above to the general public, and/or any persons other than itself;

(3) **Special Rules:**

(i) A person will not be considered unavailable for full time employment by Contributing Employers if his unavailability is due solely to:

(a) Continuous and total disability,

(b) Other medical conditions,

(c) Working under a reciprocal agreement,

(d) Retirement resulting in receiving benefits from the ACRA Local 725 Pension Plan, or

(e) Withdrawal from the trade and industry unless the withdrawee is offered employment with a Contributing Employer and refuses to accept same and it can be established that withdrawee has not, in the determination of the Trustees experienced a withdrawal. ("Withdrawal" means performing no work described in paragraph 1 above.)

(ii) Special Rules for performing work for non-contributing employers which are not "trade Employers." Work performed for an employer, other than a "trade employer" in the trade and/or geographic jurisdiction which is performed for that employer's own account and property (such as maintenance of its own buildings), will be considered work for a "Non Trade Employer." Such work will result only in loss of the right to use. "HOUR BANK" ELIGIBILITY TO CONTINUE COVERAGE UNDER THE PLAN AFTER THE END OF THE LAST BENEFIT QUARTER FOR WHICH HE EARNED ELIGIBILITY PERFORMING WORK DESCRIBED IN PARAGRAPH 1 ABOVE FOR A CONTRIBUTING EMPLOYER. COVERAGE WILL CONTINUE FOR THE BENEFIT QUARTER IN WHICH SUCH WORK IS PERFORMED BUT TERMINATED AT THE END OF IT. Hour Bank eligibility will be frozen from the date on which the individual commences performing work for the "Non Trade Employer". If the individual returns to performing work described in paragraph 1 hereof for a Contributing Employer their hour bank will be reinstated. If the individual does not return to performing work described in paragraph 1 for a Contributing Employer prior to the expiration of a 30 day period all accrued Hour Bank eligibility will terminate.

COBRA Continuation Coverage may be available under circumstance described in the rules governing COBRA Continuation Coverage. [See COBRA Notice and/or contact Core Management Resources regarding same.]

(4) Work performed not described in paragraph 1 above will result in eligibility being determined in accordance with the general rules of eligibility under the Plan.

(iii) If, after April 30, 1975, you fail to earn eligibility credits solely because of active service in the Armed Forces of the United States of America, you may retain your Hour Bank credits up to a maximum of 1,000 credit hours, provided you have given notice to your Employer of your "Active Military Service" pursuant to 38 U.S.C. Section

4312 prior to leaving for such active military service and your Employer notifies the Fund of your military service within 10 days of the receipt of your notice.

You must return to work under the Collective Bargaining Agreement with your same Employer or another Contributing Employer within 90 days of the date of your discharge from active military service or from the hospital if you where hospitalized at the time of your separation form the Armed Services. If you fail to return to such employment within the 90-day period, you will forfeit all of your earned credit and our Bank Credit unless you are unable to return to work with a Contributing Employer within the jurisdiction due to lack of work and you have reported to the Union and are qualified for referral by the Union for a period of 180 days.

11. **COBRA** continuation coverage:

A. Description of Coverage:

Federal law requires that the plan offer employees and their families the opportunity for a temporary extension of health coverage ("called continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. If you choose continuation coverage, the plan is required to give you coverage, which is identical to the coverage provided under the plan to similarly relief situated employees or family members.

(B) Eligibility:

1) Employee - A covered employee whose coverage is terminated due to a "qualifying event" shall be eligible to elect continuation coverage.

2) Dependents - A spouse, surviving spouse or a dependent child of a covered employee whose coverage terminated may also elect continuation coverage on their own behalf, even if the coverage employee who is terminated fails to elect continuation coverage.

(C) Qualifying Events - A "qualifying event" includes only the following described events which result in the loss of coverage:

1) The failure of the covered employee to be credited with the minimum required hours as a result of a reduction in hours of employment or termination of covered employment with contributing employers; or

2) Death of the covered employee; or

3) Divorce or legal separation of the covered employee; or

4) A dependent child ceasing to be covered dependent under this plan; or

5) Commencement of a bankruptcy proceeding under Chapter 11 of you U.S. Code by a former employer after retirement of the covered employee resulting in substantial elimination of any post retirement health benefits of such retired covered employee or spouse, surviving spouse and/or dependent child.

6) Special Armed Forces coverage for the afore described Qualifying Events, shall provide coverage for the following period:

(i) Coverage elected prior to December 10, 2004 shall be allowed for a period not to exceed 18 months commencing with the date of the occurrence.

(ii)Coverage elected after December 9, 2004 shall be allowed for a period not to exceed 24 months commencing with the date of the occurrence.

Note: Coverage will terminate the day after the date on which you fail to apply for or return to employment with employer as outlined and item 10 (f)3(iii) entitled Termination Date of Coverage in Part III of this booklet.

D) Notices:

1) Notice From Plan: The plan must provide to any Qualified Beneficiary, notice of such beneficiaries rights to Continuation Coverage and the manner of electing coverage, within 14 days of the date on which the Plan receives notice of the qualifying event as described in paragraphs (2) or (3) below, whichever is applicable. Any written notification to Qualified Beneficiary who is the spouse of a covered employee shall constitute notification to all other Qualified Beneficiaries residing with such spouse at the time such notification is made.

2) Notice from Employee: The Employer of any Covered Employee must notify the Plan of any Qualifying Event, which is:

a) The death of a covered employee, termination, or reduction of hours of covered employment or,

b) The commencement of a proceeding under Title 11, United States Code (relating to bankruptcy proceedings) affecting an employer from which employment a covered employee, retired at any time within 30 days of the commencement of such proceeding.

3) Notices From Employees, Spouse and Children: Each covered Employee or Qualified Beneficiary shall provide notice to the Plan of:

a) The name and address of the Covered Employee, Spouse and each Dependent Child of such Covered Employee, within 15 days of the date an individual becomes such a person;

b) Any change of address of the Covered Employee, Spouse or Dependent Child within 15 days of such change of address;

c) Any qualifying event which:

(i) Is the divorce or legal separation of Covered Employee from the Employee's Spouse or,

(ii) A Dependent Child ceasing to be a Dependent Child under the terms of this plan within seven (7) but no later than sixty (60) days of the occurrence of such event;

d) Any event which would terminate coverage by virtue of the Qualified Beneficiary becoming covered under another group plan, becoming eligible for Medicare benefits or a Dependent Child ceasing to be a Dependent Child under the terms of the plan; upon occurrence of such event.

e) Any disability determined under Title II or XVI of the Social Security Act at the time of a Qualifying Event defined in Section (C)(1) above within the eighteen (18) month period described in Section (a)(fi) below, and also within sixty (60) days after the date of determination;

f) Any termination of a disability described in (e) above within thirty (30) days after any final determination under Title II or XVI of the Social Security Act that said Qualified Beneficiary is no longer disabled.

4) Manner of Providing Notice: All notices must be written and shall be deemed made as follows:

a) **Notices by the Plan** shall be deemed made effective when actually delivered or when deposited in the US mails, postage free prepaid to the last address of the Covered Employee and or Qualifying Beneficiary as the case may be reflected on the records of the plan.

b) **Notices by Employers, Covered Employees and or Qualified Beneficiaries** shall be in writing and deemed effective only upon delivery or deposit in the US mails, postage prepaid, addressed to the Plan at its administrative office located at:

ACRA Local Union 725
Health and Welfare Plan c/o
Core Management Resources
P.O. Box 840
Macon, GA 31202

5) **Effect or Failure to Provide Notice.**

a) Failure to give Noticed by the Plan shall subject the Plan and/or the Trust Fund to the remedies provided by law. No party shall be entitled to seek any claim or penalty, any damages or other remedy except the specific right under the law to extend the time period within which the covered employee and/or qualified beneficiary may elect continuation coverage.

b) **Failure to Give Noticed by the Covered Employee or Qualified Beneficiary.**

(i) In the event of failure to give notice of names, addresses or changes of same, then any Notice given by the Plan to the Covered Employee, Spouse or Dependent Child as listed at the address set forth on the last statement received by the Plan shall be deemed effective and complete notice by the Plan of the contents of such notice to all Qualified Beneficiaries affected by such notice, and complete satisfaction by the Plan of all notice requirements under the Plan and COBRA.

(ii) In any case in which a covered employee or qualified beneficiaries obligated to give notice pursuant to Article (D)(3)(C) above, failure to do so within the 60 days of the date of the Qualifying Event shall result in forfeiture of the right to elect Continuation Coverage.

(iii) Failure to give Notice required under (D)(3)(c) and/or (d), and/or (e)(ii) hereof within seven (7) days of the event for which notice is required to be given shall entitle the Plan to recoup all sums paid to or on behalf of such beneficiary after loss of coverage, which it should not have paid for any reason. The Fund shall be entitled to recoup these sums from any party who received the benefit and/or any party legally responsible for medical expenses of such party and/or any party required to provide the notice. In addition to all other methods of recovery the Fund may collect the sums due buy deduction from any benefits payable to any party described above and/ or any of their covered beneficiaries or persons receiving benefits or coverage by, through or under such person.

c) Failure to give Noticed by the Employer, shall entitle the plan to recoup from the employee all costs, damages, penalties and liabilities which it incurs as a result thereof; including the full amount of the benefits and payments which the Plan must make to any qualified beneficiary or covered employee prior to the time Plan received notice from the employer. Failure to make payment of same within five (5) days demand by the Plan shall constitute a delinquency under the trust instrument.

6) **Rules of Construction**

The date for determining the obligation to provide notices of a Qualifying Event under these rules shall be the date of loss of coverage or the date of the actual Qualifying Event, whichever is later.

E) **Election of Continuation Coverage**

A person who is eligible to elect continuation coverage must:

1) Sign a written election on a form provided by the Board of Trustees;

2) The form must be received by the Fund Office not later than sixty (60) days after the person is

terminated from non-COBRA coverage under the Plan, or if later, sixty (60) days after the date the person was notified of their right to elect continuation coverage.

3) **Separate Election Allowed** - Each qualified beneficiary shall be entitled to separately elect continuation coverage in the event that another qualified beneficiary declines to let continuation coverage.

F) **Length of Continuation Coverage**

1) **18 Month Coverage** - Any person who is terminated due to a reduction of hours or termination of employment of the covered employee may be eligible to elect continuation coverage only up to eighteen (18) months from the date of termination of coverage.

2) **29 Month Coverage** - Any person who is determined to be disabled under the Social Security Act at the time of loss of coverage may be eligible to elect continuation coverage up to 29 months, provided that the person provides notice to the Plan of the Social Security disability determination within the first eighteen (18) months of coverage and also within sixty (60) days of the date that the determination from the Social Security Administration has been made.

3) **36 Month Coverage** - Any person who is terminated for any qualifying event other than a reduction of hours of the covered employee may be eligible to elect continuation coverage only up to thirty-six (36) months from the date of termination.

4) **Multiple Qualifying Event** - A divorced or surviving spouse or a former eligible dependent child who has a second qualifying event while already covered under Continuation Coverage may elect Continuation Coverage only for the balance of the thirty-six (36) month period from the earliest date of eligibility of Continuation Coverage.

5) **Coordination with Hour Bank Utilization**

A) If an individual was receiving coverage from the Plan by virtue of Hour Bank or Self-Pay Provision which coverage commenced prior to January 1, 1987 and during that period of time a Qualifying Event, then such Qualifying Event will entitle to qualified beneficiary to elect the Continuation Coverage hereunder but the period of coverage shall be measured, as if such subsequent Qualifying Event occurred on January 1, 1987 and thus continuation coverage may be exercised or elected only for the remaining portion of the Period of Coverage which would terminate either 18 months or 36 months in accordance with subparagraphs (1),(3) or (4)(iii) above, from the date on which said subsequent Qualifying Event is deemed to have occurred, (i.e. January 1, 1987) rather than the date of the actual occurrence.

B) If a Qualifying Event occurs after January 1, 1987 and the individual is entitled to continue to be covered by virtue of hour bank pay coverage, and elects to exhaust such coverage, such a period of Hour Bank coverage shall be deducted from the maximum Period of Coverage set forth under (1) through (4) above and such individuals shall be entitled to elect COBRA Continuation Coverage only for the maximum monthly duration of COBRA Continuation Coverage measured from the date of the Qualifying Event, then remaining after exhaustion of the period of Hour Bank coverage or self-pay coverage.

G) **Premium Cost**

1) **Determination of Applicable Premium**

The determination of the applicable premium for continuation coverage shall be made by the Board of Trustees on a plan year basis based upon the cost to the plan during the prior plan year, including, among other factors, cost of providing benefits, costs of administration, reserve for increased costs and expenses. The cost of continuation coverage shall be no more than 102% of the applicable premium, except in the case of disability Continuation Coverage, wherein the cost of Continuation Coverage shall be no more than 150% of the applicable premium for months of coverage 19 through 29. All participants covered under Continuation Coverage shall be promptly notified, in writing, of the premium cost in effect for that plan year. All persons under Continuation Coverage shall be required to pay the premium cost in effect for that plan year. The premium for continuation coverage may be paid in monthly installments at the option of the covered person.

H) **Premium Due Dates**

1) **Payment Required** - Except for the First Payment for Continuation Coverage, payment is due at the Fund Office on the first day of the coverage period. If the person elects to pay the premium in monthly installments, each month's installment is due at the Fund Office on the first day of each month.

2) **First Payment** - The payment must be received by the Fund Office no later than 45 days after the date the Fund Office timely receives the completed election form. If the person elects to pay monthly installments rather than the entire premium, then all installment payments due by the first payment date must also be paid with the first payment.

3) **Grace Period** - The Fund provides a 30 day grace period following the due date. This grace period does not apply to the first payment but only to the following premium payments.

I) **Early Termination of Coverage**

1) **Termination** - Continuation Coverage shall be terminated upon any of the following events:

a) Nonpayment of the first payment within 45 days after the date the Fund Office receives the completed election form;

b) Nonpayment of any premium after the initial premium, in full by the end of the grace period; or

c) The person becomes covered under another group health plan which does not contain any exclusion or limitation for a pre-existing condition in which the covered person may have; or

d) The person is entitled to Medicare Benefits; or

e) The Fund stops providing any group health plan to any employee; or

f) Failure to comply with the Plan's rules and regulations including eligibility rules; or

g) In the case of extended disability coverage when Social Security makes a final determination that the disability no longer exists.

h) Remaining employed in the trade and geographic jurisdiction of United Association Local 725 but becoming unavailable for full time employment by a contributing employer.

2) **Date of Termination** - Continuation Coverage shall immediately cease without notice on the date of occurrence of any of the above described events, except

a) In the case of (1)(b) above, in which event continuation coverage shall cease on the first day of the month that begins more than 30 days after the date final determination that the person is no longer disabled.

b) In the case of 1(a) above in which case coverage would terminate retroactive to the first day of the first insurance period.

3) **No Right of Reinstatement**, There shall be no right of reinstatement after early termination.

j) **Conversion Option**

1) No conversion option shall be available to any person covered under Continuation Coverage unless such right of conversion to an individual enrollment is otherwise available to all other participants.

k) **Definitions**

1) **Spouse** - A spouse must be married to the covered employee as of the day before the occurrence of the qualifying event for the employee.

2) **Dependent Child** - A dependent child must be a dependent child, as defined in this plan, as of the day before the occurrence of the qualifying event for the employee.

3) **Core Coverage** - Core coverage means all the coverage other than dental and vision benefits that a qualified beneficiary was receiving under the Plan immediately prior to the qualifying event.

4) **Non-Core Coverage** - Non-Core Coverage means coverage for vision benefits and dental benefits.

l) **Benefits Provided**

1) **Election of Core and Non-Core Coverage** - Any person electing Continuation Coverage shall be entitled to elect: (a) core benefits only or (b) core and non-core benefits in the event that the applicable premium for core benefits is less than 95% of the applicable premium for core benefits and non-core benefits combined.

2) **Changes In Benefits** Any amendment to the Plan of Benefits adopted by the Board of Trustees and applicable to active employees modifying coverage shall also apply to any person eligible under continuation coverage.

M) **Effects of Certain Incapacities** - If any adult (i.e. 18 years of age or older) who is eligible for COBRA Continuation Coverage has been determined by a court of competent jurisdiction to be incapacitated or incompetent, as of a date prior to the expiration of any applicable Election Period, Payment Period and/or Grace Period or a personal representative or legal guardian has been appointed for their affairs, as of a date prior to the expiration of any applicable Election Period, Payment period, and or Grace period then:

1) Notice of the nature of such incompetency, copy of the court order of incompetency and/or appointing the personal representative or guardian, and name and address of the guardian must be delivered in writing to the plan within 10 days of the order of incompetency appointing such personal representative or guardian;

2) The forms and instructions shall be forwarded to such guardian, and.

3) The personal representative or guardian must file the necessary election within the number of days after entry of the court order equal to:

A) The number of days remaining in the applicable Election Payment or Grace Period, plus.

B) The number of days in the Period commencing on the date of incompetency established by the court order and ending on the date of the court's order.

4) The period for making the election shall recommence the day after the appointment of the personal representative, or guardian.

12. DETERMINATION OF COVERAGE AND BENEFITS:

A) Eligibility, coverage and benefits are determined solely on the basis of the Plan documents, and the applicable rules, regulations and procedures of the Trust Funds. All determinations of eligibility and benefits are based on the precise facts and any particular circumstances including the data on hand with the trust fund, such as employment history, and contribution history. Final determination will be provided to each Participant in writing.

B) No oral representatives are binding on the Trust Fund. **No oral representation, confirmation, or explanation of** coverage and/or benefits given by any person whatsoever are binding upon the Trust Fund. From time to time certain general descriptions of coverage and/or benefits may be provided strictly as a courtesy accommodation to participants beneficiaries and/or service providers but they are not to be considered final determination of whether an individual is eligible, covered or whether a particular service will be paid for by the Trust Fund, but merely general information. Final determinations of coverage and benefits are made only upon full adjustment of written claims, full-proof of claims and evaluation of all relevant data in the hands of the Trust Fund. Final determinations, explanation, confirmation, and/or reports may be relied on by any person whatsoever.

13) SUPPLEMENTAL SELF-PAY COVERAGE:

As of January 1, 1983, the Board of Trustees adopted additional Plan provisions which would allow certain persons to continue their Health Coverage after they have exhausted all other Coverage under the Plan. This is entitled "Supplemental Self-Pay Coverage." The conditions are set forth below.

A) Description of Supplemental Self-Pay Coverage.

An individual's Supplemental Self-Pay Coverage shall be the same coverage as provided under the Plan for then current employees and family members of the same class as the Participant and Participant's Eligible Dependents. However, Supplemental Self-Pay Coverage shall not include the Life Insurance Coverage, Accidental Death Coverage, Dismemberment Coverage, Disability Coverage, or Retiree Coverage. It shall not provide any Beneficiary Coverage except as described below.

B) Persons Eligible to Elect Supplemental Self-Pay Eligibility.

The following persons may elect Supplemental Self-pay Coverage.

1) **Election by Participant** Any participant may elect Supplemental Self-Pay Coverage provided that:

a) The participant was covered under the Plan by virtue of employer contributions being paid on their behalf for a period of not less than five (5) years; as

(i) A Bargaining Unit Participant, or

(ii) A Non-Bargaining Unit Participant whose coverage under the Plan was terminated for a reason other than violation of the Participation Agreement under which the Non-Bargaining Unit Participant was covered; and

b) The Participant has used and exhausted all other coverage available under the Plan, (without any default or any early termination by virtue of Participant's failure to comply with all requirements to continue said coverage, for its maximum duration.) This includes (but is not limited) to Coverage based on current contributions by Employers, Hour bank coverage and having been eligible for, elected and paid for all COBRA Continuation Coverage for the maximum of time permitted under the Plan.

2) ELECTION BY CERTAIN DEPENDANT

If a participant satisfies all of the requirements of subparagraph (1) above except the requirements of paragraphs 1(b) for the reason that Participant is disabled under the Social Security Act and/or eligible for Medicare benefits, then the Eligible Dependents of that participant may elect Supplemental Self-Pay Coverage under the following conditions:

a) If the Participant is married, then the election must be made by the spouse and may cover either the spouse only, or the spouse and all of such Participant's Eligible Dependents;

b) If said Participant is not married, but nonetheless has Eligible Dependents, (such as dependent children), those eligible dependents may elect Supplemental Self-Pay Coverage for such Eligible Dependents, provided that such election covers all such Eligible Dependents;

c) The period of Coverage for such Eligible Dependents described in paragraph (a) and/or (b) above shall be only the unused balance of the Coverage Period described in paragraph (J) below;

d) The spouse and/or other Eligible Dependents must have previously elected and exhausted all other Coverage available to them under this Plan (without any default by them, and without any early termination by virtue of any failure by the Participant, Spouse or an Eligible Dependent to comply with all requirements necessary to

continue that coverage in effect, for its maximum duration under the terms of this Plan);

e) The election must also comply with all other requirements of Supplemental Self-Pay Coverage.

C) PERSONS NOT ELIGIBLE TO ELECT SUPPLEMENTAL SELF-PAY ELIGIBILITY

Persons not eligible to elect supplemental include without limitation, spouse, (except as described in paragraph (B)(2) dependent children, or other beneficiaries and/or individuals described in plan provisions regarding disability, Armed Forces, Dependents of Deceased Employees, those eligible for Medicare.

D) PERSONS COVERED BY AN ELECTION

1) Election by Eligible Participant

Any Participant who is eligible to make an election under paragraph (B)(2) may elect to cover the Participant only, the Participant and Spouse only, or all of the Participants Eligible dependents. (Family coverage.)

(i) The Participants and dependents to be covered must be designated in the election (with such specificity and information as may be reasonably required by the Plan,) and

(ii) The appropriate premium must be paid for such Participant in the Covered Dependents in accordance with Section (G) below.

2) **Election by Others.** If the Participant is in the category described in paragraph (B)(2)(a) above, then:

a) Any Spouse who is eligible to make an election may elect to cover

(i) only such Spouse, or

(ii) Such Spouse and all of the Participant's Eligible Dependents (family coverage).

b) Any Participant who makes an election under paragraph (B)(2)(b) must elect to cover all of such Participant's Eligible Dependents (family coverage).

c) Any election under subparagraphs (a) or (b) must also:

(i) Designate the Dependents in the election (with such specificity and information as may be reasonably required by the Plan), and

(ii) Be accompanied by the appropriate premium to be paid for such Dependents.

E) Manner of Making Election

An election must be made in writing on forms approved by the Board of Trustees, and shall provide such information as the Plan may require, including the following, without limitation:

1) Name, address and Social Security number of:

a) Participant making such election,

b) Each eligible dependent to be covered by said election.

2) Date on which last coverage of said employee eligibility was terminated.

3) The reason for termination of said coverage.

4) In the event of an election under paragraph (B)(2) above, the basis of the election and reason for ineligibility of the Participant.

5) Payment of the premium described in paragraph gone below.

F) Time of Making Election

Each election must be made within 30 days after termination of the last coverage under which the individual was covered.

G) **Premium.** The Premium for Supplemental Self-Pay Coverage shall be determined semi-annually by the Board of Trustees to be effective January 1 and July 1 of each year, and must be paid as a condition precedent to any coverage and/or paying any benefits under these Supplemental Self-Pay Provisions.

1) **Payment of Premium.** The premium must be paid to the Board of Trustees and received at their Administrative Offices.

2) **Time of Payment.** The premium must be paid on the first day of each month. Failure to pay same on the first day of any month shall result in automatic termination of Supplemental Self-Pay Coverage. However, the initial premium for the initial period of coverage shall be made simultaneously with the election of supplemental self-pay coverage, and shall include all premiums which might be due commencing from the date of termination of the last coverage under which the individual as a Participant was covered through the last day of the calendar month in which the initial payment is made.

H) **Failure to Pay Premium.** In the event any premium is not received by the Plan on its due date, Supplemental Self-Pay Coverage shall be immediately terminated for the Participant and all beneficiaries covered under said elections. The term "payment received", means actual receipt by the Plan at the Plan's Administrative Offices set forth in this SPD.

I) **Notices From The Participants and/or Eligible Dependent.** The Participant and/or Eligible Dependents must advise the Plan immediately but not later than ten (10) days after the occurrence of the following:

1) Divorce of the Participant and Spouse;

2) Dependent Child ceasing to be a dependent child within the terms of the plan;

3) Coverage under any other health plan and/or health insurance, including without limitation, private insurance, any employer with the group plan, or Medicare;

4) Disability of the participant.

J) **Term and Duration of Coverage.**

Supplemental Self-Pay Coverage shall commence on the 1st day following the last day of all other Coverage under the Plan and terminate on the earliest of.

1) Thirty-six (36) months, (1,095) days from such commencement date;

2) Failure to pay any premium when due;

3) Upon divorce of the Participant from the Spouse (but only as to such spouse);

4) Upon a Dependent Child ceasing to be a Dependent Child (but termination shall occur only as to such Dependent Child);

5) Upon a Participant becoming disabled or Covered under any other Health Plan or insurance, as to the Participant and all Eligible Dependents; provided however that Eligible Dependents may independently elect Supplemental Self-Pay Coverage to the extent permitted by paragraph (B)(2);

6) Upon a Spouse or Dependent Child being covered under any other health plan by insurance, but termination shall occur only as to such Spouse and or Dependent Child;

7) Adoption of a resolution by the Board of Trustees terminating Self-Pay Coverage to all Participants applies to beneficiaries which resolution may be adopted no later than thirty (30) days prior to its effective date at any time by the Board of Trustees. For further information regarding Supplemental Self-Pay Coverage, contact or management resources.

14) AMENDMENT TO THE PLAN

The Trustees reserve the right to alter the plan and benefits and any rules and regulations of this Plan any time in accordance with the terms of the agreement and declaration of trust. Such amendments and alterations include, without limitation the right to eliminate totally and/or reduce any benefits, rights and election or other privilege or perogative of any beneficiary under this Plan, unless such termination and/or reduction is specifically prohibited by law.

15) PRE-EXISTING CONDITION LIMITATION

If the treatment is received for a condition within a three (3) month period immediately prior to an individual becoming eligible for coverage, benefits will not be provided for that particular condition until the earlier of:

a) If the individual has been eligible for coverage for a period of twelve (12) consecutive months from the effective date of coverage under this plan.

(i) This limitation will not apply to any previously eligible participant or dependent of such participant unless no contributions have been made in the participant's behalf to the Fund and/ or has not been eligible for benefits in accordance with the Rules of Eligibility for a period of eight (8) consecutive quarters.

(ii) This limitation does not apply to pre-existing pregnancy, newborns or children adopted or placed for adoption prior to attaining age 18 provided such child enrolled under the Plan within the first 30 days of birth, adoption or placement for adoption. Credit will also be given for each month prior creditable coverage you had before becoming eligible for this Plan provided there has not been more than 63 days time lapse between your previous coverage and your or your dependents eligibility under this Plan.

16) SCHEDULE OF BENEFITS

The Schedule of current benefits is provided in Schedule A at the back of this booklet begining on page 42 through 53. Please note the Schedule of Benefits may be amended from time to time.

MEDICARE COORDINATION OF BENEFITS

Coordination with Medicare is subject to regulations and guidelines published by the Federal Government. Regulations for Active employees and dependents covered under an employer sponsored and group health plan required the employer sponsored plan to pay first with Medicare secondary payor. There are special provisions apply to recipients of Medicare benefits due to End Stage Renal Disease and for participants covered under a Retiree Plan.

END STAGE RENAL DISEASE (ESRD)

Benefits shall be payable under the Plan without regard to employee's or dependent's entitlement to Medicare if the employee or dependent is entitled to Medicare as an ESRD beneficiary, and not more than 12 months has elapsed since the earliest of the following months:

a) The month in which the employee or dependent began a regular course of renal dialysis;

b) The month in which the employee or dependent received a Kidney transplant;

c) The month in which the employee or dependent was admitted to the hospital in anticipation of a kidney transplant that was performed within the next two months; or

d) The second month before the month in which the kidney transplant was performed, if performed more than two months after admission.

In no event will be total amount of benefits provided by the Plan, together with the amount of "like benefits" the eligible person receives or would be entitled to receive from Medicare, exceed the actual expense incurred.

"Medicare" means Title XVIII of the Social security Act of 1965 as amended.

"Like benefits" means services and supplies for which benefits would otherwise be payable under the Plan. In determining the amount of benefits payable, the Plan will consider only regular and customary expense as determined by the charges gently incurred in the particular geographical area concerned.

This Medicare Coordination of Benefits provision will be superseded and replace any other Coordination of Benefits or Non-Duplication of Benefits Provision contained in the Plan with respect to Medicare only.

EXTENDED BENEFITS PROVISION

If you or your Eligible Dependents coverage terminates, in accordance with the termination provisions of the Plan, coverage will continue beyond the day it would otherwise terminate if on the date of such termination.

If the above provisions are satisfied, those Covered Charges incurred within three months from the date of termination will be eligible for benefit payment, subject to the applicable maximum amounts and Plan provisions for which such individual was covered at the time coverage terminated.

The words "totally disabled", as used herein, shall mean with respect to an employee, that the employee is prevented, solely because of disease or accidental bodily injury, from engaging in his regular customary occupation, and with respect to an Eligible Dependent, that the Dependent is prevented, solely because of disease or accidental bodily injury, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

PART IV
COORDINATION WITH MEDICARE, (APPLICABLE TO CLASS 2 AND 3 AND THEIR DEPENDENTS)

In order to avoid payment of benefits in a total amount greater than the expenses incurred, the benefits payable under the group plan will be coordinated with the benefits payable under Medicare for same expenses. This means you will be reimbursed under the Medicare plan if there are any expenses remaining unpaid, you will be reimbursed for those expenses for which benefits are payable under the group plan. You will be considered to be insured under Part (a) and Part (b) of Medicare whether or not you have registered for Part (a) or enrolled for Part (b).

DEFINITIONS:

For the purpose of the plan:

1) The term "Physician" shall include, with respect to any particular medical care and services, any holder of a certificate of license authorizing such holder or licensee to perform the particular medical or surgical services.

2) The term "hospital" shall mean an institution which:

a) Is primary engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic services and therapeutic services for medical diagnosis, treatment and cure of injured, disabled, or sick persons, or (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

b) Maintains clinical records on all patients, and;

c) Has bylaws in effect with respect to its staff of physicians, and;

d) Has a requirement that every patient be under the care of a physician, and;

e) Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and;

f) Has in effect a hospital utilization review plan, and;

g) Is licensed pursuant to any state or agency of the state responsible for licensing hospitals, and;

h) Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

PART V
COORDINATION OF BENEFITS

Because of the growing number of group health plans and the increasing number of two-income families, more and more people are becoming covered under two group plans. There is nothing wrong with this, provided the benefits payable under all plans do not exceed the expenses incurred - that is, do not result in overpayment.

It has been found that duplicate coverage and overpayment tend to encourage unnecessary use of health services resulting in higher contribution rates needed for the same coverage. To remedy this condition, the industry has adopted a Coordination of Benefits Provision. The

Coordination of Benefits Provision for this plan is integrated with all other group health plans, but not with an individual's personal health insurance.

Under the Coordination of Benefits provision, if you or your eligible dependent is also covered under another plan, the total benefits received by any one patient in all plans combined may not amount to more than 100% of the allowable expenses.

Payments will be reduced only to the extent necessary to prevent an individual from making a profit on their group coverage, and to ensure that you and/or your eligible dependents have satisfied all conditions necessary under the terms of another plan to obtain full payment and/or reimbursement which is due under that plan. Therefore, if you fail to satisfy conditions to obtaining benefits other than under the other plan, then payments from this plan will be reduced to the same which would have been paid for this plan, if you have satisfied the conditions of by the other plan and have received payments from the other plan. You must report such duplicate health coverage on your claim forms which you submit to secure reimbursement of the medical expenses.

RULES FOR ORDER OF BENEFIT DETERMINATION

When duplicate coverage arises, the following rules will be applied to the Plan to establish the order of benefit determination.

1) The Plan that covers the person incurring the expense as an employee (rather than as a dependent) pays benefits first.

2) When this Plan and another Plan cover the same child as a Dependent of each of the child's parents, benefits of the Plan of the parent whose birthday occurs earlier in the calendar year are determined before for those of the Plan of the parent whose birthday occurs later in the calendar year, except in the case of a person for whom claim is made as a dependent child:

a) When the parents are legally separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with the custody of the child will be determined before the benefits of a plan which covers the child as a dependant of the parent without custody.

b) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers the child as a dependent of the stepparent, and the benefit of a plan which covers that child as a dependant of the stepparent will be determined before the benefits of a Plan which covers that child as a Dependent of the parent without custody.

If there is a court decree which could otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan, which covers the child as a Dependent child.

3) When this Plan covers the person incurring the expense as a laid off or retired employee or as an employee self-paying for continuation coverage and another Plan covers the person as an active employee (not laid off, retired or on continuation coverage), the other Plan pays benefits first. This rule applies identically to expenses incurred by this persons covered dependent.

4) When rules 1, 2 and 3 do not establish an order of benefits determination, a Plan, which has covered person for the longer period of time is the primary Plan and pays first.

DEFINITIONS

The terms used in this section are defined as follows:

1) "Plan" means any program or health, dental or vision benefits or services provided through any one or more of the following:

a) Insurance, whether on a group or blanket basis;

b) Service benefits, whether through a Hospital, medical service organization, Health Maintenance Organization or other party providing prepaid health, dental or related services, if provided through group or in connection with a group of remittance arrangement;

c) Any program of benefits or services provided through a school or other educational institution;

d) Any program of benefits or services provided through a government or required by statute, other than Medicare: or

e) Any program of benefits or services for individuals as a group, whether on an insured or uninsured basis; or

f) No-Fault Automobile Insurance as used herein refers to that coverage required by Florida Automobile Reparation Act under which "personal injury protection" (PIP) Benefits are paid or payable irrespective of whether such was in effect at the time of loss. The maximum PIP coverage level recognized by the plan shall be $10,000 and only eligible expenses in excess of this amount or such other maximum amount of PIP Coverage designated by Florida Law be considered. It shall also be assumed the PIP benefit is first dollar coverage with no deductible.

2) "Allowable expenses" means any necessary, reasonable and customary item of expense, which is covered, wholly or partially, under at least one of the Plans covering the person for whom claim is made. The reasonable cash value of any benefit provided in the form of a service is considered both an Allowable Expense and a Benefit Paid.

Allowable expenses include expenses, which would have been paid by another plan if all conditions of that plan had been satisfied. Therefore if an item was allowable expense under another plan, but was not paid because you or your beneficiary failed to satisfy condition of that plan, and it will not be paid under this plan.

3) "Benefits payable" means the benefits that would have been payable if claim for such benefits have been made under any Plan and the terms, provision, conditions and requirements of said plan for payments of such benefits were fully complied with and satisfied.

Compliance with terms of other plan is a condition to the payment of benefits under this plan. In any case in which an injury or illness may be covered both under this Plan and/or any other Plan as defined in paragraph 1 above, then no benefits will be payable under this Plan, which are described under the Scheduled of Benefits of the other Plan and would have been payable by the other Plan in accordance with this Coordination of Benefits Section. Such benefits would not be paid by this Plan even if they were not paid by the other Plan for any reason including the assertion that the Participant or Beneficiary failed to comply with the other Plan's requirements for payment of benefits.

Example: Assume an individual is covered under another Group Plan, which is a Health Maintenance Organization with a limited panel of providers. The other Plan is primary. The individual becomes ill on a non-emergency basis and receives medical treatment from a doctor who is not included in the panel of service providers appointed by the HMO. The other plan refuses to pay the doctors fees because the individual did not seek treatment from a service provider, who was included in the panel. The individual then applies to this Plan to pay for that doctors fees. This Plan will not pay that benefit because the individual had failed to comply with the terms of provisions of the other Plan, which was primary.

PART VI
REIMBURSEMENT AND SUBROGATION:

As a condition precedent for the receipt of benefits under this plan, the covered person agrees by the acceptance and/or receipt of benefits, payments, services and/or credits (hereafter collectively called "benefits") from the Plan and Trust Fund (whether by direct receipt or by receipt by any other party on behalf of the Covered Person) that:

a) In the case of any illness, injury or other physical condition, for which third party may be liable or for which reimbursement is sought from third-party the Plan has, to the extent of Benefits paid under the Plan, the right of reimbursement from the Covered Person in an amount equal to one hundred percent (100%), [but reduced to seventy percent (70%) for injuries incurred after November 1, 1990 but before November 1, 2005] of any sums recovered by, and/or sums of money payable to, the Covered Person, their Spouse, Heirs, Personal Representative, Successors or assigns (hereafter collectively called Covered Party) through suite, settlement or otherwise from any Third Party, including without limitation, any insurance carrier. The terms of "Sums Recovered" means the gross amount received from all Third Parties before deduction of costs and attorney's fees, even if a lesser sum and/or no part of said sums is allocated to, attributable to and/or designated as payment for medical benefits, including without limitation any insurance carrier, due to the illness or injury for which Benefits are claimed. For purposes here in the term "Insurance Carrier" includes insurance of any third party and/or insurance of the Covered Party including uninsured motorist insurance, Worker's Compensation carrier or fund, and/or homeowners insurance of the Covered Party, and/or any other person against whom and/or buy through or under whom the Covered Party may have and/or may assert a claim. This right includes Subrogation against any such Third Party, but the right of Subrogation is in addition to and not in lieu of the Right of Reimbursement.

b) As a further condition precedent to the Receipt of Benefits, such Covered party Shall execute and deliver and cause their counsel, if any, to execute and deliver to the Plan such Agreements (including, without limitation, the Plans then current Reimbursement Agreement) and/or other documents as the Trustees may require to evidence, secure, confirm and/or perfect rights of the Plan under this provision, including pleadings in any pending judicial and/or quasi judicial proceedings. The Covered Party further agrees to notify the Plan of any claim or legal action asserted against any Third Party, identify any insurance carrier against which any claim may exist and/or be asserted for such injuries and to promptly notify the Plan of the name and address of such Third-Party including any insurance carrier. The Covered Party shall take no action inconsistent with the requirements of this provision, and shall fully corporate with the Plan in order to confirm and/or enforce its rights and liberties hereunder.

Failure of the Covered Party to execute and/or deliver any Agreement, or any document requested by the Plan hereunder, within one year from the date of occurrence of the injury or onset of the illness or physical conditions, or any other failure to comply with the terms of this provision shall constitute a breach of the Plan and Trust by the Covered Party, entitling the Trustees to all remedies available under the Trust Plan and/or applicable law, including without limitation a ruling that no Benefits shall be payable by the Plan to and/or on behalf of such Covered Party, and reimbursement of all attorneys fees and other costs incurred in enforcing this provision.

This provision is in addition to and not in lieu of any Coordination of Benefits provision of this Plan.

For purposes of this provision "Covered Party" includes all family members, guardians, personal representatives, successors and assigns of the Covered Party.

The term "Covered Party" includes the term "Covered Person" where ever used in this document the Plan and/or the Reimbursement Agreement.

1) Th Plan requires a form of Reimbursement Agreement to be executed by the Covered Party and all other necessary Parties, as determined by the Trust, which form of Agreement and other required documents:

1) may be amended from time to time by the Board of Trustees in their discretion, in order to accomplish the purposes of this provision, and
2) after October 24, 2007, must be filed with the Trust within 365 days from the date on which the injury occurred or the illness commenced.

EXAMPLE 1:

A Covered Party is injured in an automobile accident for which he claims third party is at fault. He seeks recovery against the third party for personal injury, pain and suffering, loss of work. He also applies to the appropriate Health and Welfare Trust Fund for payment of medical bills incurred in the injury. However, he refuses to execute a Reimbursement/Subrogation Agreement required to be executed by the Trust Fund. Under these circumstances, his claim would not be processed by the Trust Fund until the appropriate agreements are signed and delivered to the Trust Fund by the covered party. This would apply regardless of whether or not the covered party had filed a lawsuit or legal proceeding against the driver of the other core.

EXAMPLE 2:

The same facts as above, except that the Covered Party and the Covered Party's spouse jointly filed a lawsuit. The Covered Party executes the agreements, but the spouse refuses to do so. The application for benefits from the trust fund would not be processed until the spouse also executed the agreement.

EXAMPLE 3:

The same facts in example 1, except that the Covered Party is in the minor child of participant. The minor child agrees to execute the Agreement but one or more parents as legal guardians refuses to execute the agreement. The application for benefits would not be processed until the guardians of the covered party executed the Agreement.

EXAMPLE 4:

The same circumstances as example 1 except that the driver of the other vehicle was uninsured. The covered party files a claim against his own insurance company under an Uninsured Motor Vehicle Provision. The covered party refuses to execute a Reimbursement/Subrogation Agreement with respect to its own uninsured motor vehicle coverage. Until such agreement is executed, the application for benefits would not be processed.

EXAMPLE 5:

Same facts as example 1. The Covered Party and all necessary parties execute the Agreement but refused to execute a lien in the court file on a lawsuit filed against the drive of the other vehicle. In these circumstances all future benefits would be suspended pending execution of the necessary court documents and the Trust Fund would be entitled to recover all prior or sums previously paid in connection with the incident. Upon executing such documents and filing in the court file, payments would resume.

EXAMPLE 6:

Lawsuit is filed against the third person for the benefits and the covered party has executed all necessary documents so that the Trust Fund has paid medical benefits. And judgment is entered against the driver of the other vehicle for one hundred thousand dollars ($100,000.00) for personal injuries and lost wages and pain and suffering only. The award is made for medical reimbursement because the state in question has a "Collateral Source Rule" which prohibits recovery for benefits where benefits have been paid by a party other than the injured individual. No award is made for attorneys fees (on a contingency or other basis.) The Covered Party

has agreed to pay total attorney's fees and court costs paid by the plaintiff, total twenty five thousand dollars ($25,000.00). The medical expenses paid by the Health and Welfare Trust Fund totaled fifty thousand dollars ($50,000.00). The Trust Fund receives its fifty thousand dollars ($50,000.00) before any sums are paid to the attorney for the plaintiff, or the plaintiff.

EXAMPLE 7:

Same facts as example 6, except the judgment against the other driver is forty thousand dollars ($40,000.00). The trust fund would receive the entire forty thousand dollars ($40,000.00) for any injury or illness occurring prior to November 1, 1990. For any injury or illness occurring after November 1, 1990 but before November 1, 2005 the amount of reimbursement for which the fund is entitled to seventy percent (70%).

Thus the amount that the trust fund would receive in example 7 is twenty eight thousand dollars ($28,000.00), seventy percent (70%) of forty thousand dollars ($40,000.00). The amount of the Trust Fund would receive in example 6 remains unchanged, even if the illness or injury occurred on after November 1, 1990 because the amount of medical expenses paid by the Trust Fund in example fifty thousand dollars ($50,000.00) is less than seventy percent (70%) of the total one hundred thousand dollars ($100,000.00) award ($100,000.00 times 70% is equal to $70,000.00)

EXAMPLE 8:

Same facts as example 6, except the judgment against the other driver is forty thousand dollars ($40,000.00). The Trust Fund would receive the entire forty thousand dollars ($40,000.00) for any injury or illness occurring after the November 1, 2005.

EXAMPLE 9:

Same facts as example 1, but the Covered Party does not seek recovery from the Third Party. A reimbursement agreement must, nonetheless be executed, prior to payment of any claim, because the Fund has the right to pursue the claim directly, or through the Covered Party under its right of some ordination.

EXAMPLE 10:

Same facts as in all above examples, except that a Reimbursement Agreement and other required documents, executed by the Covered Party and all other necessary parties, is not delivered to the Trust within 365 days of the date of the Injury. (For example, the injury occurred on January 2, 2008 and the Reimbursement Agreement and/or required documents are not delivered to the Trust until January 2, 2009). All benefits for or related to that injury are forever barred.

PART VII
CHANGE IN FAMILY STATUS

It is important that you give prompt written notice to the Fund Office of any change in your family status such as marriage or divorce, birth of a child, the marriage of any of your enrolled children, or death of any dependent.

If you are unmarried and subsequently marry or otherwise acquire a dependent, dependent coverage will become effective on the date you aquire the dependent, provided you notify the Administration Office of the change in status.

PART VIII
ERRORS IN BENEFIT PAYMENTS

The Trustees specifically retained the right to recover all monies paid in error to, or on behalf of any person, from such person. Upon the discovery of a payment "made in error", the Trustees shall notify the recipient or beneficiary of such payment, indicating the circumstances and amount of such payment, together with a request for repayment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as may be necessary, or in the case of up to a participant of the fund, the amount of the payment made an error may be deducted from any future benefit payments at such participants or his dependents or beneficiary may become entitled to under this plan.

PART IX
EXAMINATIONS:

The Trustees, at their expense, shall have the right and opportunity to have any participant or dependent examined when and as often as may be reasonably required during the pendency of a claim hereunder. Failure without reasonable cause to report to the Physician designated by the Trustees after notice to do so, may at the Trustee's discretion, disqualify a claimant for further benefit payments.

PART X
FRAUD

Any person attempting to submit false, misleading or incomplete information, or who in any way attempt to defraud the Fund may be prosecuted in such manner as the Trustees deemed advisable.

PART XI
TRUSTEES RIGHT TO AMEND THE PLAN

The Trustees reserve the right to alter the Plan of Benefits of the Rules and Regulations of this Plan any time, in accordance with the terms of the

Agreement and Declaration of Trust. Such amendments and alterations include, without limitation the right to eliminate totally and/or reduce any benefits, rights, elections, or other privileges or prerogative of any beneficiary under this Plan, unless such termination and/or reduction is specifically prohibited by law.

PART XII
FACILITY OF PAYMENT

If a covered person is, in the opinion of the Trustees, legally capable of giving valid receipt for any past due him, the trust reserve the right, in the absence of the appointment of a legal guardian, to make payment to the party, who, in its opinion, is entitled to such payment. Payments so made shall discharge in the Plan obligations, with respect to the amount so paid.

If a beneficiary is designated, the consent of the Beneficiary shall not be required to change the Beneficiary, or to make other changes in the Fund records, except as may be specifically provided by the Trustees. If any Beneficiary shall die before the employee, the interest of such Beneficiary shall automatically terminate. If there is no beneficiary designated by the Covered Person or surviving at the death of the covered employee, payment will be made in a single sum to the first surviving class of the covered employee (a) widow or widower; (b) surviving children; (c) surviving parents; (d) surviving brothers or sisters; (e) executors or administrators.

PART XIII
GENERAL LIMITATIONS

Any bodily injury or sickness that is self-inflicted while sane or insane. An injury or illness Shall be deemed "self inflicted" if it would otherwise be deemed "self-inflicted" even though the individual was deemed to be temporarily or permanently insane or to otherwise have been lacking in mental, intellectual or emotional capacity of any kind, including without limitation to the capacity to form an intent or to comprehend the consequences of any action or non-action on their part.

Any bodily injury or sickness, which is the result of the insured's commission of a crime.

Any bodily injury or sickness, which is the result of your occupation or job. Occupational injury or illness normally covered under Worker's Compensation Law is in effect or is adequate to pay the expense of such injury or illness. However, certain temporary non-permanent benefits may be payable under certain very limited circumstances and conditions, including, without limitation, compliance with the Reimbursement and Subrogation Provisions described under Article IV with respect to some Asbestosis cases.

Experimental surgery or therapy, drugs, procedures, treatment or other services are not covered under the plan. "Experimental" means those procedures, surgery, drugs, treatment or services which are defined as experimental by the American Medical Association.

PART XIV
BENEFITS NOT ASSIGNABLE

This Plan is considered a Spendthrift Trust under Florida law; except as provided hereunder, the right of any person under this Health and Welfare Plan shall not be subject to assignment, and alienation or voluntary or involuntary transfer, and to the fullest extent permitted by law, shall not be subject to attachment, execution, garnishment, sequestrian or other legal or equitable process. However, benefits payable for expenses incurred in connection with a specific period of disability, hospital care or surgical for medical treatment, resulting from one injury or period of sickness may be assigned only to the institution or individual furnishing the respective services or supplies for which such benefits are payable.

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

PART XV
HOW TO OBTAIN THE PLAN HOSPITAL/ MEDICAL BENEFITS

Your trustees have enlisted the services of the Blue Cross and Blue Shield of Florida. The Blue Choice preferred provider organization. The Blue Choice Preferred Provider networks include hospitals and other service providers who have agreed to pre-negotiated charges which reflect significant discounts. By choosing a participating provider, you can save money and still receive the medical care you need without sacrificing quality. Here are a few suggestions that will help you get the most out of your benefit program and at the same time help assure prompt payment of your claims:

1) When you have advance knowledge that you or one of your eligible dependents is going to require hospitalization or other medical services, you should check to see if the hospital or service provider participating in the Blue Choice PPO program. You can call the de-BCBS customer

service Center at 1-800-328-7091 or log onto their website at www.BCBSFL.com and click on the myblueservice.

2) Before receiving services, if possible, always check to be certain that the service provider is in the Blue Choice PPO Network. Service of a non-PPO provider are paid at a much lower coinsurance rate thus your costs are much higher. As an example, a number of anesthesiologists do not participate in the PPO even though the Hospital and your surgeon might participate.

3) Always review all charges made by the hospital and service provider for accuracy.

4) Before signing any claim form, be certain you are signing the correct location. There are two places to sign:

a) Authorization to Release Information - this section of the form should always be signed by the patient;

b) Authorization to Pay Benefits - do not sign this section of the form unless you wish the Fund to pay benefits directly to the service provider;

c) Time limit for submission for proof of loss - you must furnish the Fund proof of loss within ninety (90) days after the date of the loss, if reasonably possible. However, in no event will claims delayed in excess of 12 months be accepted or payable.

5) Dental claims and weekly disability claim should be sent to core Management Resources Group, Inc. at P.O. Box 840, Macon, GA 31202. You may obtain claim forms by calling the Fund office at toll free 1-888-741-2673;

PART XVI
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE UNDERWRITTEN BY: AETNA LIFE INSURANCE COMPANY

Important Notice: This portion of this summary plan description has been prepared by Aetna Life Insurance Company. It describes the life insurance and accidental death and dismemberment benefits, which have been purchased by the Acra Local 725 Health and Welfare Trust Fund for eligible employees. These benefits are paid directly by Aetna Life Insurance Company. The only sums paid by ACRA Local 725 Health and Welfare Trust Fund are insurance premiums to make this benefit available. Therefore this certificate and the remaining pages of this summary plan description contain provisions (which include various legal information, time requirements, definitions), and use certain terms which have meanings that are different from the meanings of the same or similar provisions and terms as used in the prior portions of this summary plan description. Therefore the following provisions in terms are not applicable to any of the benefits or the same or similar provision and/or terms as described in the prior pages of this summary plan description. These include provisions in terms as to "Plan", "Legal Actions", etc. None of the provisions and/or terms, set forth in the summary plan description, can be relied upon or used by anyone to make any determinations regarding the meaning of the same or similar provisions and/or terms or benefits provided for in the prior pages of this summary plan description. You must rely on the terms used on the prior portions of the booklet for the menu of the provisions and/or terms, and benefits described in the prior portions of the summary plan description.

AETNA LIFE INSURANCE COMPANY, HARTFORD, CONNECTICUT

Policy Holder: The Trustees of the ACRA Local 725 Health and Welfare Trust Fund of Dade, Broward and Monroe counties, Florida

GROUP POLICY NUMBER:

GP — 861791.

EFFECTIVE DATE OF YOUR INSURANCE

The effective date of your insurance is subject to the Effective Date Provision and all other terms of this certificate. Certificate Rider Forms or other important papers relating to your insurance should be placed at the back of this certificate.

GENERAL NOTICE:

Certain provisions of the Group Policy of parts thereof are quoted and statements concerning same are made in this certificate. All provisions of the Group Policy, whether mentioned or not, apply to the insurance evidenced by this certificate. The Group Policy under which the certificate is issued may at any time be amended or ended in accordance with its terms without the consent of the employee or any other person who claims rights or benefits under the group policy.

NOT WORKER'S COMPENSATION INSURANCE

The insurance afforded by the Group Policy is not in place of, nor does it affect any requirements for coverage by Worker's Compensation Insurance.

AETNA LIFE INSURANCE COMPANY

This certificate describes the benefits in effect under this policy as of July 1, 2006.

INTRODUCTION

Your Trustees have chosen the benefits described in this booklet/certificate for many reasons. The

most important of these are to provide you (and your family) with significant financial protection against the emotional and economic strain injury or death can bring.

Please read this document carefully to familiarize yourself with the benefits it describes and procedures for filing claims. If you have any questions about your coverage, please contact the plan representative.

Please remember, benefits are payable only for covered losses incurred while insured under the plan, unless otherwise stated.

When used in this plan, unless otherwise stated, the terms are as defined in:

1) The General Definition Section, or
2) The Specific Benefits Section.

ELIGIBILITY

ELIGIBLE EMPLOYEES

You are in an eligible class for coverage under this Plan if you are an employee doing work for contributing Employers whose employment is the subject of the Collective Bargaining Agreement by and between the Employees and ACRA Local Union 725 of the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

You will be eligible for insurance under this Plan on the date you become eligible by satisfying the Rules of Eligibility (see page 12 titled when you become covered.)

WHEN COVERAGE BEGINS

Subject to the Effective Date Provision, your coverage will be made effective on the date you are eligible.

EFFECTIVE DATE PROVISION

The effective date of your coverage is subject to the following:

1) If you were not at work, (whether or not you were scheduled to work), due to an injury or illness, on the date before your coverage would first be made effective or increased:

a) None of your coverage will be made effective or increased until you return active to work on a full time basis.

WHEN COVERAGE ENDS

FOR EMPLOYEES

Your coverage will end on the date of the first of these events:

1) The date cease to qualify as an eligible employee.

2) The date your coverage ends in accordance with the hour bank requirements of the Plan.

3) As to any one coverage or class, the date the plan is amended or changed to exclude that coverage or class.

4) The date the group contact with Aetna is terminated.

The Fund Office will notify AETNA of the date your eligibility ceases for the purposes of termination of coverage under this Plan. The Fund Office will use the same role for all employees. If you are not at work on this date due to one of the following, eligibility may be deemed to continue up to the limits shown below.

If you are not work due to disease or injury:

- For Life Insurance, your eligibility will be continued for 6 months from the start of the absence. It may be further continued, but not beyond 12 months from the start of the absence.

- For all other coverage, your eligibility may be continued, but not beyond 12 months from the start of the absence.

If no eligible class of retired employees is shown, there is no coverage for retired employees.

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Fund Office to notify Aetna. This can be done by telling Aetna no or by stopping premium payments.

If you lose eligibility ask your Trustees if any coverage can be continued.

LIFE INSURANCE BENEFIT SCHEDULE EMPLOYEE ONLY INSURANCE COVERAGE

LIFE INSURANCE

If you die while you are covered for this benefit, the Plan will pay your beneficiary the benefit amount in force of the date of your death only after Aetna receives written proof at their Home Office of your death.

MANNER OF PAYMENT

The Plan will pay this benefit in a lump sum unless your beneficiary requests, on a form approved by Aetna, one of the optional payment methods. Your beneficiary must make this request within 90 days of your death.

BENEFICIARY

"Beneficiary" means the person you designate to receive your life insurance benefit. You can name or change your beneficiary at any time by sending a written notice to Aetna's Home Office on a form they approve. If you name more than one

beneficiary, the Plan will pay the benefit in equal shares unless you indicate otherwise.

If the Plan pays the benefit before receiving the notice of a changing of beneficiary, the plan does not have to pay the benefit again. If your beneficiary dies before you do, the plan will pay the benefit to any remaining beneficiaries.

Unless you indicate otherwise, the plan will pay the benefit in the same proportion as was to be paid among your other beneficiaries. If you do not name a beneficiary, or if not beneficiary survives you, the plan will pay the benefit in this order to:

1) Your spouse, if living;

2) Your surviving children, in equal shares;

3) Your parents, in equal shares, or to the survivor;

4) Your estate.

The naming of a beneficiary under a policy issued or applied for under the Conversion Privilege shall be considered a change of beneficiary.

CONVERSION PRIVILEGE

You may apply for an individual life insurance policy if your insurance or any part of it ends because: (a)you cease to be an eligible employee or (b) you cease to be eligible for this benefit. Your amount of insurance which ceases may be converted to an individual life insurance policy.

Your converted policy may be any kind of individual policy then customarily being issued by Aetna for the amount being converted and for your age, (nearest birthday) on the date it will be issued, except a term policy or one with disability or other supplementary benefits.

When Life Insurance ceases because that part of the group contact discontinues as to your employee class, and insurance on the life of the person has been in force under the group contract for least 5 years in a row prior to such discontinuance, the amount that ceases less the amount of any group life insurance for which the person becomes eligible within 31 days of discontinuance may be converted to an individual policy. The maximum amount that can be converted by each person in any event is $10,000.

In order to convert, written application must be made for individual policy and the first premium must be paid on it within 31 days after cessation of insurance for any of the above reasons.

No evidence of insurability will be required.

The individual policy will become effective at the end of the 31st day period during which conversion is possible.

The premiums for the converted policy will be at Aetna's then customary rates for the same policy issue to any other person of the same class of risk and age at the time to converted policy is to become effective.

After an individual policy becomes effective for any person, that policy will be in exchange for all benefits and privileges under the group contract, as regards the person involved in the amount that could have been converted.

However, for insurance on your life, if it is later determined that you were totally disabled at the time premium payments for your Life Insurance ceased, you may be entitled certain rights described in the Life Insurance Benefits section.

LIFE INSURANCE AFTER TERMINATION

In most cases a person can apply for an individual policy under the conversion privilege within 31 days after his or her life insurance ceases. If a person dies during his 31 days and before the individual policy goes into effect, the amount payable under the group contract is limited to the maximum that could have been converted. This limit applies even if he or she has not applied for or paid the first premium on the individual policy.

A PERMANENT AND TOTAL DISABILITY FEATURE

If you are not able to work due to disease or injury, your life insurance, (but not Accidental Death and Personal Loss Coverage) may be extended if Aetna determines you are permanently and totally disabled. If the determination of permanent total disability is made, you will not have to make any further contributions for your coverage and no premium payments will be required from your Employer.

NOTE: YOU MUST APPLY DIRECTLY TO AETNA TO RECEIVE THIS BENEFIT. THE PLAN DOES NOT PAY OR FACILITATE THIS BENEFIT, AND NEITHER THE TRUST NOR THE FUND OFFICE PROVIDE ANY SERVICE OR INFORMATION TO AETNA, NOR COORDINATE THE APPLICATION, PROCESSING OR ANY MATTERS OR PROCEDURES REGARDING THIS BENEFIT. THEREFORE IT IS SOLELY YOUR RESPONSIBILITY TO ADVISE AETNA OF FACTS AND CIRCUMSTANCES WHICH MAY ENTITLE YOU TO THIS BENEFIT, AND APPLY FOR AND COMPLETE ALL PROCEDURES TO RECEIVE THIS BENEFIT.

You are permanently and totally disabled only if disease or injury stops you from working at:

- Your own job; or
- Any other job for pay or profit;

and it must continue to stop you from working any reasonable job.

A "reasonable job" is any job for pay or profit which you are, or may reasonably become, fitted for by education, training, or experience.

You must meet all of the following to be eligible:

- Your life insurance must be in force when you cease to work due to disease or injury.
- You must be under the age 60 when you cease active work.
- You must be absent from work for at least 9 consecutive months without interruption.

Aetna must receive your written notice of claim for this extension at its Home Office within 12 months from the date you cease active work. If your written notice is not received by Aetna within 12 months, you will not be eligible for this benefit extension. Upon receipt of your written notice, Aetna may require you to furnish proof of your permanent and total disability before approving your claim. If proof is required, you must furnish all proof when requested. Aetna also has the right to examine you at its expense before proving your claim.

This extended insurance will be the amount you were insured for on the date your total disability began. If a Reduction Rule for Life Insurance extended due to the Permanent and Total Disability is an effect on the date you become so disabled, this extended insurance will be reduced when you reach the age or ages set forth in the Age Reduction Rule.

This extension period will cease on the first to occur of:

- The date Aetna sends you a request that your last address shown on Aetna's records:
- For an exam, if you do not go for the exam within 31 days of that date.
- For proof that you are still permanently and totally disabled, if proof is not given within 31 days of that date.
- The date you are well enough to work in any reasonable job.
- The date you start work in any job prepare profit.

After insurance has been extended continuously for 2 years, Aetna will not request an exam or proof more often than once in a 12 month period.

When the extension period stops, you may be eligible to convert to an individual life insurance policy, as described in the "Conversion Privilege" section, as if your employment had ceased. However, if you become eligible for life insurance under any group policy within 31 days after the date of the extension period, the privilege is not allowed.

If you where insured for Accidental Death and Personal Loss Coverage, that coverage ends on the date this section applies your Life Insurance Coverage.

EXTENDED DEATH BENEFIT

If Aetna received proof, at its Home Office, that all of the following apply, it will pay your beneficiary the amount of Life Insurance, which may be extended under the Permanent and Total Disability Feature:

- Premium payments for your Life Insurance ceased before Aetna received your written notice of claim for the Life Insurance Extension.
- You died during the uninterrupted period of absence from active work.
- Death occurs no later than 12 months after the date you ceased active work with your employer.
- You would have qualified for extended insurance except that:

Your total disability had not lasted at least 9 consecutive months; or

The required proof has not yet been received or approved by Aetna.

Written notice of your death must be given to Aetna's Home Office within 12 months of your death. If it is not given, Aetna will not have to pay this benefit.

When Aetna approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of Aetna's obligations.

If any individual policy has been issued to you under the current Conversion Privilege, your rights under this section may be restored. In order to restore those rights, you must give up all such policies without claim, except for the return of the premiums you paid.

ACCELERATED DEATH BENEFIT

If, while covered under this Plan for Life Insurance, you become terminally ill, you may request that Aetna pay and Accelerated Death Benefit (herein called ADB). Upon Aetna's approval of any such request, Aetna will pay to you the amount of ADB; subject to all of the following terms:

A person is terminally ill if the person:

- Suffers from an incurable, progressive, and medically recognized disease or condition; and,
- To a reasonable medical probability and based on a generally accepted prognosis protocol, will

not survive more than the ADB months beyond the date of the request for an ADB.

You may request an ADB at any time by completing an Aetna request for Accelerated Death Benefit form and submitting it to Aetna. The request must include a statement of a currently license United States physician that you are terminally ill.

The physician statement must include:

- All medical test results;
- Laboratory reports; and
- Any other information on which the statement is based, including the generally accepted prognostic protocol used by the physician to determine your expected remaining lifespan.

Your request for an ADB must state the amount of the benefit requested. You must request as an ADB up to the ADB Percentage of the amount of Life Insurance then in force for you; but in no event may the requested amount of ADB be equal to:

- Less than the 18 being minimal; or
- more than the ADB maximum.

You may request an ADB under this plan only once.

If, by assignment or otherwise, someone other than you is the owner of your Life Insurance Coverage an ADB will not be available under this Plan for you.

If, during the ADB Months following the date of your request for an ADB, the amount of your life insurance would reduce due to the attainment of a special age or retirement, the ADB amount will be calculated by multiplying the percentage that you have requested by the amount of life insurance that would remain in effect after any reduction.

The amount of the ADB payable to you will be reduced by an interest charge equal to the sum of daily interest that would have accrued on such amount during ADB months, which begins on the date of the ADB is paid.

The interest rate used to calculate the interest charge will not exceed the current yield on 90-Day United States treasury bills on the date the ADB payment is requested. When your request for an ADB has been approved, the amount of life insurance then in force for you will be reduced by the amount of ADB that would have been payable in the absence of any interest charge. If your amount of Life Insurance has been so reduced, you will not be entitled to the conversion of Life Insurance for the amount of Life Insurance that ceases because of the reduction by the amount of the ADB.

In considering your request for an ADB, Aetna may require you, and at Aetna's expense, to submit to an independent medical exam by a physician chosen by Aetna. Aetna may suspend its review of a request for an ADB until the exam has been completed and the results submitted to Aetna.

Aetna may refuse your request for an ADB if:

- Prior to Aetna's receipt of approval of the request:
- The group contract terminates as to your Eligible Class (even though all or part of your Life Insurance Coverage continues for any reason); or
- The entire amount of your Life Insurance ceases under the group contract for any reason; or
- Prior to payment of the ADB, you die.

Upon approval by Aetna, the amount of ADB will be paid to you in a lump sum.

To the extent followed by the law:

- Any ADB paid to you is exempt from any illegal or equitable process for your debts; and
- You will not be required to request an ADB in order to satisfy claims of creditors.

If:

- Aetna has extended your Life Insurance under the terms of the Permanent and Total Disability Feature; and
- You have not previously requested and received an ADB;

You may apply for an ADB. All of the preceding terms of this ADB section will apply to any ADB requested while your Life Insurance is being extended under the terms of the Permanent and Total Disability Feature.

PART XVII
ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) SCHEDULE EMPLOYEE ONLY INSURANCE COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Maximum amount $30,000.00

This plan pays a benefit if, while insured, you suffer a bodily injury caused by an accident; and if, within 365 days after the accident and as a direct result of the injury, you lose:

- Your life.
- A hand, by actual severance at or above the wrist joint.
- A foot, by actual severance at or above the ankle joint.

• An eye involving irrecoverable and complete loss of sight in the eye.

• Your speech or hearing; the loss must be total and deemed permanent.

• Your thumb and index finger of the same hand, by actual severance of the entire digit.

• Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint above digits.

A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending physician states otherwise.

Loss of Life due to exposure or natural or chemical elements will be deemed to be accidental if the exposure was a direct result of an accident.

If:

• You disappear as a direct result of an accidental disappearance, wrecking, or sinking of the conveyance in which you were an occupant; and

• There is no contrary evidence about the circumstances of your disappearance within one year the accident;

your disappearance will be deemed an accidental death.

This Plan also pays a benefit if, while insured, you suffer a bodily injury in an accident and if, as a direct result of the accident, suffer a full thickness of third-degree burn caused by direct contact with a chemical, fire, steam, water or heat except sunburns or, within 30 days after the accident as a direct result of the injury, you are stricken with one of the following forms of paralysis:

• Quadriplegia - the entire in irrecoverable paralysis of both upper and lower limbs.

• Paraplegia - the entire and irrecoverable paralysis of both lower limbs.

• Hemiplegia - the entire and irrecoverable paralysis of the upper and lower limbs on one side of the body.

• Uniplegia - the entire and irrevocable paralysis of one limb.

A limb means the entire arm or leg.

BENEFIT

The full principal sum is payable for the loss of life.

The full principle, some is payable for loss of both hands, both feet, or both eyes.

The full principal sum is payable for loss of both hearing and speech.

The full principal sum is payable for quadriplegia.

The full principal sum is payable for third-degree burns covering 75% or more of the body.

Half the principal sum is payable for loss of either hearing or speech.

Half the principal sum is payable for loss of a hand, loss of a foot, or loss of an eye.

Half the principal sum is payable for paraplegia or hemiplegia.

Half the principal sum is payable for third-degree burns covering 50 to 74% of the body.

One quarter of the principal sum is payable for loss of the thumb and index finger of the same hand.

One quarter of the principal sum is payable for uniplegia.

No more than the full principal sum is payable for all losses listed above resulting from one accident.

TOTAL DISABILITY BENEFIT

If you become totally disabled as defined below because an accident of the type covered by this benefit section and that disability is continuous for the date of the accident to your death, Aetna will pay your beneficiary the amount of your Principal Sum if all of the following are true:

• You are not able to work at your own job.

• You are not able to work in any other job for pay or profit.

• You're under age 60 and the time of the accident.

• You die while your group policy is in effect your employer continues to make premium payments for your coverage.

If a death benefit is payable, it will be reduced by any other benefit, which is payable under this benefit section because the same accident.

Written notice of your death must be given to Aetna at its Home Office within 12 months of your death. If it is not given, Aetna will not have to pay this benefit.

ADDITIONAL ACCIDENTAL DEATH BENEFITS

The following benefits will be payable if while insured, a person suffers a bodily injury caused by an accident and if, within 365 days after the accident, he or she suffers a loss of life solely and as a direct result of the accident.

COMA BENEFIT

If, while insured, you suffer a bodily injury caused by an accident and if, within 30 days after the accident, you become comatose solely as a direct

result of the accident, Aetna will pay a monthly benefit on your behalf, provided you are continually comatose for at least 30 consecutive days.

Proof that you are comatose must be submitted to any Aetna no later than 60 days after the date you become comatose.

The first monthly benefit will be payable on the first day of the month following the day you have been continually comatose for at least 30 days.

The monthly benefit is the Coma Benefit Percentage less any benefit amount paid or payable under this benefit section for any loss you suffer as a direct result of a bodily injury caused by the same accident. The monthly benefit is payable for 11 months. The full principal sum less any benefit amount paid or payable under this benefit section because of the same accident will be payable after you have been continually comatose for 12 months.

No more than the full principal sum is payable for all losses resulting from the same as accident.

The monthly benefit is payable for as long as the Coma continues, until the earliest to occur of:

- failure to have any required exams;
- failure to give proof that the Coma continues;
- the date the full principal sum is paid under this benefit section;
- the date you are no longer comatose, by death, recovery, or any other change in condition, as certified by a physician; or
- Termination of the group policy.

Aetna will have the right to require proof of the continuation of the coma. Aetna, at its own expense, also has the right to examine you while the Coma continues. Aetna will not request an exam or proof more often than twice in a 12 month period. A physician's certification will be required before the final payment is made to your beneficiary.

Your monthly benefit is payable to your named beneficiary. No benefit will be payable if:

- No named beneficiary survives you; or
- No beneficiary has been named; and
- No immediate family member to whom the benefit may be paid, at Aetna's discretion, survives you.
- No immediate family member to whom the benefit may be paid, at Aetna's discretion survives you, immediate family members are: your spouse, your children, your parents, and your brothers and sisters.

If the monthly payments are less than $20 each, the payments will be paid in one lump sum on the first day of the month following the day you have been continually comatose for 12 months.

PASSENGER RESTRAINT AND AIRBAG BENEFIT

If the loss of life occurs solely and as a direct result of an accident involving a motor vehicle while this person:

- Is an occupant of the motor vehicle; and
- At the time of the accident, is properly using a passenger restraint; and
- if the driver has, at the time of the accident, a valid drivers license;

A Passenger Restraint Benefit will be payable if an airbag is also activated as a result of the same accident, and Airbag Benefit will be payable if the motor vehicle's airbag system is not effective in helping save person's life it was designed to protect. Verification of the actual use of the passenger restraint and activation of the airbag system, if applicable, at the time of the loss must be part of an official report of the accident or certified, in writing, by investigating officer.

No airbag benefit will be payable unless the Passenger Restraint Benefit is paid.

EDUCATION BENEFIT

Education Benefit for Your Dependent Child

If you suffer a loss of life solely and as a direct result of an accident, and Education Benefit is payable on behalf of each Dependent Child as defined below.

The Education Benefit will be payable in annual installments until the earliest to occur of:

- Four years from the date of your death; or
- The date no dependent qualifies as a dependent child, as defined below; or
- The date that satisfactory proof of dependent eligibility status is not provided to Aetna within 30 days of a request for it; or
- Discontinuance of the group policy.

The first education benefit will be paid:

- Your Principal Sum becomes payable; and
- Aetna receives written proof that the Dependent Child is attending school on a regular basis.

Education Benefits will be paid on each anniversary of the first education benefit, provided Aetna receives written proof that a Dependent Child is attending school on a regular basis.

A Dependent Child means a child who is:

- Your biological child; or

• Your adopted child; or

• Your stepchild; or

• Any other child you support them is with you in a parent-child relationship; and, for the purpose of this benefit, is an unmarried, full-time student and

• Is attending school, up to and including the 12th grade of high school; or

• Is under the age of 23, and

- Attending college or trade school on a regular basis at the time of your death; or

- In roles in a college or trade school within 365 days after the claim has been approved.

The Education Benefit will be payable to the Dependent Child if that child has attained the age of the majority. Otherwise, the Education Benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

Education Benefit For Your Spouse.

An Education Benefit will be paid to your surviving spouse for costs incurred, as a result of your death, towards employment training if your spouse has enrolled for the purpose of obtaining or supplementing an independent source of income. Written proof of your spouse's enrollment in an employment training program must be received within 365 days after the claim has been approved.

The education benefit will be payable in annual installments until the earliest to occur of:

• Four years from the date of your death; or

• the date that satisfactory proof of dependent eligibility status is not provided to Aetna within 30 days of a request for it; or

• Discontinuance of the group policy.

The first education benefit will be paid when:

• Your principal sum becomes payable: and

• Aetna receives written proof that your spouse is enrolled in an employment training program.

Education Benefits will be paid on each anniversary of the first Education Benefit provided Aetna receives written proof that your dependent spouse is enrolled in an employment training program.

The Education Benefit will be payable to your surviving spouse, regardless of the beneficiary for your Life Insurance amount.

CHILDCARE BENEFIT

If you suffer a loss of life solely and as a direct result of an accident, a Childcare Benefit may be payable with respect to any Dependent Child as defined below. If the Dependent Child is enrolled in a legally licensed childcare center, the childcare benefit is payable in annual installments until the earliest to occur of:

• Four years from the date of your death; or

• Mine the date no dependent qualifies as a dependent child, as defined below; or

• The date that satisfactory proof of dependent eligibility status is not provided to Aetna within 30 days of a request for it; or

• Discontinuance of the group policy.

The first childcare benefit will be paid when:

• Your principal sum becomes payable; and

• Aetna receives written proof that the dependent child is enrolled in a legally licensed childcare center.

Childcare Benefits will be paid on each anniversary of the Childcare Benefit, provided Aetna receives written proof that the dependent child is attending a legally licensed childcare center.

For purposes of this benefit, a Dependent Child means a child who is under age 13 and is enrolled in a legally licensed childcare center on the date of the accident or subsequently enrolled in a legally licensed child care center within 90 calendar days after the date the claim is approved and is either:

• Your biological child; or

• Your adopted child; or

• Your stepchild; or

• Any other child you support him is with you in a parent-child relationship.

The Childcare Benefit will be payable to the guardian of the estate of the minor, or the to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

REPATRIATION OF REMAINS BENEFIT

This plan pays a Repatriation of Remains Benefit for the actual expenses incurred to prepare a person's body for transportation to a mortuary, as a direct result of an accident for which a benefit is payable under this section, he or she suffers a loss of life while outside a 200 mile radius from his or her principal place of residence.

LIMITATIONS

This coverage is only for losses caused by accidents. No benefits are payable for loss caused or contributed by:

• A bodily or mentally infirmity.

• A disease, ptomaine, or bacterial infection.

• Medical or surgical treatment.

• Suicide or attempted suicide (while same or insane).

• An intentionally self-inflicted injury.

• A war or any act of war declared or not declared.

• Voluntary inhalation of poisonous gases.

• Commission of or attempt to commit a criminal act.

• Use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.

• Intended or accidental contact with nuclear or atomic energy by explosion and/or release.

• Air or space travel. This is not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo.)

* these do not apply if the loss is caused by:

• An infection which results directly from the injury.

• Surgery needed because of the injury.
The injury must not be one which is excluded by the terms of this section.

GENERAL INFORMATION FOR LIFE AND AD&D BENEFITS

ADDITIONAL PROVISIONS

The following additional provisions apply to your coverage.

• You cannot receive multiple coverage under this Plan because you are connected with more than one employer

• In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage of force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna. Your employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

ASSIGNMENTS

Life Insurance may be assigned with the consent of Aetna and Employer. All coverage may be assigned with only the written consent of Aetna.

CLAIMS OF CREDITORS

If allowed by law, Life Insurance and Accidental Death and Personal Loss Coverage Benefits are exempt from legal or equitable process for your debts. This also applies to the debts of your beneficiary.

REPORTING OF CLAIMS

A claim must be submitted to Aetna in writing. It must be a proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefit is 90 days after the date of the loss causing the claim. The deadline does not apply to Life Insurance.

If, through no fault of your own, you're not able to meet the deadline for filing claims, your claim will still be accepted if you file soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are followed more than one year after the deadline.

PAYMENT OF BENEFITS

Benefits will be paid as soon as the necessary proof to support the claim is received. For all benefits except any Temporary Disability Benefit, written proof must be provided. Any Death Benefit for your loss of life will be paid in one lump sum and in accordance with the beneficiary designation.

All other benefits are payable to you.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof. This paragraph does not apply Life Insurance.

If your beneficiary is a minor or, in Aetna's opinion, legally unable to give a valid release for payment of any Life Insurance Benefit, the benefit will be payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or adult caretaker, when permitted under applicable state law.

Aetna may pay up to $1000.00 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your state.

LEGAL ACTION DOES NOT APPLY TO LIFE INSURANCE

No action can be brought to recover under any benefit within 60 days after written proof of loss has been given. No such action may be brought

after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

Except in the case of fraud, no statement made by you or your employer shall avoid any coverage or reduce any benefits or be used in defense of a claim unless it is in writing.

Aetna will not try to reduce or deny a the benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than two years from the date coverage is commenced. This will not apply to conditions excluded from coverage on the date of the loss.

EFFECT OR PRIOR COVERAGE - TRANSFERRED BUSINESS

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior Coverage" is any plan of group coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage, if provided by another group contract or any benefits section of this Plan.

A person's Life Insurance under this Plan replaces and supersedes any prior Life Insurance. It will be in exchange for everything under the prior Life Insurance if you or your beneficiary become entitled to claim under the prior Life Insurance, your Life Insurance under this Plan will be canceled. This will be done as of its effective date. Any premiums paid for your Life Insurance Plan will be returned to your employer.

The mode of settlement you chose in the beneficiary you named under a prior Aetna Life Insurance Plan will apply to this Plan. This can be changed according to the terms of this Plan.

Coverage under any other section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

The beneficiary you named under a prior Aetna Accidental Death and Dismemberment Coverage Plan will be applied to this plan. This can change according to the terms of this Plan.

GLOSSARY TERMS FOR LIFE AND AD&D INSURANCE

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the glossary, the definition in the benefit section will apply in Lieu of the definition in the glossary.

AIRBAG

An airbag is:

- An unaltered airbag installed by the manufacturer of the motor vehicle; or
- An airbag provided by the manufacturer of the motor vehicle; and
- Installed by an authorized motor vehicle dealer.

Coma

This means the condition of being comatose.

Comatose

This means a profound state of unconsciousness from which the person cannot be aroused to consciousness, even by powerful stimulation, as certified by a physician.

LEGALLY LICENSED CHILD CARE CENTER

This is a facility which is duly licensed, certified, or accredited by the jurisdiction in which it is located to provide child care and is operating in compliance with applicable laws and regulations of the jurisdiction.

MOTOR VEHICLE

This is a vehicle that is a registered and licensed vehicle and is:

- A passenger land vehicle of pleasure design which includes autos, vans, four wheel drive vehicles, and self-propelled motorhomes; or
- A truck of commercial design.

For purposes of the Passenger Restraint in Airbag Benefit only, the following will not be considered to be a motor vehicle:

- A motor vehicle which has been altered and no longer meets the licensing and registration requirements; or
- A motorcycle; or
- An "ATV" all-terrain vehicle; or
- A military vehicle; or
- A vehicle while being used for farming or racing or any other type of competitive event.

PASSENGER RESTRAINT

This is a restraint that is:

- An unaltered seatbelt or lap and shoulder restraint installed by the manufacturer of the motor vehicle; or
- A seatbelt or lap and shoulder restraint;

provided by the manufacturer; and installed by an authorized motor vehicle dealer; and

• Any child restraint device, which is properly secured in the motor vehicle and meets the definition of the law of the state in the in which the motor vehicle is licensed and registered.

THIRD DEGREE BURN

A third degree burn or full thickness burn is the most severe of the three burns extending near or to the bone.

CLAIM PROCEDURES

Your booklet-certificate contains information reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

NOTE: If applicable state law not preempted by federal law requires the plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.

You may file claims for Plan Benefits, and appeal adverse claim decisions, either yourself or through an authorized representative, and

An "authorized representative" means your legal spouse or adult child, or person you authorize, in writing, to act on your behalf. In addition, the Plan will recognize a court order giving a person authority to submit claims on your behalf.

FILING LIFE CLAIMS UNDER THE PLAN

You'll be notified of an adverse benefit termination, not later than 90 days after the plans receipt of the claim. This plan period maybe extended up to an additional 90 days to special circumstances. In that case, you will be notified of the extension before the end of the initial 90-day period. Notice of the extension will explain the special circumstances requiring the extension and the date by which the decision is expected.

FILING PREMIUM WAIVER, DBO OR DPO-AID CLAIMS UNDER THE PLAN

You will be notified of an adverse benefit determination not later than 45 days after the Plan's receipt of the claim. This time period may be extended up to an additional 30 days due to circumstances outside the Plan control. In that case, you will be notified of the extension before the end of the initial 45-day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the Plans control, the time period maybe extended up to an additional 30 days, in which case you will be notified before the end of the first 30 day extension period. Notice of the extension will explain the special circumstances requiring the extension and the date by which the decision is expected.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and review procedure.

FOLLOWING AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

LIFE CLAIMS

You may request a review of the denial claim. You will have 60 days following receipt of an adverse benefit decision to appeal the decision. The request must be submitted, in writing, and include your reasons for requesting the review. Submit your request to the office of the Aetna Life Insurance company to which you submitted your initial request for benefit payment. You will be notified of the decision not later than 60 days after the appeal is received. If an extension of time for processing the appeal is needed, the time period maybe extended up to an additional 60 days, in which case you will be notified prior to the end of the first 60 day period. The notice will indicate the special circumstances requiring an extension and the date by which the decision is expected.

PREMIUM WAIVER, DBO OR DPO-AID CLAIMS

You may request a review of the denial claim. You will have 180 days following receipt of an adverse benefit decision to appeal the decision. The request must be submitted, in writing, and include your reasons for requesting the review. Submit your request to the office of the Aetna life insurance company to which you submitted your initial request for benefit payment. You'll be notified of the decision not later than 45 days after the appeal is received. If an extension of time for processing the appeal is needed, the time period maybe extended up to an additional 45 days, in which case you will be notified prior to the end of the first 45 day period. The notice will indicate the special circumstances requiring an extension by the date by which a decision is expected.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, records or information were submitted in connection with the initial claim. You may also request that the plan provides you, free of charge, copies of all documents, records, and other information relevant to the claim.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Fund Office.

APPENDXIX
EMPLOYEE RETIREMENT INCOME SECURITY ACT INFORMATION

PLAN ADMINISTRATORS DISCRETIONARY AUTHORITY

The plan administrator shall have the discretionary authority to control and manage the operation and administration of the plan. The plan administrator, in his discretionary authority, shall determine eligibility for benefits, construe the terms of the plan and resolve any disputes which may arise with regard to the rights of any persons under the terms of the plan, including, but not limited to, eligibility for participation and claim for benefits.

REVIEW PROCEDURES FOR DENIAL OF CLAIMS NOTICE OF DENIAL

If the claimant for a policy benefit is wholly or partially denied, written notice of the decision shall be furnished to the claimant by the company within a reasonable period of time after receipt of such claim, which notice shall contain the following information:

1) The specific reason or reasons for denial;

2) Specific reference to the pertinent policy provisions upon which the denial is based;

3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4) An explanation of the policies claim review procedure.

REVIEW PROCEDURE

In order that a claimant may appeal a denial of a claim, any explanation referred to in (d) above shall specifically inform the claimant that he or his duly authorized representative:

1) May request a review of the decision by written application to the company not later than 60 days after receipt by the claimant of written notification of denial of a claim;

2) May review pertinent documents; and

3) May submit issues and comments in writing.

DECISION OF REVIEW

A decision on review of a denied claim shall be made, not later than 60 days after the Company's receipt of a request for review, unless special circumstances require an extension of time processing, in which a case decision shall be rendered within a reasonable period of time, but no later than 120 days after receipt of a request for review.

The decision on review shall be in writing and shall include the specific reasons for the decision and the specific references to the pertinent policy provisions on which the decision is based. Nothing provided in the above claims procedure shall modify or amended various other claim provisions set out in this policy.

CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave required by Family and Medical Leave Act of 1993 (FMLA). If your employer Grants you an approved FMLA leave for a period in excess of the period required by at FMLA, and any continuation of coverage during that excess period it will be subject to prior written agreement between Aetna and the fund.

If your employer grants you an approved FMLA leave in accordance with FMLA, your employer may allow you to continue coverage for which you were covered under the group contract on the day before the approved FMLA leaves starts.

At the time you request the leave, you must agree to make any contribution required by your employer to continue coverage. Your Employer must continue to make premium payments.

If any coverage your employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules for your own FMLA leave.

Coverage will not be continued beyond the first to occur:

- The date you were required to make any contribution and you failed to do so.
- The date, your employer determines your approved FMLA leave is terminated.
- The day the coverage involved discontinues as to your eligible class.

If the group contract provides continuation of coverage (for example, upon termination of employment), you may be eligible for such continuation on the date the fund determined your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you return to work for a contributing and employer following the date the fund determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued an active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date the fund

determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be affected under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as through your employment had terminated on the date the Fund determines the approved FMLA leave is terminated.

CONFIDENTIALITY NOTICE

Both the Trust and Aetna consider personal information to be confidential and has policies and procedures in place to protect against unlawful use and disclosure. By "personal information", we mean information that relates to a member's physical or mental health or condition, the provision of the health care to the member, or payment for the provision of healthcare or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported and is summarized or aggregate fashion, but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to healthcare providers (doctors, dentists, pharmacies, hospitals and other caregivers), payers, (health care provider organizations, employers who self sponsors self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventative health, early detection, vocational rehabilitation and disease and case management; quality assessment and improved activity; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer policies or contracts to and from other insurers, HMOs and third-party administrator, underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive solicit marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consent. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.Aetna.com or contact Blue Cross and Blue Shield at 1-800-328-7091.

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

Under Federal law, group health plans and insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy, shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall, at minimum, provide for:

1) Reconstruction of the breast on which the mastectomy has been performed;

2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3) Prosthesis and physical complications for all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

As a part of the Plan's Scheduled of Benefits, such benefits are subject to the Plans appropriate cost control provisions such as deductibles and coinsurance.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty eight [48] hours following a vaginal delivery, or less than ninety six [96] hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider. [**For example**, your

Physician, nurse midwife, or physician assistant], after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty eight [48] hour or ninety six [96] hour stay is treated in a manner less favorable to the mother or newborn and any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other healthcare provider obtain paid authorization for prescribing a length of stay of up to forty eight [48] hours or ninety six [96] hours.

SCHEDULE A-1
ACRA LOCAL 725
HEALTH AND WELFARE TRUST FUND

ACTIVE

SCHEDULE A-I
LOCAL 725 HEALTH AND WELFARE TRUST FUND OF DADE, BROWARD, AND MONROE COUNTIES, FLORIDA
SCHEDULE OF BENEFITS
CLASS 1 - ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS

FOR EMPLOYEES:

1) **Life, Accidental Death and Dismemberment, and Loss of Time Benefit Provisions:**

Life Insurance*	$30,000.00
Accidental Death and Dismemberment Principles, sum	$30,000.00
Loss of Time Benefit - Weekly Indemnity	
Non-Occupational	$250.00
Occupational - first week	$250.00
Subsequent 25 weeks	$84.00

(Loss of Time Benefit not to exceed 60% of your average weekly earnings.)

FOR EMPLOYEES AND DEPENDENTS:

2) **Comprehensive Major Medical Expense Benefit Provisions:**

Benefits provided utilizing the Blue Cross and Blue Shield of Florida, Preferred Provider Organization: Blue Choice PPO Family Physician Plan.

Deductibles

Individual Calendar Year Deductible	$300.00
Family Aggregate Calendar Year Deductible	$900.00
Hospital Per Admission Deductible	
PPO Hospitals	$0.00
Non-PPO Hospitals	$300.00
Emergency Room Per Visit Deductible (all hospitals)	$100.00

Note: the calendar year deductible is waived for independent clinical laboratory services. The Hospital per admission deductible and the emergency room per visit deductible are in addition to the calendar year deductible.

Coinsurance Percentage:

PPO providers - Allowed amount	80%
Non-PPO Providers - Allowed amount	60%
Ambulance Services	80%

Maximum Out-of-Pocket Per Calendar Year:

PPO Providers of - Individual Co-Insurance Limit	$2000.00
Non—PPO Providers	no maximum

Note: Maximum Out-of-Pocket Coinsurance responsibility limits do not include any deductibles, copay, any benefit penalty reduction, non-covered charges or any charges in excess of the allowed amount.

Doctors Office and Visit Services:

PPO Family Physicians (Family Practice, General Practice, Internal Medicine, or Pediatrics)	$35.00 co-pay
Allergy Injections	$5.00 co-pay

Other PPO Providers and all Non-PPO Providers Calendar Year Deductible and Coinsurance.

Note: Durable medical equipment, prosthetics, and orthotics are not subject to the co-pay requirement, but are subject to the individual calendar year deductible and a coinsurance responsibility.

Calendar Year Maximum Per Person:

Home Health Care	$2,500.00
Skilled Nursing Facility Days	$60.00
Low-Protein Food Products	$2,500.00

Lifetime Maximum Per Person:

Total	$1,000,000.00
Hospice Benefit	$7,500.00
Organ Transplant	$65,000.00
Outpatient Cardiac, Physical and Massage Therapies and Spinal Manipulations	$25,000.00
Speech Therapy	$3,500.00
Nervous, Mental Substance Abuse Care	noncovered

Additional Benefits:

Accident care services are subject to the calendar year deductible, co-pay, coinsurance and other deductible provisions of the plan.

Infertility Services not covered

Mammogram Screening Services Covered at 100% of Allowed amount

Maternity Covered for all members and spouses.

Transplant Services Heart, heart-lung combination, liver, kidney, cornea and bone marrow transplants.

Well Child Care: Birth to age 16, 18 visits; deductible waived

Wellness Benefit Adults covered services for an adult age 17 over include an annual exam and related wellness services up to a calender year maximum of $200. These services are not subject to the calendar year deductible, but are subject to the applicable co-pay or coinsurance responsibility. Routine vision and hearing examinations are not covered. Mammograms do not accumulate to the calendar year maximum.

Pre-Existing Conditions Covered after 12 months.

3) Prescription Drugs - Card.
(Subject to a $5,000 Calender Year Maximum Per Person.)

*NOTE: **See page 30 for A Permanent and Total Disability Feature.**

Retail.

Generic Drugs	$8.00 co-pay.
Preferred Brand Drugs,	$25 co-pay.
Non-Preferred Brand Drugs	$40 co-pay.
Maximum Supply,	One month
Oral Contraceptives	Covered

Mail order.

Generic Drugs	$16 co-pay.
Preferred Brand Drugs,	$50 co-pay.
Non-Preferred Brand Drugs,	$80 co-pay.
Maximum Supply	90 days.
Oral Contraceptives	Covered.

4) **Dental Expense Benefit Provisions:**

Co-Insurance Percentage,	70%
Deductible Amount Calendar Year	$50.00
Maximum Amount Per Insured Individual or Per Family Unit	$2000.00
Orthodontia Co-insurance Percentage,	70%.
Orthodontia Deductible Amount	None
Orthodontia Lifetime Maximum Per Insured Individual	$1000.00

LOSS OF TIME BENEFITS FOR CLASS ONE ONLY - ELIGIBLE EMPLOYEES.

COVERAGE CLAUSE

Upon receipt by the Plan of the required notice and satisfactory proof that you have become totally disabled due to bodily injury or sickness while eligible for benefits, the Fund will pay weekly to you in accordance to the Schedule of Benefits. Benefits will begin as of the first day of disability due to an accident or as of the eighth day of disability due to sickness and will continue for any one period of a disability for a maximum of twenty-six (26) weeks. Fractional parts of the week will be paid at a rate of one-seventh 1/7 of the weekly benefit for each day. You do not have to be confined to your home to collect benefits, but you must be under the care of physician.

PERIODS OF TOTAL DISABILITY

Successive of disability periods separated by less than one week of continuous active employment shall be considered as one continuous period of disability unless they arise from different and unrelated causes, in which case returned to work on full-time basis is required.

LIMITATIONS

Benefits are not payable for any period of total disability during which you are not under the regular care and attendance of a Physician.

COMPREHENSIVE MAJOR MEDICAL EXPENSE OF BENEFITS FOR CLASS - 1 ONLY - ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS.

Upon receipt by the plan of the required notice and satisfactory proof that you or your Dependent has incurred during a Calender Year Covered Charges in excess of the applicable deductible requirement, the fund will pay to you or on your behalf an amount in accordance with the Schedule of Benefits, provided that:

1) Benefits are not payable for Cover Charges used to satisfy the deductible requirement or incurred during such Calender Year prior to the date the deductible requirement is satisfied.

2) The aggregate amount of benefits payable during any calendar year for all covered charges with respect to any person (whether or not there is any interruption in the coverage with respect to such person and whether or not there is any change in status of such person from Employee to Dependent or vice versa) shall not exceed the applicable comprehensive Medical Maximum shown in the Schedule of Benefits.

3) Time limit for submission for proof of loss - you must furnish the Claim Center of proof of loss within ninety (90) days after the date of the loss, if reasonably possible. However, in no event will claims delayed in excess of 12 must be accepted or payable.

CALENDAR YEAR DEDUCTIBLE

In order to qualify for Comprehensive Medical Benefits you must first pay a deductible of $300.00 per eligible person for Covered Charges incurred within the calendar year, as specified in the Schedule of Benefits.

A deductible amount can be carried over from one year to next if all or part of the deductible was incurred during the final three months of calendar year. The part that was incurred during the final three months of the calendar year need not be paid in the next calendar year.

In the event of a common accident in which more than one Covered Family Member receives nonoccupational bodily injuries, a single deductible requirement will be applicable once in the calendar year in which the accident occurred with respect to all Covered Charges for you and your dependents injured in such accident. This combined deductible amount will also apply to future reapplications of the Deductible amount for such common accident. However, nothing herein shall be construed to reduce the maximum payment for each eligible person.

CO-PAYMENT OF BENEFITS

Subject to the Calendar Year Deductible, the Plan pays you the coinsurance percentage reflected in the schedule of benefits.

NERVOUS, MENTAL AND SUBSTANCE ABUSE AT LIMITATIONS

Charges for care and treatment for nervous, mental or substance abuse disorders are not covered under this plan.

REINSTATEMENT

On every January 1, any used portion of your Lifetime Maximum Benefit will be restored by an amount equal to the lesser of (a) $1000.00 and (b) the amount of any benefits remaining charged against your Lifetime Maximum Benefit. No restoration of the lifetime maximum benefit is provided for charges incurred for organ transplant, rehabilitation therapy, or speech therapy.

COVERED CHARGES

The term "Covered Charges" include those Reasonable and Customary Charges actually incurred by you or your eligible Dependents for medical care, services and supplies provided on the recommendation and approval of your attending physician. Such Covered Charges are limited to the maximum amount shown in the Schedules of Benefits. Covered Charges shall be deemed to have been incurred on the date the service or supply is performed or received and shall include the following:

1) **In-Patient Hospital Charges.**

a) Room and Board up to Hospitals average cost of semi-private accommodations.

b) Intensive or Cardiac Care of Accommodations not to exceed the Reasonable and Customary Charges actually incurred.

c) Hospital services and supplies

d) Services of any Physician, or for any nursing services.

2) **Out-Patient Charges.** Charges for Hospital services and supplies required for and furnished to you or your Dependent, while not confined as an inpatient in such hospital.

3) **Anesthetic Services.** Charges for anesthetic and its administration.

4) **Physicians Charges.** Charges by a physician for the performance of a surgical operation or procedure and for each visit for treatment, which is not for the performance of a surgical operation or procedure, or for the administration of anesthetics.

5) **Radiology or Laboratory Examination.** Charges made for X-ray, radiotherapy, (including X-ray, radio, cobalt or other radioactive substances), or laboratory examination.

6) **Registered Graduate Nurse, or Licensed Practical Nurse.** Charges for nursing made to the Covered Person by a registered graduate nurse, or licensed practical nurse who does not ordinarily reside in the Covered Person's home and is not the Employee's spouse or child, nor a brother, sister or parent of the Employee or Employee's Spouse, subject to the limitations shown in the Schedule of Benefits.

7) **Medical Supplies and Services.**

a) Charges by an ambulance service to and from a local hospital, or if the injuries or sickness require special and unique hospital treatment, transportation by the most appropriate means within the United States or Canada to the nearest hospital equipped to furnish such treatment.

b) Charges by a Hospital for Out-Patient Services and supplies while the Covered Person is not confined as in-patient in such Hospital to the extent such charges are not included as in-patient hospital charges.

c) Charges for artificial eyes, limbs or portions of limbs for the initial replacement of natural eyes or limbs or portions of limbs.

d) Cast's, splints or crutches.

e) The initial trusts, brace or support required as a direct result of a non-occupational bodily injury sustained or a non-occupational sickness contracted while covered, or a disabling congenital condition of a newborn child whose mother is covered under the plan.

f) Oxygen and rental equipment for its administration.

g) Rental of a manually operated wheelchair or manually operated hospital type bed.

h) Anesthetics, blood or blood plasma and other solutions intravenously administered.

i) Charges for dental services rendered by a physician or dentist for treatment;

(a) of an accident within 12 months of a non-occupational injury to the jaw or natural teeth and any necessary dental x-ray provided such injury is the result of an accident occurring while covered under the plan.

(b) the surgical removal of an impacted or interrupted a wisdom tooth.

j) Charges for any Federal legend drug or medicine requiring a prescription under State law or injectable insulin requiring a written prescription and subject to the copays, the Calendar Year maximum benefit of $3,500.00 per

person and daily supply limitations reflected in the Schedule of Benefits of this booklet. A complete listing of Generic Drugs, Preferred Brand Name Drugs and Non-Preferred Brand-Name Drugs may be found by visiting www.bcbsfl.com or calling Customer Service of Blue Cross and Blue Shield of Florida. The following are not covered charges:

1) Dietary supplements, immunizations, except as provided on page 45, appliances and other non-drug items (note: needles, syringes and other diabetic supplies are covered as any other medical expense and subjected to the Calendar Year deductible and coinsurance feature.)

2) Injectable prescription drugs are not covered under the Prescription Drug Card Plan but are covered under the Medical Plan up to the $3,500.00 prescription drug limit per calendar year. Such injectable drugs are subject to the Medical Plan's deductible and coinsurance.

3) Pharmaceuticals lawfully obtainable without prescription.

4) Patent medicines, biologicals, allergens, nose drops, or other nasal preparations.

5) Any drug not approved by the Food and Drug Administration.

6) Drugs not prescribed for the treatment of illness or accident.

8) Charges for you or your eligible dependent if you elect to utilize the services of a qualified freestanding birthing center because of pregnancy. The Plan will pay an amount equal to the charges made by the facility, but no more than the reasonable and customary charges relating to childbirth or those maximum amounts as stated in a Schedule of Benefits.

No benefit will be payable unless your Physician or certified nurse midwife certifies that you or your cover dependent's pregnancy is considered low risk.

Only free-standing birthing centers which meet the following requirement will be considered eligible, the facility must:

a) Be licensed by the governmental agency located in the United States or in Canada, or in a State or Province thereof, authorized to license such facility;

b) Be under the direct supervision of a qualified licensed physician (M.D or D.O);

c) Provide skilled nursing care (including the supervision of midwives by registered nurses);

d) Have facilities for X-rays, laboratory, minor surgery, the administration of anesthesia during delivery, the treatment of minor medical emergencies and it must maintain written records on the mother and newborn child or children;

e) Provide immediate postpartum care including routine newborn care;

f) Have a written agreement with a nearby hospital for emergency care and maintain at least a two bed birthing (delivery/recovery) room;

g) Extend staff privileges to all physicians;

h) Provide sufficient medical documentation for any condition which warrants confinements for periods in excess of 24 hours after delivery.

9) Surgical charges incurred for orthogenetic procedures if they are deemed medically necessary for health reasons and if the patient is at least 20 years of age or over. Benefits payable shall be limited to a maximum of $3,500.00 for all expenses.

10) Charges for surgical expenses incurred for Radial Keratotomy's shall not be considered as Covered Charges under the terms of the plan except, if the participant's vision cannot be corrected to at least 20/70 in the better eye by normal corrective glasses and the participant medically cannot wear contact lenses. The maximum benefit payable shall be limited to $1,500.00 per eye and shall be payable only once per eye in the participant's lifetime.

11) Charges for services and treatment provided by a licensed Chiropractor or Physical Therapist, not to exceed 26 visits in a calendar year.

EXCLUDED CHARGES

No expense benefits will be payable for or in connection with any:

1) Charges for routine care and other treatments or procedures which are not Medically Necessary unless specifically covered otherwise in the Plan.

2) Charges for services and procedures which are considered to be Experimental or Investigated in nature unless such course of treatment has been approved by two additional Physicians as proper treatment of illness or injury.

3) Expenses incurred by you or your dependent which are in excess of reasonable expense.

4) Charges for the introduction into or attachment to the body of an artificial organ, except for kidney dialysis.

5) Charges for the removal of an organ or portions thereof for donor purposes.

6) Charges for services, supplies and/or treatment if not recommended and in approved by a Physician who is attending you or your Dependent

or if not performed by or under the supervision of a duly qualified Physician.

7) Charges which would not have been made in the absence of this coverage or which you or your Dependent are not legally obligated to pay, or which are furnished without charge or which are reimbursable by or through a national, state or political subdivision, agency or arm thereof.

8) Charges for services or supplies arising out of, or in the course of employment for pay or profit, or charges for services, which are covered by Workers Compensation or similar wall.

9) Charged for medical care, services or supplies received or furnished in connection with, or as a result of, any injury, or sickness resulting from, or caused, directly or indirectly, or wholly or partly, by (i) war or any act of war, whether declared or undeclared, or (ii) service in any military, naval, or Air Force of any country while such country is engaged in war, whether declared or undeclared, or (iii) police duty as a member of any military, naval or Air Force organization, or (iv) insurrection, or (v) any atomic explosion or other release of nuclear (energy except only when being used solely for medical treatment of a Non-Occupational Bodily Injury or Sickness) whether in peace or in war and whether intended or accidental, (vi) participation in a riot, or any bodily injury or sickness that is self-inflicted while sane or insane. An injury or illness shall be deemed "self-inflicted" if it would otherwise be deemed self-inflicted even thought the individual was deemed to be temporarily or permanently insane or to otherwise have been lacking in mental, intellectual or emotional capacity of any kind, including without limitation the capacity to form an intent or to comprehend the consequences of any action or non-action on their part and/or any physical impairment, loss of consciousness, balance, and/or coordination related to the voluntary or involuntary consumption of alcohol or any controlled substance, described in 29 CFR 1630. 3(2) intoxication in violation of the laws of the state in which the even occured.

10) Charges for blood or blood plasma for which the Hospital or other supplier makes a refund or allowance to or on behalf of the Covered Person, either as a result of the operation of a group blood bank, private donor or otherwise.

11) Charges for medical care, services or supplies received or furnished in connection with, or as a result of, any cosmetic surgery, except (i) charges in connection with and as a result of the necessary repair of this disfigurement caused by bodily injuries sustained in an accident occurring while a Covered Person provided such cosmetic surgery is received promptly after such accident, and (ii) charges in connection with and as a result of an abnormal congenial condition in a child who becomes a Covered Person at birth and continuously remains a Covered Person until the charge is incurred.

12) Charges for medical care, services or supplies received in, or furnished by, a Hospital, institution, or other facility owned or operated by the United States, or any agency or instrumentality (including, without limitation, the Veterans Administration), thereof, unless such medical care, services and supplies were of an emergency nature and the Covered Person was not entitled to such medical care, services or supplies by virtue of status as a veteran, member of the armed forces, government official or employee or otherwise.

13) Charges for medical care, services or supplies received or furnished in connection with, or as a result, any injury or sickness resulting from participation in, or in consequences of having participated in the commission of a felony.

14) Charges for any medical care, services and supplies received or furnished with respect to any person while he or she is not a Covered Person.

15) Charges for tooth extractions or other dental work for surgery that involves any tooth, tooth structure, alveolar process, abscess, periodontal disease, or disease of the gingival tissue except as provided under Covered Dental Charges.

16) Charges incurred in connection with the reversal of a voluntary sterilization.

17) Charges for any medical care, services and supplies received or furnished not pertaining to an illness or injury.

18) Charges for dental work or treatment, except (i) charges in connection with the removal of on impacted teeth and (ii) charges in connection with and as a result of injuries to natural teeth, sustained in an accident occurring while a Covered Person to the extend the dental work or treatment is received promptly after such accident.

19) Charges not incurred in the United States or Canada unless such charges are incurred in an emergency.

20) Charges incurred for treatment of infertility, except charges incurred for diagnostic and testing purposes.

21) Charges for the surgical treatment of obesity or morbid obesity such as gastroenterostomy, Gastric Stapling, Jejunoile By-Pass or Suction Assisted Lipectomy, except if all of the following requirements are satisfied, the patient must:

a) Be at least 200% over his ideal weight for his body structure and age;

b) Be at least 25 years of age or older;

c) The condition of "morbid obesity" must have existed for a document period of five years or longer;

d) Have a Physician's certification that while under the care and supervision of the Physician, all other methods of weight reduction have failed for the patient;

e) Have a Physician's documentation of the previous weight reductions employed, treatment of the medical problems arising from the obese condition, and the physicians recommendation that such surgical procedure is medically necessary; and.

f) Obtain prior authorization from the Trustees before undergoing such surgical procedures.

22) The first $10,000.00, of medical expense of any kind of related to injuries incurred in connection with operating, being an occupant of, or being struck by a motor vehicle of any kind (including motorized cycles, bikes, scooters, and/or all terrain vehicles, and/or any trailer, side car or other attachment or accessory to any motor vehicle.)

23) Charges for which any third party may be liable or obligated, unless you and if applicable your dependents have delivered to the Trust an executed Reimbursement/Subrogation Agreement and any other documentation required by the Plan (see Part 1).

23) Charges for injuries or illnesses sustained while operating, being an occupant or being struck by any motor vehicle except as to charges in excess of the maximum deductible limit under the FLorida Personal Injury Protection Law (F.S. 627.733).

DENTAL BENEFITS FOR CLASS 1 ONLY - ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS

COVERAGE CLAUSE

Upon receipt of due notice and satisfactory proof as required, that you or your Dependent has incurred expense for the performance of a dental service by or under the direction of the Physician or Dentist, the Fund will pay Covered Dental Charges in accordance with the Schedule of Benefits.

COVERED DENTAL CHARGES

Covered Dental Charges are those charges made for services, supplies, and treatments itemized below when performed by a legally qualified dentist for oral examinations and treatment of accidentally injured or diseased teeth or supporting the tissue; provided such services are reasonably necessary and the charges are not reasonably priced or of a cosmetic nature. The reasonableness of a charge is determined by the charges incurred for cases of comparable nature and severity in the particular geographical area concerned. The Trustees may, at their discretion request as supporting proofs of loss, clinical reports, charts, and X-rays.

Covered Dental Charges shall be deemed to have been incurred on the date the demo service is performed and shall include the following:

1) Oral examinations, including scaling and cleaning of teeth, but not more than two examination or scaling and cleaning in any period of 12 consecutive months.

2) Topical application of sodium or stannous fluoride, once in each period of 12 consecutive months, but only if the Covered Family Member has not yet attained the age of 15 years.

3) Dental X-rays.

4) Extractions.

5) Fillings.

6) General anesthetics administered in connection with oral surgery or other covered dental services.

7) Injections or antibiotic drugs by the attending dentist.

8) Space maintainer.

9) Treatment of periodontal and other disease of the gums and tissues of the mouth.

10) Endodontic treatment, including root canal therapy.

11) The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures were fixed bridge work, provided that such installation is required as a result of the extraction on or after the effective date of you or your dependents eligibility under this Plan, of one or more natural teeth, injured or diseased, and that such denture or bridgework includes replacement of teeth so extracted.

12) Replacement, or alteration of, full or partial of dentures, or fixed bridge work, which is necessary because off:

a) Structural change within the mouth, but only if more than five years has elapsed since the initial placement.

b) The initial placement of an opposing full denture, but only after you or your dependent has been covered under this Plan for at least two years, or

c) The prior installation of an immediate temporary denture, but only within 12 months of the installation of the temporary.

13) Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed

bridgework by a new denture or by a new bridgework, but only if:

a) The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while eligible under this plan, and after the existing denture or bridgework was installed, or

b) The existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

14) The replacement of a crown restoration providing the original crown was installed more than five years prior to replacement.

15) Inlays, gold fillings, crayons, including precision prosthetics for dentures.

16) Repair or receiving of crowns, inlays, bridgework, or dentures or relining of dentures.

17) Charges for dental implants if required for other than cosmetic purposes.

DENTAL EXCLUSIONS

The following services or charges for services are not covered under Dental Benefits:

1) Treatment on or to the teeth or gums for cosmetic purposes.

2) Expense incurred after termination of eligibility except for prosthetic devices which where fitted and ordered prior to termination which are delivered to you or your Dependent within 30 days after the date of termination.

3) Rebase or reline of a denture in less than six months from the date of initial replacement,

4) Replacement of lost or stolen prosthetics,

5) Replacement of prosthetics less than five years after preceding placement, except as provided in 13 (A) and (B) of Covered Dental Charges, and,

6) Charges for which you or your Dependent are not required to pay, including charges for services furnished by any Hospital or Organization which normally makes no charge if the patient has no hospital, surgical, medical, or dental insurance.

ORTHODONTIC BENEFITS FOR CLASS 1 ONLY - ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS

COVERAGE CLAUSE

Upon receipt of due notice and satisfactory proof as required that you or your Dependent has incurred expense for the performance of orthodontic services by or under the direction of a Physician or Dentist, the Fund will pay Covered Orthodontic Charges in accordance with the Schedule of Benefits.

COVERED ORTHODONTIC CHARGES

Covered Orthodontic Charges are those charges made for services, supplies and treatment when performed by legally qualified dentist for orthodontic services, provided such services are reasonably priced, as determined by the charged generally incurred for cases of comparable nature and severity and the particular geographical area concerned. The Trustees may, at their discretion, request supporting proofs of loss, clinical reports, charts and X-rays.

ORTHODONTIC EXCLUSIONS

The following services or charges for services are not covered under Orthodontic Benefits:

1) expense incurred after termination of eligibility;

2) expense incurred for appliances in place prior to the effective date of coverage under the plan;

3) expense covered under the Dental Benefits of the Plan;

4) Charges for which you or your Dependent are not required to pay including charges for services furnished by any Hospital or Organization which normally makes no charge if the patient has no hospital, surgical, medical or dental insurance.

5) Charges for services or supplies received or furnished in connection with, or as a result of, any injury, or sickness resulting from, or caused, directly or indirectly, or wholly or partly by, war or any act of war, whether declared or undeclared.

SCHEDULE A-II
ACRA LOCAL 725
HEALTH AND WELFARE TRUST FUND

DISABLED

SCHEDULE A-II
LOCAL 725 HEALTH AND WELFARE TRUST FUND OF DADE, BROWARD AND MONROE COUNTIES, FLORIDA SCHEDULE OF BENEFITS

CLASS 2 - PERMANENTLY AND TOTALLY DISABLED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

For Employees and Dependents:

1) Hospital Expense Benefit:

Maximum Daily Benefit	$12.00
Maximum Room and Board Benefit	31 days.
Maximum Additional Charges Benefit	$150.00
Maximum Ambulance Charges Benefit Per Disability	$40.00

2) Surgical and Anesthesia Expense Benefit:

Maximum Surgical Expense Benefit	$250.00
Maximum Anesthesia Benefit	$50.00
Obstetrical Procedures.	
Normal Deliveries,	$62.50
Caesarean Sections	$125.00
Miscarriages	$31.25

3) Second Surgical Opinion Expense Benefit:

Maximum Payment Per Consultation	$100.00

4) In-Hospital Medical Expense Benefit.

Medical Visit Benefit	$5.00
Maximum Medical Benefit	$155.00

*Not payable more than once in each calendar year.

HOSPITAL EXPENSE BENEFIT FOR CLASS 2 ONLY - PERMANENTLY AND TOTALLY DISABLED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

If you or the eligible dependent are confined in a lawfully operated hospital for a non-occupational bodily injury or sickness, you will be reimbursed the charges incurred for room and board and other hospital expenses.

ROOM AND BOARD CHARGES:

Benefits will be payable for each day of hospital confinement, but not to exceed the Maximum Room and Board Benefit show in the Schedule of Benefits for any one period of confinement.

OTHER HOSPITAL CHARGES:

You will also be reimbursed the charges incurred for miscellaneous items, for example, the use of an operating room, X-rays, laboratory tests, medicines, and drugs up to the Maximum Additional Charges Benefit shown in the Schedule of Benefits.

In addition, you will also be reimbursed charges for transportation costs with respect to a newborn dependent child, to and from the nearest available facility properly staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending Physician to protect the health and safety of the newborn child up to a maximum of $100.00, but in no event shall the amount payable under this section exceed the Maximum Additional Charges Benefit show in Schedule of Benefits.

SUCCESSIVE CONFINEMENTS

Successive hospital confinements shall be considered one (1) confinement unless with respect to any employee only, they have either, (a) returned to work for a contributing Employer on an active full-time basis for at least one (1) day or (b) the confinements are separated by a period of 90 consecutive days. The Plan can waive these periods if, based upon competent medical evidence and in its sole judgment, consecutive periods of confinement are due to totally unrelated causes.

OUT-PATIENT HOSPITAL TREATMENT:

If hospital charges are incurred where 1) emergency treatment is provided within 72 hours of an accidental bodily injury, or 2) surgery is performed, payment will be made, up to the Maximum Additional Charges Benefit shown in the Schedule of Benefits, although the individual is not confined as a bed patient.

If you or your dependent incur charges by a professional ambulance service for transportation to or from a local hospital for treatment is given, you will be reimbursed during any one disability up to the Maximum Ambulance Charges Benefit set forth in the Schedule of Benefits.

AMBULATORY SURGICAL FACILITY:

If you or an eligible dependent, while insured, incurs expenses for the use of an ambulatory Surgical Facility because of a non-occupational bodily injury or sickness you will be reimbursed an amount equal to the reasonable and customary charges for the use of such Ambulatory Surgical Facility provided such charges should have been covered as in-hospital service. Such payment should not exceed the Maximum Additional Charges Benefit as set forth in the Schedule of Benefits.

Any payment made under this benefit shall reduced the Maximum Additional Charges Benefit for any subsequent hospital confinement that takes place as a result of the same or related disability.

VOLUNTARY STERILIZATION:

If you or your spouse incur expenses in connection with an operation for the purpose of sterilization, you will be reimbursed the hospital charges for room and board and miscellaneous services up to the Maximum Hospital Expense Benefits as shown in the schedule of benefits. You will also

be reimbursed the fee charged by the Physician for the operation up to the amount payable in accordance with the Schedule of Operations.

LIMITATIONS:

No payment shall be made unless the hospital confinement and the charges, if any, upon which claim is based and the continuation of such confinement during the entire period thereof, where recommended and approved by legally qualified Physician: for surgical or medical fees, or for charges for nursing, for blood or blood plasma; if any hospital confinement due to nonsurgical treatment of the feet; or the hospital confinement is in hospital owned or operated by Federal Government or in any hospital which makes no charges that the insured individual is required to pay.

MATERNITY BENEFIT FOR CLASS 2 ONLY PERMANENTLY AND TOTALLY DISABLED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

Benefits for pregnancy-related conditions are provided on the same basis as any other disability including the extended benefits applicable to the totally disabled.

In order to receive benefits, the female employee or dependent spouse must be eligible at the time of delivery.

No maternity benefits are payable with respect to a dependent child except for complications of pregnancy, as defined below.

The term "complications of pregnancy" shall mean:

1) Conditions requiring hospital stays, when the pregnancy is not terminated and the diagnosis is distinct from pregnancy, but is adversely affected by pregnancy.

2) Non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Charges due to election of abortion are not payable under the Plan, except for an abortion where the life of the mother would be endangered if the fetus was carried to full-term and except for com-plications of an abortion.

The Obstetrical Benefits payable for the fee charged by the Physician performing the obstetrical procedure will be the amount stated in the Schedule of Benefits.

SURGICAL AND ANESTHESIA EXPENSE BENEFIT FOR CLASS 2 - ONLY PERMANENTLY AND TOTALLY DISABLED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

If you or your dependent, while covered under this provision, undergo an operation enumerated in the Schedule of Operations, including radiotherapy procedures, performed by legally qualified physician or surgeon as a result of a non-occupational bodily injury or sickness not due to occupational disease, you will be reimbursed the Surgical and Anesthesia fees incurred for such operation, but no event to exceed the amount provided in the Schedule of Operations for such operation or anesthesia. If more than one operation is performed during any one continuous period of a disability, surgical and anesthesia fees are payable for each operation accept that:

1) If two or more operations are performed through the same abdominal incision, the total payment for all such operations and anesthesia shall not exceed the maximum payment specified in the Schedule of Operations for that one of such operations for which the largest amount of surgical or anesthesia fees are payable;

2) If two or more operations were radiotherapy procedures performed at the same time, or in immediate succession, or under one anesthesia, the surgical and anesthesia fees will be the amount payable for each lesser procedure performed, which adds significant time for complexity to the treatment of individual;

3) The total payment for all operations or radiotherapy procedures performed during one continuous period of disability shall not exceed the Maximum Surgical Experience and the Maximum Anesthesia Benefits applicable to such individual as set forth in the Schedule of Benefits.

Successive operations shall be considered as having been performed during one continuous period of a disability unless (1) with respect to employee only, he has returned to work for a Contributing Employer for an active full-time basis for at least one day or (2) they are separated by a period of 90 consecutive days. The Plan can waive these periods if, based upon competent medical evidence and in its sole judgment consecutive periods of confinement are due to totally unrelated causes.

LIMITATIONS:

No payment shall be made for any professional fee other than the fees of the Physician or surgeon performing the operation, or the anesthist for administering the anesthesia, for local infiltration anesthesia administered by the operating Physician or surgeon, for expenses incurred in

connection with services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, (except to tumors or cysts or as otherwise specifically included herein); for services performed in a hospital owned or operated by the United States Government, or elsewhere at Federal Government Expense, or for any expenses incurred that the individual is not required to pay.

No benefit shall be payable under this section for Orthognatic Surgery, Radial Keratomony or any surgical procedure used for the treatment of obesity or morbid obesity such as Gastroenteritis, Gastric Stapling, or Jejunoileal bypass.

SECOND SURGICAL OPINION EXPENSE BENEFIT FOR CLASS 2 - ONLY PERMANENTLY AND TOTALLY DISABLED EMPLOYEES IN THEIR ELIGIBLE DEPENDENTS

If you or your eligible dependent, while covered under this Plan, consults a legally qualified physician for a second surgical opinion on the need for a surgical procedure of a non-emergency nature, you will be reimbursed for the reasonable and customary charges incurred for such consultation, including any necessary X-rays and Laboratory Examinations recommended by such a legally qualified Physician, but in no event shall the payment exceed the amount shown in the Schedule of Benefits.

In the events this second surgical opinion does not confirm the need for surgery and you or your eligible dependent consults another legally qualified Physician for a third opinion, you will also be reimbursed for the reasonable and customary charges incurred for the third consultation, including any necessary x-rays and laboratory examinations recommended by such legally qualified physician.

For the purposes of this provision, a legally qualified physician shall mean a physician who is Board certified in the field of proposed surgery or in the field of medical specialization concerning what the condition involved.

LIMITATIONS:

No payment shall be made:

1) For Surgery Consultation made by physician who is not board certified in the field of medical specialization concerned with the proposed surgery;

2) For more than two Surgery Consultations made in connection with the proposed surgery;

3 For any X-ray and laboratory charges other than charges made in connection with the surgical consultation;

4) Unless the individual is examined in person by the Physician rendering the second or third opinion in a written summary is submitted to the plan;

5) If the Physician who renders the second or third surgical opinion also performs the surgery, or has a financial interest in the outcome (for or against surgery) of his recommendation;

6) For any Surgery Consultation fees incurred for:

a) Dental work or treatment; cosmetic surgery except as required because of accidental bodily injury incurring while covered under this Plan. "Cosmetic surgery" shall not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, or reconstructive surgery because of congenital disease or anomaly of an eligible dependent child which has resulted in a functional defect.

b) Occupational disease or accidental bodily injuries arising out of and in the course of the individuals employment.

SCHEDULE OF OPERATIONS FOR CLASS 2 - ONLY PERMANENTLY AND TOTALLY DISABLED EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

	Maximum Surgical Amount	Maximum Anesthesia Amount
ABDOMEN		
Appendectomy, freeing of adhesions or exploration of, or cutting into, the end and abdominal cavity	$125.00	$25.00
Removal of, or other operation on gall bladder	$187.50	$37.50
Gastro-enterostomy	$187.50	$37.50
Resection of stomach, Bowel or rectal	$500.00	$50.00
ABSCESS, (SEE TUMORS)		
AMPUTATIONS		
Thigh, leg	$156.25	$31.25
Upper arm, forearm or entire hand or foot	$125.00	$25.00
Fingers or toes each	$18.75	$12.50
BREAST		
Removal of the benign tumor cyst requiring hospital confinement.	$62.50	$12.50
Simple Amputation	$125.00	$25.00
Radical Education	$187.50	$37.50

	Maximum Surgical Amount	Maximum Anesthesia Amount
CHEST		
Complete thoracoplasty	$187.50	$37.50
Transthoracic approach to stomach, diaphragm, or esophagus; sympathectomy or laryngectomy	$250.00	$50.00
Removal of lung or portion of lung	$250.00	$50.00
Bronchoscopy, esophagoscopy	$50.00	$12.50
Induction of artificial pneumothorax, initial	$31.25	
$12.50		
Refills, each (not more than 6)	$6.25	$6.25
DISLOCATION-REDUCTION		
Hip, ankle, joint, elbow or knee joint (patella excepted)	$43.75	$12.50
Shoulder	$31.25	$12.50
Lower jaw, collar bone, wrist or patellas	$18.75	$12.50

For a dislocation requiring an open operation, the maximum will be the Maximum Surgical Amount shown above.

EXCISION OR FIXATION BY CUTTING		
Hip joint	$187.50	$37.50
Knee joint or elbow	$156.25	$31.25
Shoulder, semilunar cartilage, wrist or ankle joint	$125.00	$25.00
Removal of diseased portion of bone, including curettage (alveolar processes except)	$62.50	$12.50
EAR, NOSE OR THROAT		
Fenestration, one or both sides	$250.00	$50.00
Mastoidectomy, one or both sides		
Simple	$125.00	$25.00
Radical	$187.50	$37.50
Tonsillectomy, adenoidectomy, or both		
Under age 15	$37.50	$12.50
Age 15 or over	$50.00	$12.50
Sinus operation by cutting (puncture of antrum excepted)	$75.00	$12.50
Tracheotomy	$93.75	$18.75
Any cutting operation	$18.75	$12.50
EYE		
Operation for detached retina	$250.00	$50.00
Cataract, removal of	$187.50	$37.50
Any other cutting operation into the eyeball through the cornea or sclera or cutting operation of eye muscles	$125.00	$25.00
Removal of eyeball	$25.00	$12.50
FRACTURE, SIMPLE – TREATMENT		
Thigh, vertebrae, pelvis (coccyx excepted)	$93.75	$18.75
Leg, kneecap, upper arm, ankle, skull	$187.50	$37.50
Lower jaw (alveolar process excepted), collar bone, shoulder blade, forearm, wrist (collies)	$31.25	$12.50
Hand, foot	$18.75	$12.50
Fingers or toes, each	$12.50	$12.50
Nose	$12.50	$12.50
Rib or ribs		
Three or more	$31.25	$12.50
Fewer than three	$12.50	$12.50

For a compound fracture, the maximum will be one and one-half times the Maximum Surgical Amount for the corresponding simple fracture.

For a fracture requiring an open operation when bone grafting, bone splinting, or metallic fixation at point a fracture, the maximum will be twice the Maximum Surgical Amount for the corresponding simple fracture.

GENITAL-URINARY TRACT		
Removal of or cutting into, kidney	$250.00	$50.00
Fixation of kidney	$187.50	$37.50
Removal of tumors or stones in ureter or bladder		
By cutting operation	$125.00	$25.00
By endoscopic means	$43.75	$12.50
Cystoscopy	$31.50	$12.50
Removal of prostate		
By open operation	$187.50	$37.50
By endoscopic means	$43.75	$12.50
Circumcision	$18.75	$12.50
Varicocele, hydrocele, orchidectomy, or epididymectomy		
Single	$62.50	$12.50
Bilaterals	$93.75	$18.75
Hysterectomy	$187.60	$37.50
Other cutting operations in uterus and its appendages with abdominal approach	$125.00	$25.00
Cervix amputation	$62.50	$12.50
Dilation and curettage Non-puerperal), cervix cauterization or conization, polyectomy, or any combination of these	$31.25	$12.50
Vaginal plastic operation for cyctocele rectocele	$93.75	$18.75

GOITRE		
Removal of the Thyroid, subtotal	$187.50	$37.50
Removal of adenoma or benign tumor of thyroid	$125.00	$25.00
HERNIA		
Single hernia	$125.00	$25.00
More than one hernia	$156.25	$31.25
JOINT		
Incision into		
Tagging excepted	$31.25	$12.50
LIGAMENTS AND TENDONS		
Cutting or transplant		
Single	$62.50	$12.50
Multiple	$93.75	$18.75
Suturing of tendon		
Single	$43.75	$12.50
Multiple	$62.50	$12.50
PARACENTESIS		
Tapping	$18.75	$12.50
PILONIDAL CYST OR SINUS		
Removal of	$62.50	$12.50
RECTUM		
Hemorrhoidectomy		
External	$31.25	$12.50
Internal or internal and external	$62.50	$12.50
Cutting operation for fissure	$31.25	$12.50
Cutting operation for thrombosed hemorrhoids	$18.75	$12.50
Cutting operation for fistula-in-anus		
Single	$62.50	$12.50
Multiple	$93.75	$18.75
SKULL		
Cutting into cranial cavity (trephine excepted)	$250.00	$50.00
Trephine	$62.50	$25.00
SPINE OR SPINAL CORD		
Operation for spinal cord tumor	$250.00	$50.00
Operation with removal or portion of vertebra or vertebrae (except coccyx, transverse or spinous process)	$187.50	$37.50
Removal of part or all of coccyx, or of transverse or spinous process	$62.50	$12.50
TUMORS		
Benign or superficial tumors and cysts or abscesses requiring hospital confinement	$31.25	$12.50
Malignant tumors of face, lop skin	$62.50	$12.50
VARICOSE VEINS		
Injection treatment, complete procedure one or both legs	$50.00	$12.50
Cutting operation, complete procedure		
One leg	$62.50	$12.50
Both legs	$93.75	$18.75

If the operation performed is not shown in this Schedule and is not expressly excluded by any of the terms of this Plan, the Trustees shall determine the Maximum Surgical Amount and Anesthesia Maximum for such operation. An operation of equal gravity and severity will be used as a basis for the determination.

SCHEDULE A-III
ACRA LOCAL 725
HEALTH AND WELFARE TRUST FUND

RETIRED

SCHEDULE A-III
LOCAL 725 HEALTH AND WELFARE TRUST FUND OF DADE, BROWARD AND MONROE COUNTIES, FLORIDA
SCHEDULE OF BENEFITS

CLASS 3 - RETIRED EMPLOYEES AND THEIR ELIGIBLE SPOUSES AGED 65 AND OVER.

For Employees and Eligible Spouses:

1) **Medicare Supplement Benefit Provisions:**

Lifetime Maximum	$5,000.00
Co-Insurance Percentage,	80%.
Calendar Year Deductible Per Individual	$50.00

2) **Benefits Not Subject to Deductible or Co-Insurance:**

Hospital Maximum Benefit (in-patient) Medicare Part A Deductible.

Medical Expense of Maximum Benefit Medicare. Part B Deductible.

Medicare Part D Premium - Up To $50 Per Month Reimbursement.

3) **Benefits Subject to Deductible and Co-Insurance.**

Nursing Expense Benefit Registered Nurse Usual and Customary Charge 80% Prescription Drug Expense Benefit Usual and Customary Charge 80%.

Note: Prescription Drug Benefits are not available if you are participating in a Medicare Part D Program.

MEDICARE SUPPLEMENT OF ITS CLASS 3 - RETIRED EMPLOYEES AND ARE ELIGIBLE SPOUSES AGED 65 AND OVER

You and your dependent spouse, age 65 or over, will be covered for the following Medicare Supplement Coverage, beginning the first day of the calendar month after all the requirements have been met. It will terminate as to the participant and dependent spouse once the lifetime maximum has been exhausted.

COVERED HOSPITAL CHARGES:

Charges for Room and Board and other necessary hospital supplies and services (excluding professional services) incurred for in-patient care during each Spell of Illness up to an amount equal to the In-Patient Hospital Deductible under Medicare.

COVERED MEDICAL CHARGES:

Charges for medical and other health services received during each calendar year up to an amount equal to the Part (b) Deductible under Medicare and the monthly premium change for Part (D) of Medicare up to $50.00 per month.

COVERED NURSING CHARGES

Charges for private-duty nursing services by a Registered Nurse (R.N.) other than one who usually lives with or is related to you or your spouse.

COVERED PRESCRIPTION DRUG CHARGES:

Charges for drugs and medicines obtainable only on the Physician's prescription, excluding those received in a hospital or administered by a Physician as an incident of his professional services.

Note: Prescription Drug Benefits are not available if you are participating in a Medicare Part D Program.

GENERAL BENEFITS INFORMATION

A charge is considered to be incurred on the date and individual receives the services or supplies for which the charge is made.

The benefits headed Covered Nursing Charges and Covered Prescription Drug Charges are payable at 80% of the expenses actually incurred by the individual after its deductible of $50 each calendar year has been satisfied.

The benefits payable under the above section, are subject to a lifetime maximum of $5,000.00 in benefits payable under the Plan for each individual.

If you or your spouse sustained injuries in the same accident, while insured, only one deductible will be applied to the Covered Nursing and Covered Prescription Drug Charges incurred by both, due to such injuries in the calendar year in which the accident occurred. In addition, an individual's deductible for a calendar year will be reduced by amounts applied to satisfy his deductible during the last three months of the preceding calendar year.

EXCLUSION:

Other than as expressly provided herein, no benefits shall be payable hereunder for any charges for which no benefits would be payable under the Plan apart from this Medicare Supplement Coverage, and in addition, no benefits shall be payable hereunder in connection with mental disorders except the benefits provided for Covered Hospital Charges. Prescription drugs are not covered if you or your spouse have Part (D) of Medicare.

SPELL OF ILLNESS:

The term "spell of illness" means a period of time beginning on the first day an individual entitled to benefits and Medicare receives inpatient hospital services or extended care services and ending immediately after the first 60 consecutive days and during which he is not an inpatient and a hospital or extended care facility.

The Trustees reserve the right to alter the plan and benefits and any rules and regulations of this

Notes

ACRA-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 ACRA 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, NEBA, Inc., at (954) 266-6322 or (800) 842-5899.

NEW COINSURANCE PERCENTAGE

The Board of Trustees have made an important **improvement** to the Health and Welfare Plan effective for claims for services incurred on or after January 1, 2018 by changing the coinsurance percentage. The coinsurance percentage is the amount of a covered claim that you must pay after satisfying the deductible. For in-network claims incurred on or after January 1, 2018, the amount of the allowed expense that you must pay on an in-network claim is reduced to 20% from the current 30%, and is reduced to 40% of the allowed expense from the prior 50% for services received out-of-network after your deductible. When these rates are in effect, the Plan will pay 80% of the covered expense for your in-network claim after the deductible, and you would pay 20% of the claim up to the existing out-of-pocket maximum. Alternatively, the Plan would pay 60% of the allowed expense for your out-of-network claim after the deductible, and you would pay 40% of the claim. There is not a cap or maximum on the coinsurance for out-of-network claims. This change applies to all medical claims subject to coinsurance. Claims with specific co-pays and separately identified coverage levels are not affected by this change.

These rates will remain in effect after January 1, 2018 until further notice. Please note that the Board of Trustees will review fund reserves each year starting in September 2018, and if reserves are projected to fall below three (3) months (after deducting for extended eligibility and incurred-but-not-reported claims) or 16 months of total reserves during a subsequent year, a change to coinsurance percentages will be considered. Local 725 will meet with its members if a change in coinsurance percentages is being contemplated to allow the membership to consider changes to the wage allocation to Health and Welfare to help maintain or restore reserve levels, subject to Trustee approval. You will be notified if there is a subsequent change in the coinsurance rates.

ACRA Local 725 Health and Welfare Trust Fund

NOTICE OF MATERIAL MODIFICATIONS to the ACRA LOCAL 725 HEALTH AND WELFARE PLAN

Date: October 24, 2014
To: All Plan Participants, Beneficiaries and Dependents
From: Board of Trustees
Re: Health and Welfare Plan Changes

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 several important changes that have been made to the ACRA 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, NEBA, Inc., at (954) 266-6322 or (800) 842-5899.

LOSS OF GRANDFATHERED STATUS

Please be advised that due to the ever increasing costs of providing healthcare coverage, and trying to match expenses with income, the Trustees adopted certain changes described below. As a result, the Plan will no longer be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Consequently, the changes included below shall become effective as of January 1, 2015, the beginning of the next Plan Year following this Summary.

As a non-grandfathered health plan, the Plan must include certain consumer protections of the Affordable Care Act that do not apply to grandfathered plans, for example, the requirement for the provision of preventive health services without any cost sharing. These consumer protections are in addition to other consumer protections in the Affordable Care Act with which even grandfathered health plans must comply. It is the intention of the Board of Trustees for the Plan to be compliant with the Affordable Care Act at all times.

Please note that the Board of Trustees will shortly be amending the Plan Document and will be issuing a new SPD to assist you in your understanding each of these changes.

MEDICAL CARE BENEFITS

- In-network preventive care services and immunizations will be covered at 100% with no copayments in accordance with the preventive care guidelines. These services include, but are not limited to annual physical examinations for all members (adults and children) plus lab work, annual gynecological examinations for women plus lab work, mammograms for women age 40 and above, pap smears for women age 21 and above, colonoscopies or sigmoidoscopies every 5 years for adults age 50 and above, and PSA tests annually for men age 40 and above. You can find additional preventive care information at:

  https://www.healthcare.gov/preventative-care-benefits/

- Coverage for in-network care will be provided for "routine patient costs" provided to "qualified individuals" in an "approved clinical trial", subject to the deductible and coinsurance. An "approved clinical trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease including federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application. A "qualified individual" is

someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate. "Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial, subject to certain limitations and exclusions.

- The calendar year deductible will increase from $300 per individual with no more than $900 per family, to $500 per individual with no more than $1,500 per family.

- The coinsurance percentage for in-network services will be reduced from 80% of allowed expenses to 70% of allowed expenses. The coinsurance percentage for out-of-network services will be reduced from 60% of allowed expenses to 50% of allowed expenses.

- The in-network out-of-pocket maximum is changing in both definition and dollar amount. The individual in-network out-of-pocket maximum will increase from $2,000 to $4,500. Further, there will now be a family out-of-pocket maximum of $9,000. Prior to this change, the in-network out-of-pocket maximum did not include the calendar year deductible and co-payments. Now, the in-network out-of-pocket maximum includes all deductibles, coinsurance and copayments including medical and prescription drug copayments. **There is still no out-of-pocket maximum for out-of-network claims.**

- The co-payment applicable to PPO Family Physicians will increase from $35 to $45.

- The Emergency Room Per Visit Deductible will increase from $100 to $300.

- The coinsurance percentage for out-of-network emergency room allowed expenses will increase from 60% to 80%.

PRESCRIPTION DRUG BENEFITS

- The co-payments for prescriptions dispensed at a retail pharmacy will increase from: (a) $8 to $15 for generic drugs; (b) $25 to $35 for preferred brand drugs; and (c) $40 to $65 for non-preferred brand drugs.

- The co-payments for prescriptions dispensed at a mail order pharmacy will increase from: (a) $16 to $30 for generic drugs; (b) $50 to $70 for preferred brand drugs; and (c) $80 to $130 for non-preferred brand drugs.

EXTERNAL APPEALS PROCESS

Previously, if your claim was denied and you appealed to the Board of Trustees and your appeal was denied, there was no further appeal.

Effective January 1, 2015, if your claim is denied and you appeal to the Board of Trustees and your appeal is denied, you can seek review by an Independent Review Organization ("IRO") if your claim involved medical judgement or a rescission of coverage. There is no charge for you to initiate this review and it will not affect your rights to any other benefits under the Plan.

- If your appeal involves an ongoing course of treatment, the Plan will continue to provide coverage while your appeal is pending.

- If the Trustees deny your appeal, you may, within four (4) months of the date you were notified of the denied appeal, make a written request for an external review of your claim by an IRO. Within five (5) days of your request, the Plan will review your request to determine whether it is eligible for external review. Plan decisions to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit or a determination that a particular type of treatment is experimental or investigational are eligible for external review. A decision to rescind coverage may be eligible for external review. Your claim may not be eligible for review if you have not exhausted your internal appeal or your claim involves a determination that you did not meet the Plan's eligibility requirements or sought a benefit that was not covered by the Plan. The Plan will inform you of any issues with your request within one (1) day of completing its review. If your request is eligible for review, but incomplete, you will be informed what information is required to complete the request and you will be given the longer of forty-eight (48) hours or the remainder of the four (4) month filing period to correct the deficiency.

- If you request external review, your claim will be submitted to an accredited IRO together with any documents and any information that the Plan and Trustees relied upon in considering your claim and internal appeal. The IRO will notify you when it has received your claim, and you will be provided ten (10) days to submit any additional information in support of your appeal.

If you submit new information, the IRO will share that information with the Plan, which may reconsider your internal appeal. If the Plan reverses its adverse determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision, and upon receipt the IRO will terminate the external review.

- The IRO will make independent medical and legal decisions concerning your claim. The IRO will issue its decision within forty-five (45) days of receiving your claim for review. If the IRO decides that the Plan must provide additional benefits, the Plan will carry out the decision. If the IRO determines that the internal appeal was correctly decided, and you disagree with that decision, you may bring legal action against the Plan within one (1) year of the IRO's decision.

- If your appeal involves (a) a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health, or ability to regain maximum function and you previously requested an expedited appeal to the Trustees, or (b) an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility, you may request expedited external review. The Plan will review your request immediately to determine whether it is eligible for external review. If it is eligible, your claim will be referred as soon as possible to an IRO and you will be informed of the IRO's decision as expeditiously as possible, but in no event more than seventy-two (72) hours after the IRO receives the claim for review. If the initial notice is not in writing, you will receive written confirmation of the decision within forty-eight (48) hours of the initial notice.

PLEASE NOTE

This Notice is intended to amend all plan documents, notices and correspondence, including, but not limited to, the Summary Plan Description and the annual Summary of Benefits and Coverage.

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to your plan of benefits. You should take the time to read this SMM carefully (and share it with your family) and keep it with your copy of the Summary Plan Description ("SPD"). While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan Document. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan Document will govern in all cases.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify, terminate or interpret and decide all matters under the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason.

ACRA Local Union No. 725
Health and Welfare Trust Fund

NOTICE OF MATERIAL MODIFICATIONS to the ACRA-LOCAL 725 HEALTH AND WELFARE PLAN

Date: November 6, 2013
To: All Plan Participants, Beneficiaries and Dependents
From: Board of Trustees
Re: Health and Welfare Plan Changes

This notice is a Summary of Material Modifications ("Summary"), 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 several important changes that have been made to the ACRA-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 will govern. If you have any questions about these changes and/or any other information provided herein, please call the Plan's Administrative Manager, NEBA, Inc., at (954) 266-6322 or (800) 842-5899.

To ensure the Plan's compliance with requirements of the Patient Protection and Affordable Care Act (the "Affordable Care Act"), please be advised that the Board of Trustees have made the following changes to your benefit plan:

1. Pre-Existing Conditions.

Effective as of January 1, 2014, the 12 month exclusionary period for pre-existing conditions will no longer apply.

2. Prescription Drugs.

Effective as of January 1, 2014, the annual limitation on prescription drugs will no longer apply.

3. Low Protein Foods.

Effective as of January 1, 2014, the annual limitation on low-protein foods will no longer apply.

4. Coverage of Employed Adult Children.

Effective as of January 1, 2014, plan participant's adult children shall not be denied coverage under the Plan based solely upon the availability of other health care coverage to them through their employment.

5. Wellness Benefits.

Effective as of January 1, 2013, the six hundred ($600.00) annual limit on wellness benefits for adults (individuals who have attained age 17 and older), will no longer apply.

Note that the Plan is jointly administered by a Board of Trustees comprised of the following eight (8) individuals, four (4) Employer Trustees appointed by the contractors association, and four (4) Union Trustees appointed by the union:

EMPLOYER TRUSTEES

EDUARDO LLOSENT
Airtech Air Conditioning, Inc.
7805 N.W. 55 Street
Miami, Florida 33166

MARK KERNEY
Hill York Service Corporation
2125 S. Andrews Avenue
Fort Lauderdale, Florida 33316

L. WADE HELMS
EDD Helms Air Conditioning, Inc.
17850 N.E. 5 Avenue
Miami, Florida 33162

JULIE DIETRICH
Air Conditioning, Refrigeration,
Heating & Piping Association, Inc.
160 W. Camino Real, #132
Boca Raton, Florida 33432

UNION TRUSTEES

KENNETH E. SCOTT, JR.
United Association Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

JAMES E. TAYLOR
United Association Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

RICHARD J. FOLKMAN
United Association Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

RALPH MARINELLO
United Association Local Union No. 725
13185 N.W. 45th Avenue
Opa Locka, Florida 33054

The Plan's Agent for Service of Legal Process, and Administrative Manager is:

National Employee Benefit Administrators, Inc.
2010 N.W. 150th Avenue
Suite 100
Pembroke Pines, Florida 33028

The Plan's Consultant is:

Horizon Actuarial Services, L.L.C.
900 Ashwood Parkway
Suite 170
Atlanta, Georgia 30338

The Plan's Auditor is:

S I Gordon & Company, P.A.
11555 Heron Bay Boulevard
Suite 200
Coral Springs, Florida 33076

The Plan's Legal Counsel is:

Richard M. Weiner, P.A.
7479 N.W. 4th Street
Plantation, Florida 33317

All claims for medical and prescription benefits should be submitted to:

Blue Cross Blue Shield of Florida
P.O. Box 1798
Jacksonville, Florida 32231

All claims for dental benefits should be submitted to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, Georgia 30023-1809

All claims for transplant benefits should be submitted to:

National Union Fire Insurance Company
of Pittsburgh, PA, a Chartis Company
c/o Medical Excess, L.L.C.
8777 Purdue Road, #330
Indianapolis, Indiana 46268

All claims for life insurance, accidental death and personal loss coverage benefits should be submitted to:

Aetna Life Insurance Company
P.O. Box 14549
Lexington, Kentucky 40512-4549

All claims for short-term disability benefits should be submitted to:

National Employee Benefit Administrators, Inc.
2010 N.W. 150th Avenue
Suite 100
Pembroke Pines, Florida 33028

If you have any questions regarding the above-referenced provisions or any other provisions of the Plan, please call the Plan's Administrative Manager, NEBA, Inc., at (954) 266-6322 or (800) 842-5899.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a Participant in the ACRA-Local 725 Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Trust Fund and Benefits

- Examine, without charge, at the Office of the Plan's Administrative Manager and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).

- Obtain, upon written request to the Office of the Plan's Administrative Manager, copies of documents governing the operation of the Trust Fund, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan may make a reasonable charge for the copies.

- Receive a summary of the Trust Fund's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Trust Fund Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Trust Fund 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 Trust Fund on the rules governing your COBRA Continuation Coverage rights.

- Be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. The Plan does not have a pre-existing condition limit. (Note: There are limitations on

plans' imposing a preexisting condition exclusion and such exclusions will become prohibited for plan years beginning in 2014 under the Affordable Care Act.)

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

If you have any questions about your Trust Fund, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Office, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W., Suite N-5623
Washington D.C, 20210.
Telephone: (202) 693-8680

The nearest office of the Employee Benefits Security Administration is located at:

Miami District Office
8040 Peters Road
Building H, Suite 104
Plantation, Florida 33324
Telephone: (954) 424.4022

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Employer Identification Number ("EIN") issued to the Plan by the Internal Revenue Service is 59-6150964, and that the Plan Number is 501.

Please note that the Plan Year ends as of each December 31st.

GRANDFATHERED HEALTH PLAN NOTICE

The Board of Trustees of the ACRA-Local 725 Health and Welfare Plan believes that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan's administrative manager at the number above. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.