FUND OFFICE ADDRESS AND PHONE NUMBERS

SOUTHEAST LABORERS HEALTH FUND
P.O. Box 1449, Goodlettsville, Tennessee 37070-1449
Street Address:
2001 Caldwell Drive, Goodlettsville, Tennessee 37072
Phone: (615) 859-0131 • Toll-Free: (800) 831-4914
Fax: (615) 859-0818

PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund participates in the CIGNA HealthCare preferred provider organization (PPO). You should have received a booklet listing participating providers in your area. If you have not received one, or if you need a replacement, please contact the Fund office and a PPO directory will be provided to you free of charge. You may contact CIGNA as follows:

Toll-Free: (800) 768-4695

or online at: www.cigna.com/SA-PPO2

MAIL ORDER DRUG COVERAGE/PHARMACY DISCOUNT PROGRAM

Coverage for prescription drugs is provided under the Comprehensive Major Medical Expense Benefit as outlined in the Schedule of Benefits. The Fund has entered into an arrangement with Express Scripts (formerly NPA) to secure discounts on prescription drugs. When you have a prescription filled at a participating pharmacy, the cost of the prescription is discounted to both you and the Fund. Additionally, Express Scripts offers a mail order drug program under which you can receive maintenance drugs by paying the appropriate copayment.

You should have received an ID card, which also serves as your drug discount card, to be presented to your pharmacy when you have a prescription filled. If you have not received one, please contact the Fund office. For information, or to locate a pharmacy, you may call Express Scripts at:

Toll-Free: (800) 467-2006

Or you may contact them on the internet at:

www.express-scripts.com

SOUTHEAST LABORERS HEALTH FUND

Dear Plan Participant:

The following pages contain a summary of the benefits provided under the Southeast Laborers Health Fund. Federal law requires that this explanation of the plan of benefits be provided to you on a periodic basis. This booklet represents an important document for you and your family, and we would request that you take the time to review its contents.

This booklet describes the benefits available to you and your dependents and contains a detailed explanation of the rules of eligibility for participation in the plan. There are many other important sections of the booklet, including instructions on how to file claims, a section which describes your right to appeal any denied claims, and a statement of your additional rights under the provisions of the Employee Retirement Income Security Act.

Please read this booklet carefully. Along with your Fund ID card and your PPO directory it will help you access important health coverage for you and your family members. If you do not have a current Fund ID card or PPO directory, please contact the Fund office and these items will be provided to you free of charge.

If you should have absolutely any questions regarding the contents of this booklet or concerning the operation of your plan, please feel free to contact the Fund office at the address and telephone numbers listed in this booklet.

Best regards,

Your Board of Trustees

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SOUTHEAST LABORERS HEALTH FUND

This Plan is Administered by:
THE BOARD OF TRUSTEES

THE TRUSTEES OF THE FUND ARE:

UNION TRUSTEES:

MR. GLENN FARNER
Business Manager
Southeast Laborers' District Council
51 Century Boulevard, Suite 300
Nashville, Tennessee 37214

MR. STEVE FARNER
International Representative
Ohio Valley and Southern States
Regional Laborers' International
Union of North America
22 Century Boulevard, Suite 450
Nashville, Tennessee 37214

MR. BRIAN HALE
Ohio Valley and Southern States
Regional Laborers' International
Union of North America
22 Century Boulevard, Suite 450
Nashville, Tennessee 37214

MR. KERRY HALE
International Representative
Ohio Valley and Southern States
Regional Laborers' International
Union of North America
22 Century Boulevard, Suite 450
Nashville, Tennessee 37214

EMPLOYER TRUSTEES:

MR. J. DAVID BECKLER
Tennessee Valley Authority
400 West Summit Hill Drive, ET6D
Knoxville, Tennessee 37902

MR. MICHAEL B. PFIEFFER
Industrial Contractors
P.O. Box 997
Columbia, Tennessee 38401

MR. F. DOUGLASS STEIN
Stein Construction Company,
Incorporated
P.O. Box 5246
Chattanooga, Tennessee 37406-0246

MR. RONALD TANNER
Manager, Business Development
Ohio Valley and Southern States LECET
1701 Central Avenue
Chattanooga, Tennessee 37408

ALTERNATE EMPLOYER TRUSTEE:

MR. DANNY C. MacMILLAN
Alloy Industrial Contractors,
Incorporated
P.O. Box 15058
Savannah, Georgia 31416-1758

ADMINISTRATIVE AND CONSULTING SERVICES ARE PROVIDED TO THE TRUSTEES BY:

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

THE PLAN ATTORNEY IS:

MR. R. JAN JENNINGS
BRANSTETTER, KILGORE, STRANCH & JENNINGS
227 Second Avenue North, Fourth Floor
Nashville, Tennessee 37201-1631
Phone: (615) 254-8801

AREAS PARTICIPATING IN THE SOUTHEAST LABORERS HEALTH FUND

As of March 1, 2008

In Tennessee:

- Laborers Local Union No. 386
- Laborers Local Union No. 818
- Laborers Local Union No. 846
- Laborers Employed by Contractors Performing Work for the Tennessee Valley Authority

In Alabama:

- Laborers Local Union No. 366

In Georgia:

- Laborers Local Union No. 515
- Laborers Local Union No. 559

SCHEDULES OF BENEFITS

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

In addition to the various maximums, restrictions and limitations listed as a part of the Schedules of Benefits, there are other restrictive Plan provisions found further in this booklet. Please read all of these sections very carefully before incurring expenses which you anticipate will be paid by the Fund.

SCHEDULE OF BENEFITS FOR ACTIVE AND RETIRED COVERED EMPLOYEES

FOR COVERED EMPLOYEES ONLY

BENEFIT	MAXIMUM PAYMENT
DEATH BENEFIT (24-hour coverage)	$6,000.00
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (24-hour coverage) Principal Amount	$6,000.00

FOR ACTIVE COVERED EMPLOYEES ONLY

LOSS OF TIME BENEFIT
Weekly Benefit ..... $ 150.00
Maximum Period for Benefits – 13 weeks
Benefits commence on: 1st day for accident
8th day for sickness

FOR COVERED EMPLOYEES AND DEPENDENTS

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

Note that improved benefits are available for services rendered by a participating PPO provider.

Benefit Maximums:

Maximum Benefit per Calendar Year per Covered Person for a Routine Medical Examination, Including Diagnostic X-Ray and Laboratory Procedures, when Performed by a Medical Doctor (M.D.)	$ 200.00
Maximum Benefit per Calendar Year per Covered Person for the Purchase and Administration of Prescription Drugs (Maximum does not Apply to Medications Required in the Direct Treatment of Cancer or to Drugs Administered During the Course of a Medically Necessary Hospital Confinement required for Reasons other than the Administration of Medications)	$ 10,000.00
Maximum Lifetime Benefit per Covered Person for all charges incurred for or in connection with the diagnosis or treatment of sleep apnea or other sleep disorders, to include the performance of sleep studies and the purchase, or rental up to the purchase price, of a continuous positive airway pressure (CPAP) machine or any similar device	$ 2,500.00
Maximum Benefit per Calendar Year per Covered Person for All Covered Medical Expenses Combined	$ 225,000.00
Maximum Lifetime Benefit for All Covered Medical Expenses Combined	$1,000,000.00

Deductible (Calendar Year):

For Prescription Drugs Purchased through the Mail Order Drug Program Sponsored by the Fund	None
For a Routine Medical Examination, Including Diagnostic X-Ray and Laboratory Procedures, when Performed by a Medical Doctor (M.D.)	None

For All Other Covered Medical Expenses for Services Rendered by a Participating PPO Provider or a Participating Pharmacy	$ 200.00
For All Other Covered Medical Expenses	$ 400.00

Co-Payment for Prescription Drugs Purchased through the Mail-Order Drug Program Sponsored by the Fund, per Prescription or Refill:

For Generic Equivalent Medications	$ 10.00
For Single-Source Brand Name Drugs	$ 20.00
For Multi-Source Brand Name Drugs	50% of cost

Benefit Percentage Paid by the Fund:

For Purchase of Generic Equivalent Drugs	90%
For Purchase of Brand Name Drugs	70%
For a Routine Medical Examination, Including Diagnostic X-Ray and Laboratory Procedures, when Performed by a Medical Doctor (M.D.)	100%
For All Other Covered Medical Expenses:	
For Services Provided by a Participating PPO Provider*	90%
For Services Rendered by a non-PPO Provider**	80%

Maximum Out-of-Pocket Expense:

Maximum Amount Payable by each Covered Person per Calendar Year, After Satisfaction of the Calendar Year Deductible, if Applicable:	
For all Charges Incurred with Participating PPO Providers	$5,000.00
For Charges Incurred with Non-PPO Providers	No Maximum

(This Maximum Out-of-Pocket Expense will not apply when the Covered Person is eligible to have these charges paid through other group health coverage.)

Other Limits:

Maximum Daily Room and Board Service Charge ..... Semi-Private Room Rate

Maximum Supply per Prescription or Refill for Prescription Drugs Purchased through the Mail Order Drug Program Sponsored by the Fund ..... 90 Days

*If the Covered Person is treated at a participating PPO facility and uses the services of a participating PPO primary Physician, charges incurred with ancillary providers such as anesthesiologists, radiologists, pathologists and laboratories will be covered as though incurred with a participating PPO provider.

**If the Covered Person lives over 35 miles from the nearest PPO provider of the same or similar covered services, charges incurred with a non-PPO provider will be covered at 90%.

SPECIAL LIMITED SCHEDULE OF BENEFITS FOR EMPLOYEES OF CONSTRUCTION EMPLOYERS PAYING 50¢ PER HOUR CONTRIBUTION RATE

FOR COVERED EMPLOYEES ONLY

BENEFIT	MAXIMUM PAYMENT
DEATH BENEFIT (24-hour coverage)	$ 2,500.00
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (24-hour coverage) Principal Amount	$ 2,500.00
LOSS OF TIME BENEFIT	
Weekly Benefit	$ 25.00
Maximum Period for Benefits – 13 weeks	
Benefits commence on: 1st day for accident	
8th day for sickness	

FOR COVERED EMPLOYEES AND DEPENDENTS

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

(Benefits are provided for a Covered Person for Covered Medical Expenses incurred as a Hospital inpatient, for surgery performed on an outpatient basis, and for the emergency treatment of Accidental Bodily Injuries received within 24 hours of the accident on an outpatient basis.)

Maximum Lifetime Benefit per Covered Person for all charges incurred for or in connection with sleep apnea or other sleep disorders ..... $ 2,500.00

Maximum Lifetime Benefit for All Covered Medical Expenses Combined $25,000.00

Deductible (Calendar Year) ..... $ 400.00

Benefit Percentage Paid by the Fund 70%

Maximum Daily Room and Board Service Charge ..... Semi-Private Room Rate

CLAIM PROCEDURES

HOW TO FILE YOUR CLAIMS

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

1. Time Limit for Filing a Claim — All claims must be submitted within 90 days after the period during which they are incurred. For major medical claims only, this means that all claims must be filed by March 31 of the year following the year in which they are incurred. All other claims **must** be filed within 90 days following the date of loss.

2. When you receive services from a doctor, hospital or other health care provider, you must furnish to that provider the information needed to file a claim with the Fund. This information is found on your Fund ID card. The provider will usually file the necessary bills and related information with the Fund office. If not, you are responsible for seeing that the claim is submitted timely.

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

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

PAYMENT OF CLAIMS BY FUND OFFICE

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

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

PRE-APPROVAL OF A CLAIM

This Fund has no mandatory pre-certification or pre-approval requirements for treatment. However, certain treatments and procedures are not covered under the Fund, and you may wish to contact the Fund office at certain times prior to receiving treatment in order to assure that the treatment will be covered. The following rules apply to pre-approval of treatment:

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

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

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

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

As explained in the preceding section, even though the plan does not have any mandatory pre-certification or pre-approval requirements, you may want to request pre-approval of treatment to ensure that it will be covered under the plan. The Fund office staff will respond to all such requests in a timely manner, as follows:

1. Urgent Care Claims — If proposed treatment is determined to be **urgent** in

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

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

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

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

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

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

APPEAL PROCEDURES

A Covered Person whose claim for benefits has been denied under the terms of the plan is entitled to certain rights, including the right to receive a full explanation of the denial and an opportunity to appeal the denial. The following procedures have been adopted by the Board of Trustees explaining those rights:

NOTICE OF ADVERSE BENEFIT DETERMINATION (Notice of Denial)

Upon determination that a claim submitted by or on behalf of a Covered Person is not covered under the plan, the Covered Employee will be notified in writing within the time frame set forth in the previous pages regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by the claimant, all of the following information:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan provisions on which the determination 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;

4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;

5. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation that the claimant will be provided free of charge upon request an explanation of the scientific or clinical judgment applied to the terms of the plan with respect to the claimant's medical circumstances used in making the determination; and

7. If the claim involves urgent care, a description of the expedited review process applicable to such claims. If an adverse benefit determination involves an urgent claim, the contents of this notice may be provided orally to the claimant. However, in such instances this written notification will be furnished to the claimant not later than three days after the oral notification.

CLAIMANT'S RIGHT TO APPEAL AN ADVERSE BENEFIT DETERMINATION

A claimant whose claim for benefits has been denied under the terms of the plan and to whom a notice of adverse benefit determination has been issued in accordance with the preceding section will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which the claimant may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below. The procedures will:

1. Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination;

2. Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of such individual;

3. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or their committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

4. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

5. Provide that the health care professional engaged for purposes of this appeal is neither an individual who was consulted in connection with the adverse

benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

6. Provide, in the case of a claim involving urgent care, for an expedited review process under which —

   (a) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and

   (b) all necessary information, including the Plan's benefit determination on review, will be transmitted between the plan and the claimant by telephone, facsimile or other available similarly expeditious method.

NOTICE OF TRUSTEES' DECISION

The Board of Trustees, or their committee, will review all appeals in accordance with the following and will notify the claimant as indicated:

1. Urgent Care Claims — When the appeal of a claim involving urgent care, as that term is defined on page 11 of this booklet, is received as provided by the Plan, a decision on the appeal will be made and will be communicated in writing (and otherwise as appropriate) within 72 hours of receipt of the claimant's request for review of an adverse benefit determination. Appeals of adverse benefit determinations involving urgent care will be addressed promptly by the Trustees, or by their committee, taking into account the urgent nature of the claim, but in no instance will the decision be made later than 72 hours after receipt of the claimant's request.

2. Non-Urgent Care Claims — Appeals of adverse benefit determinations received from claimants which are of a non-urgent care nature shall be reviewed by the Trustees, or their committee, in accordance with the following guidelines, and notification of the decision shall be communicated in writing to the claimant within the time period prescribed.

   (a) Pre-Service Claims — If the appeal involves a request for review of an adverse benefit determination for medical services which have not yet been provided, the Trustees or their committee will make a decision on the appeal and the decision will be communicated in writing to the claimant not later than 30 days after receipt of the claimant's request for review.

(b) Post-Service Claims — If the claimant's request for review of an adverse benefit determination involves a claim for medical services which have already been provided, a decision on the claimant's appeal will be made by the Trustees or their committee and communicated in writing to the participant within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee which immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the plan's receipt of the request for review, but in no instance more than 120 days following receipt of the appeal.

3. Notwithstanding the statements set forth above, notice of every appeals determination will be given to the claimant within 5 days of the determination.

ACCESS TO PLAN DOCUMENTS

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

NOTIFICATION OF DECISION ON APPEAL

Each claimant whose adverse benefit determination has been appealed to the Trustees will receive notification in writing, within the time period outlined above, of the Trustees' or the committee's decision. Such notification will set forth, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse determination;

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

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

4. A statement describing any additional voluntary appeal procedures offered by the plan and the claimant's right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a

statement of the claimant's right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and

5. The following information where applicable —

(a) If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to the claimant upon request;

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

(c) A statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency. While the Plan does not currently offer voluntary alternative dispute resolution options to the procedures set forth above, you may contact the Local U.S. Department of Labor Office and your State Insurance Regulatory Agency to determine what options might be available to the Plan.

GENERAL

1. You may, at your own expense, have legal representation at any stage of these Appeal Procedures.

2. Maximum effort will be made by the Trustees to interpret Plan provisions in a consistent and equitable manner, and you will be given maximum opportunity for review of any claim by the Trustees.

3. It is the position of the Trustees that every participant and beneficiary will be required to exhaust each and every right of recourse available under these Appeal Procedures before the participant or beneficiary proceeds to litigation and any attempt to circumvent or subvert these Appeal Procedures in any manner will be resisted by the Trustees.

DEFINITIONS

ACCIDENTAL BODILY INJURY

"Accidental Bodily Injury" means an injury to a Covered Person which:

1. Results from and is caused by a sudden and violent event;

2. Is caused by an external force or object; and

3. Occurs unexpectedly and by chance, or is not due to any fault or misconduct on the part of the injured Covered Person.

ACUTE MEDICAL CARE

"Acute Medical Care" means medical care delivered for treatment of an illness which arises suddenly and which urgently requires the patient to seek immediate medical care such as that typically delivered in a hospital emergency room, and does not include elective or routine care.

COVERED DEPENDENT

"Covered Dependent" means those individuals eligible for coverage as Covered Dependents on the date the Covered Employee becomes eligible or on the date they acquire dependent status, as defined below, provided they are not employed by any contributing Employer:

1. The Covered Employee's spouse to whom he is legally married, as evidenced by a certificate of marriage, and not including common-law spouses; and

2. The Covered Employee's unmarried child or children from date of birth until his or her twenty-third birthday, provided that during the period of time from the nineteenth birthday until the twenty-third birthday the child remains unmarried and a full time student. For purposes of coverage under the Plan, child or children shall include natural children, step-children and legally adopted children. Foster children and legal wards of the Covered Employee will also be considered Covered Dependents under the Plan provided permanent custody of the foster child or legal ward has been granted to the Covered Employee by court order or by directive of a governmental agency.

A step-child, legally adopted child, foster child or legal ward will be considered a Covered Dependent of the Covered Employee only if the child:

(a) Lives with the Covered Employee in a regular parent-child relationship;

(b) Receives full financial support from the Covered Employee;

(c) Is dependent on the Covered Employee for health care protection; and

(d) Is claimed as a dependent on the Covered Employee's federal income tax return.

Coverage will be provided for a step-child, legally adopted child, foster child or legal ward only if the Covered Employee provides written verification of that child's relationship to the Covered Employee as required by the Trustees from time to time. Coverage for foster children will be provided only to the extent of Covered Medical Expenses which are not furnished or paid for by a federal or state program.

A child who is less than nineteen years of age who has been placed with a Covered Employee for adoption, but where the adoption is not yet final, will also be considered a Covered Dependent. Being placed for adoption means that the Covered Employee has assumed, and retains, a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child's placement with the Covered Employee terminates upon termination of such legal obligation. Upon an adoption becoming final the child may continue to meet the definition of Covered Dependent in accordance with other portions of this definition.

Additionally, if an unmarried dependent child of a Covered Employee is not capable of self-sustaining employment by reason of mental retardation or physical handicap, coverage for that child will be continued under the Plan provided all of the following provisions are met:

(a) The incapacity must have begun prior to the date coverage for that child would have otherwise terminated;

(b) The child must be chiefly dependent upon the Covered Employee for support and maintenance; and

(c) The Fund office must receive proof of the incapacity within the 31 day period prior to the date on which the dependent child's coverage would otherwise have terminated.

Provided all of these requirements are met, the coverage of the disabled dependent child may be continued at the option of the Covered Employee for so long as the coverage of the Covered Employee under the Plan remains in force and as long as the dependent child remains in such condition.

COVERED EMPLOYEE

"Covered Employee" means any person who satisfies the Rules of Eligibility outlined in this booklet.

COVERED MEDICAL EXPENSE

"Covered Medical Expense" means those expenses which are outlined in this booklet which are actually incurred by a Covered Person for treatment of an illness, Accidental Bodily Injury or congenital defect, or in connection with the pregnancy of a Covered Employee or the spouse of a Covered Employee, or for the routine care of a newborn infant, or for a surgical sterilization procedure performed on a Covered Employee or the spouse of a Covered Employee, subject to all the limitations outlined in this booklet. Further, "Covered Medical Expenses" are limited to those expenses which are Medically Necessary, and which are Usual, Customary and Reasonable Expenses, as those terms are defined in this section.

COVERED PERSON

"Covered Person" means either a "Covered Employee" or a "Covered Dependent."

EXPERIMENTAL AND INVESTIGATIVE EXPENSE

"Experimental and Investigative Expense" means the use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet generally recognized as accepted medical practice and any of such items requiring federal or other governmental agency approval and for which such approval has not been granted at the time the services are rendered.

FREE STANDING OR WALK-IN CLINIC

"Free Standing or Walk-In Clinic" means a clinic or center which has been established solely for the purpose of treating minor medical emergencies and illnesses on an outpatient basis. Hospitals and other facilities which provide for treatment on an inpatient basis are not considered Free Standing or Walk-In Clinics.

HOSPITAL

"Hospital" means:

1. Any institution which is an approved and accredited hospital recognized by the American Hospital Association and which is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis OTHER THAN as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics;

OR

2. Any institution which meets all of the following requirements:

   (a) It maintains permanent and full-time facilities for bed care of five or more resident patients;

   (b) It has a Physician in regular attendance;

   (c) It continuously provides 24-hour-a-day nursing service by registered nurses;

   (d) It is primarily engaged in providing diagnostic and theapeutic facilities for medical and surgical care of injured and sick persons on a basis OTHER THAN as a rest home, nursing home, convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; and

   (e) It is operating lawfully in the jurisdiction in which it is located.

MEDICALLY NECESSARY

"Medically Necessary" means those services, treatments or supplies provided by,

or under the direction of, a Hospital or Physician that are required in the judgement of the Trustees to identify or treat an Accidental Bodily Injury or sickness or other covered condition and which are:

1. Consistent with the symptoms or diagnosis and treatment of the Covered Person's condition, disease, ailment or injury;

2. Appropriate according to standards of good medical practice;

3. Not solely for the convenience of a Covered Person, Physician or Hospital; and

4. The most appropriate which can be safely administered to the Covered Person.

PHYSICIAN

"Physician" means a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place the service is rendered. For the purpose of rendering covered services only, Doctors of Dental Surgery (D.D.S.), Doctors of Dental Medicine (D.M.D.), Doctors of Surgical Chiropody (D.S.C.), and Doctors of Podiatry (Pod. D.), when acting within the scope of their licenses, are considered Physicians.

PRE-ADMISSION TESTING

"Pre-Admission Testing" means those expenses incurred for tests and services administered prior to the Covered Person's actual Hospital confinement which are Medically Necessary and are ordered by the attending Physician for the determination of a diagnosis, or for determining the necessity for a particular surgical procedure or course of treatment.

USUAL, CUSTOMARY AND REASONABLE EXPENSE

"Usual, Customary and Reasonable Expense" and "Reasonable Expense" mean the usual, reasonable and customary fees or charges for the covered services rendered and the covered supplies furnished as determined for the geographical area in which the services are rendered or the supplies are furnished.

RULES OF ELIGIBILITY

Any person working for a contributing employer in the jurisdiction of the Southeast Laborers Health Fund will be eligible to receive benefits and will become a Covered Employee after satisfying the following requirements.

INITIAL ELIGIBILITY

An employee will become initially eligible on the first day of the second month following the month in which he has been employed by contributing Employers and worked at least 260 hours for which contributions are due and paid to the Fund during a period of no more than four consecutive months. An employee who meets this eligibility requirement will remain eligible during the Benefit Month in which he gains eligibility as well as the immediately following Benefit Month, and continuing eligibility will then be determined in accordance with the section entitled "Continuation of Eligibility."

ELIGIBILITY PERIODS

Continuing eligibility will be calculated on the basis of Contribution Months and Benefit Months as follows:

Contribution Months Hours Worked In:	**Benefit Months** Earn Eligibility For:
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

CONTINUATION OF ELIGIBILITY

A Covered Employee will continue to be eligible as long as one or more contributing employers pay on his behalf funds representing at least 130 hours of work for each Contribution Month corresponding with the respective Benefit Month. The hours must have actually been worked for a contributing employer and must be hours for which contributions are required to be paid to the Fund, and are actually paid to the Fund, under the terms of an applicable collective bargaining agreement.

HOUR BANK

An "Hour Bank" will be established for the purpose of maintaining in reserve the excess hours worked by each Covered Employee to be applied toward future eligibility when needed. When hours are withdrawn from a Covered Employee's Hour Bank, they will be credited as though they were worked by the Covered Employee in the respective Contribution Month.

When a Covered Employee works more than 130 hours for a participating employer during any Contribution Month, all hours in excess of 130 hours will be credited to his Hour Bank. The maximum number of hours that may be accumulated in this account is limited to 520 hours.

Once an employee has become initially eligible for benefits under this Fund, hours will be drawn from his Hour Bank during future Contribution Months in the amount required to continue eligibility, in the event Employer contributions are not received for the minimum of 130 hours required to maintain eligibility. Remaining Hour Bank hours which, when combined with hours worked, are insufficient to continue coverage for a Covered Employee will be used to reduce the amount of any self-contribution due as though such hours were worked in the corresponding Contribution Month. The remaining Hour Bank hours will be automatically withdrawn from the Covered Employee's Hour Bank regardless of whether he chooses to make his self-contribution.

SELF-CONTRIBUTION RULES FOR ACTIVE COVERED EMPLOYEES

After once having become eligible, if a Covered Employee fails to work for a participating employer the number of hours required to continue his eligibility in force, he will be permitted to contribute on his own behalf payments in an amount equal to the difference between hours actually credited for the Contribution Month specified and 130.

Self-contributions are limited to a maximum of six consecutive Benefit Months. However, each Covered Employee's right to make self-contributions will terminate after the Benefit Month corresponding with the third consecutive Contribution Month during which the Covered Employee has failed to be credited with a minimum of 50 hours of work for which contributions are due the Fund. This provision means that a Covered Employee will not be eligible to make additional self-contributions once he has failed to be credited with at least 50 hours in any month of a three consecutive Contribution Month period, even though he may not have made the maximum six consecutive self-contributions outlined under this section.

All self-contributions must be made in the manner and on the due date established by the Trustees.

REINSTATEMENT OF ELIGIBILITY

Once an employee has gained eligibility under the Fund and later loses his eligibility, his eligibility will be reinstated on the first day of the Benefit Month corresponding with the Contribution Month for which employer contributions are paid to the Fund representing at least 120 hours of work. An employee who meets this requirement will be eligible during the Benefit Month in which eligibility is regained.

SELF-CONTRIBUTION RULES FOR RETIRED COVERED EMPLOYEES

A Covered Employee who retires from employment will be eligible to continue his coverage through self-contributions provided he has attained at least age 62 and he is receiving a retirement benefit from the Laborers National Pension Fund, as documented in writing. This coverage may be continued so long as the Covered Employee is retired, until attainment of age 65.

A Covered Employee's right to continue his coverage under this provision will terminate on the last day of the Benefit Month in which he reaches sixty-five (65). A Covered Employee will be considered as retired from employment within the jurisdiction of the Fund so long as he does not earn wages for employment in excess of the annual amount allowed under Social Security.

Self-contributions made under this provision must be paid monthly in the amount and manner established by the Trustees.

NOTICES OF SELF-CONTRIBUTIONS DUE

To the extent possible, the Trustees will require that the Fund administrative manager issue notices concerning each Covered Employee's right to self-contribute at the appropriate time each month. However, for reasons beyond the control of the Trustees or the administrative manager, such notices may not be issued on occasion or may not be received by the Covered Employee. Regardless, it is the responsibility of each Covered Employee to make all self-contributions in a timely manner whenever such payments may be due, even though the Covered Employee may not have received a notice of the payment due. Remember, it is your responsibility to pay all amounts due when required even if you do not receive notice from the Fund office.

MAINTENANCE OF ELIGIBILITY OF EMPLOYEES RECEIVING BENEFITS

Any Covered Employee who is disabled, and who is eligible for and actually drawing Loss of Time Benefits under the Fund, or who is entitled to receive benefits under any Workmen's Compensation or Occupational Disease law will, beginning with the eighth day of disability due to sickness or accident, receive thirty-three (33) hours of work credit for each week he is entitled to draw or is drawing such benefits, up to a maximum of 130 hours per month.

This work credit accumulation will cease when the benefits cease or when such work credits total three hundred ninety (390) hours, whichever occurs first.

TERMINATION OF COVERAGE FOR DEPENDENTS OF DECEASED EMPLOYEE

When a Covered Employee dies, the eligibility of his dependents will terminate on the last day of the Benefit Month in which the employee's coverage would have otherwise terminated, had he not died, based on hours of work previously performed, including accumulated Hour Bank hours.

SERVICE IN THE ARMED FORCES

A Covered Employee who is inducted or enlists or is otherwise called to active duty in the Uniformed Services of the United States of America will be entitled to continued coverage or the right to make self-contributions for continued coverage, as set forth below:

1. For active uniformed service of 31 days or less—The Covered Employee will be credited with contributions equal to eight hours per day for each day (Monday-Friday) of active uniformed service provided the Covered Employee reports to work no later than the first regularly scheduled working period one week after termination of active duty.

2. For active uniformed service of more than 31 days—All benefits of a Covered Employee and his Covered Dependents will be terminated on the date he enters uniformed service for a period of service in excess of 31 days, except as follows:

   (a) The Covered Employee may choose to continue coverage through the use of any current hours worked or through the use of any accumulated Hour Bank hours, if such hours are available.

   The Covered Employee may elect to use this accumulated eligibility to continue coverage under the Fund, or may elect to defer the use of his hours until his reemployment as described below, or may elect to use any portion of his hours and defer usage of the remainder. Failure to elect continued coverage under this provision will result in an automatic deferral of the use of such accumulated eligibility.

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

Former Covered Employees who are discharged from active uniformed service of 60 months or less will be reinstated for benefits provided the individual submits an application for reemployment or seeks reemployment through a participating local union within 14 days (if the active uniformed service is for 31 to 180 days) or 90 days (if the active uniformed service is more than 180 days) after discharge. The time for reemployment application will be extended in the event of injury or hospitalization as further provided in the Uniformed Services Employment and Reemployment Rights Act of 1994.

If a Covered Employee has chosen to use accumulated eligibility credits as outlined under paragraph (2)(a) above and, as a result, does not have enough eligibility accumulated to his credit to continue his coverage under the Fund upon reemployment, the Covered Employee will be required to make monthly self-contributions to the Fund in order to regain and continue his coverage. Self-contributions will be required until the Covered Employee has worked enough hours to satisfy the rules of Continuation of Eligibility.

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

INDIVIDUAL TERMINATIONS

The coverage of a Covered Person will terminate: (1) on the date the Plan is terminated; or (2) on the date the Covered Employee ceases to be eligible for coverage according to the rules of eligibility established by the Trustees; or (3) on the date the Covered Person, if a Covered Dependent, ceases to be a Covered Dependent.

ELIGIBILITY FOR PREGNANCY RELATED BENEFITS

Pregnancy related expenses incurred will be payable by the Plan only for female Covered Employees or dependent wives of male Covered Employees

ELIGIBILITY FOR NON-BARGAINING EMPLOYEES ("OPTIONAL EMPLOYEES")

An employer who is obligated to make contributions to this Fund on behalf of employees working in employment covered by the collective bargaining agreement may elect to make contributions on employees whose employment is not covered by the agreement. These other employees are referred to as "Optional Employees." With respect to Optional Employees, the employer may apply to the Fund office to make contributions to the Fund for the purpose of maintaining eligibility for those individuals under the Fund. Participation of Optional Employees is subject to the approval of the Trustees. No owner or part owner of a business which is not incorporated may be covered as an Optional Employee.

The employer will be required to make a monthly contribution for every Optional Employee regularly employed by the employer on a full-time basis, except as noted below. Employment on a "full-time" basis means employment for an average of 32 hours or more per week. The amount of the monthly contribution will be equal to the highest hourly employer contribution rate in effect under the Fund multiplied by 173 hours for each covered Optional Employee.

Eligibility for Optional Employees will begin on the first day of the month for which a contribution is first made in their behalf, and coverage will terminate on the last day of the last month for which a contribution is made to the Fund. No hour bank will be established for any Optional Employee, and no Optional Employee, or his or her Covered Dependent(s), will be allowed to make any self-contribution to the Fund other than the COBRA continuation of coverage payments. No credit will be given for hours due to disability for any Optional Employee.

The benefits provided to Optional Employees will be the same benefits as those provided to the employer's other employees covered under the Fund. The employer will not be required to make contributions on behalf of any Optional Employee who is covered as an employee under another union-sponsored group health plan.

CHANGE OF ELIGIBILITY RULES

The Trustees may, in their discretion, amend these RULES OF ELIGIBILITY at any time.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

1. Your hours of employment are reduced; or

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

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

1. Your spouse dies;

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

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

4. You become divorced from your spouse; or

5. If you are the spouse of a Covered Employee who is making self-payments as a retired Covered Employee, the employee attains age 65.

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

1. The parent-employee dies;

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce, a dependent child's losing eligibility for coverage as a dependent child, or the retired Covered Employee's attainment of age 65), you must notify the Fund office within 60 days after the qualifying event occurs. You must send this notice to the Fund office at the address listed in this section. In the event of divorce, you must also furnish a copy of the divorce decree. In the event of a child ceasing to qualify as a covered dependent, you must furnish a copy of the dependent's birth certificate or other proof of date of birth.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce, a dependent child's losing eligibility as a dependent child, or the retired Covered Employee's attainment of age 65, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying

event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended, as explained below:

Disability Extension of 18 Month Period of Continuation Coverage

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

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

Maximum Period of 24 Months for Service in the Armed Forces

As described on pages 25 through 27, if you enter active duty in the Uniformed Services of the United States of America for a period of more than 31 days, the maximum period of COBRA coverage which you may elect is 24 months, provided you notify the Fund office in writing within 60 days of your entry into active uniformed service.

Second Qualifying Event Extension of 18 Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies

or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

PROCEDURE FOR OBTAINING CONTINUATION COVERAGE

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

TYPE OF COVERAGE EXTENDED

The benefits extended under COBRA will be the same as those provided to active employees and their dependents.

CANCELLATION OF COBRA COVERAGE

Continued coverage will be cancelled by the Fund upon the occurrence of any of the following events:

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

2. The Plan terminates;

3. You become covered under any other group health care plan, unless the other plan contains an exclusion or limitation with respect to any pre-existing conditions (coverage under this provision will then continue until such time as the waiting period under the other plan is satisfied, subject to the maximum period of coverage under this Plan); or

4. You become covered by Medicare.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund office at the address listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

Southeast Laborers Health Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449
Telephone: (615) 859-0131

DEATH BENEFIT
24-Hour Coverage
(For Covered Employees Only)

Upon receipt of proof of the death of a Covered Employee while eligible under the Plan, the Fund will pay, subject to the provisions outlined below, the amount of the Death Benefit specified in the Schedules of Benefits.

BENEFICIARY

Each Covered Employee may designate a beneficiary in writing, and such designation must be filed with the Fund office. If, on the death of a Covered Employee, there is no surviving designated beneficiary for all or any part of the benefit payable, the benefit will be paid, in the discretion of the Trustees, to any one of the following surviving relatives of the Covered Employee: wife, husband, mother, father, child or children, brother or sister, or the personal representative of the Covered Employee. Payment to any one or more of the above named persons will, to the extent of such payment, release the Trustees from all liability.

A Covered Employee may change his designated beneficiary from time to time by filing a written notice of change with the Fund office. A change of beneficiary will be effective as of the date the Covered Employee signs the notice of change, whether or not the Covered Employee is living on the date of filing same, but without obligation to the Fund for any payment made before a notice of change has been received.

ASSIGNMENT

The benefits provided under the Fund are nonassignable.

CONTINUATION OF DEATH BENEFITS DURING TOTAL DISABILITY

In the event of the total disability as defined in this section of any Covered Employee, that person's death benefit will not be terminated in accordance with the Plan provisions, but will be continued in force by the Fund, without payment, during the continuance of total disability for a period not exceeding twelve (12) months from the date coverage would otherwise have terminated. If the Covered Employee dies within that 12 months, due proof of the uninterrupted existence of such disability until death must be furnished to the Trustees within one year after death.

If the Fund receives, within the three month period immediately preceding the termination of the one-year continuation period provided above, proof of the total disability of any Covered Employee, such person's death benefits will be continued without payment during total disability for an additional period of one year, and for further periods of one year each provided proof of the continuance of total disability is submitted to the Fund during the three months immediately preceding each such year.

The amount of benefit that will be continued is the amount of death benefit in effect on the date the Covered Employee's coverage would otherwise have terminated.

The term "total disability" as used in this section means any disability commencing while the Covered Employee is eligible for benefits under the Fund, such eligibility being due to hours worked for a contributing Employer and/or a self-contribution paid under the provisions of this Plan, which results from bodily injury or disease and which wholly and continuously prevents the Covered Employee from performing any work or engaging in any occupation for work or profit.

The Trustees have the right at any time during the first two years after receipt of proof of total disability, and thereafter once a year, to require proof of the existence and continuation of such disability and to make examination of the disabled Covered Employee.

Coverage under this provision will cease on the date the Covered Employee ceases to be totally disabled.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
24-Hour Coverage
(For Covered Employees Only)

Upon receipt of notice and proof of the following:

1. That a Covered Employee, while covered for Accidental Death and Dismemberment Benefits under the Plan, has sustained any of the losses listed in the following Table of Losses as a direct result of Accidental Bodily Injury; and

2. The loss occurred independently of all other causes, as evidenced by a visible contusion or wound on the exterior of the body (except in the case of drowning or internal injuries revealed by an autopsy); and

3. The date of the injury was not more than 100 days prior to the date the loss was sustained;

the Fund agrees to pay, subject to the following provisions, to the Covered Employee or his designated beneficiary or other person, in the event there should be no designated beneficiary, the sum or sums of money specified for such loss as set out in the Table of Losses below and in the applicable Schedule of Benefits. The "Principal Amount" is determined from the applicable Schedule of Benefits.

TABLE OF LOSSES

In the Event of Loss of:	**The Benefit Will Be:**
Life	The Full Principal Amount
Both Hands or Both Feet	The Full Principal Amount
Sight of Both Eyes	The Full Principal Amount
One Hand and One Foot	The Full Principal Amount
One Hand and Sight of One Eye	The Full Principal Amount
One Foot and Sight of One Eye	The Full Principal Amount
One Hand	One-Half the Principal Amount
One Foot	One-Half the Principal Amount
Sight of One Eye	One-Half the Principal Amount

With respect to hands or feet, "loss" means dismemberment by severance at or above the wrist or ankle joint. With respect to eyes, "loss" means the entire and

irrecoverable loss of sight. If two or more losses listed in the Table of Losses result from the same accident, the Fund will pay only for that loss for which the largest benefit is provided.

EXCLUSIONS

No Accidental Death and Dismemberment Benefits will be paid for any loss which results directly or indirectly, wholly or partly, from:

1. Intentional self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;

2. Insurrection, or war, or any act attributable to war;

3. Participating in a riot;

4. Committing an assault or felony;

5. Disease of the body or mental infirmity, or as a result of medical or surgical treatment or diagnosis for such;

6. Ptomaine or bacterial infection (except only pyogenic infection occurring simultaneously with and as a result of a visible accidental cut or wound); or

7. Taking of poison or asphyxiation from or inhaling of gas, whether voluntarily or involuntarily.

BENEFICIARY

A Covered Employee may designate or change a beneficiary on the same basis as outlined in the "Death Benefit" section of this booklet.

EXAMINATION

The Fund will have the right and opportunity to examine any individual whose injury is the basis of a claim when and so often as it may reasonably require while a claim is pending, and also the right and opportunity to make an autopsy in the case of death, where it is not forbidden by law.

FACILITY OF PAYMENT

Benefits for loss of life, if any, and all other benefits which remain unpaid at the death of the Covered Employee are payable to the beneficiary on the same basis as under the "Death Benefit" section of this booklet.

All other benefits are payable to the Covered Employee, or his personal representative or guardian or executor.

If a beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due him, the Fund, at its option, and until claim is made by the duly appointed guardian, committee, or other legally authorized representative of such beneficiary, may make payments of the proceeds otherwise payable to such beneficiary, at a rate not exceeding $50.00 per month, to any relative by blood or connection by marriage of the beneficiary, or to any other person or institution whom the Trustees find to have assumed custody and principal support of that beneficiary.

Payments to any of the above will release the Fund from all further liability to the extent of the amount so paid.

LOSS OF TIME BENEFIT
(For Active Covered Employees Only)

Loss of Time Benefits will be payable at the weekly rate stated in the Schedules of Benefits when an active Covered Employee becomes wholly and continuously disabled while his coverage is in force by an Accidental Bodily Injury or sickness which prevents him from working at his occupation and which requires the regular care and attendance of a legally qualified Physician.

Benefits begin with the first day of disability caused by Accidental Bodily Injury, or the eighth day of disability due to sickness, and will continue for the maximum period shown in the Schedules of Benefits for any one period of disability.

Successive periods of disability resulting from the same or related causes and not separated by return to active employment will be considered as one period of disability.

Benefits are not payable for any injury or sickness entitling the Covered Employee to benefits under any Worker's Compensation or Occupational Disease Law nor during any period of time for which the Covered Employee is entitled to any form of unemployment benefits from any governmental agency.

TAX ON LOSS OF TIME BENEFITS

Loss of Time Benefits may be required to be included as part of your gross income for federal income tax purposes. You should contact a competent tax advisor to determine whether you are subject to this tax.

Additionally, federal law requires that the Fund withhold FICA taxes from Loss of Time Benefits. This tax is automatically deducted from such payments and deposited in accordance with applicable laws and regulations. The Fund itself will pay that portion of the FICA tax normally paid by an employer.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT
(For Covered Employees and Covered Dependents)

Comprehensive Major Medical Expense Benefits become payable if a Covered Person incurs Covered Medical Expenses which are in excess of the Deductible Amount.

The Deductible Amount, Covered Medical Expenses, the amount payable—called the Benefit Percentage—and the maximum amounts are described on the following pages and shown in the Schedules of Benefits.

The Deductible, Benefit Percentage and the maximum benefits are applied separately for each Covered Person. The Deductible and charges in excess of the Benefit Percentage paid by the Plan are the responsibility of the Covered Employee.

USE OF PREFERRED PROVIDER ORGANIZATION (PPO)

The Fund uses the services of a preferred provider organization to help provide quality health care at affordable prices to plan participants. A preferred provider organization (PPO) is a network of health care providers including doctors, hospitals and other facilities which provide services at discounted or fixed rates.

By securing your health care services from a participating provider, you reduce not only the cost of providing coverage under the Fund, but also the amount of your portion of any bill payable for such medical services. You may of course choose to receive services from a non-participating provider, but in that case, PPO discounts do not apply, and your benefits will be paid at a lower level. This PPO is not available to Covered Persons eligible for benefits under the 50¢ per hour Schedule of Benefits.

A directory of participating providers has been furnished to all plan participants. If you have not received a directory, or if you would like to verify that a particular doctor or hospital is still participating in the PPO, please contact the PPO as listed in the inside front cover of this booklet.

DEDUCTIBLE AMOUNT

The Deductible Amount is the amount to be paid by the Covered Person for services or supplies for treatment of an illness, an Accidental Bodily Injury or any

other covered condition. The Deductible Amount is shown in the Schedules of Benefits. Only Covered Medical Expenses may be used to satisfy this Deductible. The Deductible applies only once each calendar year for each Covered Person. Once the Deductible has been satisfied, it does not have to be re-satisfied for the balance of that calendar year.

If a Covered Person is suffering from a condition for which Covered Medical Expenses are incurred in two or more consecutive calendar years, the Deductible must be satisfied for each calendar year.

Any Covered Medical Expenses applied during October, November or December of a calendar year to that year's Deductible will also be applied in the same amount to the Deductible of the next calendar year.

COMMON ACCIDENT

If two or more Covered Persons in the same family are injured in the same accident, while covered under this provision, all Covered Medical Expenses incurred as a result of such accident may be combined and only one Deductible Amount will be charged, if applicable, against such expenses. This combined Deductible amount will also apply to future reapplications of the Deductible Amount for such common accident; however, this does not mean that the maximum payment due for each Covered Person will be reduced.

BENEFIT PERCENTAGE

Once the Deductible Amount has been satisfied by a Covered Person, the Plan will pay the Benefit Percentage specified in the Schedules of Benefits of the Covered Medical Expenses incurred by that person during the remainder of that calendar year.

After a Covered Person has paid Covered Medical Expenses in his own behalf equal to the Out-of-Pocket Maximum Amount specified in the Schedule of Benefits, the Benefit Percentage will be increased to 100%. However, this increase will not be effective until payments under all other group coverage have been exhausted through Coordination of Benefits.

MAXIMUM BENEFIT

The Maximum Lifetime Benefit and the Maximum Calendar Year benefit available

to each Covered Person are listed in the Schedules of Benefits. Any benefit payments made at any time under this Plan or any previous Major Medical Expense plans of the Fund will be used in determining the Maximum Lifetime Benefit. In addition, if there has been an interruption of coverage for a Covered Person, all payments made during all periods of coverage will be used in calculating the Maximum Lifetime Benefit.

If an individual changes from an employee to a dependent status, or changes from a dependent to an employee status, amounts paid in the previous status of the individual will be used in determining that individual's Maximum Lifetime Benefit.

After a total of $10,000 in Covered Medical Expenses has been paid under this provision on behalf of a Covered Person, on the first of the next calendar year and on the first of each calendar year thereafter, $10,000 will be added to the balance of that Covered Person's Maximum Lifetime Benefit until the maximum amount is reinstated to the amount specified in the Schedules of Benefits.

In addition to the above, after benefits have been paid for a Covered Person, the Covered Employee may ask the Trustees to reinstate that Covered Person to his full Maximum Lifetime Benefit shown in the Schedules of Benefits.

The Covered Employee will be requested to submit evidence of good health and full recovery from any previous illness or accidents. Any expense that is incurred for furnishing such proof must be borne by the Covered Employee and cannot be considered a Covered Medical Expense under the Plan. The approval of such evidence is in the sole discretion of the Trustees. In reviewing the evidence submitted, the Trustees will take into consideration the type of illness or accident, the date of the last Covered Medical Expense and the probability of additional expenses being incurred. The Trustees may, if they so desire, have the evidence reviewed by their own medical consultants.

If the Trustees do approve evidence submitted under this provision, the date of the reinstated Maximum Lifetime Benefit will be the date the Trustees approve such evidence.

EXTENSION OF BENEFIT

To qualify for this extension of benefits the Covered Employee or his Covered

Dependent must be totally and continuously disabled as a result of the Accidental Bodily Injury or sickness that occurred while the Covered Employee or his Covered Dependent was eligible under the Plan.

If a Covered Person is totally and continuously disabled, the Comprehensive Major Medical Expense Benefits will be continued for a maximum of 12 months. Benefits may terminate prior to the expiration of 12 months—on the first day that the Covered Person is not totally disabled. In any event, benefits will not be continued beyond 12 months after the date of termination. Additionally, benefits will not be continued beyond the date on which the Covered Person has received the Maximum Lifetime Benefit under the Plan.

COVERED MEDICAL EXPENSES

Covered Medical Expenses are limited to the actual Usual, Customary and Reasonable Expenses incurred by the Covered Employee or Covered Dependent for the services listed below which are required in connection with the treatment of the Covered Person and which are Medically Necessary, as all of those terms are defined in this booklet. The service or supply must be furnished upon the recommendation and approval of the attending Physician.

Covered Medical Expenses are those charges listed below:

1. Regular daily Hospital charges: Hospital room, board and general nursing services up to the amount shown in the Schedules of Benefits;

2. Miscellaneous Hospital charges: other Hospital services, supplies and treatments, exclusive of professional services;

3. Charges incurred for treatment in a Free Standing or Walk-In Clinic;

4. Surgery performed by a Physician, excluding cosmetic surgery other than (i) to remedy a condition resulting from an Accidental Bodily Injury, or (ii) as specifically outlined in this section;

5. Physicians' services for medical care and treatment;

6. Dental services rendered by a Physician for the treatment of a fractured jaw or of injury to natural teeth, including replacement of the teeth, provided the

services are rendered within six months of and as a result of an Accidental Bodily Injury;

7. Nursing services rendered by a registered nurse, or a licensed practical nurse if a registered nurse is not available, provided in either case the nurse is not a close relative;

8. X-ray and laboratory examinations, x-ray or radium therapy treatments, and treatments by a physical therapist other than a close relative;

9. Prescription drugs and medicines, including insulin and syringes used for its administration;

10. Surgical dressings, casts, splints, trusses, braces and crutches;

11. Rental of a wheel chair, hospital bed or iron lung (or ventilation equipment of similar function and purpose);

12. Expenses incurred in connection with the purchase and fitting of prosthetic limbs and eyes. Only those devices which are of a type that are in general use and are not experimental in nature will be covered. No payment will be made for such a device when a less costly device is available which will perform the basic functions generally required and expected of such a device. The initial purchase of such devices will be covered, and replacements when necessary to replace a device which has ceased to function, or when necessitated by the growth of the covered individual;

13. Blood and blood plasma (if not replaced), anesthetics and their administration;

14. Expenses charged by a Hospital for the routine care of a newborn and expenses charged by a Physician for in-hospital visits in connection with the routine care of a newborn during the confinement immediately following birth;

15. Purchase of rental or a glucometer;

16. Charges incurred in connection with a reduction mammoplasty when there is medical documentation of intractable pain, not amenable to other forms of

treatment, and which is the result of excessively large, pendulous breasts. This procedure will be covered only if all of the following criteria are met, and are documented in writing by a Physician:

(a) the pain must have been present at least one year;

(b) the suprasternal notch to nipple measurement must be at least 21 centimeters; and

(c) the amount of breast tissue removed must be at least 450 grams per side;

17. Purchase, or rental up to the purchase price, of a nebulizer, subject to a maximum allowable expense of $150.00 and application of the benefit percentage listed in the Schedules of Benefits;

18. Charges made for the following services and supplies when rendered in connection with reconstructive breast surgery following a mastectomy:

(a) reconstruction of the breast on which the mastectomy was performed,

(b) surgery and reconstruction of the other breast to produce symmetrical appearance, and

(c) coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas,

in a manner determined in consultation with the attending Physician and patient;

19. Charges listed in this section when incurred in connection with one of the following human organ and tissue transplant procedures only:

(a) bone marrow,

(b) kidney,

(c) cornea,

(d) heart,

(e) heart and lung,

(f) liver,

(g) lung, or

(h) pancreas;

20. Oxygen, and related equipment as follows:

(a) coverage will be provided for the purchase, or for the rental up to the purchase price, of an oxygen concentrator, and

(b) coverage will be provided for the rental of other equipment required to administer oxygen for a maximum period of sixty days per separate illness or Accidental Bodily Injury, provided that such equipment must be acquired in the most cost-effective manner, and subject to review and approval by the Trustees;

21. Charges made for kidney dialysis treatment;

22. Vasectomies or other sterilization procedures performed on Covered Employees or their Covered Dependent spouses only;

23. Charges incurred for routine physical examinations, including diagnostic x-ray and laboratory procedures, when performed by a medical doctor (M.D.) up to the maximum payable as provided in the Schedule of Benefits. Procedures covered will include any type of x-ray or medical laboratory testing, colon exams, EKGs, and other types of x-ray and pathological exams. (This benefit is not available under the 50¢ Schedule of Benefits). This provision does not cover immunizations or inoculations;

24. Charges made for diabetes self-management training, subject to a benefit payment percentage of 80% (70% under the 50¢ Schedule of Benefits) but not subject to the calendar year deductible;

25. Charges incurred for or in connection with pain management, subject to the following limitations:

(a) covered services will be limited to the injection of medications, and

(b) such injections will be limited to three per separate illness, Accidental Bodily Injury or other covered condition;

26. Subject to the separate Lifetime Maximum Benefit outlined in the Schedules of Benefits, charges incurred for or in connection with the diagnosis or treatment of sleep apnea or other sleep disorders, to include, under the regular Schedule of Benefits only (and not under the 50¢ Schedule), the performance of sleep studies and the purchase, or the rental up to the purchase price, of a continuous positive airway pressure (CPAP) machine or any similar device; and

27. Charges incurred for gastroenterostomy, gastric stapling, jejunoileal by-pass and suction assisted lipectomy provided all of the following requirements are met and documented:

(a) all surgical procedures of this type must be pre-authorized by the Trustees to be eligible for benefit,

(b) the patient must be at least double his ideal weight for his body structure and ages,

(c) the patient must be at least 25 years of age,

(d) the condition of morbid obesity must have existed for a period of not less than 5 years,

(e) all other methods of weight reduction under the supervision of a certifying Physician have failed and the procedure is considered Medically Necessary, and

(f) the certifying Physician must document the treatment of the medical problems arising from the obese condition.

The term "close relative" includes the Covered Person and the spouse, child, grandchild, brother, sister or parent of the Covered Person.

In determining the satisfaction of any applicable Plan deductible and the payment of benefits, a charge for any service or treatment will be considered to have been incurred on the date that the service or treatment was rendered.

EXCLUSIONS

The following exclusions and limitations apply:

1. No payment will be made for any charge that is incurred as the result of any Accidental Bodily Injury sustained while the Covered Person was performing any act of employment or doing anything pertaining to any occupation or employment.

2. No payment will be made for any charge that is incurred as the result of a disease or sickness for which benefits are payable under any Worker's Compensation Act or any Occupational Disease Act or any such similar law.

3. No payment will be made for any charges that are incurred while the Covered Person is confined in any hospital that is operated by the United States Government or any agency of the United States Government, except as may be required by law.

4. No payment will be made for any charges which are incurred by a Covered Person which the Covered Person or Covered Employee is not legally required to pay.

5. No payment will be made for any charges incurred for education, training or room and board while the Covered Person is confined to an institution which is primarily a school or institution of learning or training.

6. No payment will be made for any charges incurred while a Covered Person is confined in an institution which is primarily a place of rest, a place for the aged or a nursing home.

7. No payment will be made for any charges incurred for any type of custodial care. Custodial care means that care designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called.

8. No payment will be made for any charges incurred for any treatment or surgical procedure or service performed that is of an elective nature. This exclusion applies to such items as cosmetic surgery and breast implants or reduction procedures except as specifically outlined under the Covered Medical Expenses. However, no payment will be made for any charges incurred in connection with the removal or the removal and replacement of a breast implant, regardless of the medical necessity of the procedure or the original placement.

   This exclusion does not apply to:

   (a) cosmetic surgery that is the result of an Accidental Bodily Injury,

   (b) the correction of congenital defects or corrective surgical procedures for conditions which prevent an organ of the body from performing and functioning properly,

   (c) penile prostheses, but only when required as a result of an organic illness or condition,

   (d) reconstructive breast surgery as outlined under Covered Medical Expenses item 18, or

   (e) vasectomies or other sterilization procedures performed on Covered Employees or their Covered Dependent spouses only.

   However, reversals of vasectomies or other sterilization procedures will not be covered.

9. No payment will be made for any charges which are incurred for services, treatment, or surgical procedures rendered in connection with any overweight condition or condition of obesity, except as specifically outlined under Covered Medical Expense 27.

10. No payment will be made for any charges for any services or supplies which are not recommended and approved by an attending Physician.

11. No payment will be made for any charges for services or supplies received from a Physician, Hospital or Free Standing or Walk-in Clinic that does not meet the definition of those terms as set forth in the Definitions section of this booklet.

12. No payment will be made or any service, supply, treatment or procedure which is not rendered for the treatment or correction of, or in connection

with, a specific illness or Accidental Bodily Injury, except as specifically outlined.

13. No payment will be made for charges incurred as a result of treatment or consultation with a psychologist, social worker or marriage counselor.

14. No payment will be made for charges incurred as a result of a pregnancy or pregnancy related condition of any individual other than a female Covered Employee or the wife of a male Covered Employee.

15. No payment will be made for any physical therapy, speech therapy or any other type of therapy if either the prognosis or history of the Covered Person receiving the treatment or therapy does not indicate to the Trustees a reasonable chance of improvement.

16. No payment will be made for any charges incurred in connection with abortion procedures or pregnancy related conditions resulting in abortion unless such procedures are therapeutic in nature and are Medically Necessary to protect the life of the mother; however, in the event of medical complications arising from elective abortion procedures, charges resulting from treatment of such complications shall be payable under the terms of the Plan.

17. No payment will be made for any charges incurred as a result of or in connection with mental or nervous disorders or the prevention, cure or treatment of any condition of alcohol abuse or narcotism (drug addiction) or drug abuse for any Covered Person for any reason.

18. No payment will be made for any charges for any special education rendered to any individual. This exclusion applies regardless of the type of education, the purpose of the education, the recommendation of the attending physician or the qualifications of the individuals rendering this special education.

19. No payment will be made for any charge made by a physician or other provider of medical service for completing claim forms required by the Fund for the processing of claims.

20. No payment will be made for any expenses incurred for routine care and other treatments or procedures which are not Medically Necessary, except as specifically outlined.

21. No payment will be made for any otherwise Covered Medical Expense in excess of the Usual, Customary and Reasonable Expense, except as specifically outlined.

22. No payment will be made for any service or procedure which is an Experimental and Investigative Expense.

23. No payment will be made for any expenses incurred resulting from the removal of an organ or portion thereof for donor purposes, except where both the donor and the donee are Covered Persons and are members of the same immediate family.

24. No payment will be made for any expenses incurred for surgical sex transformation.

25. No payment will be made for any Covered Medical Expense incurred as the result of a Friday or Saturday admission to a Hospital except where the admission was in conjunction with emergency services which immediately preceded the admission.

    Sunday admissions are also excluded under the same circumstances unless the attending Physician certifies in writing that the admission was required to facilitate the treatment of the Covered Person and was not for the convenience of the Physician or Hospital.

26. No payment will be made for any expenses incurred for in-vitro fertilization, embryo transfer or in-vivo fertilization.

27. No payment will be made for any expenses incurred for acupuncture, whether or not administered by a medical doctor.

28. No payment will be made for any expenses for an external breast prosthesis or bra, except as specifically outlined.

29. No payment will be made for any expenses incurred for radial keratotomy surgery or keratomileusis surgery.

30. No payment will be made for any expenses incurred for inpatient care and services rendered solely for observation or diagnostic testing and expenses

incurred for care and services, whether inpatient or outpatient, rendered solely as preventive measures.

31. No payment will be made for any expenses incurred as the result of an intentionally self-inflicted injury or an intentionally self-induced illness, unless such injury or illness results from a medical condition, to include both physical and mental health conditions.

32. No payment will be made for any expenses incurred for the purchase of prosthetic appliances which are not determined to be necessary for the alleviation or correction of conditions arising out of Accidental Bodily Injury or sickness or birth defects, except as specifically outlined.

33. No payment will be made for any expenses incurred for the surgical installation of a Cochlear implant.

34. No payment will be made for any expenses incurred in connection with the treatment of premenstrual syndrome (PMS).

35. No payment will be made for expenses incurred as a result of a sickness or bodily injury to which a contributing cause was commission of, or attempted commission of, an act of aggression or a felony by the Covered Person.

36. No payment will be made for any expenses incurred for services or supplies related to sexual dysfunctions or inadequacies.

37. No payment will be made for any expenses incurred for birth control services or devices, except those surgical procedures specifically outlined under item 8 of this section.

38. No payment will be made for any expenses incurred for treatment rendered by, or under the direction of, a Doctor of Chiropractic (D.C.).

39. No payment will be made for any expenses incurred in connection with or as a result of anorexia nervosa or bulimia.

40. No payment will be made for any expenses incurred for treatment of a dysfunction or derangement of the temporomandibular joint by the use of an orthopedic or orthodontic appliance, nor through any other method of treatment, including neuromuscular physiotherapy, except as outlined below.

Only those Covered Medical Expenses incurred for services and supplies rendered to a Covered Person in connection with the performance of an arthroplasty which is required for the correction of an internal derangement/ dysfunction of the temporomandibular joint will be paid, but only to the extent that such surgery is required, as certified in writing by both the attending Physician and the Covered Person (or the Covered Employee if the Covered Person is a minor) for the relief of pain and for facilitation in the correction of one or more of the following:

(a) Muscular spasm,

(b) Limited functioning/opening of the temporomandibular joint,

(c) Crepitus/crepitation,

(d) Dislocation of a bone(s) connection to the joint, and/or

(e) Deviation of the mandible to either side.

41. No payment will be made for any charges incurred in connection with illness due to act of war, whether declared or undeclared.

42. No payment will be made for any charges incurred in connection with injuries sustained or sickness contracted while in the military, naval or air services of any country.

43. No payment will be made for any charges incurred for eye refractions, eyeglasses, contact lenses, hearing aids, or for the fitting of any of these.

PRE-EXISTING CONDITION LIMITATION APPLICABLE TO COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFIT

LOOK-BACK PERIOD:

No benefits will be paid for any charge incurred by a Covered Person in connection with a medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the "look-back period." The "look-back period" is the ninety day period ending on the later of the following dates:

1. For a Covered Employee or Covered Dependent, the first day of the calendar month in which the employee began a period of employment on which initial eligibility or regained eligibility was granted under the Plan; or

2. For a Covered Dependent who was not a dependent of the employee on the date described under (1) above, the date on which the Covered Dependent became a dependent of the employee.

A "medical condition," as used in this section, means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not accidental), or congenital malformation, but excluding genetic information.

WAITING PERIOD:

This exclusion will end on the earliest of the following:

1. At the end of a ninety day period during which the Covered Person is continuously covered under the Plan and during which no advice or treatment is received for the condition; or

2. At the end of a twelve month period beginning on the later of the dates outlined under the "Look-Back Period" above.

EXCEPTIONS:

1. Credit for days of "creditable coverage," as explained on the following page will be applied to reduce the waiting period outlined above.

2. No pre-existing condition exclusion will apply to a child who, as of the last day of the thirty day period beginning with the date of birth, is covered under any "creditable coverage."

3. No pre-existing condition exclusion will apply to any child who is adopted or placed for adoption with a Covered Employee before attaining eighteen years of age and who, as of the last day of the thirty day period beginning on the date of adoption or placement, is covered under "creditable coverage."

4. Pregnancy will not be considered a pre-existing condition.

YOUR RIGHT TO CREDITABLE COVERAGE:

Current Federal law requires that you be given credit for "creditable coverage" toward the waiting period described above. "Creditable Coverage" is previous coverage for health benefits or health insurance. In order to qualify as "creditable coverage," your previous coverage must not have terminated more than sixty-three days prior to the day on which you commenced employment for a contributing employer or, for a dependent you acquire after your date of employment, sixty-three days prior to the date on which that person becomes your dependent.

In order to receive credit for "creditable coverage" you can request a certificate from your prior plan or insurance carrier certifying your previous coverage. If you would like, the Fund office will be glad to assist you in requesting a certificate of your previous coverage from your former plan or insurance carrier. You may contact the Fund office for a more complete description of the effect any "creditable coverage" may have on reducing your waiting period under this pre-existing condition exclusion.

COORDINATION OF BENEFITS

The objective of this Coordination of Benefits provision is to limit the reimbursement from this Plan and any other plan providing benefits to 100% of Allowable Expenses. Payments made by the Fund cannot be more than what would normally be paid if this provision did not exist.

Benefits are coordinated with other group plans including the following coverages:

1. Group, blanket, or franchise insurance coverage;

2. Hospital or medical service organizations, group practice and other pre-payment coverage;

3. Any coverage under any labor-management plans, union welfare plans, employer organization plans or employee benefit organization plans; and

4. Any coverage provided under government programs or any coverage required or provided by any statute.

ALLOWABLE EXPENSES

Benefits are paid under this Coordination of Benefits provision for Allowable Expenses. In addition to expenses covered under this Plan, Allowable Expenses include any necessary, reasonable and customary expense that is covered under another plan. This does not imply that this Fund would normally pay benefits for such expenses. It means that when expenses are calculated to determine the Coordination of Benefits payments, any charge that is covered under another plan but is not covered under this Plan, will, for this purpose only, be considered a Covered Medical Expense.

CLAIM DETERMINATION PERIOD

The Coordination of Benefits provision is administered on a calendar year basis. This calendar year basis for administration of the Coordination of Benefits provision is sometimes referred to as the Claim Determination Period. Any benefit savings resulting from this Coordination of Benefits provision in any calendar year will be held in a benefit account for that individual for that calendar year. Monies will be released from the benefit credit during that calendar year, if necessary, to give reimbursement of 100% of Allowable Expenses.

BENEFIT DETERMINATION

When the other plan does not have a Coordination of Benefits provision it will be considered primary and will always pay first. This Plan will then pay second and will coordinate payment with the amount paid by the other plan.

If it is determined the other plan does contain a Coordination of Benefits Provision and the Covered Employee is the named insured under the other plan, that plan which has been in effect the longest will be considered primary and will always pay first. The other plan will pay second and will coordinate its payment with the first plan.

When the other plan covers the spouse as the named insured and it does have a Coordination of Benefits provision, and the claim is on the dependent spouse, the order of benefit payment will be determined as follows:

1. The other plan—the plan covering the spouse as an employee—will pay first.

2. This Plan—which covers the spouse as a Covered Dependent—will pay second and will coordinate with the other plan.

In claims involving children, the order of benefit payment will be as follows:

1. Except in cases involving dependent children whose parents are separated or divorced, this paragraph will apply. When the other plan has adopted rules similar in intent to (a) below, (a) will apply. Otherwise, subparagraph (b) below will be used in determining the order of benefit payment.

   (a) The plan covering the parent whose date of birth occurs earlier in a calendar year will pay first and the other plan will pay second.

   (b) The plan covering the father as an employee will pay first and the plan covering the mother as an employee will pay second.

2. When the parents of a child are separated or divorced, and the parent with custody of the child has not remarried, the plan covering the parent with custody will pay first, and the plan covering the parent without custody will pay second.

3. When the parents of a child are divorced, and the parent with custody of the child has remarried, the plan covering the parent with custody will pay first, the plan covering the stepparent of the child will pay second, and the plan covering the parent without custody will pay last.

4. Regardless of 2. and 3. above, when the parents of a child are separated or divorced, and there is a court decree establishing financial responsibility for the health care expenses of a child, the plan covering the parent with financial responsibility will pay first, the plan covering the parent without financial responsibility will pay second, and the plan covering the stepparent (if applicable) will pay last.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any other person, release to or obtain from any insurance company or other organization or person, any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan will be required to furnish to the Fund such information as may be necessary to implement this provision.

RIGHT OF RECOVERY

Whenever payments have been made by the Fund with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund has the right to recover such payment, to the extent of the excess, from among one or more of the following, as the Fund shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organization or any further claims made to this Fund by the Covered Person.

GENERAL

Under the Coordination of Benefits provision it is necessary that claim be made for any benefits the individual may be entitled to from any source. Whether or not claim is made to these other sources, the Coordination of Benefits provision will be fully operable as if claim were made.

INFORMATION YOU SHOULD KNOW

THIS BOOKLET IS ONLY A SUMMARY

Although this booklet contains a great deal of information about your Plan, it is not the purpose of this booklet to cover every detail or every situation that might arise under your Plan.

However, there is a formal Plan Document which governs the operation and administration of this Plan. So that you will have all the details readily available, a copy of the Plan Document will be made available for your examination at the Fund office or a copy of it will be reproduced for you at your request for a reasonable charge.

The provisions set forth in the Plan Document are final and binding. Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Plan Document itself. If there is any difference between the Plan Document and the summary in this booklet, the Plan Document will control.

THE TRUSTEES INTERPRET THE PLAN

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

THE PLAN MAY BE CHANGED

The Trustees are endowed with the authority to change the Plan, subject to any collective bargaining agreement that applies to it.

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

The Trustees also may change the Plan in any way to protect its tax exempt status under Internal Revenue Service rules. From time to time, these rules may change and the Trustees may have to alter certain Plan provisions in order to preserve the tax exempt status of your Plan.

YOUR PLAN IS TAX EXEMPT

Your Plan is classified by the Internal Revenue Service as a 501(c)(9) trust. This means that the employers' contributions to the Trust are not taxable nor are the benefits paid on your behalf generally taxable as personal income.

Also, investment earnings on Plan assets are excluded as taxable income of the Trust since they are specifically set aside for the purpose of providing benefits to participants.

Obviously, such tax exemption works to the benefit of both employer and employee. In effect, it means that money which otherwise might be payable as taxes can be used to purchase benefits and to cover administrative expenses.

The Trustees are well aware of these advantages and will take whatever steps are necessary to keep your Plan "qualified" as a tax exempt Trust under Internal Revenue Service rules.

ASSIGNMENT OF BENEFITS

Benefits which are payable under this Plan and which have not been assigned to a provider of covered services will be paid to you, whether the claim is made on behalf of yourself or one of your dependents, unless benefits are being provided under a Qualified Medical Child Support Order, as that term is defined in the Omnibus Budget Reconciliation Act of 1993. In such case, benefits otherwise payable to you will generally be paid to the custodial parent or legal guardian of the dependent child on behalf of whom the benefits are provided.

You may assign benefits which are payable to you under this Plan, but only to a Physician, Hospital, or Free Standing or Walk-In Clinic. If benefits are provided under a Qualified Medical Child Support Order, benefits may also be assigned by the custodial parent or legal guardian of the dependent child on whose behalf the benefits are provided. Benefit assignments made in accordance with any state Medicaid law will also be honored by the Plan.

MEDICAL EXAMINATION

No medical examination will be required of any Covered Employee or Covered Dependent to secure coverage initially. However, the Trustees will have the right, through their medical examiner, to examine the Covered Employee or Covered Dependent as often as they may reasonably require during the pendency of a claim, and the right to make an autopsy in case of death where it is not forbidden by law.

PAYMENT OF BENEFITS

1. Benefits are payable to the Covered Employee whether the claim is on the Covered Employee or on one of the employee's Covered Dependents. If benefits are assigned, however, benefits will be paid to the assignee instead of directly to the Covered Employee. Benefits are payable when the required forms have been submitted to the Plan.

2. If an individual, in the Trustees' opinion, is not capable of giving a valid receipt for payments due and no guardian has been appointed for such person, the Trustees may make payment to the individual or individuals, who, in their opinion, has assumed the care and principal support of the individual. If the individual should die before all amounts that are due have been paid, the Trustees may, at their option, make payment to the executor or administrator of the estate of the individual or to his surviving spouse, parent, child or children or to any individual who, in the Trustees' opinion, is entitled to the benefits.

3. Any payments that are made by the Trustees in accordance with these provisions shall fully discharge the liability of the Trustees to the extent of the payments.

ILLEGAL OCCUPATION OR COMMISSION OF FELONY

The Plan will not be liable for loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claims, or to which a contributing cause was such person's being engaged in an illegal occupation.

REIMBURSEMENT OF PAID CLAIMS

Situations sometimes arise where benefits are payable from the Fund for medical expenses incurred by a Covered Employee or Covered Dependent ("Covered Person"), due to an injury caused to the Covered Person, and the Covered Person has a right to receive full or partial payment of his or her damages caused by the injury from some other source. Typical examples of such situations are where the Covered Person is injured in an automobile accident or on the property of someone else and another individual is responsible. In such cases, either the Covered Person's or the other person's automobile, homeowners', or property insurance carrier may be liable and pay for all or part of the Covered Person's injury, although claims for the medical expenses have been submitted and paid by this Fund. On occasion, the Covered Person's own insurance carrier may be liable to pay for the damages. In these and other similar situations, the Covered Person may receive a double payment of medical bills or may have a right to recover the amounts paid by the Fund.

In accordance with the Employee Retirement Income Security Act (ERISA), a federal law which applies to this Fund, the Trustees are required to take all steps which they consider to be reasonable and necessary to maintain the financial health of the Fund so that the Fund can continue to provide all of the benefits described in the Plan. Because of the increasing cost of medical care, the Trustees have determined that it is in the best interests of the Fund and its participants and beneficiaries to adopt and incorporate provisions into the Plan to enable the Fund to recover all sums it has paid for injuries, sickness or conditions that have resulted from injury to a Covered Person and for which other persons or entities may pay damages to the Covered Person. Under these provisions, the Fund has the right to be reimbursed in full for all sums paid by it to or on behalf of a Covered Person to the extent that the Covered Person has recovered and/or has a right to recover damages from another person or entity, including the Covered Person's insurance company.

If a claim is filed with the Fund for medical or other benefits in connection with an injury, sickness or condition arising in such a situation, the Fund will still pay all benefits provided by the Plan. However, these benefits will be paid only after the Covered Person has signed and returned an Agreement, giving the Fund full rights of recovery against all persons or entities which may be liable to pay damages to the Covered Person, the right of recovery to be for the full amount of sums paid. It is the purpose of this policy and the Agreement to give the Fund a right of recovery, which includes a loan agreement, a right to reimbursement, a right to subrogation, and a first priority of recovery, all of which are described in the Agreement.

The Plan's reimbursement policy and provision will be administered as follows:

If a claim is submitted in connection with an injury, sickness or condition arising in a situation were another person or entity may be required to pay damages to the Covered Person, the Covered Person must so indicate and provide the Fund with specific details and information regarding the situation. Any corrections as well as additional information or documentation must be supplied by the Covered Person on an ongoing basis.

In order to receive benefits from the Fund, the Covered Employee must complete, sign and return an Agreement in the form designed for, and approved by, the Trustees for that purpose, and the Agreement will give the Fund full rights of recovery against all persons or entities which may be liable for damages to the Covered Person and will obligate the Covered Person to repay the Fund a loan in the amount of sums paid by the Fund, and will give the Fund a right of reimbursement and subrogation. If a claim is made on behalf of a Covered Dependent, the dependent as well as the Covered Employee must sign the Agreement. If the dependent is a minor, the Covered Employee as well as the minor's parent(s) and/or legal guardian must sign the Agreement on behalf of the minor.

Covered Persons shall do nothing that will prejudice the Fund's right of recovery, and common law doctrines such as "make whole" and "common fund" or other similar doctrines will not be applied to reduce the Fund's right of recovery, and any subrogation or reimbursement shall be as to any amounts recoverable by the Covered Person, without regard to contributory or comparative fault of the Covered Person. Further, the Fund's entitlement shall be applied against any recovery, except for loss of consortium, to which the Covered Person is entitled, including but not limited to damages for physical injury and impairment, future medical costs, past and future pain, suffering and mental anguish, and past and future lost earnings.

If a recovery is obtained by the Covered Person, either through settlement or as the result of judicial proceedings, the Fund is to be fully reimbursed, from the first dollars paid to or received by the Covered Person, for all benefits paid by the Fund on behalf of the Covered Person as well as for those medical expenses that are reasonably foreseeable. Any questions about the apportionment of a damages award or settlement agreement shall be resolved by the Trustees, who have complete discretion in establishing the reasonable portion of such award/agreement to which the Fund has a right of recovery, reimbursement or subrogation.

The Covered Person is expected to take whatever steps are reasonable and necessary to obtain a recovery from persons and/or insurance companies which may be liable for the payment of damages. Such steps include the timely filing of a claim with the appropriate insurance company. The Covered Person shall keep the Fund informed of any action taken, the progress of settlement negotiations, and of any recovery obtained.

The Covered Person is to take whatever steps he or she deems reasonable and necessary in his or her own name to obtain a recovery and is not to assume that the Fund or its representatives will take action on behalf of the Covered Employee or Covered Dependent unless notified by the Fund that such action will be taken. However, the Trustees reserve the right to either request the Covered Person to take a specific type of action or to file suit on behalf of the Covered Person if, in their discretion, such action is deemed in the best interests of the Fund. In the event the Trustees act on behalf of a Covered Person, attorney fees and costs incurred in obtaining a recovery will be deducted from the proceeds obtained from the settlement or judgment that results.

Most important: The Trustees do not authorize deductions from a recovery for attorney fees; therefore, if the Covered Person retains an attorney to pursue a claim in connection with his or her injuries, it is the Covered Person's obligation to provide the attorney with a copy of the Agreement and to inform him/her that attorney fees may be taken only from the amount of money recovered in excess of the amount to which the Fund is entitled. Any agreement between the Covered Person and an attorney that reduces the amount recoverable by the Fund will be considered as a violation of the terms of the Plan and of the Agreement.

While the Fund expects full reimbursement for all sums paid on behalf of a Covered Person, there may be occasional situations in which full reimbursement is not possible, for example, where the relevant insurance policy is insufficient to reimburse the Fund for the full amount of its claim. In such situations, the Fund will expect reimbursement to the extent of the Covered Person's recovery, except that the Covered Person may deduct, subject to approval of the Fund, from this amount and retain any out-of-pocket expenses he or she may have incurred for medical expenses as well as actual and reasonably projected lost wages. Any such recovery shall be subject to the Trustees' reasonable apportionment authority with regard to the Fund's right of recovery/reimbursement/subrogation, as well as the Fund's approval of any deduction. Any deductions for out-of-pocket medical expenses and lost wages must be fully documented.

The Fund expects full compliance with this reimbursement provision and with the provisions of the Agreement. Therefore, the Fund reserves the right to withhold future medical benefits from a Covered Employee and any of his/her Covered Dependents where the Covered Employee or any of his/her Covered Dependents has obtained a recovery from another source, as described above, but has not reimbursed the Fund as required. Future benefits may be withheld in an amount equal to the amount previously owed the Fund until such time as the Fund's claim for reimbursement has been completely paid.

The Agreement will also require a Covered Person to consent and agree that any and all litigation between the Covered Person and the Fund relating to the Agreement shall take place in the United States District Court for the Middle District of Tennessee or the Chancery Court of Davidson County, in Tennessee; and, the Covered Person expressly consents and agrees that the jurisdiction of these courts is concurrent and, at the option of the Fund, any litigation between the Covered Person and the Fund may be removed from the Chancery Court to the Federal Court.

NOTICE AND PROOF OF CLAIM

1. A written notice of the injury or of the illness for which you are making claim should be given to the Fund office within 90 days of the first day of the illness or injury for which claim is made, and all forms, bills and information necessary to pay the claim must be provided within 90 days of the first day of the illness or injury for which claim is made.

2. A notice given to the Fund office with enough information to identify the Covered Person and the Covered Employee will be considered sufficient. If the individual does not furnish notice and information within the time provided by the Plan, such lack of notice will not jeopardize the claim if it is shown that it was not reasonably possible to furnish notice when required and notice was furnished as soon as it was reasonably possible.

3. As soon as the Fund receives notice of the claim, the Fund office will furnish forms which are used by the Fund for the filing of claims. If such forms are not furnished within 30 days after the Fund office has received notification of the claim, the individual will be considered to have complied with all requirements of the Plan as to submitting claims.

NO CONVERSION PRIVILEGE

Because of the self-funded status of the Fund, the benefits cannot be converted to individual coverage. The Fund is under no obligation to notify the Covered Employee or beneficiary of any termination of coverage.

TERMINATION OF PLAN

The following information regarding the conditions under which the Fund may be terminated, and the disposition of the assets of the Plan on termination, is furnished in accordance with federal laws and regulations:

Conditions of Termination:

The Fund will be terminated upon the termination of the trust agreement establishing the Fund. The trust agreement will terminate upon the occurrence of either of the following events:

1. When there is no longer in force a collective bargaining agreement between an employer and the union which requires contributions to the Fund, the Trustees may terminate the trust agreement and the Fund; or

2. The employers and the participating local unions may jointly agree in writing to terminate the trust agreement and the Fund.

Procedure in the Event of Termination:

In the event the Fund is terminated, the Trustees will use the remaining assets of the Fund to pay the bills of the Fund and to provide benefits, and any remaining surplus will be used in such manner as will in the Trustees' opinion best accomplish the purpose of the Fund. Fund assets will only be used for the purpose of providing benefits to employees and their dependents, to pay administrative expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will any of the assets of the Fund, directly or indirectly, be paid to, or for the benefit of, the employers or the union.

DATE CLAIM INCURRED

The incurred date of a claim is the first date on which the Covered Person is under

the care of a Physician and/or has incurred expense which is payable by the Fund for that particular disability.

MINIMUM HOSPITAL STAY FOR CHILDBIRTH

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

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

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

NOTICE TO ACTIVE PARTICIPANTS AND THEIR SPOUSES WHO ARE ELIGIBLE FOR MEDICARE

This notice is required by federal law. It concerns your health care benefits once you reach age 65 if you or your spouse are eligible for Medicare and are also eligible for coverage under this Fund. In accordance with that law, coverage under this Fund is made available to all active participants age 65 or older and their spouses under the same conditions as coverage is made available to active eligible participants and spouses of active eligible participants under age 65. In addition, federal statutes currently provide that any persons age 65 or older are entitled to select Medicare for their primary health insurance coverage in place of any group health plan offered by their employer. We would therefore urge you, if you are an active eligible participant under the plan and eligible for Medicare benefits, to read the following.

If you are eligible for coverage under the plan, federal law requires that the plan pay first up to the maximum amounts provided for under the plan and then Medicare coverage be applied up to the maximum limits provided under Medicare. This applies to active participants age 65 or older as well as the dependent spouses age 65 or older of active participants.

Federal law does permit an active participant who is age 65 or older, or the dependent spouse age 65 or older of an active participant, to reject the group health care plan as the primary payer of his or her benefits and to elect Medicare as the primary payer of benefits. Although such an election will reduce the plan's expenses, it will generally not work to the advantage of a participant or his spouse. In fact, if Medicare is elected as the primary payer, a participant or spouse is likely to incur higher out-of-pocket medical expenses than would be the case if the plan is the primary payer of benefits. The reason for this is that if you or your spouse elect Medicare as the primary payer, the plan is not permitted under federal law to provide any supplemental coverage for hospital or surgical expenses. The plan is permitted, however, to provide and will continue to provide death and accidental death and dismemberment benefits and prescription drug coverage even if you or your spouse select Medicare as the primary payer.

Also, if Medicare is elected as the primary payer, the plan is not permitted to pay any of the deductibles or co-insurance required for Medicare services. If for some reason, your or your spouse would rather have Medicare as the primary payer, you each have the right to indicate this preference in writing to the Fund office. Such election can be made upon becoming eligible for Medicare, or at any time thereafter. If you do not make a written election, this Fund will continue to be your primary provider of health coverage.

In making this decision, we urge you and your spouse to carefully compare the benefits provided under this plan, as outlined in this booklet, and the benefits available under Medicare. A description of Medicare benefits can be obtained from your local Social Security office or the Fund office will provide you with a description of those benefits upon your request. Since the plan's benefits are usually more generous than Medicare benefits, it generally will not be advantageous for you or your spouse to elect Medicare as the primary payer of benefits. Remember, if you select Medicare as the primary payer, the plan may not supplement Medicare coverage in any way and you will be totally responsible for any medical expenses not covered by Medicare.

As you probably know, Part A Medicare coverage is provided at no charge to all individuals who are age 65 and older. However, in order to be entitled to Part A Medicare, is it necessary that you enroll for such coverage. It is therefore extremely important that you enroll for Medicare at least three months before your 65th birthday, even if you intend to continue working beyond age 65. If you have already reached your 65th birthday and have not applied for Medicare, we would encourage

you to determine the date the next Medicare enrollment period begins and make arrangements to apply at that time.

Please contact the Fund office for assistance and information regarding this notice.

RIGHTS OF PLAN PARTICIPANTS

As a participant in this 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 PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before

losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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, of you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

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

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

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

ERISA requires that plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedure to follow when filing a claim for benefits. This information is presented to you in this booklet.

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

TYPE OF PLAN

This plan provides death, accidental death and dismemberment, loss of time and comprehensive major medical expense benefits.

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

NAME AND ADDRESS OF THE PLAN ADMINISTRATOR AS DEFINED BY ERISA

Your Plan is maintained and administered by a Board of Trustees on which labor and management are equally represented.

There are four labor Trustee positions and four management Trustee positions on the Board as well as two Alternate Trustee positions. A list of all of the trustees as of the date this booklet was prepared is contained in the front of this booklet.

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

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

Board of Trustees
Southeast Laborers Health Fund
P.O. Box 1449
Goodlettsville, Tennessee 37070-1449

TYPE OF ADMINISTRATION

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

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

COLLECTIVE BARGAINING AGREEMENTS

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

PLAN SPONSORS

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

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

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

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

SOURCE OF CONTRIBUTIONS

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

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

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

FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS

All contributions and investment earnings are accumulated in a Trust Fund. Benefits are provided solely by the Trust Fund. Some of the plan assets are invested, and this produces additional Fund income.

CIRCUMSTANCES THAT MAY RESULT IN LOSS OF ELIGIBILITY OR BENEFITS

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

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

Branstetter, Kilgore, Stranch and Jennings
227 Second Avenue North, Fourth Floor
Nashville, Tennessee 37201-1631

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

PLAN IDENTIFICATION NUMBERS

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

Employer Identification Number (EIN)
assigned by the Internal Revenue Service 23-7100845
Plan Number 501

FISCAL YEAR

The accounting records of this Plan are kept on the basis of a fiscal year which ends on March 31st.