Amendment 1 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description, dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1 (b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to make certain clarifications to the Plan dated November 1, 2016;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

Effective March 1, 2017, Section 2.1(a) is modified as follows:

2.1 Hour Bank Eligibility for Active Employees.

a. Eligibility.

If you work under a collective bargaining agreement or for the Union or an affiliated training fund, your eligibility for Plan benefits is determined by the hour bank system.

The following Active Employees participate in the Plan under the hour bank system:

1. Employees whose Contributing Employer makes contributions to the Fund on behalf of the employee's Hours of Work as required by a collective bargaining agreement; and

2. Employees whose Contributing Employer is a Union or affiliated training fund, and makes contributions to the Fund on behalf of the employee's Hours of Work as required by a participation agreement.

Deleted: local

For an owner to participate in the hour bank system, at least 50% of their work must be under the jurisdiction of a collective bargaining agreement.

A Contributing Employer may be required to make written application to the Board of Trustees to participate in the Plan under the hour bank system. The Board of Trustees may, in its discretion, accept or reject any such application.

Adopted this 6 day of Feb, 2017.

Michael L. McDonald, Chairman

George Bosiljevac, Secretary
Employer Trustee

{00163579; 1 }

Amendment 2 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description, dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1 (b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to acknowledge changes made to the Plan by the October 2017 and October 2018 SMMs, and to make certain clarifications to the Plan;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

1. Effective as of January 1, 2019, the SUMMARY OF BENEFITS is amended to read as follows:

SUMMARY OF BENEFITS

Note: this is just a summary. See the rest of the Plan for details, limits, and exclusions.

ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES

Weekly Benefit	$200 minus FICA tax
Benefit duration per disability	21 weeks
Benefit Commencement: Injury	1st day
Benefit Commencement: Illness	8th day (or 1st day hospitalization)

MAXIMUM MEDICAL BENEFITS

Lifetime Maximums

TMJ	$2,500
Skilled Nursing Facility	70 days

Other Calendar Year Maximums

Orthotics	one pair
Chiropractic	12 visits
Acupuncture	20 visits
Anesthesia for oral surgery	$750

MEDICAL BENEFITS: ***Your calendar Year Deductible/Copays***

	Class I	Class II	Class III	Local 24 & 24A
Individual Deductible	$1,000	$750	$500	PPO - $2,500 non-PPO - $5,000
Maximum Family Deductible	$2,000	$1,500	$1,000	PPO - $5,000 non-PPO - $10,000
Physician/other practitioner office visit Copay	$0	$0	$30	$0
Hospital and other inpatient admission Copay	$100	$100	$100	$0
Emergency Room Copay	$300	$300	$300	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
* The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
* There is no Copay for acupuncture or Preventive Care.
* There is no Deductible for Preferred Provider Physician office visits (non-surgical services) and Preventive Care.

MEDICAL BENEFITS: ***Percentage of Covered Charges you pay - Coinsurance***

	Class I	Class II	Class III	Local 24 & 24A
PPO (and non-PPO outside PPO Service area) Physician office visits	30%	25%	0%	20%
PPO (and non-PPO outside PPO Service area) services and supplies	30%	25%	20%	20%
Non-PPO services and supplies within PPO Service Area	50%	50%	40%	40%
Preventive Care (PPO only—non-PPO not covered)	0%	0%	0%	0%
Maximum Coinsurance—PPO providers/non-PPO	$4,500/$7,500	$3,750/$7,500	$3,000/$6,000	See Medical Out of Pocket Maximum

* If a Covered Individual has surgery performed by a PPO Physician in a PPO facility, other services, such as anesthesia, if rendered by a non-Preferred Provider will be paid at the PPO percentage.
* In case of a life-threatening Emergency, the Plan pays benefits at the PPO percentage.
* The Plan pays nothing for Preventive Care services and supplies you receive from a non-Preferred Provider. And the Plan pays nothing for non-PPO Licensed Substance Abuse Treatment Centers,

Residential Treatment Facilities, Skilled Nursing Facilities, or Rehabilitation Facilities.

* Only medical benefit Coinsurance counts toward the Coinsurance maximum. For example, outpatient prescription drug payments do not count toward the Coinsurance maximum.

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

	Self-only coverage		Family coverage	
	Medical and pediatric dental	Out-patient prescription drugs	Medical and pediatric dental	Out-patient prescription drugs
Out-of-pocket maximum*	2019: $5,690**	2019: $1,660**	2019: $11,380**	2019: $3,320**
Local 24 & 24A PPO	2019: $5,690**	2019: $1,660**	2019: $11,380**	2019: $3,320**
Local 24 & 24A Non-PPO	2019: $11,380	2019: $3,320	2019: $22,760	2019: $6,640

* The out-of-pocket maximums have the following restrictions:
  - They apply only to Essential Health Benefits, as defined by law and the Plan.
  - They do not apply to cost sharing for vision benefits or adult dental benefits.
  - They apply only to the extent a service or supply is a Covered Charge and, except for members of Locals 24 and 24A, only if received from a PPO including, for prescription drugs, a PPO pharmacy.
  - They do not apply to expenses incurred for services or supplies in excess of another Plan limit, such as a visit limit.
  - They apply only to Covered Charges incurred for the family members you have properly enrolled for coverage in the Plan.
  - If a generic drug is available and you or your doctor choose a brand drug, you pay the difference in cost. That difference will not count toward the out-of-pocket maximum.
  - The maximums renew each calendar year. For example, cost sharing for expenses incurred in 2018 will not apply toward the out-of-pocket limits in 2019.
  - The out-of-pocket maximums are adjusted annually.
  - Once you reach the out-of-pocket maximum for medical and pediatric dental expenses, you owe no further Deductible, Copay, or Coinsurance for Covered Charges from PPOs that are for medical and pediatric dental expenses, for the remainder of the calendar year.
  - Once you reach the out-of-pocket maximum for prescription drugs, you owe no further Copay or Coinsurance for covered drugs received from a PPO pharmacy, for the remainder of the calendar year.
  - Even if you reach the out-of-pocket maximum for a year, the Plan's other limits and exclusions continue to apply – for example, the requirement that a service be Medically Necessary and visit limits.

**This is the maximum beginning January 1, 2019.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Copay or Coinsurance you pay for Prescriptions

	PPO Retail Pharmacy	PPO Mail Order Pharmacy**	Non-PPO Pharmacy
Generic Drugs	$10 34 day supply limit	$20 90 day supply limit	$10 34 day supply limit
Preferred Brand Drugs*	15% $20 min and $40 max 34 day supply limit	15% $50 min and $100 max 90 day supply limit	15% of the Allowable Fee $20 min and $40 max 34 day supply limit
Non-Preferred Brand Drugs*	15% $50 min and $100 max 34 day supply limit	20% $100 min and $200 max 90 day supply limit	15% of the Allowable Fee $50 min and $100 max 34 day supply limit
Specialty Drugs	No coverage	$75 30 day supply limit***	No coverage
Preventive Care Drugs (prescription required)*	0%	0%	No coverage
Local 24 & 24A Generic Drugs	***$20*** ***34 day supply limit***	***$40*** ***90 day supply***	***$20*** ***34 day supply limit***
Local 24 & 24A Preferred Brand	***25%*** ***$80 min and $160 max*** ***34 day supply limit***	***25%*** ***$160 min and $320 max*** ***90 day supply limit***	***25% of the Allowable Fee*** ***$80 min and $160 max*** ***34 day supply limit***
Local 24 & 24A Non-Preferred Brand	***25%*** ***$160 min and $320 max*** ***34 day supply limit***	***30%*** ***$320 min and $640 max*** ***90 day supply limit***	***25% of the Allowable Fee*** ***$160 min and $320 max*** ***34 day supply limit***

*If a Generic Drug is available and you or your doctor choose a Brand Drug, the Plan will not pay the difference between the Generic cost and Brand cost—you will have to pay that cost, plus any applicable Brand Drug Copay/Coinsurance.

** Mail order is available through EnvisionPharmacies only.

***Specialty drugs must go through EnvisionPharmacies.

If you or your pharmacy can use a manufacturer's copay assistance plan, such as a coupon or similar method, EnvisionRx may arrange for you or the Plan to pay less for your prescription drugs. A coupon or rebate will not require you to pay more and will not entitle you to cash back. Certain drugs may cost less than the amount you pay. The percentage you pay is based on the Allowable Fee.

HEARING AID (PARTICIPANTS ONLY, PPO ONLY)

$2,000 per ear every 3 years

$60 for comprehensive audiogram once every 3 years

DENTAL BENEFITS

	Adults	Pediatric (under age 19)
Calendar Year Maximum	$1,500	No maximum
Calendar Year Deductible	$25	$25 for basic & major services

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY)

Active Employee	$10,000

See the attached insurance certificate of coverage for a description of benefits.

VISION

A portion of exams and eyewear may be covered. *See Article VII.*

2. Effective January 1, 2019, Section 2.1.e is amended to read as follows:

e. Hour Bank Accumulation. Active Employees may accumulate up to 480 Hours of Work in their hour bank. Benefits and hour banks are not accrued or vested, and may be terminated at any time in the discretion of the Trustees. Effective January 1, 2019 for members of Locals 24 and 24A, your hour bank, after satisfying the initial eligibility rules (360 hours), may not exceed 240 hours. If your hour bank is higher than 240 on December 31, 2018, it will be reduced to 240 hours. If you are a Local 21, 27, 495 or 732 member and work under a Local 24 or 24A agreement, contributions will be converted as if you had worked outside the jurisdiction of the Plan and the contributions were reciprocated from another plan that has a lower contribution rate.

3. Plan Section 2.1.i is clarified to read as follows:

Reciprocity Agreements. The Board of Trustees has entered into the Iron Workers' International Reciprocity Health and Welfare Agreement. If you work outside the jurisdiction of this Plan, contact that plan for the appropriate forms.

When the Administrative Office receives reciprocal contributions from the other plan, it will divide the amount received by the Plan's then-current hourly contribution rate for your home local union's Master Collective Bargaining Agreement (construction), including the highest HRA contribution (if any), to arrive at Hours of Work to be credited to your hour bank and dollars to

be credited to your HRA. However, see the HRA at Exhibit A for a special rule when the Plan receives reciprocal contributions for your work in Canada.

Participants receive credit for hours under reciprocal plans only to the extent the Plan timely receives an accurate employer report of hours and corresponding payment of contributions. If you want the Administrative Office to transfer contributions to your Home Fund, contact the Administrative Office or your Local Union and complete the reciprocity paperwork.

4. Effective January 1, 2019, Section 2.6.a is amended to read as follows:

a. Eligibility and Application. Effective January 1, 2019, Local 24 and 24A members are no longer eligible for Retiree Coverage. All other Active Employees may elect to become a Retiree as follows:

1. Application deadline. File an application on the Plan's form after your Pension retirement date, but before your hour bank runs out or your coverage under the Plan terminates.

2. Eligibility. Be an Active Employee in the Plan for 60 of the 84 months immediately before Retiree coverage is to begin and be ineligible for Medicare on the basis of age (age 64 or under).

3. No gap in coverage. Coverage must begin the month you lose Active Employee coverage immediately following your Pension retirement date. Participants who lose Plan coverage before their Pension retirement date are ineligible for Retiree coverage. And following a Participant's Pension retirement date there can be no gap between Active and Retiree Plan coverage.

4. One-time opportunity to elect Retiree coverage. Participants who have a Pension Retirement date and do not timely elect Retiree coverage may not later elect Retiree coverage, even if they return to Covered Employment.

5. No COBRA. Retiree coverage is unavailable immediately following COBRA coverage.

6. Pension retirement date. A Pension retirement date is the date as of which the Participant receives his or her first monthly retirement payment from one of the following Pension plans: the Intermountain Ironworkers Pension Plan, or the Omaha Construction Industry Pension Plan. Participants who are not eligible for a Pension benefit from one of the above referenced plans may be eligible for Retiree Coverage if they apply timely, meet all other Retiree provisions, including being an Active Employee in the Plan and meet the following service requirement prior to disability or retirement: Active eligibility five (5) of the last seven (7) years.

7. No Active Employee coverage. Once you elect Retiree Coverage, you may not return to coverage as an Active Employee. However, if you

return to Covered Employment, the Plan will credit Contributing Employer contributions toward your monthly payments due for Retiree Coverage.

5. Effective as of January 1, 2019, Plan Section 4.3, Out-of-Pocket Maximum, is amended to read as follows:

4.3 Out-of-Pocket Maximum.

The sum of the medical benefit Deductibles, Copays, Coinsurance, and pediatric dental Deductibles you pay for Covered Charges during a calendar year will not exceed the out-of-pocket maximum. However, except for members of Locals 24 and 24A, only Covered Charges for Essential Health Benefits from PPOs will accumulate toward the out-of-pocket maximum.

The medical benefit Deductibles, Copays, Coinsurance, and pediatric dental Deductibles you pay for Covered Charges are called your "out-of-pocket" costs. Your out-of-pocket costs incurred for services and supplies from PPOs will not exceed, for any calendar year, the annual out-of-pocket maximum described in the Summary of Benefits. Members of Locals 24 and 24A also have a separate non-PPO out-of-pocket maximum described in the Summary of Benefits. Note, however, that the Plan's other limits and exclusions continue to apply, such as the requirement that a service be Medically Necessary and visit limits. Additional restrictions on the out-of-pocket maximum are described in the Summary of Benefits.

6. Effective for claims incurred on or after November 1, 2017, Plan Section 4.7.i, Pregnancy and childbirth benefits, is amended to read as follows:

Pregnancy and childbirth benefits. Services and supplies delivered as a result of pregnancy, childbirth or related medical condition. Dependent children receive pregnancy and childbirth benefits to the same extent as Covered Individuals who are Participants or Dependent spouses.

7. Effective as of January 1, 2019 the Plan is amended to add the following immediately under the title banner for ARTICLE IV. – MEDICAL BENEFITS:

NOTE: Effective January 1, 2019 Local 24 and 24A members will have different health benefits from members of Locals 21, 27, 495, and 732. Where benefits under the Plan are different for members of Locals 24 and 24A, they will be noted in the Summary of Benefits. The different benefit provisions apply regardless of whether the Local 24 or 24A member is working in an area inside or outside the jurisdiction of Local 24 or 24A, and regardless of the member's contributing employer, contribution rate, collective bargaining agreement, key man agreement or other written agreement. The Local 24 and 24A benefits also apply to employees of Local 24 and 24A and their apprenticeship/training funds, and to employees of Local 24 and 24A contractors who are not covered by a collective bargaining agreement and participate in the Plan under a participation agreement approved by the Trustees (also called "flat rate" participants).

8. Effective January 1, 2019, Section 5.5, Copays, Coinsurance, and Out-of-Pocket Maximum, is amended to read as follows:

5.5 **Copays, Coinsurance, and Out-of-Pocket Maximum.** For some prescriptions, you pay a Copay or Coinsurance, as described in the Outpatient Prescription Drug Benefits chart. These are your out-of-pocket costs. Once you reach the out-of-pocket maximum for prescription drugs, you owe no further Copay or Coinsurance for covered drugs received from a PPO pharmacy for the remainder of the calendar year. Note that members of Local 24 and 24A also have a separate non-PPO out-of-pocket maximum. See the Summary of Benefits for the out-of-pocket maximum and additional restrictions. Additionally, you will be responsible for the full cost of a covered prescription drug if the applicable Copay for the prescription drug is more than the pharmacy network price or pharmacy charge.

9. Effective January 1, 2019, Section 8.1, Benefits, is amended to read as follows:

8.1 **Benefits**. If a Participant or Dependent receives dental care, the Fund will pay the expenses incurred for covered dental services according to the Summary of Benefits chart at the beginning of this booklet. Effective January 1, 2019, Members of Locals 24 and 24A are not eligible for dental benefits.

10. Acknowledging changes in the law and to incorporate prior notices, a new Section 12.14 is added to read as follows:

Notice Regarding Wellness Programs. This notice applies to wellness programs that involve disease-related inquiries or medical examinations. These programs may ask you questions about your health-related activities and behaviors and whether you have or had certain medical conditions. For example, visit myCigna.com for details on the information in connection with a particular program.

Wellness programs are completely voluntary. If you choose to participate, the health information you provide to these programs is protected by federal law, including HIPAA. The Board of Trustees respects your right to keep your health information private and only accesses, uses and discloses your health information for certain limited purposes, as provided above in this Section 12.12. In no event will the health information you provide to these programs be used to discriminate against you, nor will you be subject to retaliation if you choose not to participate.

11. Acknowledging changes in the law and to incorporate prior notices, a new section 12.15 is added as follows:

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, please contact Dawnette Butterworth at (888) 867-9510.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Dawnette Butterworth,
Administrator
2156 West 2200 South
Salt Lake City, UT 84119
(888) 867-9510
(801) 606-2080 (TYY)
(801) 973-1007 (Fax)
Email: dawnetteb@compusysut.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Dawnette Butterworth, Administrator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you or someone you are helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (888) 867-9510.

If you, or someone you're helping, has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 801-973-1001.

AMHARIC: ማስታወሻ: የሚናገሩት ጽንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ 1-801-973-1001.

ARABIC:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-801-973-1001

BASSA: Dè ɖɛ nià kɛ dyédé gbo: Ɔ jŭ ké m̀ [Bàsɔ́ɔ̀-wùdù-po-nyɔ́] jŭ ní, nìí, à wudu kà kò ɖò po-poó ɓéin m̀ gbo kpáa. Đá 1-801-973-1001.

BURMESE:
သတိပြုရန် - အကယ်၍ သင်သည် ပြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အတွက်အခြေ အစမဲ့ သင့်အတွက်
စီစဉ်ပေးထားရှိပါကြောင်း
ဖုန်းနံပါတ် 801-973-1001

CAMBODIAN: ប្រយ័ត្ន៖ ឃើសនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយឥតគិតលុយ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-801-973-1001។

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-801-973-1001.

CUSHITE: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-801-973-1001.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-801-973-1001.

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-801-973-1001.

GUJARATI: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-801-973-1001.

HINDI: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-801-973-1001 पर कॉल करें

HMONG: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-801-973-1001.

IBO: Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-801-973-1001.

INDONESIAN: PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-801-973-1001.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-801-973-1001.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-801-973-1001 まで、お電話にてご連絡ください。

KAREN:
ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကိုဉ်အဃိ, နမၤနှဲ့ ကိုဉ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သုနှဉ်လီၤ. ကိး
1-801-973-1001.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-801-973-1001 번으로 전화해 주십시오.

KURDISH:
ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-801-973-1001

LAOTIAN:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ
ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-801-973-1001.

NAVAJO:
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-801-973-1001

NEPALI: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-801-973-1001

NORWEGIAN: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-801-973-1001.

PENNSYLVANIA DUTCH : Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-801-973-1001.

PERSIAN:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-801-973-1001 تماس بگیرید.

PORTUGUESE: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-801-973-1001.

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-801-973-1001.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-801-973-1001.

SERBO-CROATION: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-801-973-1001.

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-801-973-1001.

SWAHILI: KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-801-973-1001.

TAGALOG: PAUNAWA: Kung nagsasalita.ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-801-973-1001.

THAI: เรียน:ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-801-973-1001.

TONGAN: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-801-973-1001.

UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-801-973-1001.

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-801-973-1001.

YORUBA: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-801-973-1001.

12. A new Section 12.16 is added as follows:

12.16 Legally required benefits and changes to the Plan.

The Plan provides benefits as required by law, notwithstanding anything in the Plan to the contrary. For example, as required by the Affordable Care Act, the Plan covers Preventive Care at 100% when received from an in-network PPO provider. The list of covered Preventive Care services and supplies changes from time-to-time, according to published guidelines under Health Care Reform.

The Board of Trustees may take action to terminate, replace or amend any part of the Plan. This action might impact, for example, Plan coverage, retiree coverage, benefits and/or eligibility for benefits. Such action will be taken in accordance with applicable provisions of the Trust Agreement. Plan benefits and eligibility for benefits are not guaranteed or vested, and may be reduced, changed or eliminated at any time.

13. Effective as of January 1, 2019 EXHIBIT A of the Plan is amended to read as follows:

EXHIBIT A--HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

You are eligible for benefits from the Plan's Health Reimbursement Arrangement (HRA) only if your employer contributes to the HRA, according to a collective bargaining or other Written Agreement. HRAs are subject to all of the other terms and conditions of the Plan.

1. **Amount.** Your HRA balance is the amount of employer contributions actually made to your HRA, less HRA benefits you have already received and less administrative expenses. If the Plan receives reciprocal contributions and your home local's master collective bargaining agreement (construction) has an HRA, then your HRA is credited with a pro rata share of the reciprocated contributions. See Section 2.1.i. of the Plan for more information on reciprocated contributions.

   If the Plan receives reciprocal contributions for your work in Canada, then the amount received in excess of the then current hourly contribution rate will be credited to your HRA.

2. **Administrative Expenses.** An administrative fee is assessed monthly, and used to pay service providers to operate the HRA and for other applicable expenses. Beginning January 1, 2019, the administrative fee is $2.00 per month after you are first eligible for reimbursement from your HRA. The administrative fee may be adjusted from time-to-time, and will be reflected on a quarterly statement.

3. **Eligibility.** You are eligible for reimbursement from your HRA once you have received contributions in the amount of $120.00. You must be a Plan Participant or enrolled in Medicare to receive HRA benefits. Participants enrolled in the Plan under the flat rate system (Section 2.2 of the Plan), unless they are covered by a collective bargaining agreement, are ineligible for HRA benefits.

4. **Termination.** Your HRA balance will be permanently eliminated if you are not available for Covered Employment or if you have lost eligibility for Retiree Coverage because you work for an employer that does not have a Written Agreement with the Plan. If your HRA is permanently eliminated, it can never be reinstated.

5. **Benefits.** You may use your HRA to pay for medical care expenses (as defined by the Tax Code and as permitted by law). The expenses must be incurred by you or your enrolled Dependents while you and your Dependents are covered by the Plan. (There is one exception, if you were covered by the Plan until you turned age 65 and are enrolled in Medicare.) *Note: an expense is "incurred" when the service is rendered or the supply is delivered; a provider's billing practices do not matter.*

6. **Medical care expenses that are reimbursable under the HRA:** Medical care expenses under Tax Code Section 213(d), such as COBRA payments to the Plan, deductibles, co-pays and coinsurance, prescriptions, chiropractic care, acupuncture, vision care (including LASIK), hearing aids, and medically necessary orthodontics.

7. **Examples of medical care expenses that are not reimbursable under the HRA:** Non-Tax Code Section 213(d) expenses, wage replacement/cash, tuition, long-term care, most cosmetic procedures, toiletries, non-FDA-approved drugs, drugs obtained outside the U.S., over the counter medications (unless you also have a doctor's prescription for the medication), expenses for which the Participant has no payment responsibility or that are otherwise reimbursable, health insurance premiums, COBRA for another Plan, and payments toward Medicare or other health coverage.

8. **Debit Card.** You will receive a special debit card that you can use to pay medical care expenses you incur at participating IIAS pharmacies and medical facilities. The debit card will be activated after you agree to use it only according to the terms of the Plan and Tax Law. The Administrative Office will provide you with further details about the debit card program before your card is activated.

9. **Request Reimbursement for other Services and Supplies.** You may also apply to the Administrative Office for reimbursement of medical care expenses not charged to your debit card within 90 days of when the expense is incurred. A claim form is available from the Administrative Office or via the Trust Fund website. When you submit a claim for reimbursement, you will be asked to include written statements and/or bills from an independent third party describing the service or product, the amount of the expense, and the date of the service or sale. Depending on the circumstances, this would include an invoice, prescription, an affidavit, and/or other documentation required by the Administrative Office. Cash register receipts are not, alone, an acceptable form of substantiation. (Further details about required documentation are on the claim form.)

10. **COBRA.** If you have a COBRA qualifying event that causes you to lose coverage under the Plan you will be given an opportunity to elect to continue your Plan coverage, with or without your HRA. You must notify the Administrative Office in writing if you wish to use your HRA to pay the monthly contributions required for COBRA.

11. **Retirement.** If your active coverage ends and you elect coverage as a Retiree, your HRA

will remain available to you for payment of eligible medical care expenses. You must notify the Administrative Office in writing if you wish to use your HRA to pay the monthly contributions required for Retiree Coverage.

12. **Death.** If you die, your surviving spouse (so long as they are covered under the Plan as your Dependent) may use your HRA to pay for eligible medical care expenses, and for COBRA or continued coverage (if available) under the Plan.

13. **Opt-out.** You may permanently opt out of your HRA at any time, in which case no further HRA reimbursements will be available to you. You may not opt out of employer contributions to the HRA. Notify the Administrative Office if you would like to opt out.

14. Effective for claims and appeals filed on or after April 1, 2018, the HOW TO FILE A CLAIM FOR BENEFITS Section of the Plan is amended to read as follows:

HOW TO FILE A CLAIM FOR BENEFITS

This section describes the procedures for filing a claim for benefits and for appealing a denied claim. A "claim for benefits" means a request for Plan benefits made in accordance with the procedures described in this booklet. This section ("How to File a Claim for Benefits") applies to the Plan's Accident and Sickness Weekly Benefits and health benefits. See the applicable insurance contracts for claims procedures for the Life and Accidental Death and Dismemberment ("AD&D") benefits.

For purposes of this section, the term "Disability Benefits" refers to the Accident and Sickness Weekly Benefits and the term "Medical Benefits" refers to all health benefits, including dental, hearing aid, and vision. As described below, a dispute solely as to whether you have met the requirements for enrollment or eligibility under the Plan is treated as a claim for Disability Benefits.

GENERAL CLAIMS INFORMATION

Enrollment form. You **must** complete and submit an enrollment form to the Plan Administrative Office before your claims will be processed. You can obtain an enrollment form from the Administrative Office. You must also submit all information requested by the Administrative Office that is reasonably necessary to administer the Plan and pay benefits, such as Social Security numbers for you and your Dependents, proof of marriage, divorce, death, or birth, other insurance information, and evidence of employment. Claims will not be paid if the enrollment form and information are not timely received by the Administrative Office.

Where to obtain claim forms. In general, you can obtain a claim form for Medical Benefits or Disability Benefits from your Local Union office or from the Administrative Office. However, you may obtain a claim form for Life and AD&D Insurance benefits from the Administrative Office or from UnitedHealthcare, which is the insurer for these benefits.

Where to file claim forms and appeals. All claims must be filed with the Claims Administrator (identified below). However, a claim for Life and AD&D Insurance benefits should be submitted to the Administrative Office, which will assist in the filing of your claim with the life insurance Claims Administrator. All appeals of denied claims must be filed with the Claims Fiduciary (identified below).

Required information. You **must** provide all the information requested and reasonably required to decide your claim or appeal (as applicable). If you do not provide this information during the applicable review periods described under the "Claims Review Process," your claim (or appeal, as applicable) will be denied.

CLAIMS ADMINISTRATOR/CLAIMS FIDUCIARY CHART

PLAN BENEFITS	CLAIMS ADMINISTRATOR	CLAIMS FIDUCIARY
Medical and Disability Benefits	Administrative Office CompuSys of Utah, Inc. P.O. Box 30124 Salt Lake City, UT 84130-0124 (888)-867-9510 (801)-606-2425	Board of Trustees c/o Administrative Office (see contact information at left)
Outpatient Prescription Drug Benefits	Envision Rx 1100 Investment Blvd. El Dorado Hills, CA 95762 (800) 361-4542	Board of Trustees –c/o Administrative Office (see contact information above)
Life Insurance & AD&D Insurance Benefits	c/o Administrative Office (see contact information above) Or, you may contact UnitedHealthcare directly at: UHC specialty benefits P.O. Box 7149 Portland, ME 04112-7149 Tel.: 1-888-299-2070	United Healthcare (see contact information at left)
Hearing Aids	Epic 17870 Castleton Street Suite 308 City of Industry, CA 91748 www.epichearing.com Tel.: 1-866-956-5400	Board of Trustees c/o Administrative Office (see contact information above)

How to complete your claim form for Medical Benefits. In order for a medical claim form to be considered complete, you must:

1. Complete the employee portion of the claim form.
2. For claims after service or treatment, attach all itemized bills or provider's statements that describe the services rendered and return the claim form to the Claims Administrator.

Before submitting a claim, check the claim form to be certain that applicable portions of the form are completed and, for claims after service or treatment, that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim form has to be returned to you for information, delays in payment will result.

Claims must show the applicable procedure codes adapted from: (1) the Current Physician Terminology (CPT) Uniform Codes on Medical Procedures; (2) the American Dental Association (ADA) recommended Uniform Codes on Dental Procedures and Nomenclature, and (3) the actual charges to the Participant for all services or procedures. Most Physician's offices will submit claims for you directly to the Claims Administrator.

Time limit for filing claims for Medical Benefits. Your completed claim form with all itemized bills generally must be received by the Claims Administrator within 90 days after the date your claim was incurred. NO BENEFITS WILL BE PAID IF YOUR CLAIM IS SUBMITTED MORE THAN ONE YEAR AFTER THE DATE IT WAS INCURRED, unless you establish it was not reasonably possible to submit the claim within one year of the date it was incurred.

PPO Preferred Providers and most Non-PPO Providers will file a claim on your behalf if notified of your coverage. When you visit a Preferred Provider or non-PPO provider, advise the personnel in the provider's office that your coverage is through the Ironworkers Intermountain Health and Welfare Trust and present your Plan identification card. The provider's office will then file the claim on your behalf. If a provider submits a claim on your behalf, the Plan may, but is not required to, remit any reimbursement it owes directly to the provider as a convenience to you. *See section 12.1.*

How to complete your claim form for Disability Benefits. In order for a Disability Benefits claim form to be considered complete, you must complete the Employee section and your Physician must complete the Physician section of the form. Return the completed form to the Claims Administrator.

Time limit for filing claims for Disability Benefits. All claims for Disability Benefits must be submitted within one year of the date of your Illness or Injury.

Life and AD&D Insurance claims. Contact the Administrative Office to file a claim for Life and AD&D Insurance benefits. Life and AD&D Insurance claims, along with any required proof of loss, should be submitted as soon as possible following the date of death or dismemberment.

Eligibility claims. A dispute solely as to whether you have met the requirements for enrollment or eligibility under the Plan is subject to the Plan's internal claim and appeal procedures, as if it were a Disability Benefits claim. The internal appeal procedures need to be exhausted for such disputes before you can bring a civil action under Section 502(a) of ERISA.

Your "authorized representative" may file a claim or appeal a denied claim on your behalf. Your "authorized representative" means a person you authorize, in writing, to act on your behalf with respect to a claim. It also means a person authorized by court order to submit claims on your behalf. For a healthcare claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

CLAIMS REVIEW PROCESS

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Claims Administrator. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. Please note that the Claims Fiduciary may, outside of the timelines set forth herein, reconsider an initial claim or appeal determination at any time if facts that were not within the control of the Claims Fiduciary become known subsequent to the initial determination. In addition, if your claim is for Medical Benefits, different claim and appeal procedures apply based on whether your claim is for prior approval of a benefit before the service or treatment is obtained, or is after service or treatment, and your claim may also be eligible for an external review process.

GENERAL PROVISIONS APPLICABLE TO MEDICAL BENEFIT AND DISABILITY BENEFIT CLAIM DETERMINATIONS

Initial Denial Decisions and Appeal Decisions will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10 percent or more of the population is literate only in the same non-English language as determined by applicable federal guidance.

If the above percentage threshold standard is met, the following three conditions will apply to claimants in such counties: Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals; the Plan will provide upon request a notice in the applicable non-English language; and the Plan will include in the English version of all notices a statement in the applicable non- English language clearly indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons, such as medical or vocational experts or a claims adjudicator, involved in making decisions and no decisions regarding hiring, compensation,

termination, promotion, or other similar matters will be based upon the likelihood that the person will support a denial of benefits.

If the Plan fails to adhere to all the requirements of the Claims Review Process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable (external review is only available for certain Medical Benefit claims). A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

MEDICAL BENEFIT AND DISABILITY BENEFIT CLAIM DETERMINATIONS

The following procedures apply to any claim for Medical Benefits or Disability Benefits:

Timing of Initial Determination – Precertification Medical Benefits Claims.

The Plan requires that you get prior review or approval before you receive certain covered services or treatments in order to receive higher levels of benefits under the Plan than if prior approval is not obtained. The following rules apply to these claims for prior review or approval required by the Plan. All prior review or approval procedures required by the Plan are referred to in these procedures as "precertification" claims.

Urgent precertification claims. If your precertification claim is determined by the Plan to be a claim involving urgent care (as defined below), notice of the Plan's decision will be provided to you as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of your claim by the Plan. For this purpose, the Plan shall defer to a determination of urgent care by the attending provider. If, however, you do not provide sufficient information to decide your claim, a notice requesting specific additional information will be provided to you within 24 hours of receipt of your claim. The Plan's decision regarding your claim will then be issued no later than 48 hours after the earlier of 1) the Plan's receipt of the requested information or 2) the expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours). Benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within three days after the oral notice.

A "claim involving urgent care" is a claim for precertification where application of the normal time periods for deciding your claim 1) could seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought. If a physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the Plan as involving urgent care.

Regular precertification claims. If your precertification claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to you before the end of the initial 15-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of

1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Failure to follow precertification procedures. If your communication to the Plan concerning precertification does not comply with the Plan's procedures for filing precertification claims, notice of the proper procedures will be provided to you within five days of the communication. If, however, the communication involves urgent care, notice will be provided within 24 hours. Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service or product being requested.

Notice may be oral, unless you request written notice.

Timing of Initial Determination – Medical Benefits Claims After Service or Treatment

If your claim for a benefit does not require pre-approval in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of

1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Timing of Determination – Concurrent Care Medical Decision – Medical Benefits Claims

Reduction or termination of ongoing course of treatment. If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

Extension of ongoing course of treatment involving urgent care. If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the Plan within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

Timing of Initial Denial - Disability Benefits Claims

A written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan. If matters beyond the control of the Plan require an extension of the time for processing your claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of

1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Initial Denial – Medical Benefits Claims and Disability Benefits Claims

If your claim is denied, in whole or in part, you will be notified in writing by the Plan. The written notice will include the following:

- the specific reason or reasons for the denial,
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to

  perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's available internal appeal and external review processes (as applicable) for denied claims, including information regarding how to initiate an appeal and the applicable time limits for submitting your appeal (claims involving urgent care will have a description of expedited appeal procedures);
- a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal;
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- a statement of your right to receive upon request, free of charge, reasonable access to and copies of all Relevant Documents.

If your claim is for Medical Benefits, the notice will also include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the denial will include, to the extent applicable, the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

If your claim is for Disability Benefits, the notice will also include the following:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by you to the Plan of health care professionals that treated you and vocational professionals that evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision,

without regard to whether the advice was relied upon in making the decision, and a disability determination made by the Social Security Administration about yourself; and

- any internal rule, guideline, protocol, standard, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such internal rule, guideline, protocol, standard, or other similar criterion does not exist.

Appeal Procedure for Denied Medical Benefits and Disability Benefits Claims

A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time and can include a rescission of a determination you are disabled. If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Claims Fiduciary within 180 days after receiving notice of denial, unless your claim is for Medical Benefits and concerns the reduction or termination of a previously approved ongoing course of treatment. In that case, you must file a written appeal within a shorter time period that permits the Claims Fiduciary to issue an appeal decision before the treatment is reduced or terminated. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents. In addition:

- the appeal decision will not defer to the initial decision denying your claim and will be made by the Claims Fiduciary, who is not a person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon;
- if your claim involves urgent care, your request for an appeal may be submitted orally or

  in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method; and

- you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with the claim and any new or additional rationale upon which the decision is based, and such information will be provided as soon as possible and sufficiently in advance of the date the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

The Claims Fiduciary reviews appeals of denied claims and makes final determinations. The Claims Fiduciary has the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement in order to determine benefits under the Plan.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decision – Precertification Medical Benefits Claims

Urgent care precertification claims. A decision on your appeal will be made as soon as possible, but no later than 72 hours after an appeal is received.

Regular precertification claims. A decision on your appeal will be made within a reasonable period of time, but no later than 30 days after an appeal is received.

Timing of Appeal Decision – Medical Benefits Claims After Service or Treatment and Disability Benefits Claims

If you or your representative would like to appear before the Board of Trustees when they consider your appeal, notify the Administrative Office when you file your appeal. The Administrative Office will notify you of the time and date you may appear.

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Claims Fiduciary after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Appeal Decision – Medical Benefits and Disability Benefits Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- references to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents;

- a statement of your right to bring a civil action under Section 502(a) of ERISA, including a statement of the Plan's limitations period that applies and the calendar date on which the limitations period expires for the claim; and
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

If your claim is for Medical Benefits, the decision notice will also include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the denial will include, to the extent applicable the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim that includes a discussion of the decision;
- an explanation of the Plan's available external review process for denied claims, including information regarding how to initiate the external review and the applicable time limits;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process; and
- the following statement: "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."

If your claim is for Disability Benefits, the decision notice will also include the following:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by you to the Plan of health care professionals that treated you and vocational professionals that evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the decision, without regard to whether the advice was relied upon in making the decision, and a disability determination made by the Social Security Administration about yourself; and
- any internal rule, guideline, protocol, standard, or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such internal rule, guideline, protocol, standard, or other similar criterion does not exist.

Standard External Review Process for Denied Medical Benefits Claims

If your claim for Medical Benefits is denied in an Initial Determination or Appeal Decision and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial but only if the denial involves 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer (a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you fail to meet the requirements for eligibility under the terms of the Plan is not eligible for external review); or 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. The request must be filed with the Claims Fiduciary within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

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

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Plan shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally recognized accrediting organization to conduct the external review. The Plan has contracted with IROs for assignments under the Plan and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility

and acceptance for external review which will include a statement that you may submit within ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Plan within one business day. Upon receipt of the information, the Plan may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies

may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

Expedited External Review Process for Denied Claims

If your claim is eligible for the external review process, you may request an expedited external review if:

- an Initial Determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal Appeal Decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the Appeal Decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Plan shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Plan shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Plan.

RELEVANT DOCUMENTS

For purposes of this section ("How to File a Claim for Benefits"), "Relevant Document" means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- if the claim was a medical or disability claim, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

LIMITATIONS PERIOD FOR LAWSUITS

You must exhaust the Plan's internal claims and appeal process before filing a request for external review or filing a lawsuit. In order to bring a lawsuit in court regarding your claim, you must file suit within two years after your appeal is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in a contract for an insured benefit, then that limitations period applies to that benefit.

IF YOU HAVE QUESTIONS

If you have questions about filing your claim or an appealing a denied claim, please do not hesitate to contact the appropriate Claims Administrator. Each Claims Administrator's contact information is set forth above in the "Claims Administrator/Claims Fiduciary" chart under the "General Claims Information" heading.

KEEPING INFORMATION CURRENT

1. It is your responsibility to make sure the Administrative Office has current information regarding you and your dependents. Advise the Administrative Office promptly of any change in your home address so their records will be kept current.

2. BENEFICIARY DESIGNATION. Contact the Administrative Office to obtain the necessary form in the event you wish to change your beneficiary for your life and AD&D insurance benefits. A new enrollment form will be sent to you when you notify the

Administrative Office of a beneficiary or family composition change.

3. FAMILY COMPOSITION. Give prompt, written notice to the Administrative Office about any change in your family such as marriage or divorce, birth of a child, the marriage or loss of Dependent status of any of your children, or the death of any Dependent. A new enrollment form will be sent to you when you notify the Administrative Office of a beneficiary or family composition change.

4. OTHER INSURANCE COVERAGE. Give prompt written notice to the Administrative Office about any other insurance coverage you or your Dependents may have. Also give written notice of changes in employment of Dependent spouse or children.

It is your responsibility to notify the Administrative Office of a change in Dependent status, such as a divorce. If notice is not given and the Fund pays the claims of a person who is not eligible for coverage, you will be responsible to reimburse the Fund. If you do not promptly reimburse the Fund, the Fund will not pay your and your Dependents' future claims, which the Fund would otherwise cover. The Fund may also sue you to recover overpaid amounts.

Adopted this 29th day of April, 2019, with effective dates as noted herein.

Doug Thomas, Chairman

Lillian Santillanes, Secretary

Amendment 3 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to acknowledge changes made to the Plan by the May 2019 and July 2019 SMMs, and to make certain clarifications to the Plan;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

1. **Effective as of August 1, 2019, the portions of the SUMMARY OF BENEFITS entitled *ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES, MAXIMUM MEDICAL BENEFITS, MEDICAL BENEFITS: Your calendar Year Deductible/Copays, DENTAL BENEFITS,* and *LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY)* are amended to read as follows:**

ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES

Weekly Benefit	$350 minus FICA tax
Benefit duration per disability	21 weeks
Benefit Commencement: Injury	1st day
Benefit Commencement: Illness	8th day (or 1st day hospitalization)

MAXIMUM MEDICAL BENEFITS

Lifetime Maximums	
TMJ	$2,500
Skilled Nursing Facility	70 days
Other Calendar Year Maximums	
Orthotics	one pair
Chiropractic	20 visits
Acupuncture	20 visits
Anesthesia for oral surgery	$750

MEDICAL BENEFITS: *Your calendar year Deductible/Copays*

	Class I	Class II	Class III	Local 24 & 24A
Individual Deductible	$1,000	$750	$500	PPO - $2,500 non-PPO - $5,000
Maximum Family Deductible	$2,000	$1,500	$1,000	PPO - $5,000 non-PPO - $10,000
Physician/other practitioner office visit Copay	$0	$0	$30	$0
Hospital and other inpatient admission	$100	$100	$100	$0
Emergency Room Copay	$300	$300	$300	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
* The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
* There is no Copay for acupuncture, chiropractic benefits, or Preventive Care.
* There is no Deductible for Preferred Provider Physician office visits (non-surgical services), chiropractic benefits, and Preventive Care.

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DENTAL BENEFITS

	Adults	Pediatric (under age 19)
Calendar Year Maximum	$2,500	No maximum
Calendar Year Deductible	$25	$25 for basic & major services

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (ACTIVE EMPLOYEES ONLY)

Active Employee	$20,000

See the attached insurance certificate of coverage for a description of benefits.

2. **Effective September 1, 2019, the portions of the SUMMARY OF BENEFITS entitled *MEDICAL BENEFITS: Your calendar year Deductible/Copays* and *MEDICAL BENEFITS: Percentage of Covered Charges you pay – Coinsurance* are amended to read as follows:**

MEDICAL BENEFITS: *Your calendar year Deductible/Copays*

	Class I	Class II	Class III	Local 24 & 24A
Individual Deductible	$1,000	$750	$500	PPO - $2,500 non-PPO - $5,000
Maximum Family Deductible	$2,000	$1,500	$1,000	PPO - $5,000 non-PPO - $10,000
Physician/other practitioner office visit	$0	$0	$30	$0
Hospital and other inpatient admission	$100	$100	$100	$0
Emergency Room Copay	$300	$300	$300	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
* The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
* There is no Copay for acupuncture, chiropractic benefits, Preventive Care, or *Teladoc* program benefits.
* There is no Deductible for Preferred Provider Physician office visits (non-surgical services), chiropractic benefits, Preventive Care, or *Teladoc* program benefits.

MEDICAL BENEFITS: *Percentage of Covered Charges you pay - Coinsurance*

	Class I	Class II	Class III	Local 24 & 24A
PPO (and non-PPO outside PPO Service area) Physician office visits	30%	25%	0%	20%
PPO (and non-PPO outside PPO Service area) services and supplies	30%	25%	20%	20%
Non-PPO services and supplies within PPO Service Area	50%	50%	40%	40%
Preventive Care (PPO only—non-PPO not covered)	0%	0%	0%	0%
Maximum Coinsurance—PPO providers/non-PPO	$4,500/$7,500	$3,750/$7,500	$3,000/$6,000	See Medical Out-of-Pocket Maximum

* If a Covered Individual has surgery performed by a PPO Physician in a PPO facility, other services, such as anesthesia, if rendered by a non-Preferred Provider will be paid at the PPO percentage.
* No Coinsurance is owed for *Teladoc* program benefits.
* In case of a life-threatening Emergency, the Plan pays benefits at the PPO percentage.
* The Plan pays nothing for Preventive Care services and supplies you receive from a non-Preferred Provider. And the Plan pays nothing for non-PPO Licensed Substance Abuse Treatment Centers,

Residential Treatment Facilities, Skilled Nursing Facilities, or Rehabilitation Facilities.

* Only medical benefit Coinsurance counts toward the Coinsurance maximum. For example, outpatient prescription drug payments do not count toward the Coinsurance maximum.

3. Effective January 1, 2020, the portion of the SUMMARY OF BENEFITS entitled *CALENDAR YEAR OUT-OF-POCKET MAXIMUM* is amended to read as follows:

CALENDAR YEAR OUT-OF-POCKET MAXIMUMS

	Self-only coverage		**Family coverage**	
	Medical and pediatric dental	Out-patient prescription drugs	Medical and pediatric dental	Out-patient prescription drugs
Class I, II & III	$6,120	$1,780	$12,240	$3,560
Local 24 & 24A PPO	$6,310	$1,840	$12,620	$3,680
Local 24 & 24A Non-	$12,620	$3,680	$25,240	$7,360

* The out-of-pocket maximums have the following restrictions:
  - They apply only to Essential Health Benefits, as defined by law and the Plan.
  - They do not apply to cost sharing for vision benefits or adult dental benefits.
  - They apply only to the extent a service or supply is a Covered Charge and, except for members of Locals 24 and 24A, only if received from a PPO including, for prescription drugs, a PPO pharmacy.
  - They do not apply to expenses incurred for services or supplies in excess of another Plan limit, such as a visit limit.
  - They apply only to Covered Charges incurred for the family members you have properly enrolled for coverage in the Plan.
  - If a generic drug is available and you or your doctor choose a brand drug, you pay the difference in cost. That difference will not count toward the out-of-pocket maximums.
  - The maximums renew each calendar year. For example, cost sharing for expenses incurred in 2019 will not apply toward the out-of-pocket maximums in 2020.
  - The out-of-pocket maximums are adjusted annually.
  - Once you reach the out-of-pocket maximum for medical and pediatric dental expenses, you owe no further Deductible, Copay, or Coinsurance for Covered Charges from PPOs that are for medical and pediatric dental expenses for the remainder of the calendar year.
  - Once you reach the out-of-pocket maximum for prescription drugs, you owe no further Copay or Coinsurance for covered drugs received from a PPO pharmacy for the remainder of the calendar year.
  - Even if you reach the out-of-pocket maximums for a year, the Plan's other limits and exclusions continue to apply—for example, the requirement that a service be Medically Necessary and visit limits.

* The maximums listed in the chart above are effective beginning January 1, 2020.

4. **Effective August 1, 2019, the PRECERTIFICATION section is amended to read as follows:**

PRECERTIFICATION

PRECERTIFY YOUR VISITS TO THE HOSPITAL, AND CERTAIN SERVICES AND SUPPLIES

Precertification is required for all inpatient admissions and certain other services and supplies. If you don't obtain precertification, for some claims the Plan reduces its reimbursements by $200—that means you will have to pay an additional $200 of Covered Charges. For other claims, the Plan pays nothing, as described below.

The following services and supplies require precertification to avoid the $200 penalty: inpatient admissions (and services and supplies received while you are an inpatient), including but not limited to admissions to a Hospital, Skilled Nursing Facility, Rehabilitation Facility, Residential Treatment facility, and Licensed Substance Abuse Treatment Center, Intensive Outpatient Substance Abuse or Mental/Behavioral Health services, Durable Medical Equipment, Home Health Care, home infusion therapy, injectable medications, orthotics and prosthetics, Speech Therapy, therapeutic radiology (brachytherapy, proton beam therapy, neutron beam therapy), sleep studies, spinal procedures, and other surgical procedures rendered in an outpatient facility.

The following services and supplies require precertification to receive any Plan coverage: organ transplants, eye surgeries (LASIK, etc.), hearing aids (see below), compound drugs and specialty drugs.

You can precertify a procedure or hospital admission by calling the Plan's medical reviewer, CIGNA, at (800) 768-4695. The precertification will be provided to you in writing. If the procedure does not require precertification, you will be advised precertification is not needed. If you are uncertain if precertification should be obtained, call CIGNA. Hearing aids are precertified by calling the Hearing Aid Benefit Preferred Provider, and drugs are precertified by calling the Pharmacy Benefit Manager. See the next page (PPOs) for contact information.

In an emergency, you don't have to precertify a hospital admission. But you do have to contact CIGNA within two working days of admission, or the Plan will reduce its reimbursements by $200.

The $200 penalty or nonpayment for failure to precertify does not count toward your Deductible, Coinsurance, or out-of-pocket maximum, unless otherwise required by law.

PRECERTIFY YOUR HEARING AIDS

Precertification is required to obtain a hearing aid. If you don't obtain precertification, the Plan covers no expenses related to a hearing aid.

You can precertify by calling EPIC. Their contact information is in the section below (PPO). The precertification will be provided to you in writing.

You must also purchase your hearing aid through EPIC. See Article VI for details.

5. **Effective August 1, 2019, Plan Section 3.1(b) is amended to read as follows:**

b. Amount of Benefit. $350 per week (less FICA taxes) in which the Participant is disabled every day. The benefit is not paid for days the Participant is not totally disabled, and so is prorated for partial weeks of total disability.

6. **Effective August 1, 2019, Plan Section 7.2(b) is amended to read as follows:**

b. Materials and Dispensing Fee

	Calendar Year Maximum Benefit
Single vision lenses (pair)	$30
Bifocal lenses (pair)	$75
Trifocal lenses (pair)	$90
Lenticular lenses (pair)	$240
Eyeglass lenses for Covered Individuals under age 19	No maximum dollar amount*
Frames	$150
Contact lenses (pair) – following cataract surgery or when visual acuity cannot be corrected to 20/70 in the better eye except by their use	$500
Contact lenses – following a cornea transplant (but only for the affected eye) or in cases of keratoconus	No maximum dollar amount*
Other – when contact lenses are in lieu of glasses (including disposable contact lenses)	$150

* Limited to Medically Necessary lenses

7. **Effective September 1, 2019, the following section is added immediately following the section entitled PREFERRED PROVIDER ORGANIZATIONS (PPOs):**

TELADOC PROGRAM

Teladoc is a telemedicine program that allows you and your enrolled Dependents to consult with a Physician or licensed therapist by phone or videoconference, at no cost. *Teladoc* services are available 24 hours a day, 7 days a week.

Teladoc Physicians can treat many common minor illnesses, such as colds, sore throats, flu, allergies, upset stomach, and pink eye. Where appropriate, Physicians can provide short-term prescriptions and call the prescription in to your preferred local pharmacy. However, Physicians cannot prescribe controlled substances or certain other drugs.

For adults, *Teladoc* also offers confidential counseling with a licensed therapist for behavioral health issues such as depression, anxiety, stress, and marital or family issues. Counseling appointments must be scheduled in advance.

To request services, call *Teladoc* at 1-800-835-2362, visit www.teladoc.com or download the *Teladoc* app. Note that *Teladoc* is not intended for medical emergencies, as a replacement for your primary care Physician, or for management of a chronic or serious condition.

8. **Effective September 1, 2019, Plan Sections 4.7(o) & (v) are amended to read as follows:**

o. Physician Services. Physician services as follows:

1. daily visits when confined in a Hospital as a registered inpatient,
2. office visits and consultations,
3. emergency room visits, and
4. telemedicine provided through the *Teladoc* program.

Benefits are not payable for charges which are considered post-operative care for which surgical benefits are payable, or any charge for more than one (1) treatment per day, except for a consultation when referred by a Physician.

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v. Mental Health and Substance Abuse Benefits. The Plan provides benefits for Licensed Substance Abuse Treatment Center, Hospital, and Residential Treatment Facility charges for inpatient treatment of a Mental Illness and/or Substance Abuse, Physician Covered Charges incurred for outpatient treatment of a Mental Illness and/or Substance Abuse, and counseling services provided through the *Teladoc* program; however, coverage for Licensed Substance Abuse Treatment Centers and Residential Treatment Facilities is only provided to the extent treatment is received at a PPO facility. Admission should be precertified by the Plan's medical reviewer to avoid a failure to precertify penalty.

9. **Effective September 1, 2019, Plan Sections 9.01(z) & (gg) are amended to read as follows:**

z. situational disturbances, stress, strain, financial, marital or family counseling, environmental and social maladjustments, dissocial behavior or chronic situation reactions, except as required by law or under the *Teladoc* program.

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gg. reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved; for Physician's telephone consultations and/or travel time (other than consultations provided through the *Teladoc* program); charges in connection with shipping, handling, postage, interest, or finance.

10. **Effective August 1, 2019, the *Life and Accidental Death and Dismemberment Insurance Certificate* is replaced with the attachment hereto.**

Adopted at a meeting of Trustees on May 5, 2020, with the effective dates as noted herein.

Doug Thomas, Chairman

Lillian Santillanes, Secretary

Amendment 4 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to incorporate certain changes made to the Plan and to update the Plan;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

1. **Effective January 1, 2020, Plan Section 4.7(o) is amended to read as follows:**

   o. Physician and Physician Assistant Services. Physician services as follows:

      1. daily visits when confined in a Hospital as a registered inpatient,
      2. in-person office visits and consultations,
      3. emergency room visits, and
      4. telemedicine provided through the *Teladoc* program.

   Benefits are not payable for charges which are considered post-operative care for which surgical benefits are payable, or any charge for more than one (1) treatment per day, except for a consultation when referred by a Physician.

2. **Effective January 1, 2020, a new Plan Section 4.7(z) is added as follows:**

   z. Telehealth. Office visits provided by a Covered Individual's existing Physician or Physician Assistant via an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Telehealth, telemedicine, telephone, video and similar office visits and consultations are otherwise covered only if provided through the *Teladoc* program.

3. **Effective January 1, 2020, Plan Section 9.01 (gg) is amended to read as follows:**

   gg. reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved; for Physician to Physician travel time; charges in connection with shipping, handling, postage, interest, or finance.

4. **The NAME AND ADDRESS OF THE PERSON DESIGNATED AS THE AGENT FOR SERVICE OF LEGAL PROCESS is updated as follows:**

Deleted: 's telephone consultations and/or

Deleted: (other than consultations provided through the *Teladoc* program)

For the uninsured benefits:

Ellen Mondress
Mondress, Monaco, Parr, Lockwood PLLC
2101 Fourth Avenue, Suite 2170
Seattle, WA 98121
(206) 398-1500

Deleted: 720 Third Avenue, Suite 1500

Deleted: 98104

Service of legal process may also be made by service on the Plan Administrator or any Plan Trustee. The Plan Administrator for insured benefits is the insurance carrier.

5. **The NAME AND CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR is updated as follows:**

NAME AND CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator, except with respect to insured benefits. The Plan Administrator for an insured benefit is the insurer. The Trustees have engaged the independent contractor, CompuSys of Utah, Inc., to perform the routine administration of the Plan. Both the Board of Trustees and CompuSys of Utah, Inc., can be reached at:

P.O. Box 30124
Salt Lake City, Utah 84130-0124
2156 West 2200 South
Salt Lake City, UT 84119
Phone (801) 606-2425
Toll free (888) 867-9510

Commented [MMPL1]: CompuSys, please update.

Written communications (including written communications made electronically) to the Administrative Office, the Trustees, or their delegees, agents or representatives, must be received before the expiration of any time period expressed in this booklet or any modifications to this booklet. These parties' records will be conclusive as to whether a communication has been received and the date of such receipt, unless you procure a United States Postal Service return receipt. So the common law "mailbox rule" does not apply to determine receipt by these parties. The common law mailbox rule does apply for all other purposes under the Plan. From time to time, the above parties may communicate with you via telephone, rather than in writing. The Plan's rules on content and date of sending/receiving written communications also apply to telephonic communications. It is your responsibility to update your address with the Administrative Office. You are deemed to have received all communications sent to you at your last address on file with the Administrative Office.

6. **The NAME AND ADDRESS OF TRUSTEES is updated effective August 4, 2020 as follows:**

All Trustees may be reached through the Administrative Office:

CompuSys of Utah, Inc.
P.O. Box 30124
Salt Lake City, UT 84130-0124

Commented [MMPL2]: Address update, please

UNION TRUSTEES	*EMPLOYER TRUSTEES*
Doug Thomas, Chairman	Lillian Santillanes, Secretary
Bob Grothe	Dick DeVries
Mark Calkins	Burnie Zercher
Jeffrey Steele	Tom Moen, Jr.
Jim Wonnacott	Mark Mundy

Adopted at a meeting of Trustees on February 1, 2021 and effective that same date, except as noted above.

Doug Thomas, Chairman

Lillian Santillanes, Secretary

Amendment 5 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan"); and

AND WHEREAS, the Trustees wish to clarify the Plan; and

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows effective November 1, 2020:

ARTICLE III. – ACCIDENT AND SICKNESS WEEKLY BENEFITS

Accident and Sickness Weekly Benefits are available only to Active Employees.

If you can't work because you are sick or injured (outside of work), the Plan pays you a weekly stipend to help you make ends meet.

3.1 Amount of Benefit.

a. Requirements to Receive Benefit. To receive an Accident and Sickness Weekly Benefit, the Participant must have contracted an Illness or sustained an Injury which renders the Participant, totally disabled and unable to work, at their, own occupation. The Participant must produce an uncontroverted physician's certification to that effect acceptable to the Board of Trustees.

b. Amount of Benefit. $200 per week (less FICA taxes) in which the Participant is disabled every day. The benefit is not paid for days the Participant is not totally disabled, and so is prorated for partial weeks of total disability.

c. First Day of Benefits. Benefits begin on the first day for Injuries, the eighth day for Illnesses or, if earlier, the first day of hospitalization.

d. Maximum Period. Benefits are paid for a maximum period of twenty-one (21) weeks, whether for one or multiple Illnesses or Injuries. If the Participant returns to Covered Employment for not less than 32 hours per week for 2 consecutive weeks, the Participant may again become eligible for a new Maximum period of benefits.

3.2 Exclusions. Accident and Sickness Weekly Benefits are not payable:

a. when the Active Employee is not under the care of a Physician;

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b. when the Active Employee is receiving a benefit from any workers compensation fund or insurance, or a pension or a disability pension benefit;

c. when the Active Employee is working or receiving remuneration for any other work or service;

d. if the Injury or Illness is related to war or any act of war;

e. if the Illness or Injury arises out of or occurs in the course of employment or work for wage or profit;,

f. for any week when the Active Employee is eligible for benefits under the Ironworker Management Progressive Action Cooperative Trust ("IMPACT") Off-the Job Accident Plan; and

g. when the Participant's total disability is due in whole or in part to a possible or probable future Illness, Injury, event or risk.

Deleted: and

Adopted at a meeting of Trustees on May 3, 2021.

Doug Thomas, Chairman

Lillian Santillanes, Secretary

[00234008; 1]

Amendment 6 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to update the Plan for changes in the law; and

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

The Section titled PREFERRED PROVIDER ORGANIZATIONS (PPOs) is amended as follows effective November 1, 2022:

The Fund has entered into agreements with Preferred Provider Organization(s) ("PPO"), which in turn contract with certain medical providers, such as Hospitals, Physicians, and laboratories. These medical providers are Preferred Providers, and have agreed to charge reduced amounts for certain services or supplies. The Plan is designed so that ~~at means~~ you ~~will~~ pay a lower percentage of the cost of medical services and supplies from a PPO Hospital, Physician, and laboratory. ~~In addition, a PPO Provider has agreed to bill no more than the Plan's Allowable Fee. With a non-PPO provider, you pay the difference between the non-PPO provider's bill and the Allowable Fee.~~ Note also that~~However,~~ the Plan does not pay benefits for services or supplies received from a non-PPO Residential Treatment Facility, Rehabilitation Facility, Licensed Substance Abuse Treatment Center, or Skilled Nursing Facility.

~~PPO Hospitals, Physicians, and other providers are listed in the respective directories published periodically by each PPO, and available on their websites. Providers are added and deleted at the discretion of the PPO, and without notice to the Plan. You should contact the PPO network to verify the provider is still participating in the network.~~

MEDICAL BENEFIT PREFERRED PROVIDER (1-800-768-4695) CIGNA
To locate a Cigna PPO provider, visit Cigna's web site at www.cignasharedadministration.com and click on FIND A DOCTOR, and then select "Shared Administration OAP Provider Directory" or visit www.iiw.compusysut.com and click on the CIGNA~~igna~~ link.

CIGNA updates the provider directory at least every 90 days and will respond to your inquiry about the PPO status of a provider or facility within one business day. Beginning November 1, 2022, if you receive inaccurate information from CIGNA that a non-Preferred Provider was a Preferred Provider, the Plan will impose the PPO cost sharing amount and will count that amount toward your PPO deductible and annual out of pocket maximums (as applicable). Note, however, that it is your responsibility to confirm that the provider or facility that you have selected is a Preferred Provider at the time you receive services.

PHARMACY BENEFIT MANAGER { (Jennifer Wiseman at jwiseman@savrx.com)

Article I.-DEFINITIONS, Section 1.3 is amended as follows:

Allowable Fee. "Allowable Fee" means the charge for a service or supply furnished by a provider, which meets all of the following criteria: The charge is no more than the charge the provider actually charges the individual and that the provider most frequently makes to the majority of his or her patients for the service or supply. The charge is equal to or less than the 90^{th} percentile rate established for the geographic area by the Plan's third party service. And finally, the charge is within reasonable utilization limits, and is justifiable considering the circumstances involved.

With respect to individuals covered by Medicare, the term "Allowable Fee" is further limited to the maximum amounts allowed by Medicare for participating and non- participating Medicare Physicians.

A PPO provider's Allowable Fee is the fee set forth in the agreement between the provider and the PPO. The Plan may also separately negotiate with a provider or facility to determine the Allowable Fee for a service or supply.

Notwithstanding the above, for covered prescription drugs obtained from a PPO or non- PPO pharmacy, "Allowable Fee" means the pharmacy network price of the prescription drug as determined by the Pharmacy Benefit Manager.

The Plan will not reimburse any charge for covered services, supplies, or prescription drugs in excess of the "Allowable Fee".

Article I.-DEFINITIONS, Section 1.27 is amended as follows:

Hour of Work. "Hour of Work" means an hour of work for which a Contributing Employer is required by Written Agreement to contribute to the Trust. The Plan credits an Hour of Work only if the Trust timely receives the correct contribution for such Hour of Work. Hours of Work are generally credited to the month in which they were worked; however, where a pay period begins before or extends beyond the end of a month, hours for that pay period will be credited according to the Contributing Employer's reasonable payroll and reporting practices. If the Plan is presented with convincing proof an employer failed to make a required contribution, it will credit the Participant with up to 120 Hours of Work in each of two months. Such credit shall be made for the earliest delinquencies, and no more than once in a 12-month period. However, credit without receipt of contributions is unavailable with respect to reciprocal contributions. Section 2.01 describes crediting of Hours of Work upon receipt of reciprocal contributions.

New Section 3.2 h. is added to ARTICLE III. – ACCIDENT AND SICKNESS WEEKLY BENEFITS effective November 1, 2022, as follows:

3.2 **Exclusions.** Accident and Sickness Weekly Benefits are not payable:

a. when the Active Employee is not under the care of a Physician;

b. when the Active Employee is receiving a benefit from any workers compensation fund or insurance, or a pension or a disability pension benefit;

c. when the Active Employee is working or receiving remuneration for any other work or service;

d. if the Injury or Illness is related to war or any act of war;

e. if the Illness or Injury arises out of or occurs in the course of employment or work for wage or profit;

f. for any week when the Active Employee is eligible for benefits under the Ironworker Management Progressive Action Cooperative Trust ("IMPACT") Off-the Job Accident Plan; ~~and~~

g. when the Participant's total disability is due in whole or in part to a possible or probable future Illness, Injury, event or risk; and~~.~~

h. if the Illness or Injury arises out of commission or attempted commission of a felony, an assault, or an illegal act or occupation, whether or not charges are filed or a conviction results.

Article 4.4-ARRANGEMENTS WITH PREFERRED PROVIDER ORGANIZATIONS-is amended as follows effective November 1, 2022:

The Plan has contracted with certain physicians and hospitals to charge no more than the Contracted or Allowable Fee. See the contact information before Article I for the Preferred Provider Organization ("PPO") in your area. In general, if you visit a PPO provider, that is, a provider with whom the Plan has a contract, the Plan is designed so that you pay a lower percentage of the cost of medical services and supplies~~you receive a discount on your charges, therefore, your Coinsurance is lower~~. The following exceptions apply, to the extent required by the No Surprises Act (CAA 2021).

a. If you have an emergency and get emergency services covered by the Plan from a non-Preferred Provider, the most the non-Preferred Provider may bill you is the Plan's PPO cost-sharing amount (such as Copays, Deductible and Coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

b. When you get services covered by the Plan from a PPO hospital or ambulatory surgical center, certain providers there may be non-PPO. In these cases, the most

those providers may bill you is the Plan's PPO cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

c. If you get other services covered by the Plan at a PPO hospital or other facility, Non-PPO providers at that facility can't balance bill you unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care from a non-PPO provider. You can choose a PPO hospital, physician or other provider.

d. If you receive air ambulance services covered by the Plan, the most the air ambulance may bill you is the Plan's PPO cost-sharing amount. You can't be balance billed.

When balance billing isn't allowed, you also have the following protections for services and supplies covered by the Plan:

- You are only responsible for paying your share of the cost (like the Copays, Coinsurance, and Deductible) that you would pay if the non-Preferred Provider were a Preferred Provider. The Plan will pay non-Preferred Provider directly.

- The Plan will:

  - Cover emergency services without requiring you to get approval in advance (precertification).

  - Cover emergency services from non-Preferred Providers.

  - Base your share of the cost on what it would pay a Preferred Provider or facility, and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your PPO Deductible and out-of-pocket maximum.

New Section 4.10 is added to Article IV-MEDICAL BENEFITS, as follows:

4.10 Continuity of Coverage. Beginning November 1, 2022, the Plan will provide "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the PPO status of a provider or facility to non-PPO (except in the case of a termination of the contract for failure to meet applicable quality standards or for fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified of the contract termination and your right to elect continued transitional care from the provider or facility;

and, you will be allowed 90 days of transitional care from the provider or facility at PPO cost sharing to allow you time to transition to a new PPO provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a provider or facility, (1) is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill (under Social Security Act § 1862(dd)(3)(A), a medical prognosis that the individual's life expectancy is six months or less) and is receiving treatment for such illness from such provider or facility.

Article VII.-VISION CARE BENEFITS, Section 7.1 is amended as follows:

7.1 Benefits. Benefits for vision care will be paid for each Participant and Dependent up to the maximum amount in the following Schedule of Allowances, subject to Sections 7.03 and 7.04 and any other applicable limitations or restrictions. There are no deductibles, no copays, and no coinsurance for vision care benefits. You may decline vision care benefits by notifying the Administrative Office, in writing, that you wish to opt out.

Article VII.—DENTAL BENEFITS, Section 8.1 is amended as follows:

8.1 Benefits. If a Participant or Dependent receives dental care, the Fund will pay the expenses incurred for covered dental services according to the Summary of Benefits chart at the beginning of this booklet. Effective January 1, 2019, Members of Locals 24 and 24A are not eligible for dental benefits. You may decline dental benefits by notifying the Administrative Office, in writing, that you wish to opt out.

CLAIMS REVIEW PROCESS—Standard External Review Process for Denied Medical Benefit Claims is amended as follows:

If your claim for Medical Benefits is denied in an Initial Determination or Appeal Decision and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial but only if the denial involves 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer (a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that you fail to meet the requirements for eligibility under the terms of the Plan is not eligible for external review); or 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. Effective November 1, 2022, you may also submit a request for external review of the denial, if the denial involves (1) whether precertification was improperly required for emergency services;

(2) whether emergency services by a non-Preferred Provider should have been covered at the Plan's PPO rate; (3) whether treatment at an PPO hospital or ambulatory surgical center by a non-Preferred Provider should have been covered by the Plan at the PPO rate and cost sharing; (4) whether a non-PPO air ambulance service should have been covered at the PPO rate; or (5) consideration of whether the Plan has complied with the surprise billing and cost-sharing protections set forth in Public Health Services Act sections 2799A-1 and 2799A-2 and Health and Human Services regulations sections 149.110 through 149.130.

Adopted at a meeting of Trustees on August 10, 2022.

Doug Thomas, Chairman

July 24, 2022
Date

Lillian Santillanes, Secretary

8-12-2022
Date

Amendment 7 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

AND WHEREAS, the Trustees wish to amend the Plan;

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

Article II. – ELIGIBILITY RULES FOR ACTIVE EMPLOYEES AND RETIREES, Section 2.1 f. is amended, effective August 1, 2022 as follows:

***

f. Continuation of Eligibility While Disabled. Active Employees may make written application for disability continuation. Disability continuation is available only if you are disabled from your own occupation. Application must be made within 12 months of first becoming disabled. If the application is granted, an Active Employee who becomes continuously disabled for more than thirty (30) consecutive days will have Plan coverage without reduction of hours from their hour bank. In other words, the hour bank will be frozen and the entire program of health and welfare benefits will remain in effect for the Active Employee and his/her Dependents. This extended coverage will continue until the earlier of: (1) the last day of the month in which the disability ends, or (2) the last day of the 12th month in which the disability began, or (3) the last day of the month in which the disabled employee is awarded a Social Security benefit ~~or applies for a pension benefit~~.

***

Article II. – ELIGIBILITY RULES FOR ACTIVE EMPLOYEES AND RETIREES, Section 2.6(a) 7. is deleted, as follows:

***

~~7. No Active Employee coverage. Once you elect Retiree Coverage, you may not return to coverage as an Active Employee. However, if you return to Covered Employment, the Plan will credit Contributing Employer contributions toward your monthly payments due for Retiree Coverage.~~

***

Adopted at a meeting of Trustees on February 6, 2023.

Doug Thomas, Chairman

Lillian Santillanes, Secretary

March 6, 2023
Date

3-3-2023
Date

Amendment 8 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan");

WHEREAS, Article III Section 13 of the Trust empowers the Trustees to allocate their powers and responsibilities to a committee of Trustees;

WHEREAS, at their February 2023 meeting the Trustees designated a committee to decide whether to modify certain Plan benefits;

WHEREAS, the committee so designated did unanimously decide to modify Plan benefits effective March 1, 2023; and

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows effective March 1, 2023:

Section 9.01 is amended as follows:

9.01 General Health Plan Exclusions and Limitations.

Except as required by law, the Plan does not cover services or supplies rendered for or in connection with any treatment directly or indirectly related to the following. The phrase "in connection with" means any services, supplies which would not be necessary but for the occurrence of the excluded type of service, treatment, supply, or accommodations.

...

q. dental services or supplies not covered under Article VIII. The medical plan does cover dental treatment for accidental damage to sound natural teeth which have not been extensively restored or become extensively decayed or diseased, if the damage results from an accidental Injury and the charges are incurred within 6 months of the accident. In addition, the medical plan does cover up to 10 dental implants in the following circumstance: the Covered Individual has experienced at least 10 years of edentulism and full dentures, made necessary by acid reflux; has severe bone loss in both the maxillary and mandibular arches; has a considerable amount of sores from dentures and pain caused by denture mobility and pressure on the inferior alveolar nerve bilaterally lying on top of the mandible secondary to significant bone loss; and the dental implants are secondary to and received after performance of and success is known with respect to bone grafts to treat the Covered Individual's significant class III skeletal relationship.

Doug Thomas, Chairman

3/15/2023
Date

Lillian Santillanes, Secretary

3-14-2023
Date

Amendment 9 to the Ironworkers Intermountain Health and Welfare Plan and Summary Plan Description dated November 1, 2016

WHEREAS, the Third Restated Agreement and Declaration of Trust ("Trust") of the Ironworkers Intermountain Health & Welfare Trust Article V Section 1(b) empowers the Trustees to amend the Ironworkers Intermountain Health and Welfare Plan ("Plan"); and

WHEREAS, the Trustees wish to clarify the Plan's subrogation and reimbursement rules and the Plan's list of general exclusions and limitations.

NOW, THEREFORE, BE IT RESOLVED THAT the Plan is amended as follows:

Article IX. General Exclusions and Limitations, is amended as follows:

9.01 General Health Plan Exclusions and Limitations.

. . .

Except as required by law, the Plan does not cover services or supplies rendered for or in connection with any treatment directly or indirectly related to the following. The phrase "in connection with" means any services, supplies which would not be necessary but for the occurrence of the excluded type of service, treatment, supply, or accommodations.

. . .

r. ~~Any treatments, services, or supplies to~~ diagnosis~~e~~ or treatment of ~~gender dysphoria (or any other gender identity disorder),~~ sexual addictions, sexual or psychosexual ~~identities or~~ dysfunctions, ~~sexual deviations~~paraphilic disorders~~, sexual inadequacies, transsexualism~~, or any other similar disorders or conditions of a sexual nature, including any complications arising therefrom~~, regardless of the condition's origin~~..

. . .

qq. charges payable under any other program, plan or insurance ~~(including any type of automobile insurance),~~ or ~~charges~~ recoverable from ~~for which~~ a third party ~~is responsible for paying~~ (or that would be payable or recoverable but for coverage under this Plan), except that the Plan may coordinate benefits as described in Article X. or advance payment of expenses as described in Article XI.~~).~~

. . .

bbb. charges payable (or that would be payable in the absence of Plan coverage) by any medical benefits, personal injury protection (PIP), or similar coverage under any motor vehicle, commercial liability, homeowner's, or other insurance policy.

Article XI, Plan's Rights to Recovery, Subrogation and Reimbursement, is amended as follows:

. . .

The Plan's Subrogation and Reimbursement Rights

The Plan does not cover any health expenses for an Injury or Illness if ~~the expenses are recoverable from~~ someone else (a "third party") is responsible to pay the expenses or other damages related to the Injury or Illness. If the Plan believes a third party is or may be liable for an Injury or Illness, ~~T~~the Plan may refuse to pay any health expenses ~~the Plan believes are or may be the responsibility of a third party~~. Alternatively, the Plan may advance payment of benefits while you pursue recovery of the health expenses or other damages from a third party, subject to the Plan's right to be fully reimbursed out of any payment that a third party makes to you, your family members, your attorney or to anyone else ~~acting on your behalf~~ in connection with the Injury or Illness (a "third-party payment"). Third-party payments are assets of the Plan and cannot be transferred or paid to you or any other person until the Plan has been fully reimbursed. This is called the Plan's *right to reimbursement.*

In addition, the Plan has the right to take your place in recovering payments directly from the third party. The Plan's right to do this is called its *right of subrogation.*

For instance, if you are injured in an automobile accident, the Plan is entitled to both subrogation and reimbursement as follows:

- If your insurance company or the other driver's insurance company is responsible for making a payment to you because of the accident, the Plan has the right to demand that the insurance company first pay the Plan directly ~~first~~ for the expenses covered by the Plan, before you get any excess amount.
- If you make a claim or file a lawsuit against the other driver and get any kind of recovery, the Plan again has the right to be paid first, even if you don't agree it should. If you obtain any kind of payment before the Plan gets its share, you must reimburse the Plan immediately.

Under its rights of subrogation, the Plan may make a claim or file a lawsuit for you, or act o~~i~~n your behalf in any claim or legal proceeding, and would be entitled to reimbursement for court costs, expenses, and attorneys' fees, in addition to the benefits advanced by the Plan.

The Plan's rights to subrogation and reimbursement also constitute a "constructive trust" or "equitable lien" against any and all third-party payments made now or in the future, regardless of how the payments are characterized. The Plan's lien is in the full amount of all the health expenses paid by the Plan in connection with the Illness or Injury, regardless of when the expenses are paid or incurred (including, for example, expenses incurred

after you receive a third-party payment). In the Plan's sole discretion, the Plan's lien may also include interest on the amounts paid by the Plan from the time of payment until the time the Plan is reimbursed. The Plan is not required to pay any fees to the attorney you hire to pursue a third-party payment, or to reduce its lien for any costs or attorney's fees you incur or for any other reason.

The Plan's rights to third-party payments. The Plan is entitled to *full* reimbursement for all health expenses it pays relating to the Illness or Injury and has a "first dollar" right of reimbursement. That is, the Plan has the right to be reimbursed first from the total amount of any and all third-party payments, without reduction for any attorney's fees or costs that you may incur in pursuit of the recovery. The Plan has the right to be reimbursed even if the third-party payments are not ~~designated as~~ payment for medical or disability expenses. This includes, for example, the following payments:

- Any judgment, settlement, or other payment relating to the Illness or Injury, from any ~~whatever~~ source.
- Any payment made by your insurance or a third party's insurance, including vehicle insurance, no-fault automobile insurance, uninsured or under–insured motorist coverage, business insurance, homeowner's insurance, personal umbrella insurance, or any other ~~type of~~ insurance or insurance-type coverage, or a payment made under any workers' compensation program.
- Payments designated as medical benefits, as disability payments, as compensation for pain and suffering, as attorneys' fees, as economic, non-economic, or punitive damages, or as other specified or general damages.
- Any partial payment made for any reason, even if you are not "made whole." This means that the Plan has the right to be repaid in full first, even if you do not expect to receive full compensation for your damages from the third party.

Your notification and cooperation are required. By accepting benefits under the Plan, you agree that the Plan has the rights of subrogation and reimbursement, and you agree to promptly provide information and execute documents as requested by the Administrative Office ~~to help the Plan enforce these rights~~ and to take no action that may prejudice the Plan's rights.

You must notify the Administrative Office within 45 days of the date that you have an Injury or Illness that might be the responsibility of a third party and when you or your attorney gives notice to any third party that you intend to investigate or pursue a claim to recover damages. You must also notify the third party of the Plan's lien against any recovery.

~~In addition, t~~The Administrative Office may require that, as a condition of the Plan advancing further benefits relating to the Illness or Injury, you or your covered spouse or other family members, as well as any attorney or authorized representative for you or your covered spouse or other family members, sign a reimbursement agreement within

45 days of request by the Administrative Office. This reimbursement agreement may:

(1) incorporate any or all of the rules of the Plan regarding the Plan's rights to subrogation and reimbursement,
(2) require that your attorney agree to honor the Plan's lien on third-party payments and that the Plan is not obligated to pay any portion of your attorney's fees or costs, and/or
(3) contain any other terms necessary or appropriate to enforce the Plan's rights or to ensure that the contract will be enforceable in state or federal court, at the Plan's election.

Any benefits the Plan advances in absence of a signed reimbursement agreement will nonetheless be fully subject to the Plan's subrogation and reimbursement rights.

If you receive a third-party payment, you must promptly notify- the Plan and hold_–the total amount of the payment in an escrow or trust account acceptable to the Plan (or, if you are represented by an attorney, you must direct your attorney to hold such funds in trust) until the Plan has been fully reimbursed for the current amount of its lien. You must promptly reimburse the Plan in full, regardless of the manner in which the third-party payment is structured. A third-party payment constitutes Plan assets under ERISA, to the extent of the Plan's lien. That means that you have a fiduciary responsibility to protect the Plan's lien and reimbursement rights.

If you or your attorney do not timely provide requested information, do not timely sign the Plan's reimbursement agreement, do not timely reimburse the Plan following receipt of a third- party payment, or otherwise fail to cooperate, the Plan will stop advancing benefits related to the Injury or Illness, and any expenses previously advanced by the Plan will be considered an overpayment of Plan benefits. To recoup the overpayment, the Plan may reverse (i.e., deny) payment of such -benefits, deny coverage of your other benefit claims or the claims of your covered family members (even if the claims do not relate to the Injury or Illness), and/or take legal action. You will be responsible for all reasonable attorney's fees and costs the Plan incurs due to your failure to cooperate with the Plan. The Plan's lien continues to apply to a third-party payment regardless of whether the funds have been disbursed or commingled with other funds. In addition, failure to reimburse the Plan may result in termination of Plan coverage for you and your family members.

More about subrogation and reimbursement.

- After you have received a third-party payment, the Plan may pay no further expenses relating to the Illness or Injury, regardless of when the expenses are incurred. As a condition of advancing payment of any further expenses, the Plan may require that you continue to hold all or a portion of the total third-party payment in trust for the purpose of reimbursing the Plan.
- The Plan's subrogation and reimbursement rights (and your obligations related to the Plan's rights) also apply to: your covered spouse and other family members;

your (or their) guardians or other representatives in the event of incapacity; ~~and to~~ your (or their) estates, ~~personal~~ representatives of estates, and beneficiaries or heirs in the event of death; and, if the covered spouse or family member is a minor, to the minor's parents, guardians, or other representatives. Any recovery they obtain that relates to or arises out of an Illness or Injury for which the Plan has paid health expenses (including, for example, a recovery for wrongful death) is a third-party payment that is subject to the Plan's reimbursement rights. In the case of a wrongful death or survival claim, no allocation of a third-party payment shall be valid if it does not fully reimburse the Plan for its lien, unless the Plan provides written consent to the allocation.

- If disbursements from a third-party payment are subject to approval by a probate or other court, you must take all reasonable action to obtain court approval of full reimbursement of the Plan's lien. The Plan's lien is not affected by any allocation or similar court order that is inconsistent with the Plan's reimbursement rights.
- If you violate the Plan's subrogation and reimbursement rights, Plan coverage for you and your family members may be terminated.
- If you file a petition for bankruptcy, you acknowledge that the Plan's lien existed prior to the creation of the bankruptcy estate.
- If requested by the Plan, you will instruct the third party to reimburse the Plan's lien via a check made payable and mailed directly to the Plan, or via a joint check made payable to you and the Plan, at the Plan's option.
- The Plan's subrogation and reimbursement rights apply even if you receive a third-party payment before the Plan has paid any health expenses relating to the Injury or Illness. In that case, you are responsible to use the third-party payment to pay the health expenses.
- Where the Plan advances benefits related to an Illness or Injury, it pays secondary to any other insurance coverage (for example, personal injury protection (PIP), medical payments, ~~specific loss,~~ or homeowner's insurance). Charges that are payable by such other coverage, or that would be payable in the absence of Plan coverage, are not covered by the Plan. The Plan will pay secondary even if benefits under such other coverage are paid directly to you instead of your health care providers, or if you choose to use the benefits for a purpose other than payment of health expenses.
- The Administrative Office's determination of whether a health expense is related to the Illness or Injury controls. For purposes of the Plan's subrogation and reimbursement rights, an "Illness" also includes a disability. A health expense will not be removed from the Plan's lien if you treated the expense as related to the Injury or Illness while pursuing a third-party payment, or if you released a third party from liability for the health expense (or related treatment) in connection with obtaining a third-party payment.
- The Plan is an employee welfare benefit plan governed by ERISA. The Plan's medical benefits are self-funded.
- The Plan may reject a reimbursement agreement that has been signed on your behalf pursuant to a power of attorney, unless you are incapacitated, legally incompetent, or on military leave, and the power of attorney is valid under applicable state law.
- The Plan's rights of subrogation and reimbursement are not affected in any way by claims that you must be made whole, or that a "common fund" or any other

apportionment or equitable doctrine applies under any statute, regulation, or common law, or that the third-party payment was limited by a collateral source rule or any other law, or by your comparative fault or contributory negligence, pre-existing conditions, or other factors. The Plan disclaims all such doctrines and defenses. In addition, the Plan's rights are not dependent on a finding or admission of the third party's negligence or wrongdoing, or on whether you made a claim for health expenses against the third party.

- The Plan's subrogation and reimbursement rights also apply to the Accident and Sickness Weekly Benefits. For rules applicable to the Plan's insured benefits, see the applicable insurance company booklets.
- The Plan may share information (including, but not limited to, information relating to its lien, a third-party payment, or the Illness or Injury) with others for purposes of administering or enforcing its reimbursement rights.

The Plan Administrator has the sole and exclusive discretionary authority and control over interpretation of the terms of the Plan and of reimbursement agreements. To the extent any term relating to the Plan's subrogation and reimbursement rights is determined to be invalid or unenforceable for any reason, it shall be fully severable and shall not affect the other terms.

By accepting Plan benefits, you agree to these conditions and ~~covenant~~ you agree not to raise any contrary claims in any action ~~by~~ impacting the Plan's ~~to enforce its~~ subrogation or reimbursement ~~or recovery~~ rights.

Article X, Coordination of Benefits, is amended as follows:

. . .

Coordination with Other Health Plans

The Plan uses the following rules to determine which plan is primary. If the first rule does not determine which plan is primary, the next rule is applied, and so on until the order of benefits is determined.

. . .

Note that the Plan does not coordinate with certain other types of plans, including student accident plans. In addition, the Plan always pays secondary to any medical benefits, personal injury protection (PIP), or similar coverage under any motor vehicle, commercial liability, homeowner's, or other insurance policy.

. . .

Adopted at a meeting of Trustees on May 8, 2023.

Doug Thomas, Chairman

5-12-23
Date

Lillian Santillanes, Secretary

5-11-23
Date