IRONWORKERS INTERMOUNTAIN

HEALTH & WELFARE PLAN

Summary Plan Description

November 1, 2024

Covering Members of the International Association of Bridge, Structural, and Ornamental and Reinforcing Iron Workers

This is the Plan and Summary Plan Description for the Ironworkers Intermountain Health and Welfare Plan. This Plan describes benefits funded by the Trust: medical, prescription drug, dental, vision, hearing aid, and weekly disability benefits. The Plan also provides insured benefits: life and accidental death and dismemberment insurance, and includes the Vacation Plan of Utah. The insured benefits are described in the attached insurance certificate. In the event of conflict or ambiguity between an insurance contract and the Plan or other documents, the insurance contract controls. You can ask the Administrative Office for a copy of the insurance contracts, where your insured benefits are described in full.

The Plan was adopted for the exclusive benefit of Participants who are employed by certain companies in the iron work industry. The Plan's benefits are funded by contributions from these employers. Plan benefits are designed to help cover some of your expenses when you become sick, are injured, or die. This version of the Plan describes benefits for claims incurred on and after November 1, 2024.

Here are some important tips on using Plan benefits:

- To receive benefits, you must complete an enrollment form.
- Submit your claims for benefits as soon as possible, and never later than 12 months after the date of service or when the supply or drug is dispensed. Some Physician offices may offer to submit claims for you.
- Inform the Administrative Office if your address changes to ensure that you receive updated information.
- Inform the Administrative Office of any changes in your Dependents, including if you marry or divorce.
- Capitalized terms in the Plan have very specific meanings. If you see a capitalized term, see the definitions section for its meaning.

Eligibility provisions and benefits may be increased or decreased from time-to-time. You will be notified if there are changes.

Este folleto contiene un resumen en inglés de tu plan de derechos y beneficios bajo el Ironworkers Intermountain Health & Welfare Plan. Si se te dificulta comprender alguna parte de este folleto, contacta BeneSys al 888-867-9510 o en el PO Box 30580, Salt Lake City, UT 84130-0580.

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Contact Information:

Administrative Office and COBRA Administrator:

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(801) 904-4897

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Murray, UT 84107

P.O. Box 30580
Salt Lake City, UT 84130-0580

3930 S 147th St, Suite 100
Omaha, NE 68144

www.iiwbenefits.org

QUICK ANSWERS

Here are some quick answers to a few commonly asked questions. However, these quick answers don't explain all of the Plan's rules and limits. To know the Plan's rules and limits, you must read the rest of this booklet.

When will I first be covered by the Plan?

If you work for the Union or under a collective bargaining agreement, your employer reports and the Administrative Office tracks your Hours of Work. This is called the hour bank system. If you have 360 Hours of Work in no more than 4 months, you will participate in the Plan two months later. 240 Hours of Work is required to begin coverage, and 120 Hours of Work is required in each month to continue coverage. Amounts over that remain in your hour bank, up to 480 hours. *See Section 2.1 for details.*

Example: John begins working in February. John works as follows:

February:	160 hours
March:	170 hours
April:	100 hours
Total:	430 hours

At the end of April John satisfies the Plan's initial eligibility requirements (360 hours). John's coverage begins two months later, on June 1. John's hour bank is credited with 70 hours (430 total hours, less 240 hours to begin, less 120 hours for June coverage).

What do I have to do to continue coverage?

You must have at least 120 Hours of Work in your hour bank. If your Employer timely makes contributions on your behalf, you will be credited with your Hours of Work in the month you work the Hours to provide coverage two months later.

If I lose coverage, how do I regain it?

You must have 120 Hours of Work credited to your hour bank within 3 months of the month in which it dropped below 120, to regain coverage. If you don't, you must reestablish initial eligibility, by again working 360 hours.

Example: In the above example, John has coverage in June, with 70 hours left in the hour bank. John doesn't work in May. With only 70 hours in the hour bank, John has no coverage in July. But if John works 50 hours in June, there will be 120 hours in the hour bank—70 left over from work through April, plus another 50 for work in June. That's enough to get John coverage in August.

What if I lose coverage because I'm out of work?

You will be eligible to pay to continue your health coverage under COBRA.

What if my employer pays less than the hourly amount required by the Board of Trustees for each Hour of Work?

If your employer is in the Plan's geographic jurisdiction and pays at an hourly rate that is less than the hourly rate required by the Board of Trustees, contributions will be rejected and you will receive no credit.

What if my employer doesn't make timely contributions?

If your employer doesn't pay the proper amount on time to the Fund for your Hours of Work, you will receive no credit. There is one exception: if you can prove you worked (save your pay stubs!), once each year up to 240 hours (120 hours in each of two months) will be credited to your hour bank account. Refer to Article I, Definitions, 1.26, Hour of Work.

What if I am working in another jurisdiction?

If your work is covered by a reciprocity agreement with the Plan, you can arrange for your health contributions for that work to be sent to this Plan. The amount received is divided by this Plan's current hourly contribution rate, to arrive at your Hours of Work.

> *Example:* John travels to Las Vegas to work a Union job. John completes reciprocity paperwork in Las Vegas. The Las Vegas Ironworkers health plan sends this Plan $1,015. Assume the current contribution rate for this Plan is $7.25 per hour. John earns 140 ($1,015 ÷ $7.25) Hours of Work toward coverage in this Plan.

Is my spouse covered? My children?

Yes, if you enroll them within 30 days of your initial eligibility and provide a marriage certificate (spouse) and birth certificates (children). For other opportunities to enroll your Dependents, see Article II. Common law marriages are not recognized by the Plan, and the Plan has special rules on coverage of children. *See the Definition of "Dependent" in Article I.*

What is a Deductible? What is Coinsurance? What is a Copay?

You must pay a portion of the cost of your healthcare expenses that are covered by the Plan. These are your "out-of-pocket" costs and include Deductibles, Copays, and Coinsurance. Each year you pay for health expenses up to the amount of your Deductible, before the Plan covers any expenses. Coinsurance is the percentage of Covered Charges you pay, after payment of the Deductible and Copay. A Copay is the fixed dollar amount you pay to the doctor, pharmacy, or medical facility each time you receive treatment.

How do I get the most value out of the Plan?

- Precertify your surgeries and hospital visits. That way, you'll know if your procedure is covered and you won't pay the Plan's failure to precertify penalty.
- Ask your Physician if a generic drug is appropriate for you. You'll pay less for generic than for brand name drugs. *See Article V.*
- Use PPO providers. They charge less, and you pay less. *See Section4.4.*

What do I do to qualify for Retiree coverage?

You must have been covered by the Plan for 5 of the last 7 years, retire from one of three specified pension plans, be ineligible for Medicare on the basis of age, and begin Retiree coverage immediately after you lose active coverage (because your hour bank runs out or your employer stops contributing to the Plan). If you instead elect COBRA, you will forever lose the opportunity to elect Retiree coverage under the Plan. *See Section 2.6.*

How much does Retiree coverage cost?

The cost of retiree coverage is established by the Board of Trustees, and adjusted periodically. In making adjustments, the Board may consider the Plan's funding status, costs, anticipated contributions, and other relevant factors.

What types of Retiree coverage are there?

Retirees may elect medical, dental, and vision coverage, or medical-only coverage. Retirees don't receive AD&D and Life Insurance, or Accident and Sickness Weekly Disability Benefits. *See Section 2.6.*

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	$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
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
Emergency Transportation Copay	$0	$0	$0	$0

* Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance. Once your Copay is satisfied, Covered Charges are subject to your Deductible. Once your Deductible is satisfied, Covered Charges are subject to Coinsurance. Exceptions apply, as noted below.

* 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, *Teladoc* or *Alliance Work Partners* ("*AWP*") benefits.

There is no Deductible for Preferred Provider Physician office visits (non-surgical services), chiropractic benefits, Preventive Care, or *Teladoc* or *AWP* benefits.

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

	Class I	Class II	Class III	Local 24
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%
Emergency Care (PPO and non-PPO)	30%	25%	20%	20%
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* or *AWP* program benefits.

* In case of a life-threatening Emergency, the Plan pays benefits at the PPO percentage. If you did not have an emergency medical condition when receiving treatment from a non-PPO provider or consent to non-PPO billing for post stabilization services, non-PPO coinsurance would apply. See the section below titled Arrangements with Preferred Provider Organizations for an important exception.

* 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**
Class I, II & III	$6,310	$1,840	$12,620	$3,680
Local 24 PPO	$6,620	$1,930	$13,240	$3,860
Local 24 Non-PPO	$13,240	$3,860	$26,480	$7,720

* 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 Local 24, 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 2024 will not apply toward the out-of-pocket limits in 2025.
- 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.

* The maximums listed in the chart above are effective beginning January 1, 2024.

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*	5% $50 min and $100 max 34 day supply limit	15% $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 Generic Drugs	$20 34 day supply limit	$40 90 day supply limit	$20 34 day supply limit
Local 24 Preferred Brand Drugs*Drugs	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 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.

** The Plan's coverage of mail order drugs is limited to Sav-Rx mail order.

*** The Plan's coverage of specialty drugs is limited to Sav-Rx preferred specialty pharmacies.

If you or your pharmacy can use a manufacturer's copay assistance plan, such as a coupon or similar method, Sav-Rx 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 AIDS (PARTICIPANTS ONLY, EXCLUSIVE NETWORK PROVIDER 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	$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.

VISION

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

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 medical, hearing aid, vision and certain pharmacy 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, specialty 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). Refer to Article V for a description of drugs that require precertification by Sav-Rx.

You can precertify a medical or vision 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 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 selection 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.

PREFERRED PROVIDER ORGANIZATIONS (PPOS)

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 you pay a lower percentage of the cost of medical services and supplies from a PPO Hospital, Physician, and laboratory. Note also that 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.

MEDICAL BENEFIT PREFERRED PROVIDER:

CIGNA
Tel: 1-800-768-4695

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 http://www.iiwbenefits.org and click on the CIGNA 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.

STEM CELL INTERVENTIONAL ORTHOPEDICS PROCEDURES PROVIDER:

REGENEXX

Regenexx provides certain non-surgical stem cell interventional orthopedic procedures through an exclusive physician network, which is available to you and your Enrolled Dependents. Contact Regenexx for more information on the provider network and their services. Regenexx will determine whether you are eligible for a procedure, and whether imaging or other tests are first required.

Regenexx can be reached by contacting your dedicated Regenexx Patient Liaison for the Plan at **866-942-3035**, or to learn more about Regenexx, visit **regenexxbenefits.com/iwintermountainhwp**.

HEARING AID BENEFIT NETWORK PROVIDER:

EPIC HEARING HEALTHCARE HEARING SERVICE PLAN (EPIC HSP)
Tel: 1-866-956-5400
www.epichearing.com

To locate an EPIC Hearing Healthcare provider you can call EPIC or visit their website. The Plan will not cover hearing exams or hearing aids received from a non-EPIC provider.

PHARMACY BENEFIT MANAGER:

If you need medication, take your doctor's prescription plus your prescription drug card to a pharmacy. If you use a PPO pharmacy you will pay less. You will also pay less if you request a generic drug rather than a brand name drug. For a list of PPO pharmacies near you, call the Pharmacy Benefit Manager identified below:

Sav-Rx Prescription Services
Tel: 1-888-662-IRON (4766)
www.savrx.com

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.

ALLIANCE WORK PARTNERS (EMPLOYEE ASSISTANCE PROGRAM)

Alliance Work Partners (AWP) is an Employee Assistance Program or "EAP" for you and your enrolled Dependents. An EAP is a program designed to help you address personal problems that may be affecting your performance at work or overall wellbeing, and to help you with mental health or substance use issues.

AWP provides you and your enrolled Dependents free short-term counseling (up to six sessions per issue per year) with a behavioral health professional. Benefits also include other features and services.

You can schedule an appointment with an EAP counselor for in-person or virtual sessions by calling AWP at (800) 343-3822 or by visiting the AWP website. You may create your own personal account on the website to access benefits, online resources, and forms. Simply go to www.AWPNOW.com and select "Access Your Benefits." As a first-time user, you will need to log-in by using registration code AWP-IIHWP-5574 (all in caps with no spaces).

If you require lengthier or more specialized services than the EAP offers, AWP can help you determine your options. The decision to seek additional care is always up to you, and you will be responsible for the cost of any services not included in EAP benefits.

For a brochure with additional information on AWP benefits, please contact the Plan Administrator.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

This Notice is intended to inform you and your Dependents of COBRA Self-Pay rights and obligations. Both you and your family should take the time to read it carefully.

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Participants and their covered Dependents may Self-Pay to continue their group health coverage in certain situations called Qualifying Events where their coverage would otherwise terminate. Once you lose coverage under the Plan, you may not continue your Life and AD&D, or Accident and Sickness Weekly Disability coverage.

COBRA continuation coverage is a temporary continuation of coverage, the length of which depends on the nature of the Qualifying Event. Subject to the conditions described below, COBRA coverage is available to persons who are Qualified Beneficiaries. Qualified Beneficiaries who elect COBRA continuation coverage must pay for that coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Any Qualified Beneficiary who does not elect COBRA within the specified periods and according to the procedures described below will lose their right to elect COBRA.

WHAT ARE QUALIFYING EVENTS?

If you are an Active Employee covered under the Plan, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of either of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are a covered spouse of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your spouse dies;
- Your spouse is an Active Employee, and your spouse's hours of employment are reduced;
- Your spouse is an Active Employee, and your spouse's employment ends for any reason other than gross misconduct;
- You become divorced or legally separated from your spouse.

If you are a covered Dependent child of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your parent is an Active Employee, and their employment ends for any reason other than gross misconduct;
- Your parent is an Active Employee, and their hours of employment are reduced;
- The Participant, who is your parent, dies;
- The Participant, who is your parent, divorces or legally separates; or
- You cease to be eligible for coverage under the Plan as a Dependent child.

Under the above rules, a loss of hour bank eligibility may result in a Qualifying Event that is a reduction in the hours of the Active Employee's employment or the Active Employee's termination of employment (for reasons other than gross misconduct).

HOW LONG DOES COBRA LAST?

When the Qualifying Event is the end of your employment or a reduction of your hours of employment, coverage may be continued for up to 18 months. When the Qualifying Event is your death, your divorce or legal separation, or a child losing eligibility as a Dependent child, a Dependent's coverage may continue for up to 36 months.

The period of continuation coverage may be extended past these time limits in the following circumstances: if you become eligible for Medicare, you or a Dependent is determined to be disabled by the Social Security Administration, or you or a Dependent has a second Qualifying Event.

Medicare Eligibility Extension. When the Qualifying Event is the end of employment or a reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than you may last for up to 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your covered spouse and covered children may last for 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Disability Extension. If after you experienced a Qualifying Event because of a reduction in hours or a termination of employment, you or any covered Dependent is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage, **and if you give timely notice (described below) of the disability determination to the COBRA Administrator**, you and your entire family (if covered under the Plan) can receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension. If the Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event Extension. If you or your covered spouse or children experience a second Qualifying Event while receiving 18 months of COBRA coverage, your covered spouse and children may purchase up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, **if you give timely notice (described below) of the second Qualifying Event to the COBRA Administrator**. This extension is available to your covered spouse and covered children if you die, get divorced, or obtain a legal separation. It is also available to a covered child when they stop being eligible under the Plan as a Dependent child. These events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred.

Special Second Election Period for Certain Eligible Individuals under the Federal Trade Act of 2002. Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit under Section 201 of the Federal Trade Act of 2002. These individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second period beginning on the first day of the month in which the employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the employee's group health plan coverage ended. If you believe you may qualify for the health coverage tax credit, contact the COBRA Administrator at the address or phone number shown in "How Do I Give Notice That I Want To Elect COBRA", below, for more information.

WHEN SHOULD I PROVIDE COBRA NOTIFICATION?

The Plan will offer COBRA coverage to Qualified Beneficiaries only if the Administrative Office receives timely and proper notice that one of the following Qualifying Events has occurred. If the Qualifying Event is your divorce or legal separation from your covered spouse, a covered child losing eligibility for coverage as a Dependent, or a determination of disability by the Social Security Administration, **you or another Qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the later of the Qualifying Event or the loss of coverage, using the notice procedures described below. If these notice procedures are not followed, or if notice is not provided to the COBRA Administrator during the 60-day notice period, the Qualified Beneficiaries will lose their right to elect COBRA.**

You must, in writing, tell the COBRA Administrator that you divorced, or that your child aged out or is no longer a covered Dependent, within 60 days of that event. Otherwise, no COBRA coverage will be provided.

If the Qualifying Event is the end of employment, a reduction of hours of employment, or the death of the Participant, you do not need to give notice of these Qualifying Events.

HOW DO I GIVE NOTICE THAT I WANT TO ELECT COBRA?

Your notice must be in writing. Verbal notice, including notice by telephone, notice by fax, or notice by email are not acceptable. You must mail or deliver your written notice to the Administrative Office at the following address:

Mailing Address:

COBRA Administrator
BeneSys, Inc.
P.O. Box 30580
Salt Lake City, UT 84130 – 0580

Office Address:

5295 South Commerce Dr., Ste 220
Murray, UT 84107
Phone No.: (801) 904-4897 or (888) 867-9510

You must include the name and address of the Participant and the name(s) and address(es) of the Qualified Beneficiaries. Your notice must also state the type of Qualifying Event and the date it occurred. You should include a copy of the divorce decree or legal separation agreement, if applicable. For a Social Security extension of COBRA, you must include a copy of the Social Security Administration's determination of disability.

If you use the mail, your envelope must be postmarked by no later than the last day of the 60-day deadline specified above. If you hand deliver your notice and documentation, it must be received by an authorized individual at the above address by no later than the last day of the 60- day deadline.

Once the COBRA Administrator is properly and timely notified that a Qualifying Event has occurred, the COBRA Administrator will notify each Qualified Beneficiary of their right to elect COBRA coverage. You will have 60 days to elect COBRA coverage beginning on the later of the date coverage ends due to the Qualifying Event, or the date the COBRA Administrator provides you notice of your right to elect COBRA coverage. Each Qualified Beneficiary may elect COBRA coverage for himself or herself, even if other Qualified Beneficiaries do not. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA on behalf of their dependent children.

WHAT HEALTH COVERAGE MAY BE CONTINUED?

You are eligible to continue only those medical, vision, and dental benefits for which you were previously covered. If you were covered under medical and other health benefits, you may elect to continue either just medical benefits or the full package of medical, vision, and dental benefits.

WHAT ARE THE ELECTION AND PAYMENT PROCEDURES?

Upon receipt of notice of a Qualifying Event, the COBRA Administrator will mail you a COBRA election form. The Qualified Beneficiaries who want to purchase COBRA coverage must complete and return the election form within 60 days from the later of termination of coverage under the Plan or receipt of the form. You should mail the completed form to the COBRA Administrator at the address noted on the election form and shown above, postmarked within the 60-day period.

If you do not timely return the election form, no COBRA coverage will be provided.

You will have 45 days from the date you elect COBRA to make your initial Self-Payment. The payment amount is established by the Board of Trustees, and is adjusted from time-to-time. This initial Self-Payment must include the COBRA payments due from the date you lost coverage through the end of the last full month before you pay. (This could mean payment for more than one month of coverage is due at one time.) Before the end of the grace period, which is the 30th of the month in which you pay, you must submit payment for that month. Subsequent payments are due on the first day of the coverage month. All payments must be made by check timely sent to the COBRA Administrator at the above address.

COBRA coverage will be cancelled if the COBRA Administrator does not receive your payment within the grace period, which is 30 days after each payment due date. If mailed, your payment is considered made on the date your envelope is postmarked. If your check bounces, you have not made payment.

You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

WHEN WILL COBRA COVERAGE BEGIN?

For each Qualified Beneficiary who elects it, COBRA coverage will begin on the date that health coverage under the Plan would otherwise have been lost. However, if you waive your right to COBRA, and within the 60-day election period decide to revoke your waiver, COBRA coverage will begin on the date the revocation of the waiver is postmarked. There will be no coverage for the period between the date you elect to waive COBRA and the date this election was revoked.

WHEN WILL COBRA COVERAGE END?

COBRA coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation period under any one of the following circumstances:

- Payment is not made on time (taking into account the 30-day grace period);
- The date a Qualified Beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;
- The date a Qualified Beneficiary becomes entitled to Medicare;
- The date the Trust no longer provides group health coverage;
- The first day of the month that is 30 days after the date of a determination by the Social Security Administration that a Qualified Beneficiary on extended disability coverage is no longer disabled. This applies to the extended disability coverage of all Qualified Beneficiaries, but only to the 19th through the 29th month of extended disability coverage; and
- The first day of the month that follows the date the Participant's employer stops maintaining this Plan and starts maintaining another group health plan that covers the same class of employees as the Participant when they worked for the employer.

IF YOU HAVE QUESTIONS

If you have any questions about COBRA coverage, please contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, see the Statement of Rights Under ERISA at the end of this booklet.

KEEP YOUR PLAN INFORMED OF ANY ADDRESS CHANGES

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

ARTICLE I. - DEFINITIONS

The Plan has many technical definitions. When you see a capitalized term, look here to see what it means.

1.1 **Active Employee.** "Active Employee" means an employee who currently participates pursuant to the Eligibility Rules in section 2.1 or 2.2 of Article II.

1.2 **Administrative Office.** "Administrative Office" means BeneSys, Inc., which is the entity selected by the Board of Trustees to perform certain administration functions for the Plan.

1.3 **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 their patients for the service or supply. The charge is equal to or less than the 90th 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".

1.4 **Ambulatory Surgical Facility.** "Ambulatory Surgical Facility" means a place which maintains and operates facilities for surgery and surgical diagnosis and treatment on an open panel basis by a person licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, Skilled Nursing Facility, Residential Treatment Facility, Rehabilitation Facility, Licensed Substance Abuse Center, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of preschool age, infirmary or orphanage, private sanitarium, private office or clinic or licensed health care professionals, maternity home for prenatal or postnatal care, mental health facilities, home or institutions, or any other facility which exists for the purpose of providing health care services.

1.5 **Board of Trustees or Board.** "Board of Trustees" or "Board" or "Trustees" is the named fiduciary and the Plan Sponsor. The members of the Board are individuals appointed to serve as Trustees, according to the procedures in the Trust Agreement.

1.6 **Claims Administrator.** The "Claims Administrator" for each benefit under the Plan is set forth in the "Claims Administrator/Claims Fiduciary" chart in *HOW TO FILE A CLAIM FOR BENEFITS* at the end of this booklet.

1.7 **Claims Fiduciary.** The "Claims Fiduciary" for each benefit under the Plan is set forth in the "Claims Administrator/Claims Fiduciary" chart in *HOW TO FILE A CLAIM FOR BENEFITS* at the end of this booklet.

1.8 **Coinsurance.** "Coinsurance" means the percentage of health benefit Covered Charges each Covered Individual pays. The "Coinsurance Maximum" applies only to health benefits.

1.9 **Contributing Employer.** "Contributing Employer" means any employer who is required by a Written Agreement to make contributions to the Fund. The term Contributing Employer also includes a Union and any Training and Apprenticeship Funds affiliated with such Union, provided such Union or Training and Apprenticeship Funds are required by the Trust Agreement, a participation agreement approved by the Trustees, or collective bargaining agreement to make contributions to the Trust.

1.10 **Copay.** "Copay" means the flat fee each Covered Individual pays for health benefit Covered Charges.

1.11 **Covered Charge.** "Covered Charge" means the Allowable Fee that the Plan fully or partially reimburses for a Covered Individual's Medically Necessary health care and Preventive Care services or supplies, incurred while such individual is covered by the Plan.

1.12 **Covered Employment.** "Covered Employment" means any employment or work covered by a Written Agreement for which a Contributing Employer is required to make contributions to the Fund.

1.13 **Covered Individual.** "Covered Individual" means a Plan Participant, or a Dependent covered under the Plan.

1.14 **Custodial Care.** "Custodial Care" means any care intended primarily to help a person meet basic personal needs when there is no plan of active medical treatment to reduce the disability or the plan of active medical treatment cannot reasonably be expected to reduce the disability. Custodial Care includes nursing home or assisted living expenses/charges.

1.15 **Deductible.** "Deductible" means the amount of health benefit Covered Charges a Participant and Dependent must pay during a calendar year before the Plan reimburses a percentage of health benefit Covered Charges.

1.16 **Dentist.** "Dentist" means only a person who is licensed and certified to practice dentistry and who is practicing within the scope of the license or certification as a Doctor of Dental Surgery or a Doctor of Dental Medicine.

1.17 Dependent.

If you properly complete enrollment forms, your spouse and children will be covered under the Plan, if they qualify as your "Dependents."

"Dependent" means:

a. the Participant's lawful spouse. For purposes of this Plan, a "spouse" means the person to whom the Participant is legally married and who is treated as a spouse under the Internal Revenue Code. The term "spouse" does not include a spouse by a common law marriage.

b. the Participant's children, as follows:

(i) biological or adopted (and placed for adoption) children and stepchildren, age 25 and younger;

(ii) grandchildren for whom the Participant has, by reason of a State Court order, full financial responsibility and permanent legal custody, age 25 and younger; and

(iii) biological or adopted (and placed for adoption) children, stepchildren, or grandchildren as described in (ii) above, age 26 or older, who are incapable of self-sustaining employment by reason of mental retardation or a physical handicap provided the Participant continues the child's coverage under the Plan; the child was covered by the Plan and such incapacity commenced prior to the date the Dependent child's coverage would have otherwise terminated; and the child is dependent upon the Participant for support and maintenance. The incapacity must not have resulted from the child's commission or attempted commission of a felony or an illegal act or occupation. To obtain coverage, the Participant must submit notification and proof of incapacity to the Administrative Office within thirty-one (31) days of the date the Dependent child's coverage would otherwise terminate. The Administrative Office may, on occasion, request proof of continued incapacity and dependency.

The Plan may at initial enrollment and on occasion request proof of status as a Dependent, and other information (such as a Social Security number) required to administer the Plan. The Plan may terminate Dependent coverage or may not pay Dependent claims for failure to timely submit the requested information.

1.18 Durable Medical Equipment. "Durable Medical Equipment" means reusable medical equipment such as walkers, hospital beds, wheelchairs, and home oxygen equipment, and has the same meaning as Medicare-covered Durable Medical Equipment.

1.19 Emergency. "Emergency" means an unforeseen Injury or Illness that requires immediate medical attention to avoid serious and permanent risk to health.

1.20 Essential Health Benefit. "Essential Health Benefit" means a service or supply for which the Patient Protection and Affordable Care Act of 2010 prohibits the Plan from imposing lifetime dollar limits.

1.21 Health Care Reform. "Health Care Reform" means the Patient Protection and Affordable Care Act of 2010, as amended, and applicable agency regulations.

1.22 **Home Health Care.** "Home Health Care" means services rendered by an organization or agency which meets the requirements for participation as a home health agency under Medicare.

1.23 **Hospice Benefit Period.** "Hospice Benefit Period" means the period that begins on the date the Physician certifies that an individual is a Terminally Ill Patient and ends six (6) months after it began or on the death of the individual, if sooner. If the Hospice Benefit Period ends before the death of the individual, a new Hospice Benefit Period may begin if the Physician again certifies that the individual is a Terminally Ill Patient.

1.24 **Hospice Care.** "Hospice Care" means palliative and supportive medical, health and other services provided to Terminally Ill Patients to meet special physical or emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary.

1.25 **Hospital.** "Hospital" means an institution licensed by the State in which it operates as a Hospital and is primarily engaged in providing (for compensation from its patients) medical, diagnostic, therapeutic, and surgical facilities for the care and treatment of Illnesses and Injuries on an inpatient basis, and which provides such facilities under the supervision of the staff of Physicians and with twenty-four (24) hours a day nursing service by registered nurses (R.N.). In no event, however, shall such term include any institution or part thereof which is used principally as a clinic, a rest facility, nursing facility, convalescent facility, facility for the chronically ill, residential facility, a halfway house, a survival skills facility, a facility of the aged, or a facility providing Custodial Care, maintenance care, or educational care. In addition, Skilled Nursing Facilities, Residential Treatment Facilities, Rehabilitation Facilities, and Licensed Substance Abuse Centers are not "Hospitals."

1.26 **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 2.1 describes crediting of Hours of Work upon receipt of reciprocal contributions.

1.27 **Illness.** "Illness" means a disease or infection and all related symptoms or conditions related to the same Illness.

1.28 **Injury.** "Injury" means a condition resulting from an external violent force and all related symptoms and conditions resulting from the same force, independent of Illness and all other causes.

1.29 **Intensive Care Unit or Coronary Care Unit.** "Intensive Care Unit" or "Coronary Care Unit" means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a registered nurse (R.N.) or other trained Hospital personnel.

1.30 **Legend Drug.** "Legend Drug" means any drug which Federal or State law prohibits dispensing without a prescription order as follows:

a) Legend Drugs plus injectable insulin on prescription only;

b) Compounded medications of which at least one (1) ingredient is a prescription Legend Drug.

1.31 **Licensed Ambulatory Surgical Facility.** "Licensed Ambulatory Surgical Facility" means a place which maintains and operates facilities for surgical and surgical diagnosis and treatment on an open panel basis by persons licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, Skilled Nursing Facility, Residential Treatment Facility, Rehabilitation Facility, Licensed Substance Abuse Center, extended care facility, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of pre-school age, infirmary or orphanage, private sanitarium, private office or clinic of licensed health care, mental health facility, home or institution, or any other facility which exists for the purpose of providing health care services.

1.32 **Licensed Substance Abuse Treatment Center.** "Licensed Substance Abuse Treatment Center" means a treatment center licensed by the state of its situs as a facility providing treatment of Substance Abuse. To be a Licensed Substance Abuse Treatment Center under the Plan, such a treatment center must be contracted as a PPO Provider.

1.33 **Medically Necessary.** "Medically Necessary" means a service or supply which is required, appropriate, and consistent to treat or diagnose the patient's Illness or Injury, is in accordance with accepted standards of medical practice (or, as applicable, practice of dentistry), and could not have been omitted without adversely affecting the patient's condition or quality of medical care.

1.34 **Medicare.** "Medicare" means the benefits provided under Title XVIII of the Social Security Act of 1965, as amended from time to time.

1.35 **Mental Illness.** "Mental Illness" means those disorders listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other nonpsychotic mental disorders. No other disorders or conditions are included in the term "Mental Illness" for purposes of the benefit provisions of the Plan.

1.36 **Occupational Therapy.** "Occupational Therapy" means the use of Rehabilitative techniques to improve a patient's functional ability to live independently.

1.37 **Participant.** "Participant" means an Active Employee or a Retiree.

1.38 **Pharmacy Benefit Manager.** "Pharmacy Benefit Manager" means the entity designated by the Trustees to process outpatient prescription drug claims. Their contact information is under *PREFERRED PROVIDER ORGANIZATIONS*, earlier in this booklet.

1.39 **Physical Therapy.** "Physical Therapy" means the use of Rehabilitative techniques to improve a patient's functional ability to live independently.

1.40 **Physician.** "Physician" means a person who is licensed by the State in which they practice, and is acting within the scope of that license when they render services as: a Doctor of Medicine or a Doctor of Osteopathy, Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, or Optometrist. In addition, the term Physician will include, to the extent that benefits are provided for herein and while practicing within the scope of their license, the following licensed providers of care: psychologist, clinical social worker, clinical specialist psychiatric registered nurse (CSPRN), acupuncturist, and audiologist. "Physician" does not include any other practitioner, including homeopath or naturopath.

1.41 **Physician Assistant.** "Physician Assistant" means an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a Physician, and must be certified by the state to practice.

1.42 **Plan Administrator.** "Plan Administrator" means the Board of Trustees for self- funded benefits, and the applicable insurer for insured benefits.

1.43 **Plan Year.** "Plan Year" means the Plan's fiscal year which begins November 1 and ends October 31 of each year.

1.44 **Precertification.** "Precertification" means that an individual must get prior certification from the agent designated by the Board of Trustees for services listed in the Precertification section earlier in this booklet.

1.45 **Preferred Provider or Preferred Provider Organization (PPO).** "Preferred Provider" means a service provider that is a member of a "Preferred Provider Organization" that has contracted with the Plan to provide services or supplies for a reduced or fixed charge.

1.46 **Preferred Provider Service Area or Preferred Provider Organization (PPO) Service Area.** "Preferred Provider Service Area" or "Preferred Provider Organization Service Area" means the geographic area in which a PPO operates.

1.47 **Preventive Care.** "Preventive Care" means those services and supplies designated as "preventive care" in published guidelines under Health Care Reform, and which the Plan is required by law to provide. Preventive Care excludes services and supplies which are, based on the individual's diagnosis, Medically Necessary. For more information, see Sections IV and V. Reasonable medical management techniques such as age, location for service, and test frequency also apply in determining whether a Preventive Care service or supply is a Covered Charge.

1.48 **Rehabilitation or Rehabilitative Therapy.** "Rehabilitation or Rehabilitative Therapy" means services or supplies to help an individual regain a skill that has been acquired but then lost or impaired due to Illness or Injury.

1.49 **Rehabilitation Facility.** "Rehabilitation Facility" means a facility that is licensed by the State in which it operates to perform rehabilitative health care services. To be a Rehabilitation Facility under the Plan, such a facility must be contracted as a PPO Provider.

1.50 **Residential Treatment Facility.** "Residential Treatment Facility" means a facility that provides intermediate non-hospital 24-hour care that operates 7 days a week, and exclusively treats individuals with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/drug) disorders that are unable to be safely and effectively managed in outpatient care. To be a Residential Treatment Facility under the Plan, such a facility must be licensed as a residential treatment facility (licensure requirements for this residential level of care may vary by state) and contracted as a PPO Provider.

1.51 **Respite Care.** "Respite Care" means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that family members may have relief from the stress of the care of the patient, who is a Participant or Dependent.

1.52 **Retired Employee or Retiree.** "Retired Employee" or "Retiree" means a Participant who qualifies for and elects Retiree coverage under the Plan. The terms Retired Employee or Retiree shall not include a Dependent or the surviving spouse of a deceased Retiree.

1.53 **Self-Pay Participant.** "Self-Pay Participant" means an individual who loses Plan coverage and properly elects to continue coverage under COBRA or as a Retiree.

1.54 **Skilled Nursing Facility.** "Skilled Nursing Facility" means a state-licensed and lawfully operated institution for the care and treatment of persons convalescing from an Illness or Injury that is unable to be safely and effectively managed in outpatient care, which provides room and board and twenty-four (24) hour nursing service by licensed nurses, and is under the full-time supervision of a Physician or a registered nurse (R.N.). To be a Skilled Nursing Facility under the Plan, such an institution must be contracted as a PPO Provider.

1.55 **Specialty Drug.** "Specialty Drug" is an outpatient prescription drug that is covered only if dispensed by the Pharmacy Benefit Manager. For a current list of Specialty Drugs, contact the Pharmacy Benefit Manager (contact information is under *PREFERRED PROVIDER ORGANIZATIONS*, earlier in this booklet).

1.56 **Speech Therapy.** "Speech Therapy" means the use of Rehabilitative techniques for treatment of speech and language disorders, incurred as a result of Illness or Injury.

1.57 **Substance Abuse.** "Substance Abuse" means those disorders listed in the International Classification of Diseases as mental and behavioral disorders due to dependence on alcohol or other drugs (including the nondependent abuse of drugs).

1.58 **Terminally Ill Patient.** "Terminally Ill Patient" means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.

1.59 **TRICARE.** "TRICARE" includes Champus, and means the federal government's managed health care program for active members of the United States uniformed services and their families, retired members of the United States uniformed services and their families, and the survivors of members of the United States uniformed services who died while on active duty.

1.60 **Trust Agreement or Trust or Fund.** "Trust Agreement" means the Agreement and Declaration of Trust establishing the Ironworkers Intermountain Health & Welfare Trust dated May 1, 2008 as modified or amended. "Trust" or "Fund" refers to the assets held pursuant to the Trust Agreement.

1.61 **Union.** "Union" means Local Unions No. 21, 24, 27, 495, and 732 of the International Association of Bridge, Structural, and Ornamental and Reinforcing Ironworkers, and any other union admitted by the Trustees.

1.62 **Vocational Rehabilitation.** "Vocational Rehabilitation" means teaching and training which allows an individual to resume their previous job or to train for a new job.

1.63 **Written Agreement.** "Written Agreement" means a collective bargaining agreement (including the applicable compliance agreement) that provides for contributions to the Trust, or a participation agreement that is approved by the Trustees. The Trustees reserve the right to reject any Written Agreement.

ARTICLE II. – ELIGIBILITY RULES FOR ACTIVE EMPLOYEES AND RETIREES

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.

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.

b. Initial Eligibility and Class of Coverage.

> You must earn 360 Hours of Work to satisfy the Plan's initial eligibility requirements. Your coverage will begin the second month after you satisfy the Plan's initial eligibility requirements.

New employees are eligible to participate in the Plan two months after they earn 360 Hours of Work within 4 consecutive months. Hours of Work in excess of 360 are credited to the Active Employee's hour bank following initial eligibility.

Once an Active Employee satisfies the initial eligibility requirements above, Article IV, medical benefits are paid by the Plan according to the following coverage classifications:

Classification	Hours of Work
Class I	0 – 3000
Class II	3001 – 6000
Class III	More than 6000

Each coverage classification has a different Medical Plan Deductible, Coinsurance, and Copay level (described in the Summary of Benefits chart). All new or rehired employees following loss of coverage under the Plan must complete the initial eligibility period to again become covered under the Plan, and are eligible for the Class I level of benefits. However, an Active Employee who was covered by the Plan for a period of at least six (6) months of the most recent twenty-four (24) months prior to reestablishing eligibility, is eligible for coverage under the coverage classification for which they were previously eligible.

c. Effective Date of Coverage. The effective date of coverage for any Active Employee is the first day of the second month after performing 360 Hours of Work within 4 consecutive months. See the example in *Quick Answers*.

d. Continuation of Eligibility. Hours of Work are credited to an Active Employee's hour bank the month in which the hours are worked to provide coverage two months following the month of work. After initial eligibility, an Active Employee must have 120 Hours of Work in their hour bank to receive coverage. 120 Hours of Work are deducted from the Active Employee's hour bank for each month of coverage. See the example in *Quick Answers.*

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. For members of Local 24, your hour bank, after satisfying the initial eligibility rules (360 hours), may not exceed 240 hours. If you are a Local 21, 27, 495 or 732 member and work under a Local 24 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.

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 their 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.

g. Termination of Eligibility. An Active Employee's hour bank coverage will terminate on the earliest to occur of the following:

1. The first day of the month in which their hour bank contains less than one hundred twenty (120) Hours of Work.

2. The last day of the month in which they work in the Plan's geographic area and in a trade or craft covered by the Plan, for an employer not subject to a Written Agreement requiring the payment of contributions to the Fund;

3. The date as of which the Active Employee or their Contributing Employer has not provided all requested information (including social security number) or has misrepresented information to the Plan;

4. The date the Active Employee or their employer fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);

5. The date they enter full-time active duty in the United States armed forces or other armed forces, except as otherwise provided by law;

6. The date the Plan, or the Participant's or their employer's participation in the Plan, is terminated by the Board of Trustees.

h. Reinstatement of Eligibility.

- If your hour bank account drops below 120 hours, you will lose Plan coverage.
- If within 3 months you work enough Covered Hours for your hour bank account to grow to at least 120 hours, you will regain coverage.
- If it takes you more than 3 months to build your hour bank account to 120 hours, your hour bank account will drop to zero. You must again satisfy the Plan's initial eligibility requirements to regain coverage—that is, you must work 360 hours in 4 months.

An Active Employee whose hour bank dropped below 120 hours or whose eligibility terminated either under the hour bank or the Self-Payment provisions for COBRA shall again become eligible if their hour bank is credited with at least 120 Hours of Work within three (3) calendar months.

If an employee is not credited with 120 Hours of Work within three (3) calendar months, any remaining hours in their hour bank is forfeited. The employee will again become eligible for coverage upon completion of the eligibility requirement as set forth in the "Initial Eligibility" provisions.

i. 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.

j. Waiver of Initial Eligibility Requirements with Respect to Employees of a Newly Organized Contributing Employer. The Trustees may, in their sole discretion, waive the Plan's initial eligibility requirements with respect to employees of a newly organized Contributing Employer that had previously offered their employees group medical coverage. The requirements to receive and effect of this waiver shall be as follows:

1. The Plan will provide eligibility for bargaining employees' first month of Coverage on the basis of one hundred twenty (120) Hours of Work for each bargaining employee.

2. The newly organized Contributing Employer will make an initial contribution equal to 120 times the Fund's current hourly contribution rate, on all bargaining employees. This initial contribution will provide eligibility for bargaining employees' second month of Coverage.

3. In addition, the newly organized Contributing Employer shall make contributions on behalf of all such bargaining employees based on the actual Hours of Work beginning with the first month of Coverage. Such hours shall be used for the purpose of the third month's eligibility and so forth, as described in section 2.1, e. Excess hours, if any, will be credited to the bargaining employee's hour bank.

4. In the event the employee's hour bank falls below one hundred (120) hours in any subsequent month of employment with a newly organized Contributing Employer, the employee's eligibility will be terminated and they will be eligible to continue coverage in accordance with Continuation Coverage Rights Under COBRA.

5. This waiver of initial eligibility shall apply only in those instances where an employee remains in the employment of a newly organized Contributing Employer.

6. This provision shall apply only to those bargained employees who were employed by the newly organized Contributing Employer on the employer's effective date of participation and for whom the employer had previously provided group medical coverage. Employees employed on and after the employer's initial effective date of participation shall be subject to the initial eligibility requirements described in section 2.1, c.

7. Bargaining employees covered under a Written Agreement with a Contributing Employer subject to this provision will have their hour bank eligibility terminated at the end of the month following the date such Contributing Employer elects to withdraw from participation in the Ironworkers Intermountain Health & Welfare Trust, whether or not such employer maintains a collective bargaining agreement with the Union.

k. Hourly Rate-Contribution Amount. The hourly contribution rate or (other contribution amount) to be remitted by Contributing Employers on behalf of each Active Employee is the rate established by the Trustees from time-to-time, in their discretion. If the Administrative Office receives contributions representing less than the hourly rate established by the Trustees, the contributions will be rejected and no credit for Hours of Work will be granted. If the Administrative Office receives late contributions it will apply the amount received to the earliest contributions owed.

2.2 Flat Rate Eligibility for Active Employees.

A Contributing Employer must make written application to the Board of Trustees to participate in the Plan under the flat rate system. The Board of Trustees may, in its discretion, accept or reject any such application.

a. Initial Eligibility.

> If you don't work under a collective bargaining agreement but your Employer has signed a participation agreement and has agreed to contribute to the Fund for you, then you have coverage on a flat rate basis. For every month of work, your employer must, without interruption, make the correct amount of contributions to the Fund on your behalf. In addition, you must satisfy all the requirements of your employer's Participation Agreement with the Fund. You may contact the Administrative Office for a copy of your employer's Participation Agreement.

The following Active Employees may participate in the Plan under the flat-rate system:

1. Employees who are not covered by a collective bargaining agreement, but who work for an employer that contributes to the Fund for other employees who are covered by a collective bargaining agreement with the Union.

2. Employees of Unions and affiliated training funds, but only to the extent required by a collective bargaining agreement with a craft other than the Union's.

b. Flat Rate Employee Application for Participation and Enrollment. Each prospective Active Employee under the flat rate system must complete an application and enrollment form and submit it to the Administrative Office within 30 days of the employee's initial date of employment or, if later, the employee's satisfaction of the participation requirements set forth in the participation agreement applicable to the employee.

c. Flat Rate Employees Eligible. A Contributing Employer must contribute to the Plan for those employees who meet the requirements set forth in the participation agreement approved by the Trustees. Also, an employee must work at least 20 hours per week to be eligible for coverage under the Plan.

> *Example*: Iron Co. has signed the Local 27 Compliance Agreement. Mary owns Iron Co., and she works full-time for Iron Co. Her work isn't covered by the Collective Bargaining Agreement. Iron Co. and the Trustees sign a participation agreement, and Iron Co. begins making contributions to the Fund for Mary. Mary's eligibility for coverage is determined under these flat rate rules, not the hour bank rules.

d. Contributing Employer Participation Effective Date. The effective date of the Contributing Employer's flat rate participation shall be the first day of the calendar month specified in the employer's participation agreement; provided, however, that the effective date of participation shall not be earlier than the first day of the month after latest of the following: (1) the date of notification from the Administrative Office that the application has been approved by the Board of Trustees, (2) the date the participation agreement has been executed, or (3) the date the Contributing Employer has paid to the Fund an amount equal to two months of contributions for current employees covered under the participation agreement. The initial two months of contributions provides no Plan coverage.

e. Flat Rate Employee Initial Eligibility and Effective Date of Coverage.

Flat rate employees also have a lag month: if after initial eligibility they work enough hours for their employer to make a contribution, they are eligible to participate in the Plan two months later.

Prospective flat rate Active Employees covered under a Contributing Employer's participation agreement will become eligible for coverage on the latest of:

(1) the Contributing Employer's flat rate participation effective date (described above),

(2) satisfaction of the eligibility requirements in the participation agreement, and

(3) the Contributing Employer's payment of two months of contributions for the employee. Thereafter, coverage is provided on the following schedule: if an employee satisfies the eligibility requirements in month 1 and the Contributing Employer makes timely contributions to the Trust in month 2, this contribution provides Plan coverage in month 3.

Flat rate Active Employees will be entitled to the medical benefits as described in Article IV in accordance with the following coverage classifications:

Classification	Months for which Contributions Are Received
Class I	1 – 18
Class II	19 – 36
Class III	Over 36 months

Following loss of coverage under the Plan, employees must complete the initial eligibility period to again become covered under the Plan. An employee who was covered by the Plan for a period of at least six (6) continuous months of the most recent twenty-four (24) months prior to reestablishing eligibility, is eligible for coverage under the coverage classification for which the employee was previously eligible.

f. Monthly Contributions. The amount of monthly contributions a Contributing Employer must make to the Fund for each participating flat rate Active Employee is established by the Board of Trustees from time to time, and in their sole discretion. Currently the monthly contribution required for each flat rate Active Employee is 160 hours times the then-current contribution rate for hour bank Employees under Section 2.1. Contributions for flat rate coverage are due on the same schedule as contributions for hour bank Active Employees. If for any month a Contributing Employer fails to make contributions owed under a collective bargaining agreement that requires contributions to the Fund, all contributions made for flat rate employees in that month will be applied toward employees working under the collective bargaining agreement. If the Administrative Office receives partial or late contributions, it applies the amount received to the earliest contributions owed.

g. No Hour Bank. Flat rate employees have no hour bank. Their coverage ends the month after the month their employer stops making contributions to the Plan.

h. Termination of Coverage. For Active Employees participating under the flat rate system, coverage will terminate on the earliest of the following dates:

1. the last day of the month following the month in which termination of employment occurs;

2. the last day of the month following the month in which the employee fails to satisfy the eligibility requirements set forth in the participation agreement;

3. the date the Plan is discontinued;

4. the date the employee's Contributing Employer (other than the Union or affiliated training fund) is no longer signatory to a collective bargaining agreement that requires contributions to the Plan;

5. the date as of which the Contributing Employer or employee (including Dependents) has not provided all requested information (including social security number) or has misrepresented information to the Plan;

6. the date the employee or their employer fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);

7. the date the employee enters full-time active duty in the United States armed forces or other armed forces, except as otherwise provided by law;

8. the date as of which the employee's Contributing Employer terminates its participation agreement in accordance with permissible termination events in that agreement, or the date as of which the Trustees terminate the Contributing Employer's participation; or

9. the month for which the employee's Contributing Employer fails to make a required contribution under a collective bargaining agreement or participation agreement.

i. Reinstatement Provision. Once coverage terminates the Contributing Employer and/or Active Employee (as applicable) may recommence participation in the Plan as a new Contributing Employer and/or Active Employee (as applicable), but only subject to the rules and procedures previously described for new Contributing Employers and/or Active Employees (as applicable).

2.3 Family and Medical Leave Act. Participants are entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993 ("FMLA"), as may be amended. The Plan will accept contributions made by Contributing Employers as required by the FMLA, but the Plan will not, without contributions, provide coverage during a FMLA leave.

2.4 **Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").** If an Active Employee leaves employment to perform "service in the uniformed services" as defined by USERRA (hereafter "Uniformed Service") for a period of up to thirty (30) days, their coverage will continue during such period in accordance with section 2.1 or section 2.2. If an Active Employee leaves employment to perform Uniformed Service for a period of more than thirty (30) days, the Active Employee and their Dependents may continue coverage in accordance with USERRA for up to twenty-four (24) months measured from the date the Active Employee's absence begins. The requirements and procedure to elect continuation coverage under USERRA; the terms and conditions of such coverage; the applicable payment options; and the rules for reinstatement of Plan coverage on reemployment following Uniformed Service are described in the Plan's USERRA Procedures. Continuation coverage under USERRA runs concurrently with continuation coverage under COBRA. If there is any conflict between this section or the Plan's USERRA Procedures and the requirements of USERRA, the requirements of USERRA shall control.

2.5 Eligibility for Dependents.

Once you become eligible for coverage, so will your spouse and children. The Plan doesn't cover spouses by common law marriage. Children include your biological children, adopted children, stepchildren and some grandchildren over whom you have permanent legal custody, age 25 and younger. See the definition of "Dependent" in Article I for details.

a. Effective Date. Dependents of a Participant become eligible for coverage on the latest of the following:

1. the date the Participant becomes eligible for coverage under Section 2.1 or 2.2 (as applicable);

2. the date the Participant acquires the Dependent. A Dependent spouse becomes eligible on the date of marriage. A Dependent child becomes eligible on the date the child satisfies the Plan's definition of a Dependent; or

3. the effective date of the Dependent's enrollment in the Plan (see Enrollment Requirement, below).

b. Dual Coverage. If a Dependent is also covered as Participant or is covered as a Dependent of two Participants, the Plan coordinates benefits with itself. In addition, the Plan will never pay more than actual expenses incurred or benefits otherwise promised in the Plan.

c. Enrollment Requirement for Dependents of Active Employees.

1. When you are first eligible for coverage (or if you lose coverage and then regain it), you must enroll your Dependents before the Plan will cover their medical expenses. The Plan offers no coverage for expenses incurred before the effective date of enrollment. You have 30 days to enroll your Dependents after you are first eligible for coverage. Their coverage will then be effective the date your coverage begins. If you do not complete and return the enrollment form within 30 days, your Dependents will have no Plan coverage.

2. You may enroll or disenroll a Dependent mid-year, effective the first month after the Plan receives the Dependent's enrollment materials. Except for the mid-year enrollment opportunities described in the following paragraph, you may not enroll or disenroll a Dependent within 12 months after disenrolling or enrolling that Dependent.

3. You may also enroll a Dependent mid-year within 60 days of the following events (with enrollment effective as of the date of the applicable event):

   (i) you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption (you may also enroll your spouse in this situation); or

   (ii) you did not previously enroll your Dependent because they had other healthcare coverage, and the Dependent loses eligibility for other healthcare coverage in which they were previously enrolled due to (a) legal separation, divorce, death of an employee, loss of status as a dependent, termination of employment, reduction in the number of hours of employment, exhaustion of the other plan's lifetime limit on all benefits, termination of employer contributions, or any other reason for which a special enrollment opportunity is required by HIPAA, if the other coverage was non- COBRA coverage; or (b) exhaustion of the COBRA coverage period, if the other coverage was COBRA coverage; or

   (iii) your Dependent (a) loses eligibility under a Medicaid plan or a state child health plan offered under the State Children's Health Insurance Program ("SCHIP"), or (b) becomes eligible for a premium assistance subsidy through a Medicaid plan or a state child health plan offered under SCHIP.

4. To enroll your Dependent you must properly complete the Plan's enrollment form, and the Administrative Office must receive your completed form within the time limits described above.

5. When enrolling your Dependent, you must verify their status as Dependent by submitting the supporting adoption, birth, or marriage certificate.

d. Enrollment Requirement for Dependents of Retirees. See Section 2.6 for the rules on enrolling Dependents of Retirees. The Administrative Office must also receive a supporting adoption, birth, or marriage certificate for each Dependent.

e. Termination of Dependent Eligibility. A Dependent's eligibility shall terminate for any of the following reasons, whichever should occur first:

1. the date the Participant's eligibility terminates;

2. the date the Dependent ceases to qualify under the definition of Dependent;

3. the date the Dependent enters into full-time active duty with the armed forces of the United States (except as prohibited by law);

4. the date the Dependent fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);

5. the date the Participant fails to provide confirming proof of Dependent status (such as marriage or birth certificates), as requested by the Administrative Office;

6. the date the Dependent has not provided all requested information (including social security number) or has misrepresented information to the Plan; or

7. the date the Trustees discontinue coverage for the Dependent.

The Administrative Office must be notified of a Dependent's loss of eligibility within 60 days of the event causing loss (e.g., divorce). Participants are responsible and liable to reimburse the Plan for any payments made for a family member following loss of eligibility. *See Article XI.*

f. Hour Bank Coverage for Dependents of a Deceased Active Employee. If you die while you are an Active Employee participating pursuant to the eligibility rules under section 2.1, your Dependents will continue to be eligible for Plan benefits for as long as you would have remained eligible under your hour bank, plus six months. Thereafter, your Dependents may elect to continue coverage under COBRA on a self-payment basis as described in the Notice of Continuation Coverage Rights under COBRA.

g. Benefits Available to Dependents. Dependents are covered by the same medical coverage classification as the Participant who enrolls the Dependent. However, Dependents are ineligible for Accident and Sickness Weekly Benefits, Life Insurance and Accidental Death and Dismemberment Benefits, and hearing aids; in addition, Dependent children are ineligible for eye surgery.

2.6 Retiree Coverage.

If when your coverage as an Active Employee ends you also retire from certain pension plans, you may elect Retiree health coverage under the Plan. You must pay each monthly contribution on time. If you are late, you will forever lose Retiree coverage under the Plan. The Administrative Office can arrange for automatic payment from some pension plans.

a. Eligibility and Application. Local 24 members are not 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 their 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.

b. Coverage of Dependents. A Retiree must enroll all Dependents when electing Retiree coverage—there is no later enrollment of Dependents. However, a Retiree who later marries, has a newborn biological child, or adopts a child (or has a child placed for adoption) may later enroll that new Dependent as well as the Retiree's Dependent spouse by submitting the Plan's enrollment form and remitting payment to the Administrative Office within thirty-one (31) days from the date of marriage, birth, or adoption. Enrollment must be effective on the date of marriage, birth, or adoption. A Retiree's Dependent who is eligible for Medicare based on age is not eligible for Plan coverage.

Coverage ends when the spouse or child is no longer a Dependent, when the Dependent becomes eligible for Medicare based on age, when the Retiree's coverage ends (except that if the Retiree's coverage ends due to Medicare eligibility, the Dependent coverage continues until the Dependent is eligible for Medicare based on age), if the Administrative Office does not receive other requested information, or the first of the month for which the Plan doesn't timely receive the payment for coverage.

c. Payment for coverage. Retirees make monthly payments for coverage. Premium rates are established from time-to-time by the Board of Trustees, and may be changed periodically. The first payment must accompany the application for coverage. Each subsequent payment is due in the Administrative Office by the fifteenth (15^{th}) day of the month for which the coverage is intended.

d. Cancellation of coverage. A Retiree's coverage (and a Retiree Dependent's coverage) is cancelled upon the first of the following to occur:

1. The date the Retired Employee goes to work in the occupational jurisdiction of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers Union in the United States, Mexico, or Canada, and the work is not subject to an agreement with such union. However, coverage will not end if the work is in the geographic jurisdiction of the Plan but would not be suspendible employment under the Intermountain Ironworkers Pension Plan.

2. The date the Trustees change or terminate coverage for Retirees and/or their Dependents.

3. The month for which the Administrative Office does not timely receive the full payment for coverage.

4. The date the Retiree (or their Dependent) fails to comply with material terms of the Plan, the Trust, or a reimbursement agreement.

5. The date the Retiree (or their Dependent) enters into full-time active duty with the armed forces of the Unites States (except as prohibited by law).

6. The date the Retiree (or their Dependent) has not provided all requested information (including social security number) or has misrepresented information to the Plan.

7. Death of the Retiree, unless the Retiree's surviving spouse makes timely payment of the Retiree contribution amount and elects to immediately continue coverage for herself and the Participant's Dependent children, in which case coverage ends upon remarriage of the surviving spouse, or when it would have otherwise ended for the Retiree had they survived.

8. The date the Retiree becomes eligible for Medicare based on age, except that the Retiree's Dependent coverage may continue until the Dependent is eligible for Medicare based on age.

   Once cancelled, the Participant is forever ineligible to again elect Retiree coverage.

e. Benefits. Retirees may elect and pay for the type of benefits the Trustees, from time-to-time, make available to Retirees. Currently, Retirees may elect medical benefits, or Medical, Vision, and Dental benefits. Retirees may not elect coverage for Accident and Sickness Weekly Benefits, or Life Insurance and Accidental Death and Dismemberment Benefit.

f. Medicare Eligibility. Retirees eligible for Medicare based on age are ineligible for the Plan. Other Medicare eligible Retirees need to enroll for both Medicare Part A and Medicare Part B or benefits payable under this Plan will be reduced by the amount Medicare would have paid (to the extent permitted by law).

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. $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.

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;

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;

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 IV. – MEDICAL BENEFITS

NOTE: Local 24 members have different health benefits than members of Locals 21, 27, 495, and 732. Where benefits under the Plan are different for members of Locals 24, they will be noted in the Summary of Benefits. The different benefit provisions apply regardless of whether the Local 24 member is working in an area inside or outside the jurisdiction of Local 24, and regardless of the member's contributing employer, contribution rate, collective bargaining agreement, key man agreement or other written agreement. The Local 24 benefits also apply to employees of Local 24 and their apprenticeship/training funds, and to employees of Local 24 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).

How Medical Benefits Work. The Plan pays a portion of the cost of Covered Charges after you pay an annual Deductible, and for some Covered Charges, a Copay. Participants are responsible to pay the rest. However, if a Charge is excluded in Article IX, the Plan will not reimburse any related expenses. And if an expense is not a "Covered Charge," the Plan pays none of it.

4.1 **Benefits.** The Plan pays a portion of the cost of Medically Necessary health care expenses that are Covered Charges. The Plan also pays the cost of Preventive Care, but only if received from a PPO provider. The Plan pays no more than the Allowable Fee for a health care expense.

4.2 **Maximum Benefits Payable.** There is a maximum amount the Plan pays for certain benefits, during a Covered Individual's life and each calendar year. See the Summary of Benefits earlier in this booklet for these maximum amounts.

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 Local 24, 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.

4.4 **Arrangements with Preferred Provider Organizations.**

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. 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.

If you believe that you've been wrongly billed, you may contact CIGNA. You should submit requests that the Plan cover a provider's bill to CIGNA at 1-888-867-9510. Call the Centers for Medicare & Medicaid Service's No Surprises Help Desk at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

4.5 Deductible and Copays.

Covered Individuals pay the Deductible and the Copay for Covered Charges. There is no Copay for many services, and there is no Deductible for Preventive Care.

The medical benefit Deductible is the amount of Covered Charges each Covered Individual, and each family must pay in a calendar year before medical benefits are payable by the Plan. The medical benefit Copay is the amount each Covered Individual pays for each Physician office visit (if applicable), Hospital admission, and emergency room admission. Your Deductible and Copay depend on your coverage classification (Classification I, II, or III—see Sections 2.1 and 2.2 to determine your coverage classification). The longer a Participant has been in the Plan, the lower the Deductible. See the Summary of Benefits for the Copay and Deductible applicable to your coverage classification.

4.6 Percentage of Covered Charges Payable: Coinsurance

The Plan pays a percentage of medical benefit Covered Charges, and you pay the rest. The percentage of Covered Charges you pay is called "Coinsurance."

a. Coinsurance amount. Medical benefit Coinsurance depends on the Participant's coverage classification (Classification I, II, or III—see Sections 2.1 and 2.2 to determine your coverage classification). The longer you've been in the Plan, the lower your Coinsurance. And if you use a PPO provider, your Coinsurance is lower. See the Summary of Benefits for your Coinsurance percentage. Coinsurance applies to Covered Charges still owing after you pay the Copay and/or Deductible.

b. Annual Coinsurance Maximum.

Once a Covered Individual's Coinsurance payments for medical benefit Covered Charges reach the annual maximum indicated in the Summary of Benefits chart at the beginning of this booklet, that Covered Individual owes no further Coinsurance on medical benefits for that calendar year.

c. Exceptions to Coinsurance Maximum. The Plan only counts medical benefit claims that are Covered Charges toward the Coinsurance Maximum.

4.7 Covered Charges. Covered Charges are services and supplies that are Medically Necessary and no more than the Allowable Fee, and are described below and not otherwise excluded by the Plan. See Article IX for general exclusions and limitations.

Covered Individuals must pay Copays, Deductibles, and Coinsurance when a service or supply is a Medically Necessary Covered Charge. If a service or supply is not a Medically Necessary Covered Charge, the Plan pays nothing (unless the Covered Charge is for Preventive Care. See Section 4.8).

a. Hospital services and supplies, as follows:

1. room and board up to the daily average semi-private room rate.

2. routine nursery care of a newborn child.

3. services and supplies provided while an inpatient, excluding charges for private duty nursing. Inpatient admissions must first be precertified by the Plan's medical reviewer to avoid a failure to precertify penalty.

4. Intensive Care Unit or Coronary Care Unit room and board.

5. Prescription drugs dispensed while an inpatient.

6. Hospital emergency room (ER) and ancillary charges (such as lab or x- ray) performed during the emergency room visit for a medical emergency.

7. Gene therapy, as well as any drugs, procedures, or health care services related to the introduction of genetic material into a person, intended for the purpose of replacing or correcting faulty or missing genetic material, as approved by the Food and Drug Administration and determined Medically Necessary. Precertification is required.

b. Anesthesia during performance of a surgical procedure.

c. Whole blood or blood plasma, if not replaced, and the cost of its administration.

d. Autologous blood donation for use by the donor during a scheduled surgery.

e. Professional ambulance service to transport an individual to or from a Hospital or Skilled Nursing Facility where emergency medical treatment is given.

f. Skilled Nursing Facility. Services and supplies, up to seventy (70) days per lifetime, to the extent such would have been payable if the individual had instead been confined in a Hospital; a Physician certifies in writing that in lieu of such services being provided in a Skilled Nursing Facility the individual would have to be confined in a Hospital; and the Physician submits a written treatment plan, but only to the extent received at a PPO Skilled Nursing Facility. Admission to a Skilled Nursing Facility must first be precertified by the Plan's medical reviewer to avoid a failure to precertify penalty.

g. Licensed Ambulatory Surgical Facility. Services and supplies for outpatient surgery.

h. Dental Anesthesia. Medically Necessary outpatient Hospital, surgical, anesthesia services and supplies provided for dental treatment up to $750 per year when the patient has a physical, mental or medically compromising condition that makes anesthesia medically necessary to perform the dental procedure, or the patient is under age 5.

i. 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.

j. Rehabilitation Facility. Inpatient services and supplies, but only to the extent received at a PPO Rehabilitation Facility. Admission to a Rehabilitation Facility must first be precertified by the Plan's medical reviewer to avoid a failure to precertify penalty.

k. Surgery. Services and supplies for the following surgical services:

1. professional surgical services rendered by the operating Physician in the performance of a surgical procedure.

2. professional surgical services rendered by an assistant surgeon, in the performance of a surgical procedure where an assistant surgeon is Medically Necessary, not to exceed 20% of the operating surgeon's benefit allowed by the Plan.

3. professional surgical service rendered by a legally licensed and qualified Physician Assistant, registered nurse (R.N.), or surgical assistant who is acting in the stead of an assistant surgeon (where an assistant surgeon is Medically Necessary) as part of the surgical team not to exceed 10% of the benefit allowed.

4. professional services rendered by an anesthesiologist during performance of a surgical operation.

When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session, through the same incision, the total amount payable shall be for the major procedure, plus 50% of the lesser procedures. When multiple procedures are carried out through separate incisions or on separate sites, the total shall be the value of the major procedure plus 50% of the lesser procedure.

l. Radiologist services and supplies, including X-rays, ultrasounds, catscans, and MRI's.

m. Chemotherapy. Chemotherapy services and supplies to treat malignant conditions and diseases of certain body systems.

n. Laboratory services, testing, and supplies.

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 and telehealth 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.

p. Chiropractic Benefits. Office visits, examinations, manipulations, modalities, and diagnostic X-ray for treatment of spinal maladjustments or subluxation limited to 20 visits per calendar year. See the Summary of Benefits for visit limits. No other benefits are payable for services rendered by a chiropractor.

q. Appliances, Nursing Care and Durable Medical Equipment for the following:

1. rental of a wheelchair, hospital bed and other similar Durable Medical Equipment. When purchase of Durable Medical Equipment would be less expensive than renting, or such equipment is not available for rental, purchase is covered.

2. purchase of a prosthetic device. However, replacement of a prosthetic device is a Covered Charge only if the device is too worn to be repaired or there has been a change in physical condition and the current device is no longer usable.

3. cast, splints, trusses, braces and crutches, and surgical dressings.

4. oxygen and rental of oxygen equipment.

5. services of a registered nurse (R.N.) or licensed practical nurse.

6. Foot-related orthotics.

r. Home Health Care. Services and supplies furnished on a visiting basis in a private residence (not necessarily the residence of such individual) only for the following:

1. services of a home health aide on a part-time or intermittent basis.

2. Rehabilitation Therapies that are Physical, Occupational or Speech Rehabilitation Therapies (all described below under "Therapies"), respiratory or inhalation therapy.

A Home Health Care benefit will be payable only if all of the following conditions are met:

1. a Physician must certify that the individual would require inpatient confinement in a Hospital or Skilled Nursing Facility if Home Health Care were not available.

2. the Home Health Care must be provided according to a plan of treatment ordered by a Physician.

3. the continuing need for Home Health Care must be certified periodically by the attending Physician.

4. the provider of the Home Health Care may not be a person who ordinarily resides with the individual or is a member of the individual's family.

5. the provider of the Home Health Care may not be a person who owns the private residence where the care is provided or who ordinarily resides there.

Home Health Care benefits will not be provided for the following services:

1. a masseur, physical culturist or physical education instructor.

2. routine housekeeping chores.

3. any services rendered to the individual which could have been provided by any other properly trained person of the household without endangering the individual's life or seriously impairing condition.

4. any services or supply that would be excluded if the individual were confined as an inpatient in a Hospital or Skilled Nursing Facility.

s. Hospice Care. Services and supplies for the following:

1. the inpatient confinement of the Terminally Ill Patient. The Plan will not pay for more than a total of eight (8) days of inpatient care for Respite Care.

2. home Hospice Care furnished to the Terminally Ill Patient in a private residence. Covered Charges for home Hospice Care include only the following:

   (a) services of a home health aide.

   (b) professional services of a registered nurse (R.N.).

   (c) Rehabilitation Therapy (physical) and respiratory therapy.

   (d) nutrition counseling and special meals.

   (e) services of a licensed or certified social worker for medical social services rendered during a Hospice Benefit Period not to exceed a maximum of six (6) visits.

(f) Room and board that is furnished by a licensed hospice organization.

No benefits will be paid for Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services.

t. Therapies. Physical, Occupational, and Speech Rehabilitation Therapy services prescribed by a Physician are payable to treat an Illness or Injury when in the judgment of the Physician, significant improvement can be obtained. The Plan does not cover habilitative therapy, that is, therapy to attain a skill or function never learned or acquired, except to treat autism spectrum disorder.

Therapy must be Medically Necessary. Benefits are not payable for therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. When non-therapy treatment is available (whether or not the therapy is prescribed by a Physician, e.g., exercise), therapy is not a Covered Charge.

When prescribed or provided by a Physician, the following types of therapy are covered:

1. Physical Therapy performed by a Physician or a registered physical therapist.

2. Occupational Therapy performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA);

3. Speech Therapy when performed by a qualified speech therapist.

u. Dental Benefits. Services and Supplies for repair to sound, natural teeth (not decayed or extensively restored) as a result of an accidental Injury, so long as the charges are incurred within 6 months of the date of the accident.

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* and *AWP* programs; 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.

w. Organ Transplants. The Plan provides benefits with respect to the following types of organ transplants:

- allogeneic bone marrow/stem cell
- autologous bone marrow/stem cell
- cornea
- heart
- lung
- heart and lung combination
- kidney
- pancreas
- pancreas and kidney combination
- liver
- intestinal which includes small bowel alone or in combination with liver and/or pancreas

1. Transplant services for Covered Individuals (Recipients must be Covered Individuals) are as follows:

   (a) Recipient's medical, surgical and hospital services
   (b) inpatient immunosuppressive medications
   (c) organ or bone marrow/stem cell procurement (explained further below)

2. Travel expenses for donor and recipient to and from the treatment facility (except for cornea transplant): actual reasonable transportation cost; lodging and food up to $200 per day, limited to $10,000 per transplant.

3. Procurement costs related directly to the procurement of an organ/tissue including surgery necessary for organ/tissue removal; organ/tissue transportation; transportation, hospitalization, surgery of a live donor. These donor expenses are paid by the Plan only when the Recipient is a Covered Individual.

4. Certification. Transplant services are not paid by the Plan unless first precertified by the Plan's medical reviewer.

5. Re-certification. For Covered Individuals on a transplant waitlist, regular and ongoing updates and reviews are performed on a case-by-case basis, and must be initiated by the Participant no less than once a year. Benefits and eligibility will also be checked at least once per year.

6. Concurrent Review. Determines whether a continued inpatient stay is Medically Necessary. Such reviews are required for all Covered Individuals during a hospital stay for the actual transplant procedure.

7. Transplant services and facilities. Transplant services must be performed at a PPO Network facility that is a Medicare-approved facility, has a Medicare provider agreement, and the transplant program must comply with all Medicare conditions.

x. Reconstruction Following a Mastectomy. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health & Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy- related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductible and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Administrative Office at (801) 606-2425.

y. Acupuncture Benefits. Charges for acupuncture treatments performed by a licensed acupuncturist. (See the Summary of Benefits for visit limits.) No other benefits are payable for services rendered by an acupuncturist.

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* or *AWP* programs subject to Plan terms.

4.8 Preventive Care. The Plan pays for immunizations recommended by the Centers for Disease Control and other Preventive Care services and supplies based on published guidelines and as required by Health Care Reform. For example, HPV and COVID-19 vaccines are covered in full by the Plan. However, the Plan does not cover Preventive Care services rendered by a non-PPO provider and does not cover Preventive Care supplies received from a non-PPO provider.

In general, preventive care includes, but is not limited, to:

- Well-child visits.
- Routine adult Physicals/Wellness Exam.
- Breast Cancer Screening.
- Cervical Cancer Screening.
- Colon and Rectal Cancer Screening.
- Birth control devices and procedures for women.

This list of covered Preventive Care services and supplies changes from time to time. In addition, the Plan may apply age, frequency, reasonable medical management techniques and other limits in accordance with published guidelines under Health Care Reform. For an up-to date list of Preventive Care services and supplies see https://www.healthcare.gov/preventive-care-benefits/.

Reasonable medical management techniques such as age, location for service and test frequency also apply in determining whether a Preventive Care service or supply is a Covered Charge.

4.9 Concurrent Review. When you are receiving medical services in a Hospital or other inpatient non-Hospital health care facility (for example, a Skilled Nursing Facility, Rehabilitation Facility, Residential Treatment Facility, or Licensed Substance Abuse Treatment Center), the Plan's medical reviewer will monitor your stay by contacting your Physician or other health care providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services in that facility; and/or, advising your Physician or other health care providers of various options and alternatives for your medical care available under this Plan.

If at any point your stay or services are found to NOT be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Physician will be notified. This does not mean that you must leave the Hospital/facility or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility. If it is determined that your admission or services were not Medically Necessary, no benefits will be paid.

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 V. – OUTPATIENT PRESCRIPTION DRUG BENEFITS

5.1 Benefits.

If you need medication, take your doctor's prescription plus your prescription drug card to a pharmacy. If you use a PPO pharmacy you will pay less. You will also pay less if you request a generic drug rather than a brand name drug. For a list of PPO pharmacies near you, call the Pharmacy Benefit Manager identified in the beginning of this booklet in the PPO list.

The Plan's list of preferred drugs changes from time to time and some drugs are not covered by the Plan. In addition, certain drugs require precertification and/or have quantity limits. Contact the Pharmacy Benefit Manager for a complete list of covered drugs and any limitations on coverage (see the PPO list for contact information).

5.2 Prescription Drug Card Retail Program.

a. Participating Pharmacies. Each Participant and Dependent will be issued a prescription drug identification card which must be presented to the participating pharmacy with each prescription to be filled or refilled. The Participant and Dependents must pay, to the PPO Pharmacy, the amount in the Benefit Summary chart at the beginning of this booklet. For a current list of PPO pharmacies, contact the Pharmacy Benefit Manager (identified in the PPO list).

b. Non-Participating Pharmacies. If you go to a non-PPO pharmacy, you will have to pay the full cost for the prescription and file a claim for reimbursement with the Plan's Pharmacy Benefit Manager. See the PPO list at the beginning of this booklet for contact information.

c. Over-the-Counter Drugs. The Plan only pays for over-the-counter drugs that are for Preventive Care for which you have a doctor's prescription and that are obtained using your prescription drug card or by PPO mail order.

5.3 Mail Order Benefits. For prescription drugs you regularly use (such as maintenance medications), you will save money by using the mail order program. Contact the Pharmacy Benefit Manager (see the PPO list) for information on mail order prescription drugs. See the Benefit Summary chart at the beginning of this booklet for the amount you pay when you order prescriptions through the mail order program.

5.4 Specialty Drugs. The Plan only pays for specialty drugs that you obtain from the Plan's Pharmacy Benefit Manager. The list of specialty drugs changes from time-to-time; for a current list of the Plan's specialty drugs contact the Plan's Pharmacy Benefit Manager (see the PPO list for contact information). See the Benefit Summary chart at the beginning of this booklet for the amount you pay for specialty drugs. In addition, the Plan only pays for those specialty drugs that were precertified by the Plan's Pharmacy Benefit Manager

Please note that in situations where patients do not meet criteria for coverage through the Plan, or a medication is not covered by the Plan, the Pharmacy Benefit Manager will actively assist patients to pursue financial assistance through programs made available by pharmaceutical manufacturers or benevolence organizations.

5.5 **Precertification.** Precertification also applies to certain other medications, such as oral and topical pain medications, androgen replacement, CNS stimulants, topical and oral dermatological agents, weight loss medications, and medications used for chemical dependency and miscellaneous agents. For a current list of drugs that require precertification contact the Plan's Pharmacy Benefit Manager (see the PPO list for contact information).

5.6 **Step Therapy.** The Plan's Pharmacy Benefit Manager also sometimes requires the use of a more cost-effective drug (Step 1) prior to the approval of a less cost-effect brand name medication (Step 2). Drugs that qualify for step therapy are often high priced and largely advertised. Medication classes that are subject to step therapy may include cholesterol-lowering statins, ARB antihypertensives, migraine medications, Proton Pump Inhibitors, and more. For a current list of drugs that require step therapy, contact the Plan's Pharmacy Benefit Manager (see the PPO list for contact information).

5.7 **Mandatory Generic Program.** 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.

5.8 **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 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.

5.9 **Covered Charges for Prescription Drugs.**

a. Legend Drugs that are in the Pharmacy Benefit Manager's list of covered outpatient prescription drugs.

b. Insulin.

c. Disposable needles/syringes.

d. Disposable blood/urine glucose/acetone testing agents, (e.g., Chemstrips, Clinitest tablets, Diastix Strips, and Tes-Tape).

e. Lancets.

f. Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber.

g. Growth hormones subject to precertification and approval as medically necessary.

h. Preventive Care birth control drugs and supplies.

5.10 **Exclusions.** In addition to the General Exclusions and Limitations in Article IX, outpatient prescription drug benefits are not payable for:

a. drugs or medications procured or procurable without a Physician's written prescription (over-the-counter).

b. immunization agents, blood or blood plasma.

c. hair growth stimulants.

d. non-Legend drugs.

e. therapeutic devices, appliances or supplies, support garments, appliances, prosthetics, bandages, heat lamps, braces, splints, other non-drug items and over-the-counter items, regardless of intended use.

f. anorectics, and any drug used for the purpose of weight loss, except as required by law.

g. anti-wrinkle agents (e.g., Renova, Retin A).

h. drugs labeled: "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the Participant or Dependent.

i. charges for the administration or injection of any drug.

j. medication which is to be taken by or administered to the Participant or Dependent, in whole or in part, while confined on an inpatient or outpatient basis in any facility or institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

k. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the original order of a Physician.

l. prescription drugs which may be properly received without charge under local, state, or federal programs including Worker's Compensation.

m. infertility or fertility medications (e.g., Antagon, Lutrepulse, Profasi, Pregnyl, Follistim, Gonal-F, Fertinex, Pergonal, Clomid, Serophene).

n. smoking deterrent or medications to treat nicotine addiction or any other smoking cessation aids, all dosage forms, except to the extent such drugs or medications are considered Preventive Care.

o. impotence medications (e.g., Viagra, Cialis, Levitra, Edex, Cverject, Muse).

p. Tretinoin, all dosage forms (e.g., Retin-A), for individuals age 20 or older.

q. cosmetic products, including hair enhancement or removal products (e.g., Vaniga, Renova, Minoxidil).

r. blood monitoring units.

s. Vitamins and minerals (except as required by the Affordable Care Act).

t. anabolic steroids or other athletic enhancement drugs.

u. drugs that are illegal or purchased in a foreign country.

v. drugs not approved for marketing or for the prescribed use by the FDA.

ARTICLE VI. – HEARING AID BENEFIT

6.1 **Hearing Aid Benefit: Device.** The Plan will pay benefits for the cost of hearing aid devices and the fitting thereof for Participants up to the maximum benefit identified in the Summary of Benefits, and subject to the other limitations described in this booklet.

6.2 **Hearing Aid Benefit: Audiogram.** The Plan will pay for a comprehensive audiogram, up to the maximum benefit identified in the Summary of Benefits.

6.3 **Provider Limitation.** The Plan will pay benefits for hearing aid devices purchased from, and an audiogram administered by, a network Hearing Aid Benefit Provider. Contact Epic Hearing Healthcare to obtain a list of network Hearing Aid benefit providers near you.

6.4 **Coverage Limitation.** Dependents (spouses and children) are ineligible for hearing aid benefits.

6.5 **Exclusions.** The General Exclusions and Limitations in Article IX apply to hearing aid benefits.

ARTICLE VII. – VISION CARE BENEFITS

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 7.3 and 7.4 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.

7.2 **Schedule of Allowances.**

a. Examination

	Calendar Year Maximum Benefit
With or without tonometry	$50
Vision survey	$22.50
Covered Individuals under age 19	No maximum dollar amount for Preventive Care

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

c. Eye Surgery Procedures (Participants and their spouses only)

Benefits are payable for the following procedures (up to the following lifetime maximums) per Participant and spouse when medically necessary to correct moderate, severe, and extreme degrees of myopia or hyperopia:

Radial Keratotomy (RK), per eye	$1,400
Photorefractive Radial Keratotomy (PKR), per eye	$1,400
LASIK (in-site Keratomileusis) surgery, per eye	$2,000

7.3 **Availability of Benefits.** An eye examination, lenses, and frames are available to each Covered Individual once each calendar year. Eye surgery procedures are available up to the lifetime maximums described in section 7.2, c, above.

7.4 **Exclusions and Limitations.** In addition to the General Exclusions and Limitations in Article IX, vision care benefits are not payable for:

a. contact lenses (except as noted above);

b. subnormal vision aids;

c. aniseikonic lenses;

d. coated lenses;

e. no line bifocals (blended type);

f. two (2) pairs of glasses in lieu of bifocals;

g. tinted lenses;

h. photochromatic lenses;

i. sunglasses;

j. any lenses that do not require a prescription;

k. oversized lenses;

l. replacement or repair of lost or broken lenses or frames, except at the normal intervals when services are otherwise available;

m. medical or surgical treatment of the eyes, except as specifically provided for in section 7.2, c. and section 7.3; and

n. orthoptics, eye therapy, vision training, or other vision treatment.

ARTICLE VIII. – DENTAL BENEFITS

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. Members of Locals 24 are not eligible for dental benefits. You may decline dental benefits by notifying the Administrative Office, in writing, that you wish to opt out.

8.2 **Deductible and Out-of-Pocket Maximum.** The dental Deductible is the amount of covered dental services which first must be incurred during each calendar year before benefits are payable. The Deductible amount is at the Summary of Benefits chart at the beginning of this booklet. The Deductible applies to all covered dental services. The dental Deductible paid for pediatric (under age 19) services and supplies will count towards the medical and pediatric dental out-of-pocket maximum. See the Summary of Benefits chart for the amount of the maximum and additional restrictions.

8.3 **Maximum Dental Benefit.** The maximum dental benefit payable for any individual, after the dental Deductible has been satisfied, is at the Summary of Benefits chart. Benefits are payable at 100% up to the calendar year maximum (if applicable) of the Allowable Fee.

8.4 **Covered Dental Services.** The Plan covers only the following dental services and supplies, delivered by a Dentist:

a. Diagnostic and Routine Services and Supplies.

1. Complete mouth X-rays are covered once in a three year period.

2. Bite-wing X-rays are covered twice per calendar year.

3. Oral examinations and prophylaxis are covered twice per calendar year.

4. Topical fluoride application is allowed for children under age 19, once each calendar year.

5. Periodontal maintenance is covered four times per calendar year. Combined periodontal maintenance and prophylaxis (item 3. above) is covered a maximum four times per calendar year.

b. Basic Services.

1. Restorative – Provides the necessary procedures to restore the teeth, other than cast restoration.

2. Oral Surgery – Provides the necessary procedures for extractions and other oral surgery including pre- and post-operative care.

3. Endodontics – Provides the necessary procedures for pulpal and root canal therapy.

4. Periodontics – Provides the necessary procedures for treatment of the tissues supporting the teeth.

5. Sealants for permanent molars--for individuals younger than age 19 are covered once every 36 months.

c. Major Services.

1. Prosthodontics – Provides the necessary procedures associated with the construction, placement, or repair of fixed bridges, partial and complete dentures.

2. Cast Restorations – Provides for gold restorations, crowns and jackets when teeth cannot be restored with other materials.

d. Limitations (Major Services).

1. Appliances for the replacement of the same natural teeth are covered only once in a five (5) year period.

2. Replacement of an existing prosthetic appliance is covered only if the appliance is unsatisfactory and cannot be made satisfactory.

3. Temporary partial dentures are covered only when anterior teeth are missing.

4. Specialized techniques, precision attachments, personalization, and characterizations are not covered dental services.

5. Fixed bridges and/or cast partials are not covered for children under age sixteen (16).

6. A posterior fixed bridge is not a covered dental service when done in connection with a removable appliance in the same arch.

7. Porcelain, gold, porcelain veneer, and acrylic veneer precious metal crowns over vital teeth and implants are not covered dental services for children under age twelve (12).

8.5 **Exclusions.** In addition to the General Exclusions in Article IX, dental benefits are not payable for:

a. charges for general anesthesia except when administered by a dentist in association with oral surgery and except as provided under medical benefits (up to $750 annually);

b. charges for prescription drugs (see the prescription drug plan);

c. charges for hospitalization, including Hospital visits;

d. charges for completion of forms;

e. charges for lost or stolen appliances;

f. correction of congenital, developmental, or acquired malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate.

g. treatment for the disturbances of the temporomandibular joint (TMJ) (see the medical plan for TMJ benefits)

h. procedures necessary to alter or correct occlusion or vertical dimension, or restoration of tooth structure lost through attrition;

i. analgesics and sedation (including intravenous sedation and nitrous oxide);

j. hypnosis;

k. pre-medication;

l. treatment for cosmetic reasons;

m. plaque control programs;

n. photographs of teeth, gums, or oral cavities;

o. study models or molds;

p. infection control procedures;

q. mouth guards;

r. orthodontics;

s. inlays; and

t. replacement of amalgams or composites within 18 months of initial restoration.

ARTICLE IX. – GENERAL EXCLUSIONS AND LIMITATIONS

9.1 General Health Plan Exclusions and Limitations.

Because the Plan has limited funding, it cannot cover all of your health care needs. If a service or supply is not a Covered Charge, then it won't apply toward your Deductible or Coinsurance medical benefit maximum, even if the treatment is Medically Necessary.

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.

a. any services or supplies not specifically identified as a Covered Charge.

b. services or supplies for which coverage is available or furnished under any federal, state, or government program, or while incarcerated, except as required by law.

c. unless specifically provided otherwise, no benefits are payable for any charge under more than one (1) coverage.

d. charges for which the individual is not obligated to pay, is not billed or would not have been billed except for the fact that the individual was covered under this Plan, except for care rendered in a Veterans Administration Hospital for a non- service connected disability.

e. charges submitted to the Plan more than 12 months after the service was rendered or supply was dispensed.

f. services or supplies that are not provided for the treatment or diagnosis of a bodily Injury or Illness, and services or supplies that are not prescribed by, or provided at the direction of, a Physician.

g. charges resulting from, in connection with, arising out of, or occurring in the course of, any work, employment, or activity for wages, compensation or profit.

h. Injury or Illness resulting from military service, any act of war, armed invasion or aggression, insurrection, rebellion, riot, or military service (except as required by law).

i. Injury or Illness resulting from any release of nuclear energy, except only when being used solely for medical treatment of a bodily Injury or Illness under the direction and prescription of a Physician.

j. Injury or Illness resulting from or arising out of the Covered Individual's 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.

k. expenses for learning deficiencies, behavioral problems, and education.

l. Vocational Rehabilitation.

m. orthopedic shoes, or supportive devices for feet such as arch supports, heel lifts, callous or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat pronated foot metatarsalgia, hallux valgus, foot strain, except removing nail roots and care prescribed by a Physician treating metabolic or peripheral vascular disease.

n. services or supplies to diagnose or treat infertility or assist in fertility or conception or to reverse surgically induced infertility, in-vitro fertilization, sexual impotency, genetic studies, family planning, and elective abortions, except the Plan will cover tubal ligation and vasectomy procedures.

o. humidifiers, air conditioners, exercise equipment, or whirlpools, health spas, and swimming pools, or air filtration units, vaporizers or humidifiers, heating lamps or pads, blood pressure monitors or machines.

p. charges incurred for services rendered or supplies delivered prior to the individual's effective date of coverage or after coverage ends.

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.

r. diagnosis or treatment of sexual addictions, sexual or psychosexual dysfunctions, paraphilic disorders, or any other similar disorders or conditions of a sexual nature, including any complications arising therefrom.

s. services rendered by an individual that ordinarily resides in the patient's home or who is a member of the patient's immediate family.

t. reduction of weight, regardless of adjunctive, medical or psychological condition, gastric or intestinal bypass, gastric stapling or other similar surgical procedure, services or supplies to treat obesity, or physical fitness programs, except to the extent such services or supplies are considered Preventive Care.

u. supplies for special formulas, food supplements, special diets, laetrile, and enzymes.

v. Biofeedback.

w. nutrition counseling, except as specifically provided herein under hospice care.

x. hair loss or restoration.

y. educational material, literature, or charges related to scholastic education, vocational training, learning disabilities, or behavior modification, or for dealing with normal living such as diet, or medication management for Illness.

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* or *AWP* programs.

aa. Physician's Hospital visits following surgery, except for a separate Illness unrelated to the surgery.

bb. foreign travel immunizations.

cc. motor vehicles, motor vehicle devices such as hand controls, lifts or specialized vehicle alterations.

dd. wheelchair ramps, handrails or other specialized construction in or around the home; commode, bath bench, or other convenience items for activities of daily living; batteries or routine maintenance of equipment or repair of wheelchair upholstery.

ee. prescription drugs not dispensed while an inpatient or outpatient (see also the outpatient prescription drug benefit (Article V)).

ff. smoking cessation or nicotine addiction services, supplies, drugs and/or devices, except to the extent such services or supplies are considered Preventive Care.

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.

hh. services and supplies to treat eating disorders such as bulimia and anorexia, and diet aids.

ii. personal convenience and/or hygiene items, radio, television, and the like.

jj. services or supplies provided by any camp, public or private school, or halfway house, or by employees thereof, or provided solely to satisfy institutional or legal requirements.

kk. charges for missed appointments, concierge fees, insurance.

ll. inpatient care and treatment when it was not Medically Necessary to obtain such care and treatment on an inpatient basis.

mm. any surcharges as a result of state laws (e.g., New York Health Care Reform Act).

nn. any charges incurred through Medicare private contracting arrangements.

oo. genetic testing except as required by Health Care Reform.

pp. Services or supplies which are experimental or investigative. A service or supply is experimental or investigative if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.

qq. charges payable under any other program, plan or insurance or recoverable from a third party (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.

rr. charges that would have been paid or reimbursed by automobile insurance for health expenses, in the greater of the following amounts: (1) the amount of such insurance that the Participant or Dependent did not purchase, but which state law requires be purchased; or (2) the amount of such insurance that the Participant or Dependent did not purchase, but which is the minimum amount that state law requires insurance brokers/agents offer.

ss. charges for services or supplies incurred outside of the U.S.A and any transportation originating or ending outside of the U.S.A.,, except when Medically Necessary to treat an Emergency.

tt. cosmetic services or supplies.

uu. court-ordered services or supplies.

vv. services or supplies that are not Medically Necessary or for Preventive Care, that exceed the Allowable Fee, are in excess of the maximum benefits provided by the Plan, or that were incurred before or after the individual's effective date of coverage under the Plan.

ww. therapies that are habilitative or habilitation therapies, that is, therapies to help an individual gain a skill or function never attained or acquired, except when medically necessary to treat autism spectrum disorder.

xx. the following therapies: hypnotism, carbon dioxide therapy, primal therapy, rolfing, bioenergetic therapy, vision perception training, cranial sacral therapy.

yy. Services or supplies delivered by or under the supervision of a non-Physician or non-Physician's Assistant, such as a naturopath or homeopath.

zz. Services or supplies to treat pervasive developmental disorder, developmental delay, encephalopathy and other similar disorders, with the exception of autism spectrum disorder.

aaa. Services or supplies an employer is required to provide under a labor agreement or that are a condition of employment.

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 X. – COORDINATION OF BENEFITS

If you are covered by another health plan, let the Administrative Office know. The Plan will then coordinate benefits, which usually results in you paying for less of your health expenses. You can never receive more from your health plans than you are charged by your doctor and other providers.

Many people enroll in more than one health care plan in order to protect themselves against the high costs of medical or dental care. To keep the cost of Plan benefits as low as possible, the Plan coordinates benefit payments with other health care plans, automobile insurance, Medicare, and other governmental plans, and in situations where a person has dual coverage under the Plan.

If you or your Dependents are covered under another health plan, Medicare, or other governmental plan, you must submit identical itemized bills to both plans. Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) pays after the primary plan and may reduce the benefits it pays so that the payments from all plans do not exceed 100% of the total allowable expenses. An "allowable expense" is a health care expense covered by this plan, including Copays, Coinsurance and Deductibles. Sometimes the combined benefits that are paid will be less than total allowable expenses.

Effect on Plan Benefits

When the Plan is primary, it pays its regular benefits in full. When the other plan is primary, the Plan pays a reduced amount.

If your primary plan reduced benefits because you did not use a primary plan preferred provider or you did not comply with the primary plan's provisions, such as precertification requirements, the Plan will not pay those reductions.

In no event will the Plan reimburse an expense that is or should be covered by another plan, government program, insurance, or other source.

If you have dual coverage under the Plan (for example, because you are a Participant and you are married to another Participant), the Plan will coordinate benefits—Participant coverage is primary and dependent coverage is secondary.

To administer coordination of benefits, the Plan has the right to: exchange information with other plans involved in paying claims; require that you, your Physician, or your health care provider furnish information; reimburse any plan that made payments the Plan should have made; and recover overpayments.

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.

- If the other plan does not have a coordination of benefits provision, or if it has a coordination of benefits provision different from these rules, that plan is primary.

- If a person is covered by a plan as a dependent and by another plan other than as a dependent (for example, as an employee, member, subscriber, policyholder, or retiree), the plan covering the person other than as a dependent is primary.

However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person other than as a dependent, then the order of benefits between the two plans is reversed (so that the plan covering the person as a dependent is primary and the plan covering the person other than as a dependent is secondary).

- If a child is covered under more than one plan and a court decree provides that one plan shall be primary, that plan is primary.

- For a child of parents who are married or living together, whether or not they have ever been married, the "birthday rule" applies: the plan of the parent whose birthday comes first in the calendar year is primary (unless the parents' birthdays are the same, in which case the plan of the parent that has provided coverage to that parent for the longer period is primary).

- For a child of parents who are divorced or legally separated or are not living together, whether or not they have ever been married, the following rules apply:

  – If a court decree states that *one* of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the child's health care expenses, but that parent's spouse does, the spouse's plan is primary.

  – If a court decree states that *both* of the parents are responsible for the child's health care expenses or coverage, or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the child's health care expenses or coverage, then the birthday rule applies.

  – If there is no court decree allocating responsibility for the child's health care expenses or coverage, benefit payments are made in the following order by the plan covering:

    - The custodial parent;
    - The custodial parent's spouse;
    - The non-custodial parent; and then
    - The non-custodial parent's spouse.

  The "custodial parent" means the parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than one-half of the calendar year without regard to any temporary visitation.

- For a child covered under more than one plan of individuals who are not the child's parents,

  the order of benefits shall be determined, as applicable, under the birthday rule or the above rule for children of parents who are divorced or separated or are not living together, as if those individuals were the child's parents.

- A plan covering a person as an active employee (that is, an employee who is neither laid-off nor retired and, if the plan is a multiemployer plan, for whom employer contributions are being made to the plan) or as a dependent of an active employee is primary over a plan covering the person as other than an active employee or as a dependent of a person other than an active employee.

- If a person has COBRA or other continuation coverage pursuant to state or other federal law and is covered by another plan, the plan providing continuation coverage is secondary to the plan covering the person as an employee, member, subscriber or retiree (or as a dependent of an employee, member, subscriber or retiree).

- The plan that has covered the person for the longer period of time is primary.

- Whenever the Plan pays on a secondary basis, the difference between the amount the Plan actually paid as secondary versus the amount the Plan would have paid if primary is considered a credit. The credit can be used for unpaid covered expenses on future claims involving coordination with other health plans but only when the Plan pays secondary.

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.

If You Are Eligible for Medicare

Medicare is a health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD). When you or your spouse reaches age 65, Medicare Part A (hospital insurance) is generally automatic if you apply for Social Security benefits. Medicare Part B (medical insurance) requires enrollment and monthly premium payments. Contact your local Social Security Administration Office for information about enrolling in Medicare.

The Plan follows federal law to determine whether the Plan is a primary or secondary payer to Medicare. When the Plan is secondary, the Plan pays claims as if you had enrolled in Medicare Parts A, B and D—that is, even if you or a Dependent do not enroll in and utilize Medicare when eligible, benefits payable under the Plan will be reduced by the amount Medicare would have paid if you had enrolled. In addition, if the Plan pays primary and you enroll in Part D, the Plan won't pay for your prescription drug coverage.

In general, Medicare is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over), and you are *not* an Active Employee, or

- You or your Dependent are entitled to Medicare on the basis of a disability, and you are *not* an Active Employee.

This Plan is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over) and you are an Active Employee, or

- Your Dependent is entitled to Medicare on the basis of a disability, and you are an Active Employee, or

- You or your Dependent become eligible for Medicare as a result of having end-stage renal disease (ESRD). After 30 months, Medicare becomes primary.

For these purposes, COBRA qualified beneficiaries and individuals enrolled in Retiree coverage and their Dependents are not considered to be enrolled in Active Employee coverage.

For more information on whether the Plan pays primary or secondary to Medicare, see https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer

Coordination With Medicaid, TRICARE & Other Coverage Provided By Law

This Plan is always primary to Medicaid, TRICARE, and any other coverage provided by any other state or federal law that requires the Plan pay primary.

However, if you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related condition, benefits are not payable by the Plan. If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of any illness or injury that is *not* a military service-related condition, benefits are payable only to the extent those services are otherwise covered by the Plan.

Notifying the Plan of Other Coverage

It is your responsibility to notify the Administrative Office if you or your Dependents have coverage other than Plan coverage, or if your other coverage terminates. Failure to provide this notice may result in loss of your Plan benefits. In addition, you will be required to fully reimburse the Plan for any claims paid in excess of the amount that should have been paid under the Plan.

By participating in the Plan, you agree that if the Plan pays primary and later determines that it is the secondary plan, the Plan will be subrogated to all the rights you may have against the other plan, and you agree to execute any documents required or requested by the Plan to pursue its claims for reimbursement of the amount advanced.

ARTICLE XI. – PLAN'S RIGHTS TO RECOVERY, SUBROGATION AND REIMBURSEMENT

The Plan's Rights to Recovery

Payment is made for claims based upon your representations and those of your covered family members and/or providers concerning the services rendered and is contingent upon benefits being covered under the terms of the Plan.

By accepting benefits, you and your covered family members agree:

- to promptly refund to the Plan any amount that exceeds the amount covered by the Plan or any amount that is subject to the Plan's subrogation or reimbursement rights, discussed in the following section,

- that the Plan may reduce or deny coverage of your claims or the claims of your covered family members as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and

- to reimburse the Plan in full for any benefits from the Plan to which the individual is later found not to be entitled.

The Plan may also recover interest on the amounts paid by the Plan from the time of the payment until the time the Plan is reimbursed.

Furthermore, whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan will be authorized to pay such benefits to the other party. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you. An individual who receives benefits from the Plan to which they are later found not to be entitled will be required to reimburse the Plan in full.

The Plan's Subrogation and Reimbursement Rights

The Plan does not cover any health expenses for an Injury or Illness if 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, the Plan may refuse to pay any health expenses. 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 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 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 on 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 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 source.

- Any payment made by your insurance or a third party's insurance, including vehicle insurance, no-fault automobile insurance, uninsured or underinsured motorist coverage, business insurance, homeowner's insurance, personal umbrella insurance, or any other 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 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.

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; and to your (or their) estates or heirs in the event of death.

- 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; 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, 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 you agree not to raise any contrary claims in any action impacting the Plan's subrogation or reimbursement rights.

Article XII. – General Provisions

12.1 **Assignment of Benefits.** Benefits payable hereunder or any other rights under the Plan shall not be subject in any manner to anticipation, alienation, sale transfer, assignment, pledge, encumbrance or charge by any person; however, the Plan will pay benefits directly to the legal guardian of a covered person. The Plan may, but is not required to, pay benefits or provide Plan documents directly to a provider who provided Services or Supplies to a covered person; however, any such payment or provision of Plan documents will be done as a convenience and will not constitute an assignment of health benefits under the Plan. Any payment in accordance with the provisions of the Plan shall discharge the obligation of the Fund hereunder.

12.2 **Discretion of the Board of Trustees.** The Board of Trustees has the sole, exclusive, and discretionary authority and control to make any and all determinations under the Plan, including eligibility for benefits, amount of benefits payable, the interpretation and meaning of Plan documents, the Trust Agreement, Plan policies and rules, and factual determinations, except as follows. The Board may delegate its discretionary authority and control to third parties other than the Board to carry out its responsibilities under the Plan to the extent permitted by ERISA. This includes delegating ministerial and discretionary authority and control for the administration of eligibility, enrollment, and benefit claims and appeals to third parties serving as Claims Administrators and Claims Fiduciaries to the Plan. The Plan Administrative Office is the only party authorized by the Board of Trustees to answer questions about the Trust and the Plan. No Trustee, Employer, employer association, or labor organization, nor any of their employees or representatives, has any authority in this regard. The Trustees reserve the right to change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

The terms of the Plan govern over oral or other written communications (including electronic communications) concerning the Plan. The Plan is not bound by any oral or written communication that conflicts with Plan documents.

Decisions of the Board of Trustees, or their delegates, shall be final and binding. For insured benefits, the applicable carrier has authority to interpret and decide the terms of benefits provided under the insurance contract.

12.3 **Right of Examination.** The Fund, at its own expense, shall have the right and opportunity to hire a physician to examine an individual when and so often as it may reasonably require to determine the legitimacy of a claim involving that individual.

12.4 **Trust Agreement.** The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

12.5 **Amendment and Termination.** The Board of Trustees may exercise its discretionary authority, at any time and from time to time, to:

a. terminate, change, or amend either the amount or the conditions with respect to any benefit;

b. alter or postpone the method of payment of any benefit;

c. change the eligibility rules of the Plan or eliminate coverage for any class of persons, including retired persons;

d. determine the amount of the required contribution by the Participant;

e. change the providers for any portion of the plan of benefits; or

f. terminate the Plan in its entirety or in part.

12.6 **Payment of Benefits.** None of the benefits provided in this Plan Document are guaranteed by the Board of Trustees, any Contributing Employer, Union or any other individual or entity. The Board has, however, purchased certain insurance policies, which are held by the Trust. Plan benefits are paid from amounts in the Fund and from insurance.

12.7 **Titles.** Titles of provisions are for convenience of reference only and are not to be considered in interpreting this Plan.

12.8 **Attorney's Fees.** The covered person and the health care provider shall be liable for the Plan's collections costs, including court costs, witness fees, and reasonable attorneys' fees, if after demand for payment by the Fund, the individual or health care provider fails to pay to the Fund any excess payments paid by the Fund resulting from claims payment made in error or fails to pay any money due the Fund under Article XI.

12.9 **No Vested Rights.** No person shall have any vested right to any current or future benefit provided by this Plan, whether funded by the Trust or insured. In addition, the Trustees may, at any time, discontinue your right to benefits or to participate in the Plan.

12.10 **Submission of Falsified or Fraudulent Claims.** All claims submitted to the Fund shall be honest, accurate and complete. If an intentionally false or fraudulent claim is submitted with an individual's knowledge or consent, that individual's coverage under the Plan will terminate. If the coverage terminated is that of a Participant, then the coverage of that Participant's Dependents shall also terminate. Termination of coverage under this section is not a COBRA qualifying event and forever eliminates all rights to Self-Pay coverage. In addition, an individual's Plan coverage may be retroactively terminated if the individual (or a person seeking coverage on that individual's behalf) performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact. If the individual's coverage is retroactively terminated, the individual is responsible for reimbursing the Plan for any overpaid benefits.

12.11 **Non-Reversion of Employer Funds; Mistaken Payments.** Plan assets shall not revert to the Contributing Employers or Participants or be subject to any claims of any kind or nature by the Contributing Employers or Participants, except for benefits payable under the Plan. However, if contributions made by a Contributing Employer by mistake of fact or law have not been used to provide health care coverage to an individual, the Contributing Employer may, within six (6) months after the Plan Administrator determines that the contribution was made by such a mistake, request they be returned.

12.12 **Disclosure of Protected Health Information (PHI) to the Board of Trustees.** Unless otherwise permitted by law, the Plan may disclose protected health information ("PHI"), including electronic PHI, to the Board of Trustees (as Plan sponsor) only if the information is exempt information, or if the disclosure is for plan administration functions.

a. Definitions. The following terms, as used in this section, shall have the meanings given below:

1. "Protected health information" or "PHI" means information that is created or received by the Plan that identifies a living or deceased individual, or for which there is a reasonable basis to believe the information can be used to identify the individual, and which relates to: the past, present, or future physical or mental health or condition of the individual; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual.

2. "Electronic PHI" means PHI that is transmitted or maintained in electronic media.

3. "Exempt information" means: (a) summary health information, if requested for purposes of obtaining premium bids or modifying amending, or terminating the Plan; (b) information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from health insurance offered by the Plan; and (c) PHI that may be disclosed pursuant to an authorization that satisfies the applicable requirements of 45 C.F.R. § 164.508.

4. "Summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals provided health benefits under the Plan, and from which information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

5. "Plan administration functions" are administration functions performed by the Board of Trustees on behalf of the Plan (such as quality assurance, claims appeals, auditing and monitoring), and exclude functions performed by the Board of Trustees in connection with any other benefit or benefit plan of the Board of Trustees.

6. "Security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

b. Certification by Board of Trustees. With respect to PHI and electronic PHI (other than exempt information, which is not subject to this subsection) that it creates, receives, maintains or transmits while performing plan administration functions, the Board of Trustees certifies that it will:

1. not use or further disclose PHI other than as permitted or required by this section or as required by law;

2. ensure that any agents, including a subcontractor, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI, and agree to implement reasonable and appropriate security measures to protect any electronic PHI received from the Board of Trustees;

3. not use or disclose PHI for employment-related actions and decisions;

4. not use or disclose PHI in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees;

5. report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware, and report to the Plan any security incident of which it becomes aware;

6. make PHI available for purposes of the access, amendment, and accounting of disclosures provisions in 45 C.F.R. §§ 164.524-528, and incorporate any amendments to PHI;

7. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with 45 C.F.R. Part 164;

8. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

9. ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) between the Plan and Board of Trustees (the "firewall") is established, and ensure that such adequate separation is supported by reasonable and appropriate security measures; and

10. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI.

c. Firewall. The members of the Board of Trustees shall have access to PHI (other than exempt information, which is not subject to this subsection) only to the extent necessary to perform plan administration functions, or as otherwise permitted by law. If any member of the Board of Trustees does not comply with the requirements of this section, that Trustee may be subject to removal under Article III of the Trust Agreement.

d. Hybrid entity designation. To the extent the Plan qualifies as a "hybrid entity" under 45 C.F.R. § 164.103, only its health care components are subject to this section. The Plan designates as its "health care components" all benefits provided by the Plan except for accident and sickness weekly benefits, life insurance benefits, and accidental death and dismemberment benefits.

12.13 Provider and Clinical Trial Nondiscrimination. The Plan will comply with applicable law on clinical trial and provider nondiscrimination. These rules are subject to reasonable medical management techniques, such as frequency, method, treatment, or setting for an item or service. Contact the Administrative Office for additional information.

12.14 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.

12.15 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. If you need communication or language assistance services, please call (888) 867-9510.

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.

EXHIBIT A – HEALTH REIMBURSEMENT ARRANGEMENTS

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. 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. The Tax Code requires the Plan to substantiate payments from your HRA as a reimbursable medical care expense under Code Section 213(d). If you use your debit card and afterwards your purchase cannot be substantiated, you will be asked to provide additional information, such as an itemized receipt, invoice, prescription, affidavit, and/or other documentation. If you do not provide sufficient information within the time period requested you will receive a Form 1099 reflecting the amount of the expense, which you must report on your Form 1040 as taxable income. You should always save an itemized receipt of your debit card purchases—cash register receipts without detail will not be sufficient.

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 12 months 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.

EXHIBIT B – VACATION PLAN OF UTAH

You are eligible for benefits from the Plan's Vacation Plan of Utah ("Vacation Plan") if your employer has contributed to the Vacation Plan, according to a collective bargaining or other Written Agreement. The Vacation Plan is established, maintained and operated under, and subject to all of the terms and conditions of, the Ironworkers Intermountain Health & Welfare Plan ("Plan").

1. **Amount.** Your Vacation Plan benefit is the amount of employer contributions actually made to the Plan toward your Vacation benefits, less Vacation benefits that have already been sent to you and less administrative expenses.

2. **No Credit for Reciprocal Contributions.** Vacation benefits are not credited when the Plan receives reciprocal contributions for your work in other jurisdictions, and employer contributions toward your Vacation benefits are not reciprocated to other plans.

3. **Administrative Expenses.** An administrative fee of 2% will be taken from each distribution made after October 2024. The administrative fee may be adjusted in the future.

4. **Benefit Payment Timing.** Your Vacation benefit will be automatically paid to you each November. If you have signed up for ACH, it will be deposited into your bank account. Otherwise, a check will be sent to your address on record with the Plan. The Vacation Plan does not permit interim distributions, and hardship distributions are unavailable.

5. **Death.** If you die, your Vacation benefit will be paid to your spouse. If you are not legally married when you die, your Vacation benefit will be paid to your estate. If you do not have an estate, your Vacation benefit may be paid in accordance with a small estate affidavit. Any death beneficiary forms you may have previously filed are ineffective, null and void if you die after October 31, 2024. Your death beneficiary should submit a claim for benefits soon after your death.

6. **Payment failure and escheat.** In the following circumstances, your Vacation Plan benefit will be escheated to the State of Utah: your Vacation benefit check is not cashed and you cannot be located; the Administrative Office has no address on file for you and you cannot be located; or no person claims your benefit following your death. If your benefit is escheated, you may still be able to obtain it from the state of Utah. Go to mycash.utah.gov for more information.

7. **Assignment Prohibited.** Participants may not assign, pledge or transfer their Vacation Plan benefits, and they may not be transferred to a spouse or former spouse, or other family member.

OTHER INFORMATION ABOUT THE PLAN

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

Name: The Ironworkers Intermountain Health & Welfare Plan.

Type: The Fund is a collectively bargained, joint-trusteed, labor management trust.

IDENTIFICATION NUMBERS

Employer Identification No. 87-6123188. The plan number is 501.

TYPE OF PLAN

The Plan provides certain hospitalization, medical, prescription drug, vision, dental, AD&D, life insurance, and accident and sickness weekly benefits, to participants and beneficiaries, as described in this Plan and SPD.

This document serves as both the written Plan document and the summary plan description required under ERISA.

SOURCE OF FUNDING OF PLAN BENEFITS AND METHOD OF ADMINISTRATION

The Plan is funded through Employer contributions as specified in collective bargaining agreements and participation agreements. Self-Payments by participants are also permitted, as described herein. The amount of Self-Payments is fixed from time to time by the Board of Trustees.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying administrative expenses. All of the benefits provided by the Plan are set forth in this Plan and certain insurance company booklets. Some benefits are provided directly under a group insurance policy or contract with an insurance company ("insured benefits"), and some benefits are funded by the Trust. (Details about insured benefits are contained in separate booklets.) For each type of benefit, the following chart states how the benefit is funded. The Claims Administrator and the Claims Fiduciary (and the contact information for each) is listed in the claims procedure section of the Plan.

Benefit Type	Source of Benefits and Type of Funding
Medical, Dental, Vision Care, Disability (i.e., Accident and Sickness Weekly Benefits), Hearing Aid, Outpatient Drug	Funded by the Trust
Life Insurance and Accidental Death & Dismemberment Insurance	Insured by United Healthcare
Vacation Plan	Funded by the Trust

In addition, the Trust owns stop loss coverage.

NAME AND ADDRESS OF THE PERSON DESIGNATED AS THE AGENT FOR SERVICE OF LEGAL PROCESS

For the uninsured benefits:

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

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.

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, BeneSys, Inc., to perform the routine administration of the Plan. Both the Board of Trustees and BeneSys, Inc., can be reached at:

BeneSys, Inc.
P.O. Box 30580
Salt Lake City, Utah 84130-0580

5295 S. Commerce Dr., Suite 220
Salt Lake City, UT 84107

Phone (801) 904-4897
Toll free (888) 867-9510

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.

Name and Address of Trustees

All Trustees may be reached through the Administrative Office:

BeneSys, Inc.
P.O. Box 30580
Salt Lake City, Utah 84130-0580

5295 S. Commerce Dr., Suite 220
Salt Lake City, UT 84107

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

ELIGIBILITY AND BENEFITS

Only the Board of Trustees or personnel of the Administrative Office, as authorized by the Board of Trustees, are allowed to respond to questions regarding eligibility or benefits. No one member of the Board of Trustees speaks officially for the entire Board, and all communication regarding benefits and eligibility is in writing.

SPONSORS OF THE PLAN

The Administrative Office will provide you, upon written request, with information as whether to a particular employer is contributing to this Plan pursuant to a collective bargaining agreement, and, if applicable, a copy of the relevant collective bargaining agreement.

PLAN FISCAL YEAR

The Plan Year ends each October 31.

HEALTHCARE LEGISLATION

NEWBORN AND MATERNITY COVERAGE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing the length of stay not in excess of 48 hours (or 96 hours).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Benefits under this Plan are subject to the provisions of Qualified Medical Child Support Orders (QMCSO). Participants and Dependents can obtain, without charge, a copy of the procedures governing QMCSOs from the Administrative Office.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the Ironworkers Intermountain Health & Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your

rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

The Board of Trustees has the sole, exclusive, and discretionary authority to make any and all decisions with regard to benefits and eligibility, and to interpret the Plan. The Board communicates with you in writing, and only through the Administrative Office. Any contrary or unwritten communication about the Plan is ineffective, and you should not rely on it. No one Trustee or other person speaks for the entire Board. The Trustees reserve the right to change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

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 Vacation Plan, and the term **"**Medical Benefits" refers to all health benefits, including outpatient prescription drug, 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, Vision and Disability Benefits	Administrative Office BeneSys, Inc. P.O. Box 30580 Salt Lake City, UT 84130-0124 (888) 867-9510 (801) 904-4897	Board of Trustees c/o Administrative Office (see contact information at left)
Outpatient Prescription Drug Benefits	Sav-Rx Prescription Services 224 N. Park Ave. Fremont, NE 68025 (888) 662-IRON (4766)	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)
Teladoc	Teladoc 2 Manhattanville Road, Suite 203 Purchase, NY 10577	Board of Trustees c/o Administrative Office (see contact information at left)
Employee Assistance Plan (EAP)	Alliance Work Partners 2525 Wallingwood Drive, Building 5 Austin, TX 78744 Tel: 1-800-343-3822	Board of Trustees c/o Administrative Office (see contact information at left)
Vacation Plan of Utah	Administrative Office BeneSys, Inc. P.O. Box 30580 Salt Lake City, UT 84130-0124 (888) 867-9510 (801) 904-4897	Board of Trustees c/o Administrative Office (see contact information at left)

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

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 or a determination of whether the Plan complies with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) under ERISA § 712 and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques), 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); 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time; or 3) 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 (including whether precertification was improperly required for emergency services; whether emergency services by a non-Preferred Provider should have been covered at the Plan's PPO rate; whether treatment at a 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; and whether a non-PPO air ambulance service should have been covered at the PPO rate). 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.

ATTACHED – LIFE AND ACCIDENTAL DEATH AND DISABILITY INSURANCE CERTIFICATE