Iron Workers St. Louis

District Council Welfare Plan

SUMMARY PLAN DESCRIPTION

2014 Edition

Dear Participant:

We are pleased to provide you with this new Summary Plan Description (SPD) that outlines the benefits provided on behalf of eligible active and retired participants and their dependents under the Iron Workers St. Louis District Council Welfare Plan as of January 1, 2014. This new SPD reflects changes to the Plan made in accordance with the Mental Health Parity Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA).

The Plan provides you and your eligible family members with coverage that can help protect you against serious financial loss should you ever become ill or injured, including benefits for medical care and prescription drugs, and weekly income and accidental death and dismemberment benefits.

Whether you are beginning a new job, having a child or adopting one, getting married or divorced, battling an illness, or qualifying for retirement benefits, the Plan offers health care coverage that is designed to help meet the needs of you and your family. This booklet is designed to show you how your benefits fit into the different stages of your life.

We have tried to describe your benefits as completely as possible and in everyday language. We have also tried to organize the SPD in a way that will be useful to you. Please read the SPD carefully as it is important that you understand your benefits and the protection they provide. If you are married, share it with your spouse.

This SPD replaces and supersedes all prior SPDs and announcements provided before January 1, 2014. We recommend that you keep this with your important papers so you can refer to it when needed.

The Plan may be amended from time to time—either to revise the benefits or to bring the Plan into compliance with changes in the laws. If this occurs, you will be provided with written notification explaining the change(s). You will also receive a Summary of Benefits and Coverages on an annual basis, and on the occurrence of certain events.

If you have any questions about your benefits or if you need a claim form, please call the Fund Office at 1-877-597-8704 or visit the Fund's website at www.iwstldc.org. The website is a secure vehicle that you can use to review contributions and other benefit related information 24 hours a day, 7 days a week.

Sincerely,

Board of Trustees

This SPD also contains details of the insured dental and life insurance benefits. Additional details about these benefits are contained in the insurance contracts or other Plan Documents. If there is a discrepancy between this SPD and these other documents, then the other documents will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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Article I. Plan Service Providers

The Plan contracts with several service providers to ensure you receive the best possible care at the lowest cost from qualified medical professionals practicing close to where you live or work. To some extent, the medical benefits available to you depend on your home Local.

Contracted service providers include:

- **Preferred Provider Organization (PPO):** The Fund has agreements with Anthem, which cover all participants. The PPO plan is a self-insured plan, which means the Fund pays Anthem for access to its networks, but the Fund pays the claims for the care you receive. The PPO networks consist of Doctors, Hospitals and other medical professionals who have agreed to charge discounted rates for their services. Generally, you and the Fund share in paying the costs for eligible services you receive from any doctor, hospital, or medical care provider, regardless of whether the provider participates in the PPO network. However, when you receive your care from a provider who is contracted with the PPO, the Plan will pay a higher percentage of the billed charges and you will pay a lower percentage.
- **Pharmacy Benefit Manager (PBM):** The Fund has an agreement with LDI Pharmacy Benefit Services that covers all participants. The PBM provides access to network pharmacies, a mail-order pharmacy plan, and specialty drugs. Generally, you and the Fund share in paying the costs for eligible prescriptions. However, when you use a generic drug, if available, or a preferred drug, the Plan will pay a higher percentage of the cost. For maintenance medication, you need to use the mail order program, which will save money for you and the Fund.
- **Dental Plan:** The Fund provides dental coverage through an insurance agreement with Delta Dental of Missouri for participants who have eligibility from work in Locals 46, 392, or 396.
- **Vision Plan:** The Fund provides vision coverage through VSP for participants who have eligibility from work in Locals 46, 321, 392, or 396. This is a self-insured benefit administered by VSP.
- **Life Insurance:** The Fund provides an insured life insurance benefit through The Union Labor Life Insurance Company.

Non-Medicare (generally prior to age 65) Retirees are covered by the Anthem PPO and the LDI PBM. Retirees are also provided with a limited vision plan, and have the option to self-pay to add dental coverage. If you retire and are age 65 or disabled, any benefits payable to you under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under Medicare. If you are retired and your dependent is age 65 or disabled, that dependent's coverage is reduced by Medicare, regardless of whether you are eligible for Medicare.

To find a participating provider in your area, contact the provider at the phone number identified in the Contact Information section on page 2.

Article II. Contact Information

The chart that follows shows the telephone numbers and/or web addresses for the various organizations that provide services under the Plan.

If you or your providers have questions or need information about:	Contact:	At:
Eligibility, Benefits and Claims	Fund Office through BeneSys, Inc.	1-877-597-8704 **www.iwstldc.org**
Medical Network Providers	Anthem	1-800-810-2583 **www.anthem.com**
Medical Management Review	HealthLink	1-877-284-0102
Pharmacy Services Provider	LDI Pharmacy Benefit Services	1-866-516-3121 **www.ldirx.com/**
Dental Network Provider	Delta Dental of Missouri	1-800-335-8266 **www.deltadentalmo.com/ironworkers**
Vision Network Provider	VSP Vision Care (VSP)	1-800-877-7195 **www.vsp.com**
Life Insurance	The Union Labor Life Insurance Company	1-866-795-0680 **www.ullico.com**

Article III. Summary of Medical Benefits

Section 3.01 Schedule of Medical Benefits—All Locals Except 321

The following chart highlights key features of the PPO plan provided to eligible Active and non-Medicare-eligible retired Participants and their Dependents participating in all Locals, except Local 321. A chart setting out the benefits for Participants and Dependents whose home Local is 321 follows.

Comprehensive Medical Expense Benefit all locals except Local 321		
Benefit	**In-Network**	**Out-of-Network[1]**
Deductible • Individual • Family	 $400 $1,200	 $700 $1,400
Coinsurance	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Annual Out-of-Pocket Maximum [2] • Individual • Family	 $700 $2,100	 $1,400 $2,800
Doctor Office Visits/Specialist Office Visits Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 30%; Plan pays 70% after deductible
Hospital Inpatient and Outpatient Services, including outpatient surgery, hospital urgent care facility, hospital testing center, and organ and tissue transplants	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Home Health Care and Hospice	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Maternity Care, Office Visits Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment for first visit only if billed separately from the delivery fee for confirmation of the pregnancy	You pay 30%; Plan pays 70% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or if the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

[2] Co-payments (including prescription drug co-payments), and deductibles do not count toward the out-of-pocket maximum. However, co-insurance does count towards the out-of-pocket maximum.

Comprehensive Medical Expense Benefit all locals except Local 321		
Benefit	**In-Network**	**Out-of-Network[1]**
Skilled Nursing Facility (in lieu of inpatient hospital admission when approved by Plan. Semi-private room)	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Admission Limitation	45 days per benefit period	45 days per benefit period
Preventive Care Services Includes standard immunizations and those services recommended by the U.S. Preventive Services Task Force at the time the service is provided including, as appropriate for the age and gender of the individual, mammograms, colonoscopies, blood pressure screening, and cholesterol screening	100%, with no deductible and no co-payment	Not covered [1]
Emergency Room	You pay $150 co-payment per visit (waived if admitted); Plan pays 100% after co-payment	
Emergency Ambulance Services	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Chiropractic Services/Spinal Manipulation	You pay a $5 co-payment; Plan pays 100% after co-payment Retirees pay a $25 co-payment	You pay a $5 co-payment; Plan pays 100% after co-payment Retirees pay a $25 co-payment
Treatment Limit	26 days per calendar year combined	
Physical, Occupational, and Speech Therapy	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Maximum Visits	60 combined visits per person per calendar year	
Speech Treatment Children under 6 years of age, limit of 10 visits per calendar year	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Second/Third Surgical Opinions	Plan pays 100%	
Inpatient Mental Health and Substance Use Disorder Treatment	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment, provider office visit and related diagnostic tests and procedures	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 30%; Plan pays 70% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment other than provider office visit and related services	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Durable Medical Equipment	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible
Orthotics and Prosthetics	You pay 10%; Plan pays 90% after deductible	You pay 30%; Plan pays 70% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence, then in-network benefit levels apply for out-of-network providers.

Comprehensive Medical Expense Benefit all locals except Local 321		
Benefit	**In-Network**	**Out-of-Network[1]**
Hearing Aids, when medically necessary and prescribed by an audiologist or other doctor specializing in ear, nose, and throat (an ENT)	After a $500 co-payment, up to $2,600 per hearing aid	
Prescription Drugs		
• Retail (30-day supply)	You pay a $10 co-payment for generics. You pay a $25 co-payment for preferred brands. You pay a $40 co-payment for non-preferred brands.	
• Mail Order (90-day supply)	You pay a $20 co-payment for generics. You pay a $45 co-payment for preferred brands. You pay a $75 co-payment for non-preferred brands.	

Section 3.02 Schedule of Medical Benefits—Local 321

The following chart highlights key features of the PPO plan provided to eligible Active and non-Medicare-eligible retired Participants and their Dependents participating in Local 321. Section 3.01 provides a chart, which highlights key features of the PPO plan provided to eligible Active and retired Participants and their Dependents participating in all Locals, except Local 321.

Comprehensive Medical Expense Benefit Local 321		
Benefit	**In-Network**	**Out-of-Network[1]**
Deductible		
• Individual	$900	$1,800
• Family	$2,700	$3,600
Coinsurance	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Annual Out-of-Pocket Maximum [2]		
• Individual	$3,800	$7,600
• Family	$11,400	$15,200
Doctor Office Visits/Specialist Office Visits Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment; Plan pays 100% after co-payment	You pay 40%; Plan pays 60% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought then in-network benefit levels apply for out-of-network providers.

[2] Deductibles and copayments do not count toward the out-of-pocket maximum. However, co-insurance does count towards the out-of-pocket maximum.

Comprehensive Medical Expense Benefit Local 321		
Benefit	**In-Network**	**Out-of-Network**[1]
Hospital Inpatient and Outpatient Services, including outpatient surgery, hospital urgent care facility, hospital testing center, and organ and tissue transplants	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Home Health Care and Hospice	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Maternity Care, Office Visits Covered services include the office visit, and related diagnostic tests and procedures (e.g., x-ray, lab, office surgery) whether rendered in a doctor's office, clinic or other facility not part of a hospital outpatient or inpatient department	You pay a $25 co-payment for first visit only if billed separately from the delivery fee for confirmation of the pregnancy	You pay 40%; Plan pays 60% after deductible
Skilled Nursing Facility (in lieu of inpatient hospital admission when approved by Plan. Semi-private room)	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Admission Limitation	45 days per benefit period	45 days per benefit period
Preventive Care Services Includes standard immunizations and those services recommended by the U.S. Preventive Services Task Force at the time the service is provided including, as appropriate for the age and gender of the individual, mammograms, colonoscopies, blood pressure screening, and cholesterol screening	100%, with no deductible and no co-payment	Not covered [1]
Emergency Room	You pay $150 co-payment per visit (waived if admitted); Plan pays 100% after co-payment	
Emergency Ambulance Services	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Chiropractic Services/Spinal Manipulation	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Treatment Limit	26 visits per calendar year	
Physical, Occupational, and Speech Therapy	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Maximum Visits	60 combined visits per person per calendar year	
Speech Treatment Children under 6 years of age, limit of 10 visits per calendar year	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Second /Third Surgical Opinions	Plan pays 100%	
Inpatient Mental Health and Substance Use Disorder Treatment	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible

[1] If no in-network provider is located within 25 miles of a Participant's or Dependent's primary residence or the Participant or Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought, then in-network benefit levels apply for out-of-network providers.

Comprehensive Medical Expense Benefit Local 321		
Benefit	**In-Network**	**Out-of-Network**[1]
Outpatient Mental Health and Substance Use Disorder Treatment, provider office visit and related diagnostic tests and procedures	You pay $25 co-payment; Plan pays 100% after co-payment	You pay 40%; Plan pays 60% after deductible
Outpatient Mental Health and Substance Use Disorder Treatment other than provider office visit and related services	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Durable Medical Equipment	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Orthotics and Prosthetics	You pay 20%; Plan pays 80% after deductible	You pay 40%; Plan pays 60% after deductible
Hearing Aids, when medically necessary and prescribed by an audiologist or other doctor specializing in ear, nose, and throat (an ENT)	After a $500 deductible, up to $2,600 per hearing aid	
Prescription Drugs		
• Retail (30-day supply)	You pay a $10 co-payment for generics. You pay a $40 co-payment for preferred brands. You pay a $55 co-payment for non-preferred brands.	
• Mail Order (90-day supply)	You pay a $20 co-payment for generics. You pay a $75 co-payment for preferred brands. You pay a $100 co-payment for non-preferred brands.	

Article IV. Summary of Vision Benefits – VSP Vision Care

The following chart highlights key features of the vision plan for eligible Active Participants and their Qualified Dependents eligible from work in Locals 46, 321, 392 and 396.

Section 4.01 Schedule of Vision Benefits

Benefit	
Eye exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months

	Coverage From a VSP Doctor (In-Network)	Out-of-Network Reimbursement Amounts[1]
Eye Exam	Plan pays 100%, after you pay a $10 co-payment	Up to $42
Prescription Lenses		
Single vision	Plan pays 100%	Up to $40
Lined bifocal	Plan pays 100%	Up to $60
Lined trifocal	Plan pays 100%	Up to $80
Covered Lens Options		
Anti-reflective coatings	Plan pays 100%	N/A
Blended lenses	Plan pays 100%	N/A
Hi-index lenses	Plan pays 100%	N/A
Mirror coating	Plan pays 100%	N/A
Photochromic lenses	Plan pays 100%	N/A
Polarized lenses	Plan pays 100%	N/A
Polycarbonate lenses	Plan pays 100%	N/A
Progressive lenses	Plan pays 100%	N/A
Tints	Plan pays 100%	Up to $5
Ultra-violet coating	Plan pays 100%	N/A
Frames	Covered up to $115 allowance for any frame of your choice, plus 20% off the amount over your allowance	Up to $45

[1] Co-payment still applies.

	Coverage From a VSP Doctor (In-Network)	Out-of-Network Reimbursement Amounts[1]
Contact Lenses (in lieu of glasses)	Covered up to $125, plus 15% off cost of contact lens exam (fitting and evaluation)	Up to $125
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted VSP facilities	Not available

Section 4.02 Pediatric Vision Benefits

For Dependents up to their 13th birthday, the annual maximum will not apply to essential vision care as long as benefits are provided by an in-network provider or an out-of-network provider in those situations where there is no in-network provider within twenty-five (25) miles of your or your Dependent's residence.

Essential vision care includes one routine eye exam every calendar year, and a pair of corrective lenses once every 12 months. Corrective lenses are the lens for a pair of glasses or a 12-month supply of contact lenses. In connection with the cost of frames, the Fund only covers the least costly frame that will support the prescription once every 24 months.

Pediatric vision only applies for eligible Dependents of Participants with vision benefits.

Section 4.03 Retiree Vision Benefit

All Retirees with Retiree Medical Coverage have access to a vision program administered by Vision Service Plan (VSP). Under this program, Retirees and their Dependents can get a comprehensive eye exam every 12 months from a VSP doctor for $10. Retirees and their Dependents also receive discounts on all of the products and services offered by VSP—including lenses, frames, contacts, and laser vision correction services.

	Coverage From a VSP Doctor (In-Network)	Out-of-Network Reimbursement Amounts[1]
Eye Exam (every 12 months)	Plan pays 100%, after you pay a $10 co-payment	Up to $45, after you pay a $10 co-payment
Glasses and Sunglasses (purchased within 12 months of last WellVision eye exam)	20% off additional glasses and sunglasses, including lens options, from any VSP doctor	Not available
Laser Vision Correction	Average of 15% off the regular price or 5% off the promotional price; discounts only available from contracted VSP facilities	Not available

[1] Retirees will not receive a discount on the cost of the exam, and will have to pay the full cost of the exam upfront.

Article V. Summary of Dental Benefits – Delta Dental of Missouri

The following chart highlights key features of the dental plan for eligible Active Members and their Qualified Dependents eligible from work in Locals 46, 392 and 396. The Delta Dental program is an insured benefit. The Delta Dental contract will govern with respect to provisions applicable under the program.

Section 5.01 Schedule of Dental Benefits

Benefit	Delta Dental PPO Dentists	Delta Dental Premier Dentists	Non-Participating Dentists [1]
Annual Deductible [2]			
• Per Person	$25	$25	$25
• Family	$75	$75	$75
Annual Maximum			
• Per Person	$2,000	$2,000	$2,000
Preventive Services (exams, cleanings (including periodontal maintenance visits), fluoride and x-rays)			
Coinsurance	100% No deductible	100% No deductible	100% of allowable amount No deductible
Basic Restorative Services (sealants for permanent molars, root canal therapy, fillings, extractions, surgical removal of tooth, osseous surgery, anesthesia, denture repairs)			
Coinsurance	100% after deductible	85% after deductible	85% of allowable amount after deductible
Major Restorative Services (inlays, onlays and crowns, dentures, bridges, and implants)			
Coinsurance	60% after deductible	50% after deductible	50% of allowable amount after deductible
Orthodontic Services (for children only) [3]	50%	50%	50%
Lifetime Maximum Per Person	$2,000	$2,000	$2,000

1 Non-participating Dentists do not offer their services at discounted rates. Your out-of-pocket costs for services from a non-participating Dentist may be higher than for services received from Delta Dental PPO or Delta Dental Premier Dentists.

2 The annual dental deductible applies to Basic and Major restorative services only.

3 Appliance must be placed prior to age 20.

Section 5.02 Pediatric Dental Benefits

Benefits are provided under this dental benefit program for essential pediatric dental care provided to a Dependent child under the age of 13. The annual benefit maximum does not apply to essential pediatric dental care. For purposes of this dental benefit program, essential pediatric dental care is defined as periodic age appropriate examinations (for example, checkups and dental x-rays) and medically appropriate treatments necessary to prevent disease (such as cleanings twice a year), as long as such dental care is provided by a Delta Dental participating Dentist or by a non-participating Dentist when there is no participating Dentist within twenty-five (25) miles of the Participant's or Dependent's residence.

Pediatric dental only applies for eligible Dependents of Participants with dental benefits.

Section 5.03 Retiree Dental Benefit

Retired Participants and their Dependents have the option to self-pay to enroll in Delta Dental coverage at the time of retirement. A schedule of benefits will be provided to anyone who enrolls.

Article VI. Summary of Benefits – Life Insurance, AD&D, and Disability

Life Insurance and AD&D Benefits—Active Participants and/or their Dependents	
Participants	
Life Insurance	$10,000
Accidental Death & Dismemberment Full Amount (paid upon death or loss of both hands; both feet; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; or sight of both eyes)	$ 3,000
One-half of full amount (paid for the loss of one hand, one foot, or sight of one eye)	$ 1,500
Dependents	
Life Insurance	
• Spouse	$ 5,000
• Child older than 14 days of age	$ 2,500
Life Insurance Benefits—Retirees and their Dependents	
Retirees	
Life Insurance	$ 5,000
Dependents	
Life Insurance	
• Spouse	$ 1,000
Disability Benefits—Active Participants	
Weekly Income Benefit	
Effective 1st day for non-occupational Injury and 8th day for Illness; maximum of 13 weeks per disability	$ 300
There is no benefit for an occupational injury	

The life insurance and AD&D benefits are insured benefits. The ULLICO contract will govern with respect to applicable provisions.

Article VII. Plan Eligibility

Section 7.01 Active Participants

Participating Local Unions:
- Local 46
- Local 103
- Local 321
- Local 392
- Local 396
- Local 577
- Local 782

You will be eligible for benefits under the Plan if you perform work for a participating employer with a collective bargaining agreement or participating agreement requiring contributions to this plan on your behalf and contributions are actually made on your behalf by your employer in accordance with the ***Initial Eligibility Requirements***.

You will be considered an owner-operator and not be eligible for benefits as a Participant if you are a partner, sole proprietor, president, or shareholder (or an immediate family member of one of these) of a business that is a contributing employer, or anyone else whose ownership would, in the opinion of the Trustees, jeopardize the tax-exempt status of the Fund or violate provisions of ERISA. If you are considered an owner-operator, you may elect to participate by completing a form available from the Fund Office and then reporting and paying the required contributions. Contact the Fund Office for information if this applies to you. If you qualify as an owner-operator and decline to participate or withdraw and later want to participate you must again meet the requirements for initial eligibility (two consecutive quarters during which you paid contributions on at least 425 hours/quarter).

1. **Initial Eligibility Requirements**

Calendar quarters begin January 1, April 1, July 1, and October 1.

You will become eligible on the first day of the month following any two consecutive calendar quarters (six consecutive months) in which you worked in both quarters and your employer made contributions to the Fund on your behalf for at least 440 hours (425 hours per quarter for two consecutive quarters if you are an owner-operator).

Once the Initial Eligibility Requirements are met, you will be eligible to receive benefits for two consecutive calendar quarters.

Example: Michael worked during both calendar quarters January through March and April through June. During this six-month period, Michael's employer made contributions to the Fund for 440 hours that Michael worked. Therefore, Michael is eligible for benefits July 1 through December 31.

2. **Continuing Eligibility**

If you move from one participating employer to another, your coverage will continue as long as you meet the requirements necessary to maintain your eligibility. Make sure that your new employer is contributing to the Plan.

You will continue to be eligible for benefits during any two consecutive calendar quarters that immediately follow two consecutive quarters in which you worked in both quarters and for which your employer makes contributions to the Fund for at least 440 hours (425 hours per quarter for two consecutive quarters if you are an owner-operator) or non-work credit hours are granted due to an approved disability.

If your employer reports and pays hours worked based on the month in which a pay week ends and if the reporting of hours at the end of a quarter in the first month of the next quarter would result in a loss of eligibility, the Fund may be able to count those hours in the quarter in which they were worked. Contact the Fund Office for details about how this works.

3. **Disability**

If you are unable to work due to a **non-occupational disability**, you will be given non-work credit of 34 hours for each week of Weekly Income Benefits you receive from this Plan, up to a maximum of 26 weeks of credit for each disability. The Fund Office may request that you submit a Doctor's statement that you are still disabled at any time. See Section 9.08 regarding periods of disability.

If you are unable to work due to an **occupational Injury or Illness** that occurred while you were working for a contributing employer or an employer signatory to a collective bargaining agreement recognized by the Plan, you will be given non-work credit of 34 hours for each week you receive Workers' Compensation benefits, up to a maximum of 26 weeks of credit for each disability. You must give written proof of such disability to the Fund Office and submit proof of the receipt of Workers' Compensation Benefits within 12 months of the date of Injury. The Fund, however, does not pay claims related to the work related Injury or Illness.

If your employer does not pay the contributions due on work that you perform, then the Trustees will, at their discretion, give you credit for up to two months of unpaid contributions, but only if there are reports or other evidence of wages and hours on which contributions are due. This does not apply to owner-operators.

To be entitled to non-work credit hours as described above, the disability absence must begin while you are eligible for Welfare Plan benefits. The provision of disability-credited hours does not apply to owner-operators.

4. **Credit for Unpaid Contributions**

The Trustees, at their discretion, will credit limited hours for which contributions are due but not paid by the Employer.

5. **When Eligibility Ends**

Your eligibility will end as of the last day of the last two consecutive calendar quarters that immediately follow two consecutive quarters for which you did not meet the requirements for continuing eligibility of work in both quarters and 440 hours of contributions paid (425 hours per quarter for two consecutive quarters if you are an owner-operator) or non-work credit hours granted due to an approved disability.

COBRA Continuation Coverage

If your eligibility ends, you may be able to continue your coverage by electing COBRA Continuation Coverage. See Article VIII, page 21, for more information.

6. **Rescission of Coverage**

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that the cancellation will be effective back to the time you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact after you have been provided with 30 days advance written notice of the rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

a. When the Plan terminates your coverage retroactive to the date you lost eligibility, if there is a delay in administrative recordkeeping between your loss of eligibility for coverage and the date the Plan is notified of your loss of eligibility;

b. When the Plan retroactively terminates your coverage because you fail to make timely self-payments; and

c. When any unintentional mistakes or errors result in your being covered by the Plan when you should not have been. The Plan will cancel your coverage prospectively once the mistake is identified.

7. **Certificate of Creditable Coverage**

When your coverage ends (including when COBRA Continuation Coverage ends), you will be provided with a Certificate of Creditable Coverage, free of charge, that indicates the period you were covered under this Plan, and any additional information required by law. This Certificate may help reduce or eliminate any pre-existing condition limitations under a new group medical plan. You may request a Certificate at any time while covered under the Plan or within 24 months of the date your Plan coverage ends.

The Certificate will be sent by first class mail. If the Certificate is addressed and mailed to you and your spouse at your last known address, then the notice requirement will be satisfied for all covered individuals living at that address. If your Dependent's last known address is different from your last known address, a separate Certificate will be sent to your Dependent at his/her last known address.

Section 7.02 Retired Participants

1. **Initial Retiree Eligibility**

If you retire at age 55 or older, you will be eligible for the Retiree Medical Plan provided you notify the Fund Office, in writing, within 60 days of your retirement. You must maintain continuous coverage from active status in order to be eligible under the Retiree Medical Plan. Also, you must have attained vested status in the Iron Workers St. Louis District Council Pension Fund under the rules of that Pension Fund. If you retire before reaching age 55, you may be able to elect COBRA Continuation Coverage and bridge into Retiree coverage as long as you had no break in coverage.

When you initially retire, you can continue your active coverage (only once) for up to two consecutive calendar quarters at the time of your retirement if you have worked the hours for continuing coverage. After the continuation is over, Retiree or COBRA coverage will begin, if applicable.

2. **Plan Coverage and Medicare**

The Retiree Medical Plan includes medical and prescription drug coverage, as well as life insurance benefits for you and your Dependents. There is no Accidental Death and Dismemberment or Weekly Income Benefit available to retired Participants.

It is strongly recommended that you enroll in Medicare Part A and Part B when you become eligible (generally at age 65) because all benefits from this Plan will be covered as if you enrolled. Once you reach Medicare eligibility, the Plan will coordinate with Medicare. See page 78 for more information.

If you enroll in a Medicare Part D Prescription Drug Plan (PDP), you will still be eligible for medical benefits under the Retiree Medical Plan, but not prescription drug benefits. Your premium will not be reduced if you enroll in a PDP and are receiving only medical benefits from this plan.

The monthly amount of the contribution is determined periodically by the Trustees based on the cost of benefits provided and the cost to administer the Plan. Payments for the Retiree Medical Plan will be deducted from your monthly pension benefit. If your pension benefit is less than your Retiree Medical Plan self-payment, you must pay the difference so that the full payment is made.

3. **When Eligibility Ends**

As a retired Participant, your eligibility ends on the earliest of the:

a. Last day of the period for which a self-payment contribution was received;

b. Date the Plan ends coverage for Retirees;

c. Date the Plan ends; or

d. You die.

If you retire and return to active work, your Retiree coverage will end when you are eligible for active coverage. However, your new active coverage will end if you retire a second time or resume receipt of pension benefits without any extended eligibility based on your hours in the prior two quarters. Your active coverage will not continue for the remainder of that eligibility period, nor will it extend into the next eligibility period.

4. **Reinstating Eligibility in Active Coverage**

Once you retire a second time, your active eligibility cannot be reinstated.

5. **Declining and Electing Spousal Coverage on Retirement**

If you decline coverage for your spouse at the time you retire, you will have **one** opportunity to re-elect Retiree coverage for your spouse at a later date, provided:

a. Your spouse was covered under the active Plan as a Dependent on the day before you retired;

b. Your spouse had other group welfare coverage (for example, through his or her employer) in effect on the date you retired and proof of that coverage was provided to the Fund Office with the election to decline spousal coverage at retirement;

c. You provide annual proof that your spouse continues to have other group welfare coverage;

d. Your Retiree coverage under the Plan is continuous and you make all the required self-contributions; and

e. You notify the Fund Office in writing **within 30 days** of when your spouse loses other group welfare coverage and you make the required contributions for spousal coverage back to the date your spouse's other group welfare coverage ends; *or* your spouse notifies the Fund Office in writing **within 30 days** of your death and makes the required contributions for surviving spousal coverage back to the date of your death.

Before your spouse begins coverage, you will pay the premium rate for a single individual (unless you are covering Dependents). When your spouse begins coverage, the monthly cost of spousal coverage will be the same amount that would have been charged had you been continuously covering your spouse under the Plan.

Section 7.03 Dependents

1. **Initial Eligibility**

Generally, Dependents of active and retired Participants become eligible for coverage on the date the Participant becomes eligible, or, if later, on the date the Dependent satisfies the Plan's definition of a Dependent (see page 92).

2. **Acquiring a Dependent**

Whenever you acquire a new Dependent, you should contact the Fund Office to update your personal information on file.

If you acquire a Dependent after you become eligible, the Dependent will become eligible:

a. On the date of marriage for a spouse; or

b. On the date the Dependent child satisfies the Plan's definition of a Dependent (see page 92).

If you want a child covered retroactive to the date he or she was born, adopted, or placed with you for adoption, you should notify the Fund Office promptly within 30 days of the date the child is born, adopted, or placed for adoption. Claims for the child will not be paid until you provide the Fund Office with the necessary documentation of the child's birth, adoption, or placement for adoption. Necessary documentation includes a copy of the

newborn's birth certificate and for an adopted child or a child placed for adoption, it means a copy of the relevant documentation verifying a legal adoption or placement for adoption. If you fail to notify the Fund Office or provide the required documentation within 30 days, the child's coverage will begin the first day of the month in which documentation is provided.

You may enroll a new spouse effective as of the date of your marriage if you notify the Fund Office and provide a copy of your marriage certificate within 30 days of your marriage. Until you notify the Fund Office and provide a copy of your marriage certificate, no coverage will be provided. If you fail to notify the Fund Office or provide the required documentation within 30 days, your spouse's coverage will begin the first day of the month in which documentation is provided.

Your Dependents are generally eligible for the same coverage you are, with the exception of the Weekly Income, Life, and Accidental Death and Dismemberment Benefits. This includes the Dependents of owner-operators. Dependent children are not covered for pregnancy related expenses and some other benefits are age related.

3. **Continuing Eligibility**

Your Dependent will continue to be considered a Dependent until the earliest of:

a. The date he/she no longer meets the Plan's definition of a Dependent;

b. The date your coverage terminates; or

c. In the event of your death, the date you would have ceased to be eligible if you had lived but performed no more work in covered employment after the date of your death.

4. **Dependent Coverage In the Event of Your Death**

If you had active coverage at the time of your death, your Dependents' coverage will continue for as long as your coverage would have continued had you lived but performed no additional covered employment. When this coverage ends, your Dependents may elect COBRA Continuation Coverage (See Article VIII, page 21).

If you had Retiree Coverage at the time of your death, your surviving spouse may continue Retiree Coverage for the spouse and any Dependents as long as the surviving spouse (and other Dependent) was covered by the plan as a Dependent on the date you died.

The surviving spouse is responsible for continuing to pay the applicable premium based on the number of covered lives. If the surviving spouse is receiving a monthly surviving spouse pension payment then the premium will continue to be deducted from the pension payment. If the pension payment is not sufficient to cover the premium or if the Retiree was receiving a single life pension benefit, then the surviving spouse must timely pay the monthly premium.

Benefits under this provision will terminate upon the death of the surviving spouse; the remarriage of the surviving spouse; the surviving spouse's eligibility for other coverage (except Medicare); or the failure of the surviving spouse to pay the premium.

5. **When Eligibility Ends**

When your Dependent's coverage ends, he/she may be eligible to continue coverage by making monthly payments for COBRA Continuation Coverage (See Article VIII, page 21).

When coverage ends (including after COBRA Continuation Coverage ends), your Dependent will be provided, free of charge, with a Certificate of Creditable Coverage that indicates the period he/she was covered under this Plan, and any additional information required by law. This Certificate may help reduce or eliminate any pre-existing condition limitations under a new group medical plan. You or your Dependent may request a Certificate at any time while covered under the Plan or within 24 months of the date Plan coverage ends.

The Certificate will be sent by first class mail. If the Certificate is addressed and mailed to you and your spouse at your last known address, then the notice requirement will be satisfied for all covered individuals living at that address. If your Dependent's last known address is different from your last known address, a separate Certificate will be sent to your Dependent at his/her last known address.

Your Dependent's eligibility for coverage will end on the earlier of the:

a. First day of the month in which you do not meet the Plan's continuing eligibility requirements;

b. Date he/she no longer meets the Plan's definition of an Dependent;

c. First day of a Benefit Month for which you do not make the required self-payment contribution by the due date (if you participate in the Retiree Medical Plan or are continuing coverage through COBRA); or

d. Date that is the first day of the 60-day COBRA Continuation Coverage election period, if you or your Dependent does not elect COBRA Continuation Coverage for that Dependent.

6. **In the Event of Your Death**

In the event of your death, your Dependents may elect COBRA Continuation Coverage (See Article VIII, page 21).

Section 7.04 Special Enrollment Rights

Your Dependents automatically become eligible on the date you become eligible and they meet the definition of an eligible Dependent. However, federal law requires that they be eligible to enroll if:

1. You and/or your Dependents decline coverage under this Plan because you have other health coverage and then you and/or your Dependents later lose the other health coverage; or

2. You acquire a Dependent through marriage, birth, adoption, or placement for adoption.

For enrollment due to loss of other coverage, you or your Dependent must:

1. Otherwise be eligible for Plan coverage; and
2. Have been covered under another group health plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

If the other health coverage was COBRA continuation coverage, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If the other coverage is not COBRA continuation coverage, a special enrollment is available if you or your Dependent is no longer eligible for coverage or employer contributions for the other coverage.

To enroll yourself and/or your Dependent, you will need to complete, sign, and submit an enrollment form to the Fund Office. You will also need to provide proof of Dependent status if applicable. Coverage will become effective once the Fund Office approves the enrollment form and any requested documentation of Dependent status.

If you are enrolling yourself and/or your Dependents (including your spouse) after other health coverage ends, coverage will become effective on the date you and/or your Dependents lose the other health coverage if you (or your Dependents) enroll within 30 days after the date you and/or your Dependents lose other health coverage. If enrollment occurs more than 30 days after the date you and/or your Dependents lose other health coverage, your coverage becomes effective on the date the Fund Office receives the completed enrollment form and proof of Dependent status acceptable to the Fund Office.

Note that you **must** notify the Fund Office in writing within 60 days of the date you acquire a Dependent due to that Dependent's loss of coverage under a State Children's Health Insurance Program (SCHIP) or Medicaid, and within 60 days of the date you and/or your Dependents become eligible for any state-sponsored premium assistance subsidy program.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, you must notify the Fund Office within 30 days of the loss of other coverage or the date of marriage, adoption, or placement for adoption.

Article VIII. COBRA Coverage

Under the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your Dependents ("Qualified Beneficiaries") have the right to make self-payments to extend coverage temporarily after coverage would otherwise end due to a "qualifying event." This extension is called COBRA Continuation Coverage.

Qualifying events include:

1. Termination of your employment or a reduction in your hours of work;
2. Your death;
3. Your entitlement for health care coverage under Medicare;
4. Your divorce or legal separation; and
5. Your child's loss of Dependent status under the Plan.

Qualified Beneficiaries include you, your spouse, and your Dependent child(ren) who were covered by the Plan on the day before the qualifying event. Children born, adopted or placed for adoption during the period of COBRA Continuation Coverage have the same rights as a Dependent who was covered by the Plan on the day of the event that triggered COBRA Continuation Coverage.

Evidence of good health is not required to obtain COBRA Continuation Coverage.

Section 8.01 COBRA Benefits

You and/or your Dependents may elect COBRA Continuation Coverage and make self-payments to continue to receive the same health care benefits you were eligible for on the day preceding the qualifying event that caused your loss of coverage.

You should notify the Fund Office of any qualifying event within 60 days of the date you lose coverage due to a qualifying event. Failure to notify the Fund Office may prevent you and/or your Dependents from obtaining or extending COBRA Continuation Coverage.

Under COBRA Continuation Coverage, you and your Dependents will have coverage for medical, prescription drug, dental and vision benefits, to the same extent as when you were covered as an Active Member. Coverage for Life Insurance, Weekly Income, and Accidental Death and Dismemberment benefits are not included under COBRA Continuation Coverage.

Section 8.02 Periods of Coverage

1. **18-Month COBRA Continuation Coverage**

   You and/or your Dependents are entitled to elect COBRA Continuation Coverage and to make self-payments for the coverage for up to 18 months after coverage terminates because of one of the following qualifying events:

   a. A reduction in your hours that causes a loss of eligibility; or

   b. Your loss of employment (which includes retirement), unless termination of employment is due to your gross misconduct.

2. **29-Month COBRA Continuation Coverage for Disabled Individuals**

A special extension of the initial 18-month continuation period is available for disabled individuals under COBRA Continuation Coverage.

If you or one of your covered Dependents, who is a qualified beneficiary, is determined to be disabled by the Social Security Administration at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the 18-month period will be extended to 29 months for all eligible family members if you notify the Fund Office of the disability in writing. Your written notification to the Fund Office about the Social Security Administration's determination must be provided within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA Continuation Coverage.

If the Social Security Administration later determines that you are no longer disabled or that your Dependent is no longer disabled, you or your Dependent must notify the Fund Office in writing within 30 days of the date such notice is received from the Social Security Administration.

3. **36-Month COBRA Continuation Coverage**

Your Dependents are entitled to elect COBRA Continuation Coverage and to make self-payments for the coverage for up to 36 months after coverage terminates because of one of the following qualifying events:

a. You die;

b. You become entitled to Medicare Benefits (eligible for and enrolled in coverage under Part A, Part B, or both);

c. You get divorced or legally separated; or

d. Your Dependent child(ren) stops being eligible under the Plan as a Dependent child.

4. **Second Qualifying Event**

If a family member experiences a second qualifying event while receiving COBRA Continuation Coverage during the first 18 months of coverage, he or she can receive up to 18 additional months of COBRA Continuation Coverage (a maximum of 36 months) if notice of the second qualifying event is properly given to the Plan. The extension is available only if the second event would have caused your spouse or Dependent child(ren) to lose coverage under the Plan had the first qualifying event not occurred.

Section 8.03 Employer Notification Responsibility

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. Under the law, your employer is required to notify the Fund Office of your death, termination of employment or reduction in hours, or entitlement to Medicare within 60 days of its occurrence. However, because your employer may not be aware of these events, we urge you or a family member to notify the Fund Office of any and all qualifying events as soon as they occur.

Section 8.04 Participant Notification Responsibility

For other qualifying events (your divorce or legal separation from your spouse, or an Dependent Child's loss of Dependent status), it is your responsibility to notify the Fund Office within 60 days of the later of the date on which the qualifying event occurred or the date coverage ends due to the qualifying event. In addition, a Dependent should notify the Fund Office within 60 days of the date coverage is lost due to the death of a Retiree.

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

If you are providing notice of a Social Security Administration determination that you or a Dependent is no longer disabled, notice must be sent to the Fund Office no later than 30 days after the date of the determination by the Social Security Administration that you or your Dependent is no longer disabled.

Notice should be sent to:

Iron Workers St. Louis District Council Welfare Plan
13801 Riverport Drive, Suite 401
Maryland Heights, MO 63043

If you do not notify the Fund Office in a timely manner, you will lose your right to elect COBRA Continuation Coverage.

Section 8.05 The Plan's Notification Responsibility

Within 14 days from the date the Fund Office is notified of a qualifying event, a COBRA election notice and COBRA election form will be sent to you and/or any Dependent(s) who lose coverage due to the qualifying event. The notice will inform you and your Dependents of the right to elect COBRA Continuation Coverage, the due dates for returning the election form and the amount of the self-payment, as well as other necessary information.

To protect your family's rights, you should keep the Fund Office informed of any change in your address or the addresses of family members.

Section 8.06 Electing Coverage

Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. You may elect COBRA on behalf of yourself and your family members or they can each elect their own COBRA Coverage. Parents may elect COBRA Coverage for their children.

To elect COBRA, you must pay a premium(s) back to the date you lost coverage.

You or your Dependents must complete the election form and send it back to the Fund Office to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. If you elect COBRA Continuation Coverage for yourself and your Dependents, your election is binding on your Dependents.

2. If you do not elect COBRA Continuation Coverage for your Dependents when they are entitled to COBRA Continuation Coverage, your Dependents (including your spouse and your Dependent children) have the right to elect COBRA Continuation Coverage for themselves.

3. The person electing COBRA Continuation Coverage has 60 days after the election notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed form. An election of COBRA Continuation Coverage is considered to be made on the date the election form is mailed back to the Fund Office. A person who has waived coverage has a right to make a new election within the original 60-day period.

4. If the election form is not mailed back to the Fund Office within the allowable period, you and/or your Dependents will be considered to have waived your right to COBRA Continuation Coverage.

5. During the period after your coverage ends but before you elect COBRA (or the election period ends) a provider will be told that you and your Dependents are not eligible but that you have the right to elect COBRA.

6. If you elect COBRA, you must pay the premium back to the termination of coverage.

If COBRA Continuation Coverage is elected, the Plan will provide coverage that is identical to the health coverage (excluding Weekly Income, Life Insurance, and AD&D benefits) provided to Participants and their Dependents.

COBRA continuation coverage is not available to anyone who was not covered under the Plan the day before coverage ended. However, you may add newly acquired Dependent children during the continuation period by notifying the Fund Office within 30 days after acquiring the new Dependent through marriage, birth, adoption, or placement for adoption, and by paying the required premium.

Section 8.07 Self-Payments

Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage is determined by the Board of Trustees on a yearly basis and will not exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

The following rules apply to your self-payments for COBRA Continuation Coverage:

1. COBRA Continuation Coverage self-payments must be made monthly.
2. The amounts of the monthly self-payments are determined by the Trustees. The amounts are subject to change, but not more often than once a year, unless substantial changes are made in the benefits.
3. You and/or your Dependents who are electing COBRA Continuation Coverage must make the initial self-payment for coverage no later than 45 days after the postmark date of the signed election form that was mailed to the Fund Office.
4. You must pay the premiums from the date coverage would have terminated.
5. The due date for each following monthly payment is the first day of the month for which payment is due. A payment will be considered on time if it is received within 30 days of the due date.
6. If you do not make a self-payment within the time allowed, COBRA Continuation Coverage for all family members for whom the payment is being made will end.

Section 8.08 Termination of Coverage

COBRA Continuation Coverage will terminate on the earliest of the following:

1. The day of the last period for which you or your Dependent(s) make a timely self-payment, if you or your Dependent(s) fail to make any self-payment on time;
2. The day on which the Plan is discontinued by the Trustees;
3. The day you or your Dependent(s) becomes entitled to Medicare coverage;
4. The day you or your Dependent(s) enroll in another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition (note that there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act);
5. The day the Social Security Administration determines that you or your Dependent(s) are no longer disabled, if applicable; or
6. The last day of the 18-, 29-, or 36-month period, whichever is applicable, after COBRA Continuation Coverage began.

If your COBRA Continuation Coverage ends before the end of the maximum COBRA Continuation Coverage period, the Fund Office will send you a written notice as soon as practical after the Fund Office determines that your COBRA Continuation Coverage has ended.

Section 8.09 Health Coverage Alternatives

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Article IX. Life Events

At some point in your life, you will probably experience an event that affects your welfare benefits. You can minimize delays in processing claims by notifying the Fund Office when you move or experience a life-changing event.

You should contact the Fund Office within 30 days of such an event to request the appropriate form. It is important that you return the completed form to the Fund Office because it will help to ensure that your correct address and family information are on file. It also enables the Fund Office to keep your marital status, dependent information, and data concerning your benefits coverage up-to-date. This information helps in processing your claims quickly and accurately.

In certain circumstances the Fund is required to provide your information, including social security number, to Medicare or other governmental agencies and contracted service providers. It is important that you provide information to the Fund in a timely manner when it is requested. Failure to provide information can affect your eligibility for benefits and/or the payment of claims.

Section 9.01 If You Move

Information about your Plan is sent to you by mail. If you move, you must notify the Fund Office. Failure to do so may jeopardize your receiving information about changes in the Plan's eligibility rules or benefits.

Section 9.02 If You Add a Dependent

If you have a new Dependent (due to marriage, birth, adoption, or placement for adoption), you must inform the Fund Office within 30 days of the marriage, birth, adoption, or placement for adoption. You must supply all of the necessary documentation to the Fund Office. If you do not inform the Fund Office of your new Dependent and provide the required documentation in a timely manner, your claims may be denied.

Section 9.03 If You Legally Separate or Divorce or if there is a QMCSO

In the event of a legal separation or divorce, your ex-spouse will no longer be eligible for coverage as a Dependent under the Plan. If your ex-spouse was covered under the Plan and wants to continue coverage under COBRA Continuation Coverage, you or your ex-spouse must contact the Fund Office within 30 days from the date of the divorce or legal separation in order to request information on COBRA Continuation Coverage (Article VIII, page 21).

You should also notify the Fund Office if your situation involves a Qualified Medical Child Support Order (QMCSO). The Plan has written QMCSO procedures that describe the Plan's and your rights and responsibilities regarding a QMCSO. You may contact the Fund Office to obtain a free copy of the Plan's QMCSO procedures.

Section 9.04 If Your Child Is Totally and Permanently Disabled

If your child is not capable of self-supporting employment due to a total and permanent disability (either physical or mental) that began while the child was an eligible Dependent, you may continue coverage for that child for as long as your own coverage continues and the child continues to be totally and permanently disabled. See page 93 for the definition of Dependents who are disabled.

Section 9.05 If Your Child Reaches the Limiting Age

In general, your child is no longer eligible for coverage when he or she reaches age 26. You should notify the Fund Office when your child is no longer eligible for coverage. In addition, you should notify the Fund Office at least 31 days before the date your Dependent reaches age 26.

Your child may elect COBRA Continuation Coverage for up to 36 months after losing eligibility as a Dependent. See Article VIII, page 22, for more information about COBRA Continuation Coverage.

Section 9.06 If You Take Military Leave

Under the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are in active service with the U.S. Uniformed Services for up to 31 days, your medical, prescription drug, dental, and vision coverage will be continued at no cost to you for up to 31 days. If your military service lasts more than 31 days, you may run out your active coverage and then continue your medical, prescription drug, dental, and vision coverage by making any required self-payments until the earlier of 24 consecutive months after your Plan health coverage ends or the end of the period during which you are eligible to apply for reemployment in accordance with the terms of USERRA.

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, full-time National Guard duty, inactive duty training, reserve duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services include service in the:

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

You must give advance notice of your military service to your employer and the Fund Office, unless you are unable to do so because of military necessity, or when advance notice is impossible or unreasonable under the circumstances. Dependents do not have a separate right, as they do under COBRA Continuation Coverage, to elect Continuation Coverage under USERRA.

1. **How USERRA Works with COBRA**

Continuation Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described for COBRA, except that only the Participant has the right to elect USERRA coverage for himself or herself and his/her Dependents.

Your coverage under USERRA will continue until the earlier of:

a. The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or

b. 24 consecutive months after your coverage would have otherwise ended.

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

a. Your coverage would otherwise end as described directly above;

b. You lose your rights under USERRA (for instance, for a dishonorable discharge);

c. Your self-payment contribution is due and unpaid; or

d. You again become covered under the Plan.

If you do not elect to continue coverage under USERRA, your coverage will end on the later of 31 days after the date on which you enter active military service or the end of your active coverage based on the hours you worked prior to military service. Your Dependents will also have the opportunity to elect COBRA Continuation Coverage when your extended coverage from hours worked terminates.

2. **Your Reemployment Rights**

Upon your discharge from military service, you may apply for reemployment in accordance with USERRA. Such reemployment includes reinstatement in any health plan to which your former employer is required to contribute. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged, if you are hospitalized or recovering from an Illness or Injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to work for a contributing employer.

If the Fund Office is notified of your return to work during the USERRA required time period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work with the same continuing eligibility you had on the day you left.

Section 9.07 If You Take Family and/or Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to Active Participants and their Dependents if (1) the Employer is covered by FMLA, (2) the Participant is eligible for and has been granted leave by his or her employer pursuant to FMLA and (3) the Participant's employer makes the required contributions to the Fund.

1. **FMLA Provisions**

   Eligibility for benefits under FMLA will be determined by your employer. If you qualify, FMLA allows you to take up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

   a. The birth, adoption, or placement with you for adoption of a child;

   b. To care for a seriously ill spouse, parent or child;

   c. You are unable to work because of a serious Illness; or

   d. You have a qualifying exigency because your spouse, child, or parent is on active duty or notified of an impending call to active duty status in support of a contingency military operation as either a member of the Reserves component of the Armed Forces of the U.S. or as a retired member of the regular U.S. Armed Forces. A qualifying exigency is an activity to address certain common situations that arise when a covered military member is deployed. See **www.dol.gov/whd/fmla/finalrule/MilitaryFAQs.pdf** for a list.

   You may be eligible for up to 26 weeks of leave within a single 12-month period to care for a spouse, child, parent or next of kin who is a covered service member suffering from a serious Illness or Injury sustained in the line of duty that renders him or her unfit to perform the duties of his or her office, grade, rank, or rating.

   A "covered service member" is a current member of the U.S. Armed Forces (including the National Guard) who is undergoing medical treatment, recuperation or therapy, and is being treated as an outpatient or is on temporary disability.

2. **Maintenance of Plan Benefits**

   Coverage for all benefits to which you are eligible under this Plan will continue during FMLA leave on the same basis as other similarly situated Participants.

   If you and your employer have a dispute over your eligibility and coverage under FMLA, your benefits will be suspended pending resolution of the dispute. The Trustees will have no direct role in resolving such a dispute. Any right to continuation coverage under other provisions of this Plan will still apply.

3. **How FMLA Works with COBRA**

   Taking a family or medical leave is not itself considered a COBRA Continuation Coverage qualifying event. If you return from leave within 12 weeks, or 26 weeks as applicable, there will not be a loss of coverage.

Section 9.08 If You Become Disabled

If you are an Active Participant and you become disabled and are unable to work, you may be able to continue your coverage through the provision of Weekly Income Benefits and non-work credits. In addition, you may be able to pay to continue the life insurance benefit.

Refer to the Continuing Eligibility section on page 13 for information regarding non-work credits.

1. **Weekly Income Benefits**

   The Plan provides a Weekly Income Benefit to Active Participants who become disabled and cannot work due to a non-occupational disability. Weekly Income Benefits are not payable for an occupational disability (an Injury or Illness that arises out of or in the course of any employment for wage or profit) regardless of whether you receive workers compensation benefits; however, you may be eligible for non-work credits during a period of occupational disability.

2. **Life Insurance Benefits**

   If you are an Active Participant and you become Totally Disabled before age 60 and your eligibility for Plan benefits ends, you may arrange with The Union Labor Life Insurance Company to continue your life insurance under an individual policy if you apply for it within 31 days after the date your insurance ends. You may do this without a medical examination.

A Total Disability is a disability that results solely from a bodily Injury or sickness that prevents you from engaging in any occupation or employment for compensation or profit.

See Section XIV and Section XV for complete details on Weekly Income, AD&D and Life Insurance Benefits.

Article X. Medical Benefits

Your medical benefits cover a wide range of services and supplies, including Doctor's charges, diagnostic testing, prescription drugs, Hospital charges, and surgery. Whenever you need to seek medical treatment for a non-occupational Illness or Injury, your medical benefits may, in fact, cover a large part of your health care expenses.

Section 10.01 How the Plan Works

When you or your Dependents require medical treatment, most covered expenses will be paid according to a benefit formula. This formula is used to assess the percentage of the billed charges the Plan will pay and the amount, if any, that you will have to pay. Components of the benefit formula are explained below.

1. **Co-insurance**

   Your share of the costs of a covered health care service, calculated as a percent (as shown in the schedules in Article III) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

2. **Co-payment**

   A fixed amount (as shown in the schedules in Article III) that you pay for a covered health care service. You usually pay the co-payment when you receive the service. The amount can vary by the type of covered health care service.

3. **Deductible**

   The amount you owe for health care services the Plan covers before the Plan begins to pay. The deductible does not apply to all services.

   The Plan has both an in-network individual deductible of $400 and family deductible of $1,200 ($900 and $2,700 for Local 321). For out-of-network charges, the deductible is $700 for the individual and $1,400 for the family ($1,800 and $3,600 for Local 321). Charges incurred in-network apply to both deductibles as do charges incurred out-of-network. Your share of the costs, except the office visit co-payment, apply to the deductible.

   When you use an in-network provider, services rendered during a Doctor's office visit, including related diagnostic tests and procedures, as well as services rendered at a clinic or other facility that is not part of a hospital outpatient or inpatient department, are covered at 100% after a $25 co-payment without you needing to satisfy the deductible. However, when you use an out-of-network provider, such services are subject to the deductible. Once the deductible is met, you pay coinsurance and any amount in excess of Usual, Customary and Reasonable (UCR) charges.

The annual family deductible is in place to help limit how much you have to pay if you have several family members in the Plan, and it is met when any combination of covered family members' expenses reaches the family deductible limit.

Example: Here is how deductibles may work for one family with a $400 per person/$1,200 per family limit when the family incurs charges for services provided in-network:

	Covered Medical Expenses Applied to the Family Deductible	
Family Member	**As of June**	**As of August**
John	$400	$400
Mary	$255	$300
Joe	$145	$255
Ann	$125	$245
Total	**$925**	**$1,200**

As of June, John will have met his individual deductible, at which point the Plan begins paying the appropriate percentage in accordance with the Summary of Benefits. As of August, the family deductible is met for the calendar year and the Plan begins paying the appropriate percentage in accordance with the Summary of Benefits toward expenses incurred by any of the covered family members during that same calendar year—even though only John satisfied the $400 individual deductible.

4. **Out-of-Pocket Maximum**

To protect you and your family members from catastrophic medical expenses, the Plan limits how much you pay out of your pocket for most covered medical services. This is called an "out-of-pocket maximum." Charges you incur apply to both the in- and out-of-network out-of-pocket maximum including amounts applied to your deductible and your office visit co-payments as described below.

If your coverage is from work under a collective bargaining agreement other than the Local 321 collective bargaining agreement, co-payments (including prescription drug co-payments) and deductibles do not count toward the out-of-pocket maximum; however, co-insurance does count.

If your coverage is from work in Local 321, deductibles and co-payments do not count toward the out-of-pocket maximum; however, co-insurance does count.

Once you meet your individual in-network out-of-pocket maximum, the Plan pays 100% of the remaining in-network covered expenses that you incur for that year, except that you are still responsible for paying office visit co-payments.

The Plan does not always pay benefits equal to all the covered medical expenses you may have. You may be responsible for certain expenses. For instance, each year you will have to pay the following expenses out of your own pocket:

a. All expenses for medical services or supplies that are not covered by the Plan;

b. All charges in excess of any Plan limitation; and

c. All charges incurred out-of-network that are in excess of the Usual, Customary and Reasonable (UCR) charges.

Section 10.02 Preferred Provider Organization (PPO)

The Plan utilizes a Preferred Provider Organization (PPO), which is a network of participating providers (such as Hospitals and Doctors). You pay less if you use providers that belong to the PPO's network. You can use Doctors, Hospitals, and providers outside of the network, but you pay more of the cost.

The Plan's current PPO network is provided by Anthem. When you use providers that participate in the Anthem PPO network, including affiliated BlueCross/BlueShield PPO networks outside the geographic area covered by Anthem, you receive discounts on the services and the Plan pays a higher percentage of your Covered Charges than it does when you receive care from a non-network provider.

Example: Generally, the Plan pays a higher percentage of Covered Charges when you use a PPO network provider vs. the UCR Covered Charges when you use a non-network provider.

You may contact Anthem for a list of providers or ask your provider if he or she participates in the network. You can also verify a provider's participation via Anthem's website (see *Contact Information* on page 2).

1. **When an in-network provider is not available (Out-of-Area Benefit)**

   Under the out-of-area benefit, out-of-network claims will be covered as if they were in-network if either (1) the Member or Qualified Dependent lives 25 or more miles from any in-network provider providing the type of care sought or (2) the Member or Qualified Dependent needs the care when he or she is more than 150 miles away from home and more than 25 miles from any in-network provider providing the type of care sought.

   Contact the PPO network to locate a Doctor or Hospital in your area. Refer to *Contact Information* on page 2.

   When an out-of-network claim is first received and reviewed the Fund Office may not be able to determine if this out-of-area benefit applies. If you receive an EOB showing an out-of-network claim was not paid under this provision and you think this provision applies all you need to do is contact the Fund Office and the claim will be reviewed.

2. **When you seek care from an Anthem PPO network provider that uses the services of non-network providers**

   In instances when you or your eligible Dependents receive care from an Anthem PPO network Hospital or Doctor and the PPO network Hospital and/or Doctor uses the services of a non-network pathologist, emergency room physician, anesthesiologist, radiologist, or laboratory, the Plan will cover the eligible expenses billed by the provider at the "in-network" level of benefits.

3. **Medical Review Program**

   Your Plan includes a Medical Management Review program to help ensure you always receive the right level of care in the appropriate setting, and in a cost-effective manner. Anthem has registered nurses available to help you, your family, and your Doctor coordinate any care that you receive for a complex or catastrophic condition.

   A part of the Medical Management Review Program is the voluntary Case Management program. The program provides medical professionals who will contact you or your family member to offer assistance in coordinating and monitoring care for complex and catastrophic conditions such as cancer, transplants, and diabetes. Participation is voluntary but the Plan encourages you to explore how this benefit can help you manage your disease or injury.

All inpatient admissions to acute medical, rehabilitation, skilled or long-term acute care facilities, or psychiatric hospitals on an urgent or elective basis require certification. Selected procedures, medical supplies, and/or therapy also require certification to ensure that the service is medically necessary and meets standard guidelines for care. Before you receive treatment recommended by your Doctor, you or your Doctor should view the precertification list of selected procedures, medical supplies, or therapies on Anthem's website at **www.anthem.com** or your Doctor may call 1-877-284-0102 to see if review for medical necessity should be obtained. You and your Dependents will receive services and supplies without any financial penalty if you or your Doctor choose not to contact Anthem for precertification, but the charges will then be reviewed for medical necessity after you have incurred the expense and your claim(s) may be denied if it is determined that the service or supply you received was not medically necessary. A certification of medical necessity does not guarantee that a claim will be paid because claims are reviewed for eligibility and coverage.

The Medical Management Review program also includes voluntary case management services. Medical professionals will contact you or your family member to offer assistance in coordinating and monitoring care for complex and catastrophic conditions such as cancer, transplants, and diabetes. Your participation in the case management program is voluntary. However, we encourage you to explore how this benefit can help you manage a disease or injury. For more information about the program, call 1-877-284-0102.

Section 10.03 Covered Medical Expenses

Covered Charges for medical expenses are those that result from a non-occupational bodily Injury or Illness. The Plan pays benefits for the following Covered Charges that are Medically Necessary, up to the limits shown on the Summary of Benefits applicable to you and your covered Dependents, provided you are under the care of a licensed provider.

Covered Charges, subject to the limitations set forth in the Summary of Benefits, include:

1. Inpatient Hospital services:
    a. Semi-private room and board, as well as any charges that are made by the Hospital as a condition of occupancy or on a regular daily basis such as for general nursing services. However, if private accommodations are used, any excess of daily room and board charges over the Hospital's average semi-private room charge will not be counted as Covered Medical Expense. If the Hospital only has private rooms, or if a private room is medically necessary, the private room rate will be covered.

    Refer to the Summary of Benefits relative to your Plan to find specific information on your benefits coverage.

    b. Doctor, surgeon, and anesthetist services.
    c. Operating rooms and related facilities.
    d. Intensive care and coronary care units.
    e. Laboratory and diagnostic services.
    f. X-rays and radiology services and procedures.

g. Medications and biologicals.

h. Anesthesia.

i. Special duty nursing, including nursing care, as prescribed by a Doctor.

j. All short-term Rehabilitation Services.

k. Organ and tissue transplants.

2. Outpatient Services and diagnostic procedures and tests, including lab and radiology.

3. Outpatient surgery rendered in a Hospital or free standing surgical center.

4. Skilled Nursing Facility services provided instead of inpatient hospitalization. Coverage is provided for a semi-private room. **Custodial Care is not covered.**

5. Home Health Care and Hospice Care.

6. Outpatient office visits to a Primary care Doctor.

7. Outpatient office visits to a Doctor who is a specialist.

8. Allergy tests and treatment.

9. Emergency room services provided in a Hospital or free standing medical facility.

10. Oxygen and the rental of equipment for administration of oxygen.

11. X-ray, radium and radioactive therapy.

12. Rental of durable medical and surgical equipment, up to the purchase price, and as limited in the Summary of Benefits.

13. Artificial limbs and artificial eyes to replace natural limbs and eyes lost.

14. Medically Necessary professional ambulance services rendered because of an Injury or Illness. Professional ambulance services include Medically Necessary services of an approved provider for transportation requiring emergency medical support from one location to the nearest facility equipped to treat the condition or when requested by an attending nurse or Doctor.

15. Maternity care office visits, including pre-natal and post-natal care, examinations, and tests for Participants, Retirees and their spouses only. Maternity care while an inpatient in a Hospital, including Doctor services for the mother and newborn(s), delivery, newborn nursery services, and semi-private room. A Participant, Retiree, or Dependent Spouse and her newborn infant will receive at least 48 hours of inpatient Hospital care following a normal vaginal delivery and at least 96 hours of inpatient Hospital care following a cesarean section. Further, the Plan will not require the provider (Hospital or Doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. The attending Doctor may however, after consulting with the mother, discharge the mother and newborn earlier. The plan does not cover Maternity care for a Dependent Child.

16. Treatment of speech problems recommended by a Doctor for Dependent children under six years of age.

17. Occupational and Physical Therapy for inpatient and outpatient services.

18. Chiropractic and spinal manipulation.

19. Second and third surgical opinions when provided by a surgeon who is qualified to perform the surgery and who is not affiliated with the surgeon who recommends the surgery.

20. Outpatient and Inpatient treatment of mental health disorders, for services are rendered by an M.D.; a Ph.D. who is a Psychiatrist, or Psychologist; or a Masters of Social Work (MSW) or Licensed Clinical Social Worker (LCSW), when acting within the scope of his or her training to provide treatment of mental health disorders.

21. Outpatient and Inpatient treatment of drug and/or alcohol abuse.

22. Casts, splints and crutches.

23. The Plan has relinquished grandfathered status and, in accordance with the Affordable Care Act, covers preventive services without a copayment or co-insurance or deductible. This applies only when these services are delivered by a network provider. The following is a list of preventive services, which will be updated from time to time (as set out on **www.healthcare.gov/news/factsheets/2010/07 /preventive-serviceslist.html#CoveredPreventiveServicesforChildren and DOL guidance in "FAQs about Affordable Care Act Implementation Part XII" http://www.dol.gov/ebsalfags/fag-aca12.html)**.

    Covered Preventive Services for Adults

    a. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked.

    b. Alcohol Misuse screening and counseling.

    c. Aspirin use for men and women of certain ages, however, Aspirin and other OTC recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.

    d. Blood Pressure screening for all adults.

    e. Cholesterol screening for adults of certain ages or at higher risk.

    f. Colorectal Cancer screening for adults over 50. Polyp removal is an integral part of a colonoscopy so no cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. Cost-sharing may be imposed for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

    g. Depression screening for adults.

    h. Type 2 Diabetes screening for adults with high blood pressure.

    i. Diet counseling for adults at higher risk for chronic disease.

    j. HIV screening for all adults at higher risk.

    k. Immunization vaccines for adults—doses, recommended ages, and recommended populations vary:

        1) Hepatitis A

        2) Hepatitis B

3) Herpes Zoster
4) Human Papillomavirus
5) Influenza (Flu Shot)
6) Measles, Mumps, Rubella
7) Meningococcal
8) Pneumococcal
9) Tetanus, Diphtheria, Pertussis
10) Varicella

l. Obesity screening and counseling for all adults.

m. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.

n. Tobacco Use screening for all adults and cessation interventions for tobacco users.

o. Syphilis screening for all adults at higher risk.

p. Breast pumps.

Covered Preventive Services for Children

a. Alcohol and Drug Use assessments for adolescents.

b. Autism screening for children at 18 and 24 months.

c. Behavioral assessments for children of all ages.

d. Blood Pressure screening for children.

e. Cervical Dysplasia screening for sexually active females.

f. Congenital Hypothyroidism screening for newborns.

g. Depression screening for adolescents.

h. Developmental screening for children under age 3, and surveillance throughout childhood.

i. Dyslipidemia screening for children at higher risk of lipid disorders.

j. Fluoride Chemoprevention supplements for children without fluoride in their water source.

k. Gonorrhea preventive medication for the eyes of all newborns.

l. Hearing screening for all newborns.

m. Height, Weight and Body Mass Index measurements for children.

n. Hematocrit or Hemoglobin screening for children.

o. Hemoglobinopathies or sickle cell screening for newborns.

p. HIV screening for adolescents at higher risk.

q. Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
1) Diphtheria, Tetanus, Pertussis
2) Haemophilus influenzae type b

3) Hepatitis A
4) Hepatitis B
5) Human Papillomavirus
6) Inactivated Poliovirus
7) Influenza (Flu Shot)
8) Measles, Mumps, Rubella
9) Meningococcal
10) Pneumococcal
11) Rotavirus
12) Varicella

r. Iron supplements for children ages 6 to 12 months at risk for anemia.

s. Lead screening for children at risk of exposure.

t. Medical History for all children throughout development.

u. Obesity screening and counseling.

v. Oral Health risk assessment for young children.

w. Phenylketonuria (PKU) screening for this genetic disorder in newborns.

x. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.

y. Tuberculin testing for children at higher risk of tuberculosis.

z. Vision screening for all children.

Covered Preventive Services for Women, Including Pregnant Women

a. Anemia screening on a routine basis for pregnant women.

b. Bacteriuria urinary tract or other infection screening for pregnant women.

c. Both genetic counseling and BRCA testing, if appropriate, for a woman as determined by her health care provider counseling about genetic testing for women at higher risk.

d. Breast Cancer Mammography screenings every 1 to 2 years for women over 40.

e. Breast Cancer Chemoprevention counseling for women at higher risk.

f. Comprehensive prenatal and postnatal lactation support, counseling, and equipment rental (may include purchase instead of rental of equipment) for the duration of breastfeeding subject to reasonable medical management techniques to determine the frequency, method, treatment, or setting.

g. Cervical Cancer screening for sexually active women.

h. Chlamydia Infection screening for younger women and other women at higher risk.

i. Access to the full range of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, intrauterine devices, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Cover generics without cost-sharing as well as brands for any individual for

whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, in consultation with the patient, subject to reasonable medical management. Contraceptive methods that are generally available OTC are only included if the method is both FDA-approved and prescribed for a woman by her health care provider.

j. Domestic and interpersonal violence screening and counseling annually for all women consisting of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts. Human Immunodeficiency Virus(HIV) screening and counseling for sexually active women. Screening means testing.

k. Folic Acid supplements for women who may become pregnant.

l. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.

m. Gonorrhea screening for all women at higher risk.

n. Hepatitis B screening for pregnant women at their first prenatal visit.

o. Human Immunodeficiency Virus (HIV) screening and counseling annually for sexually active women.

p. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.

q. Osteoporosis screening for women over age 60 depending on risk factors.

r. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.

s. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users.

t. Sexually Transmitted Infections (STI) counseling annually for sexually active women.

u. Syphilis screening for all pregnant women or other women at increased risk.

At least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care. Additional well-woman visits as needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors as determined by clinician, subject to reasonable medical management.

Annual Physical Examination and Well Woman Visit Coverage:

The Plan will cover the expense related to a routine annual physical examination (including routine well woman examinations) by a Doctor at 100% without cost sharing. Benefits are limited to one examination (plus one well woman visit for females) per year for you and each of your covered Dependents. Services must be provided by a PPO network provider.

Eligible expenses include the Doctor's professional fees and diagnostic x-ray or laboratory charges, including colonoscopies and testing for testicular and skin cancer. The

examination may be performed in a Doctor's office, clinic, or Hospital outpatient department. Note that a chiropractor is not considered a Doctor for routine physical examination benefits.

In addition to any limitations or exclusions listed under "Non-Covered Expenses" beginning on page 44, this benefit does not cover:

a. Testing or examination related to accidental bodily Injury, Illness, or pregnancy (including resulting child birth or complications); or

b. Testing or examination related to or as a condition of employment or to the issuance of any insurance policy.

Newborn and Well-Child Care Coverage

The Plan will cover the expense related to newborn and well-child care recommended in the Bright Futures Recommendations at 100% without cost sharing. This covers well-child physical exams, including those reported to schools, camps, or sports teams. Benefits are limited to services provided by PPO network providers.

In addition to any limitations or exclusions listed under "Non-Covered Expenses" beginning on page 44, this benefit does not cover:

a. Testing or examination related to accidental bodily Injury, Illness, or pregnancy (including resulting child birth or complications); or

b. Testing or examination related to or as a condition of employment or to the issuance of any insurance policy.

Office Visit Coverage

Preventive care services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit (that is not the routine annual physical examination or annual well woman examination) is covered. The following conditions apply to payment for PPO network provider office visits.

a. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.

b. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit:

    1) Is the delivery of such preventive item or service, then the Plan will pay 100% for the office visit.

    2) Is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

24. Services of a legally qualified midwife who is duly certified or licensed to practice in the state where the treatment or care is being offered to the extent the services are within those for which the midwife is licensed or certified. The Plan provisions regarding deductibles and co-payments and the rules related to in-network and out-of-network providers will apply. In no event, however, will the Plan pay more for the services of a midwife than the Plan would have paid had the services been rendered by a medical Doctor.

25. Medical and surgical services provided to a covered person in connection with a mastectomy:

    a. Reconstruction of the breast on which the mastectomy has been performed.

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications relating to all stages of the mastectomy, including lymphedemas.

26. Expenses related to surgical treatment for TMJ, limited to a one-time-only procedure.

    Plan benefits payable for these services and supplies are subject to all applicable deductibles, co-payments, co-insurance percentages and maximum benefit limitations.

27. Contraceptive devices and injections are covered.

    The Plan will cover all FDA-approved contraceptive methods and counseling, sterilization procedures (e.g., tubal ligation, Essure implants), and patient education and counseling for women of all ages with reproductive capacity who are covered by the Plan, including the Participant, the Participant's spouse and the Participant's covered dependents. When these contraceptive services are received from a PPO network provider, they will be covered at 100%. If the services are received from a non-network provider, they will be subject to coinsurance.

28. Treatment for morbid obesity.

    Under this Plan the term means the presence of morbid obesity that has persisted for at least 5 years, defined as either:

    a. Body mass index (BMI) *(term defined at the end of this definition)* exceeding 40; or

    b. BMI greater than 35 in conjunction with ANY of the following severe comorbidities:

        1) coronary heart disease; or

        2) type 2 diabetes mellitus; or

        3) clinically significant obstructive sleep apnea; or

        4) high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic)

    AND

    Patient has completed growth (18 years of age or documentation of completion of bone growth);

    AND

    Patient has participated in a Doctor-supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Doctor-supervised nutrition and exercise program must meet ALL of the following criteria:

a. Participation in nutrition and exercise program must be supervised and monitored by a Doctor working in cooperation with dietitians and/or nutritionists; AND

b. Nutrition and exercise program must be 6 months or longer in duration; AND

c. Nutrition and exercise program must occur within the two years prior to surgery; AND

d. Participation in Doctor-supervised nutrition and exercise program must be documented in the medical record by an attending Doctor who does not perform bariatric surgery. Note: A Doctor's summary letter is not sufficient documentation.

NOTE: BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared:

BMI = (weight in kilograms) ÷ (height in meters) x (height in meters)

or compute using the Obesity Education Initiative website: **www.nhlbisupport.com/bmi/**

To convert pounds to *kilograms*, multiply pounds by 0.45.
To convert inches to *meters*, multiply inches by 0.0254.

29. Dental work and oral surgery. Expenses incurred in connection with dental work or oral surgery for the prompt repair of sound natural teeth or other body tissues and required as a result of a non-occupational accidental bodily Injury occurring while the individual is insured. Dental charges for treatment to natural teeth resulting from an accidental Injury are covered for up to one (1) year after the date of the Injury. Expenses required for the performance of the following oral surgical procedures are included as Covered Charges:

    a. The excision of partially or completely unerupted impacted teeth; or

    b. Incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

    For all other dental work or oral surgery, only charges of a Hospital and outpatient surgical facility, as listed previously, are included as Covered Charges. Other dental charges may be covered under the separate Dental Benefit.

30. Charges for "routine patient costs" incurred by a "qualifying individual" who is participating in an "approved clinical trial" will be covered in the same manner as if the charge had been incurred without the trial when incurred at an in-network provider. For purposes of this benefit,

    a. A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that his or her participation is appropriate.

    b. "Routine patient costs" are all medically necessary health care provided to the individual for purposes of the trial, consistent with a plan's medical coverage, and services that would be covered for those not enrolled in a clinical trial. Such services include those rendered by a physician, diagnostic or laboratory tests, and other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care.

Routine patient costs do not include the actual device, equipment or drug that is being studied. Also excluded are: items and services that are provided solely to satisfy data collection and analysis needs that are not used in direct clinical management of the patient; or a service that is clearly inconsistent with the widely accepted and established standards of care for a particular disease or condition.

c. An "approved clinical trial" is a Phase I, II, Ill or IV clinical trial conducted in connection with the prevention, diagnosis or treatment of cancer or other life-threatening diseases or conditions or other condition described in ACA. A life-threatening condition is defined as any disease from which the likelihood of death is probable unless the course of the disease is interrupted. The trial must be approved or sponsored by a the National Institutes of Health, the Centers for Medicare & Medicaid Services, the Food and Drug Administration (FDA) or other federal agency.

31. Medically necessary purchase of an initial orthotic or prosthetic device, as well as replacement of that orthotic or prosthetic device, as follows:

    a. The Plan covers the initial cost of a standard corrective appliance when it is ordered by a physician or health care practitioner. A standard corrective appliance is the least expensive medically necessary form of the device that is needed to provide the required support;

    b. The Plan covers the cost of a replacement corrective appliance when replacement is necessary because a change in your physical condition renders your current device inoperable or unsatisfactory in helping you to perform normal daily activities (as certified by your doctor); and

    c. The Plan covers the cost of a replacement corrective device if the device is damaged due to normal wear and tear and cannot be satisfactorily repaired.

    For purposes of this benefit, a corrective appliance refers to orthotics and prosthetics. The Plan defines an *"orthotic"* as a corrective appliance or device, either customized or available "over-the-counter," that is designed to support a weakened body part. This includes, but is not limited to, crutches, specially designed corsets, leg braces, extremity splints and walkers. This definition does not include dental orthotics.

    The Plan defines a *"prosthetic"* as a corrective appliance or device designed to replace all or part of a missing body part, such as an artificial limb.

Section 10.04 Non-Covered Expenses

Charges not covered by the Plan include (this is not an exhaustive list):

1. Charges that would not have been made if no coverage existed or charges that neither you nor any of your Dependents are required to pay or for which a third party is responsible.

2. Charges incurred in connection with Injuries or Illness sustained during the course of employment.

3. Disability due to Occupational Disease (Occupational Disease means a disease for which you are entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law or similar legislation).

4. Charges for services or supplies that are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government.

5. Charges incurred for treatment of any Injury or Illness that is a result of war or act of war, whether declared or undeclared.

6. Charges for services and supplies that are not necessary for treatment of an Injury or Illness, or are not recommended and approved by the attending Doctor, or exceed Usual, Customary and Reasonable (UCR) fees. This section notwithstanding, the Plan covers Preventive Care Services as set out under Covered Medical Expenses in Section 10.03. item 23, page 37).

7. Treatment of temporomandibular joint syndrome (TMJ) except as set out under Covered Medical Expenses in Section 10.03, item 26, page 42).

8. Services of a R.N. or L.P.N. who is not under the direct supervision of a licensed Doctor or surgeon.

9. Cosmetic surgery, unless it is required:

    a. Because of a bodily Injury;

    b. As reconstructive surgery when service is incidental to or follows surgery which results from trauma, infection, or other disease of the involved part such as Covered Charges related to a mastectomy; or

    c. As reconstructive surgery because of congenital disease or anomaly of a Dependent child that has resulted in a functional defect.

10. Charges incurred for any treatment, services or supplies; or hospital confinement (or any part of such confinement) that are not Medically Necessary or that are not ordered by a Doctor who is practicing within the scope of his or her license.

11. Charges incurred for Custodial Care. Custodial Care means services and supplies for care:

    a. Furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or

    b. That can safely and adequately be provided by persons who do not have the technical skills of a covered practitioner.

    Care that meets one of the conditions above is Custodial Care regardless of:

    a. Who recommends, provides, or directs the care;

    b. Where the care is provided; or

    c. Whether or not the patient or another caregiver can be or is being trained to care for the patient.

12. Charges incurred for treatment of any Injury that is a result of participation in a felony, riot, or insurrection.

13. Charges incurred for Experimental Procedures. This exclusion does not apply to in-network "routine patient costs" incurred by a "qualified individual" in connection with participation in an "approved clinical trial" (see Section 10.03 item 30 on page 43 for coverage in

connection with a clinical trial). Contact the Fund Office before incurring treatment if there is any doubt about coverage.

14. Charges incurred for recreational or leisure therapy.

15. Charges for dental care or treatment, or dental X-rays, unless specifically provided, except as covered under the Dental Program (see Section 13.03 on page 55).

16. Charges for eye refractions or treatments or devices for corrections to vision, except as covered under the Vision Program (see Section 12.02 on page 52).

17. Charges incurred for an Elective Abortion, except where the life of the mother is in danger if the procedure is not performed. An Elective Abortion means an abortion for any reason other than a spontaneous abortion.

18. Charges incurred in connection with any of the following procedures:

    a. Artificial insemination;

    b. In vitro fertilization; or

    c. In vivo fertilization.

19. Charges for services rendered by any provider who is your spouse, parent, child, sibling, or who lives in your home.

Article XI. Prescription Drug Benefits

Your Prescription Drug Benefits help you and your Dependents meet your prescription drug needs.

Section 11.01 How Your Prescription Drug Plan Works

When you or your Dependents incur expenses for prescription medications, the Plan will pay a portion of those expenses, as shown in the Summary of Benefits.

To locate a participating pharmacy in your area, call LDI Pharmacy Benefit Services at 1-866-516-3121.

Prescription drug program services are provided and administered by LDI Pharmacy Benefit Services (LDI). The program offers:

- A retail pharmacy program for your short-term prescriptions needs; and
- A mail order program for longer-term prescriptions.

When you need a medication for a short time (an antibiotic), it is best to have it filled at a retail pharmacy. If you are taking a medication on a long-term basis (a maintenance medication), it is mandatory that you have it filled through mail order.

1. **The Mandatory Mail Order Program**

   The mail order program, ***LDI Home Advantage Select***, makes it more convenient for you to receive maintenance medications you take on an ongoing basis, like those that treat high blood pressure, high cholesterol, or diabetes. If you are taking a maintenance medication to treat one of these conditions, your prescriptions will have to be filled through the LDI Home Advantage Select program in order for them to be covered under the Plan

2. **The Step Therapy Program**

   The Plan offers a ***Step Therapy Program*** to help keep down costs for members who take medications that treat high cholesterol, stomach ulcers, or acid reflux. It ensures that members receive the most appropriate medications, but at the lowest out-of-pocket cost possible. **You will need to follow the step therapy process if you are taking a medication to treat any of these conditions.** Step Therapy is a three-step program for prescription medication therapy. You must first try drugs available in Step 1, and progress to Step 2 and 3 only as needed.

   Step 1: Use a Tier 1 drug from the LDI Formulary. Copayments for Tier 1 (generic drugs) are usually lower than copayments for any other tier.

   Step 2: Use a Tier 2 (preferred drug) from the LDI Formulary. Copayments for Tier 2 drugs are usually higher than Tier 1.

   Step 3: Use a Tier 3 (non-Preferred drug) not on the LDI Formulary. Copayments for Tier 3 are usually the highest copayment.

If you try the drug(s) from Step 1 and they do not work, or your Doctor has a medical reason why you cannot use the drug(s) from Step 1, including a drug allergy, a drug from Step 2 will be considered for approval.

For more information about the Step Therapy Program, including a listing of drugs included, call LDI at 1-866-516-3121 or visit **www.LDIRx.com**.

3. **Your Out-of-Pocket Costs**

When you purchase your medications at participating LDI network retail pharmacies or through LDI's mail-order facility you and your Dependents will be responsible for paying the applicable co-payment, as shown in the Summary of Benefits.

If you choose to purchase your medications at a ***non-participating*** retail pharmacy, you will need to submit a paper claim form to LDI. In this situation, you will be required to pay full price for the prescription at the time of purchase. After submitting your claim form to LDI, you will be reimbursed at the discounted retail price, less the co-payment amount. You have to file a paper claim with LDI within 12 months of the date your prescription was filled.

4. **Generic Equivalents and Brand Name Medications**

Many prescription drugs are available as a generic (or sometimes under more than one generic name) and as a brand name medication. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. A generic has the same active ingredients and serves the same purpose as the original medication, but the generic's purchase price is less than the brand name.

While the Plan covers generic and brand name medications, you pay more when you receive a brand name medication. When you or your Dependent need a prescription, you may want to ask your Doctor whether a generic can be substituted for a brand name medication. Using the generic equivalent will save you money.

To learn more about the Plan's formulary, call 1-866-516-3121 or visit LDI's web site at www.ldirx.com/.

5. **The Plan's Formulary**

There are many medications that produce the same results but differ significantly in cost. The Plan has developed a list of medications called a "formulary," which consists of generic and brand name drugs that are as safe and effective as their alternatives, but cost less. You pay more when you purchase a brand name medication instead of a generic medication. Your costs increase even further when you take a brand name "non-preferred" medication that is not on the Plan's formulary. You or your Doctor can contact LDI or go to the LDI website to learn more about the Plan's formulary.

Section 11.02 Covered Expenses

1. The Plan covers drugs and medications that require a Doctor's prescription and are legally obtained from a licensed pharmacist. Only prescriptions prescribed by a Doctor to treat a covered Illness or Injury are approved under the Plan. Such coverage may include drugs prescribed for off-label use as long as they are not Experimental.
2. The first 30-day prescription for all strengths of Oxycontin will be filled for the prescribed quantity. After 30 days, prescription refills that may result in the taking of more than four pills per day will only be filled when precertified by LDI. The Plan implemented this daily limit on Oxycontin tablets to ensure members take a safe dose, as recommended by the Food and Drug Administration (FDA), and to avoid members being afflicted with the side effects associated with high dosage and misuse. If you have questions about how to obtain precertification, contact the Fund Office or LDI.

Section 11.03 Non-Covered Expenses

1. Fertility Medications.
2. Anorexic and Anti-Obesity Medications.
3. Smoking Deterrents.
4. Products for Cosmetic Indications over the age of 36.
5. All strengths of Oxycontin are limited to 4 pills/day on all prescriptions for an individual. The first 30 day prescription for Oxycontin will be filled for the prescribed quantity. After 30 days, refilled prescriptions resulting in more than 4 pills/day will only be filled if pre-certified by LDI.

Section 11.04 Specialty Medications

Specialty Medications are defined as oral, injectable, infused, or inhaled medications that are either self-administered or administered by a health care provider, and used or obtained in either an outpatient or home setting.

Specialty medications include injectable, oral, and biological, human or animal-derived products or biosynthetic agents. Preparation of such medications may be sterile and pyrogen free and include inhalation or implantation.

Specialty drugs have the following key characteristics:

1. Need frequent dosage adjustments
2. Cause more severe side effects than traditional drugs
3. Need special storage, handling, and/or administration
4. Have a narrow therapeutic range
5. Require periodic laboratory or diagnostic testing

Experimental medications used in the treatment of any Injury or Illness, including cancer, are not covered.

Specialty medications that are dispensed and administered to a Covered Person during an, outpatient hospital treatment, Doctor's office visit, home health care visit or are self-administered must go through the LDI Specialty program for preferred pricing determination and prior authorization.

Section 11.05 Medicare Prescription Drug Coverage

If you are entitled to Medicare Part A or are enrolled in Medicare Part B, you can enroll in an individual Medicare Prescription Drug Plan (Medicare Part D). However, the medications covered under an individual Medicare Part D Prescription Drug Plan may differ from those covered under the Plan's formulary. If you are currently eligible for Medicare or even as you approach age 65, we recommend that you contact the Fund Office for information about the special rules regarding formulary medications.

The Plan's prescription drug coverage through LDI and Sterling is "creditable," which means the benefits are, on average, as good as or better than the standard Medicare coverage. Therefore, you are not required by law to enroll in an individual Medicare Part D Prescription Drug Plan. Nevertheless, **if you enroll in an individual Medicare Part D Prescription Drug Plan, you will not be eligible to receive prescription drug benefits under the Plan**. You can continue to receive medical benefits as long as you remain eligible for Plan coverage and pay the required premium. Your cost for coverage under the Plan is not reduced if you are in an individual Medicare Part D Prescription Drug Plan.

Article XII. Vision Benefits

The Plan provides you with comprehensive insured vision coverage, as shown on the Summary of Benefits, if you are an Active Participant working under a collective bargaining agreement requiring a contribution on your behalf for vision coverage. Currently, this applies if you have coverage through work in Local 46, 321, 392 or 396.

All Retirees may elect to participate in Retiree vision coverage and pay the required monthly premium at time of retirement.

Section 12.01 How The Plan Works

The vision program is a self-insured benefit administered by VSP Vision Care (VSP). The Plan offers benefits for most basic eye care needs, such as examinations, eyeglasses and contact lenses, as well as a discount on laser correction services.

1. **In-Network Providers**

   To locate a VSP provider in your area, call 1-800-877-7195.

   Although the choice remains yours with respect to the vision care provider you use, you will receive a higher level of benefit when you receive your care from a VSP Doctor. You can call VSP or visit the VSP Web site at **www.vsp.com** whenever you need to locate a provider in your area. When you call to make an appointment, you should tell the Doctor you are a VSP member. **No ID card needed.** Your Doctor and VSP handle the rest.

2. **Out-of-Network Providers**

   A discount is offered for laser vision correction (PRK and LASIK surgery) through contracted laser centers. Contact VSP's Member Services Department at 1-800-877-7195 for further information or visit VSP's Web site at www.vsp.com to access the Laser VisionCare Learning SourceSM.

   If you use an out-of-network provider, you will have to pay the provider the full amount of the bill at the time of service and then seek reimbursement from VSP for the out-of-network level of benefit. A co-payment still applies.

   To receive reimbursement, log on to VSP's Web site, access the claim form and follow the instructions. If you do not have Internet access, call VSP Customer Service at 1-800-877-7195 to request this form.

   Submit the completed form along with the itemized receipts to the following address:

   VSP
   P.O. Box 997105
   Sacramento, CA 95899-7105

Section 12.02 Covered Expenses

Eye exams, lenses and frames are covered as shown on the Summary of Benefits. In addition, you receive the following discounts and savings from a VSP Doctor:

1. **Prescription Glasses and Sunglasses**

   a. Average 35% – 40% savings on all non-covered lens options.

   b. 30% off additional glasses and sunglasses, including lens options, from the same VSP Doctor on the same day as your WellVision exam. 20% off from any VSP Doctor within 12 months of your last WellVision exam.

Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing. Ask your Doctor for details.

2. **Contacts**

   A 15% discount off the cost of a contact lens exam (evaluation & fitting)

3. **Laser Vision Correction**

   Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. Contact VSP at 1-800-877-7195 to learn more.

   After surgery, you can use your frame allowance (if eligible) for prescription sunglasses from any VSP Doctor.

Section 12.03 Non-Covered Expenses

The vision plan is designed to meet your typical visual needs, and therefore, may not cover certain types of eyewear and cosmetic or elective options. The following lists eyewear and services with either limited or no coverage under the Plan. Please note that VSP Doctors may request an exception if they feel a non-covered or limited eyewear supply or service is necessary for the patient's visual welfare:

1. Options chosen for cosmetic or fashion reasons, such as oversize lenses; corrective vision services, treatments and materials of an experimental nature; laminating of the lens or lenses; cosmetic lenses; and optional cosmetic processes.
2. Orthoptics or vision training and any associated supplemental testing.
3. Non-prescription lenses.
4. Two pairs of glasses in lieu of bifocals.
5. Medical or surgical treatment of the eyes (except laser correction as previously mentioned).
6. Any eye exam or corrective eyewear required by an employer as a condition of employment.
7. Lost or broken lenses and frames, unless you have reached your normal interval for service when seeking replacements.

Section 12.04 Pediatric Care

For dependents eligible for vision coverage, the annual maximums set out in the Schedule of Benefits do not apply to essential pediatric vision care when that care is provided by an in-network provider or an out-of-network provider in those situations where there is no in-network provider within twenty-five (25) miles of the Participant's or dependent's residence. For purposes of this benefit, pediatric care means care provided up to the child's 13th birthday.

Essential vision care includes one routine eye exam every calendar year, and a pair of corrective lenses once every 12 months. Corrective lenses are the lens for a pair of glasses or a 12-month supply of contact lenses. In connection with the cost of frames, the Fund only covers the least costly frame that will support the prescription once every 24 months.

Pediatric vision only applies for eligible Dependents of Participants with vision benefits

Section 12.05 Retiree Coverage

Retirees have limited vision benefits administered by Vision Service Plan (VSP);

1. A comprehensive eye exam every 12 months from a VSP doctor for only $10;
2. Discounts on products and services—including lenses, frames, contacts, and laser vision correction services; and
3. Out of network, the plan will cover up to $45 of the cost of an annual exam after you pay a $10 co-payment. Any additional amounts will be your responsibility.

Refer to the Summary of Benefits on page 9 for further details.

Article XIII. Dental Benefits

The Plan provides you and your Dependents with comprehensive dental coverage, as shown on the Summary of Benefits, if you are an Active Participant working under a collective bargaining agreement requiring a contribution on your behalf for dental coverage. Currently, this applies if you have coverage through work in Local 46, 392, or 396.

All Retirees may elect to participate in a dental program by submitting an application and paying the required monthly premium at time of retirement. However, the benefit offering may be different from that listed in this Summary Plan Description.

Section 13.01 How the Program Works

The dental program is an insured benefit provided through Delta Dental of Missouri (Delta Dental), which provides access to both its Delta Dental PPO network and its larger Delta Dental Premier network.

You are required to meet a deductible before dental benefits are paid for basic and major restorative care. All payments made under the dental benefit are limited to the maximum benefit shown in the Summary of Dental Benefits. The maximum benefit applies to you and each of your Dependents separately.

The Plan offers benefits coverage when you receive your care from Dentists that participate in Delta Dental's networks, as well as those that do not. However, network Dentists have agreed to provide care at negotiated rates, thus saving you money.

To locate a Delta Dental provider in your area, go to www.deltadentalmo.com/ironworkers.

1. You save money when you receive services from a Delta Dental PPO Dentist or a Delta Dental Premier Dentist, instead of a non-network Dentist; and

2. You save the **most** money when you receive your care from a Delta Dental PPO Dentist.

You may visit the Dentist of your choice and select any Dentist on a treatment-by-treatment basis. It is important to remember your out-of-pocket costs may vary depending on your choice. You have three options.

1. **PPO Participating Dentist (Delta Dental PPO Network).** Delta Dental's PPO network consists of Dentists who have agreed to accept payment based on the lesser of usual fees or the applicable **PPO Maximum Plan Allowance** and to abide by Delta Dental policies. This network offers you cost control and claim filing benefits.

2. **Non-PPO Participating Dentist (Delta Dental Premier Network).** Delta Dental's Premier network consists of Dentists who have agreed to accept payment based on the lesser of filed fees or the applicable **Premier Maximum Plan Allowance**. This network also offers you cost control and claim filing benefits. However, your out-of-pocket expenses (deductibles and co-insurance amounts) may be higher with a Premier Dentist than with a PPO network Dentist.

3. **Non-Participating Dentist.** If you go to a non-participating Dentist (not contracted with a Delta Dental plan), Delta Dental will make payment directly to you based on the lesser of the **Dentist's billed charge or the applicable Maximum Plan Allowance**. It will be your obligation to make full payment to the Dentist and file your own claim. Obtain a claim form from the Fund Office or from Delta Dental.

Section 13.02 Advantages of Selecting Participating Dentists

All participating Dentists (PPO and Premier) have the necessary forms needed to submit your claim. Delta Dental participating Dentists will usually file your claims for you and Delta Dental will pay them directly for covered services. Visit Delta Dental's website at **www.deltadentalmo.com/ironworkers** to find out if your Dentist participates or contact Delta Dental to get, at no cost, a list of PPO and Premier participating Dentists in your area. You are not responsible for paying the participating Dentist any amount that exceeds the PPO or Premier Maximum Plan Allowance, whichever is applicable. You are only responsible for any non-covered charges, deductible and co-insurance amounts.

Section 13.03 Covered Expenses

You have coverage for preventive services, basic restorative services, major restorative services, and orthodontic services, as shown in the Summary of Benefits. This includes:

1. Cleanings (including periodontal maintenance visits) and x-rays, twice in any benefit period
2. A panoramic film with or without other films is considered equivalent to a full mouth series for coverage purposes. Coverage for multiple radiographs on the same date of service will not exceed the coverage level for complete mouth series.
3. Fluoride application once in any benefit period for patients under age 19.
4. Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain).
5. Restorative services using amalgam, synthetic porcelain, and plastic filling material. Charges for replacement of filling restorations are only covered once in a 24-month period, unless the damage to that tooth was caused by accidental Injury not related to the normal function of the tooth or teeth. Periodontics: treatment for diseases of the gums and bone supporting the teeth. Periodontal surgery is covered only once in a three-year period for the same site. Coverage for scaling and root planning are limited to once per 24 months.
6. Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth). Endodontic (root canal treatment) on the same tooth is covered only once in a two-year period. Re-treatment of the same tooth is allowed when performed by a different dental office.
7. Sealants for Dependent children under age 19 for caries-free occlusal surfaces of the first and second permanent molars, once in five years.

8. Space maintainers that replace prematurely lost teeth of eligible Dependent children under age 16, once in five years.
9. Oral surgery including simple and surgical extractions.
10. Denture repairs.
11. Prosthetics: bridges and dentures. If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in five years.
12. Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes, once in five years. Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in 5 years, unless the damage to that tooth was caused by accidental Injury not related to the normal function of the tooth or teeth.
13. Orthodontic care: treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. Applies to eligible Dependent children.
14. Dental implants and bone grafts, limited to once in five years (per tooth).

Section 13.04 Non-Covered Expenses

1. If your eligibility for dental benefits is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.
2. Benefits will not be paid for repair or replacement of an orthodontic appliance.
3. After completion of your orthodontic treatment plan or reaching your orthodontic maximum, no further orthodontic benefits will be provided.
4. If you receive care from more than one Dentist or service provider for the same procedure, benefits will not exceed what would have been paid to one Dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy). If alternative treatments are available, Delta Dental will be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the allowed amount for an amalgam (silver) filling; or services such as fixed bridges, in which case the benefits may be based on the allowed amount for a removable partial denture.
5. Services or supplies for which the Participants, absent this coverage, would normally incur no charge, such as care rendered by a Dentist to a member of his immediate family or the immediate family of his spouse.
6. Services or supplies for which coverage is available under Workers' Compensation or Employers' Liability Laws.
7. Services or supplies performed for cosmetic purposes or to correct congenital malformations except for newborns with congenital dental defects.
8. Charges for services that require multiple visits, which commenced prior to the membership effective date (including, but not limited to, prosthetics and orthodontic care).

9. Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws).

10. Services or supplies not specifically stated as Covered Services (including hospital or prescription drug charges).

11. Replacement of dentures and other dental appliances, which are lost or stolen.

12. Services rendered by a Dentist beyond the scope of his license.

13. Hypnosis.

14. Duplicate services provided by another group dental plan.

15. Diseases contracted or injuries or conditions sustained as a result of any act of war.

16. Denture adjustments for the first six months after the dentures are initially received. Separate fees may not be charged by participating Dentists.

17. Charges for complete occlusal adjustments, crowns for occlusal correction, Nightguards, Bruxism Appliances, and Bite Therapy appliances.

18. Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services, which are part of the complete dental procedure. These services are considered components of, and included in the fee for the complete procedure. Separate fees may not be charged by participating Dentists.

19. Analgesia, including Nitrous Oxide.

20. Charges covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by this program.

21. Services or supplies rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.

22. Services or supplies provided or paid for by any governmental agency or under any governmental program or law, except charges, which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act and its Amendments).

23. Charges for duplication of radiographs.

24. Charges for temporary appliances.

25. Charges for experimental or investigational services or supplies.

26. A Dentist need not provide dental services which for any reason, in his professional judgment, should not be provided. Charges for such services are not covered expenses.

27. Instructions in dental hygiene, dietary planning, or plaque control.

28. Missed appointments or completion of claim forms.

29. Infection control, including sterilization of supplies and equipment.

Section 13.05 Pediatric Care

Benefits are provided under this dental benefit program for essential pediatric dental care provided to a Dependent child under the age of 13. The annual benefit maximum does not apply to essential pediatric dental care. For purposes of this dental benefit program, essential pediatric dental care is defined as periodic age appropriate examinations (for example, checkups and dental x-rays) and medically appropriate treatments necessary to prevent disease (such as cleanings twice a year), as long as such dental care is provided by a Delta Dental participating Dentist or by a non-participating Dentist when there is no participating Dentist within twenty-five (25) miles of the Participant's or Dependent's residence.

Pediatric dental only applies for eligible Dependents of Participants with dental benefits.

Article XIV. Weekly Income and Accidental Death & Dismemberment Benefits

Section 14.01 Weekly Income Benefit

If you are an Active Participant, the Plan includes disability coverage that protects you and your family by providing income in the event you become disabled and cannot work due to a non-occupational disability. Weekly income benefits are not payable for an occupational disability (an Injury or Illness that arises out of or in the course of any employment for wage or profit).

Weekly income benefits are available only to eligible Active Participants, not Retirees or individuals who have coverage under the Plan through COBRA or USERRA.

The benefit is payable for a maximum of thirteen weeks during any one period of disability. The amount of your Weekly Income Benefit is shown in the Summary of Benefits.

For a new Illness or Injury, you are eligible for benefits as long as you have active coverage at the time the disability begins. Active coverage is coverage maintained through employer contributions, not COBRA coverage or Retiree coverage. If you are eligible, benefits will begin on the:

1. Eighth day of your absence due to Illness; or
2. First day of your absence due to Injury.

The Weekly Income Benefit is paid directly by the Welfare Plan from its assets. Payment of benefits is governed by rules adopted by the Trustees. If you are applying for or receiving Weekly Income Benefits, the Trustees may require that you be examined by a Doctor of their choosing.

All disability absences will be considered as having occurred during a single period of disability (same Illness or Injury) unless:

1. Acceptable evidence is furnished that the cause of the subsequent disability absence cannot be connected with the cause of any of the prior disability absences; and
2. Prior to the new Illness or Injury, you returned to work for at least eight (8) hours after the prior period of disability.

For a second period of disability for an Illness or Injury, you are eligible for benefits as follows:

1. The same Injury will be treated as a different Injury if you return to work for 120 hours;
2. There will be a combined maximum of 13 weeks of benefits on the same cause of Injury; and
3. If you return to work after a disability of less than 13 weeks, but do not return to work for at least 120 hours, and subsequently you are unable to work due to the same Injury, then you are entitled to the remainder, if any, of the 13-week benefit from the first disability.

It is not necessary to be confined to your home to collect benefits, but benefits are only payable for the following:

1. Those days on which you are under the care of a legally qualified Doctor. A period of care will be considered to have started when you have been seen and treated personally by the Doctor.
2. Those days on which you are not performing work for compensation or profit.

If you are unable to work due to occupational disability, you may be eligible for Workers' Compensation benefits. Contact your employer or your local workers' compensation office.

The disability absence must begin while you are eligible for Welfare Plan benefits.

The Weekly Income Benefit is paid directly by the Welfare Plan from its assets. Payment of benefits is governed by rules adopted by the Trustees. If you are applying for or receiving Weekly Income Benefits, the Trustees may require that you be examined by a Doctor of their choosing.

Section 14.02 Accidental Death and Dismemberment (AD&D) Insured Benefits

If you are an Active Participant, AD&D coverage provides benefits for your loss of life, limbs, or the entire and irrecoverable loss of sight including losses resulting from occupational bodily Injuries. Benefits are payable if the loss is a direct result of bodily Injury caused by an accident, and the loss is sustained within 90 days after the date of the accident. The Injury causing the loss must occur while insurance is in force. The full amount of the benefit is shown on the Summary of Benefits.

The full amount will be paid for the loss of:

1. Life;
2. Both hands;
3. Both feet;
4. One hand and one foot;
5. One hand and sight of one eye;
6. One foot and sight of one eye; or
7. Sight of both eyes.

AD&D benefits are only available to eligible Active Participants, not to Retirees or individuals covered under the Plan through COBRA or USERRA.

One-half the full amount will be paid for the loss of one hand, one foot, or sight of one eye. In no case will more than the full amount be paid for all losses sustained through any one accident.

AD&D benefits will be paid as soon as practicable after sufficient proof of the loss has been received by the Fund Office and reviewed by the insurer.

Since the purpose of this coverage is to provide benefits for losses due to accidents, no benefit will be paid for any loss that is caused directly by any of the following:

1. Bodily or mental Illness or disease of any kind;
2. Ptomaine or bacterial infections (except ptomaine and bacterial infections occurring as a result of accidental ingestion or infections caused by accidental Injury;
3. Medical or surgical treatment of an Illness or disease not covered by the Plan;
4. Suicide or attempted suicide while sane or insane;
5. Intentional self-inflicted Injury;
6. Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion; or
7. War or act of war, declared or undeclared, or any act related to war or insurrection.

Article XV. Life Insurance

Life insurance is an insured benefit that is generally payable in the event of your death from any cause at any time or place while you are insured. However, exclusions may apply in accordance with the life insurance policy, which is underwritten by The Union Labor Life Insurance Company.

Life insurance and Dependent life insurance are available to eligible Active Participants and Retirees. You do not maintain your coverage under the Plan when you enroll in COBRA or USERRA continuation coverage. However, you may separately convert to an individual plan.

Life insurance benefits will be paid in full in accordance with the terms of the Plan certificate upon verification of proof of death by the Insurance Company.

Payment will be made to your designated beneficiary. You can name any beneficiary you want. If you are married and subsequently divorce, you **must** contact the Fund Office to update the beneficiary designation that it has on file.

1. **Policy Conversion**

   You may arrange with The Union Labor Life Insurance Company to continue your life insurance under an individual policy if you apply for it within 31 days after the date your insurance ends. You may do this without a medical examination. However, if your insurance ends because the Plan ends, you only have the right to convert to an individual policy if your life benefits under this Plan have been in effect for at least five years.

   The beneficiary you name will receive your life insurance benefit in the event of your death. It is important for you to keep your records up to date with the Fund Office.

   You may choose any form of policy except term insurance, without disability or AD&D benefits, at the rate for your class of risk and age at that time. Because the life insurance will be payable if your death occurs during the 31 days after the date your employment ends, the individual policy will not become effective until after the 31-day period has expired.

   If you would like more information about individual policies, contact the insurance company.

2. **Benefits During Total Disability**

   If you become totally and permanently disabled before age 60 while insured and your eligibility for Plan benefits ends, you may be eligible to pay a premium to continue your life insurance benefits.

3. **Dependent Benefits**

   The amount of life insurance shown in the Summary of Benefits is payable to you in the event of the death of one of your Dependents from any cause, at any time or place, while insurance for that Dependent is in force.

   Children under 14 days of age and Dependents in full-time active military service are not eligible.

When your coverage ends, life insurance for your Dependents will end as well. However, if your Dependent dies within 31 days after your insurance ends, benefits will still be payable. You may arrange with The Union Labor Life Insurance Company to continue Dependent life insurance under an individual policy if you apply for it within 31 days after the date your insurance ends. You may do this without a medical examination. This conversion privilege is also provided for your surviving insured Dependents if you die.

Article XVI. Claims and Appeals

Section 16.01 Filing Claims

Most providers will file claims for you. However, in instances when you are required to file a claim, follow the steps described in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed by the Trustees as part of the appeal process. Health care claims can be submitted for review by an Independent Review Organization (IRO).

Most providers will file claims for you. If your provider does not file claims for you, follow the steps listed in this section.

1. **Health Care Claims**

   Most health care providers will submit claims for you. Health care claims include medical, prescription drug, dental and vision benefits. Be sure to show your ID card so your Provider knows where to submit your claim. If your Provider does not submit your claim for you, it is then your responsibility to do so.

   If you or a Dependent are filing a claim directly and you have coverage under two or more health care plans, including Medicare, be sure to include the name of the other health care plan(s) on your claim form. Attach a copy of the itemized bill relating to the health care service provided along with a copy of any explanation of benefits from the other health care plans or Medicare. Both the bill and explanation of benefits must be submitted.

   Health care claims under the Plan are referred to as post-service claims, which are requests for payment or reimbursement of the cost of the care that has already been provided. Post-service claims apply to Comprehensive Medical Expense, dental and vision benefits.

   If you or a Dependent has coverage under more than one health care plan, benefits are coordinated (see Article XVII, page 76).

   When you need to file a medical claim, visit the Anthem website. The Fund Office can provide you with information as to what you need to submit with the claim. To assist the Fund Office in processing claims as quickly as possible, please follow the steps listed below:

   Step 1: Obtain the appropriate claim form from **www.anthem.com**.

   Step 2: Complete the form by filling in all information requested. Be sure to include your plan ID number and sign your form. If the claim is for a Dependent, provide the name of the Dependent.

   Step 3: Have your Provider complete the appropriate portion of the claim form, including the diagnosis.

Step 4: Attach all bills or receipts relating to the service provided. Make sure each bill clearly identifies the diagnosis, the service or supply, the fee, the patient's name and the date of service.

Step 5*:* Forward the completed form and all related bills to the Anthem address on the claim form.

All medical claims should be submitted as soon as possible. If a medical claim is submitted by or for an in-network provider more than six (6) months after the expense is incurred, the claim will be denied; however, you will not be liable to the provider for the expense. If a medical claim is submitted by or for an out-of-network provider more than 15 months after the expense is incurred, the claim will be denied and you may be liable to the provider for the expense.

Your dental claims must be filed by the end of the calendar year following the year in which services were rendered. Delta Dental is not obligated to pay claims submitted after this period. If a claim is denied due to a PPO or Premier participating Dentist's failure to make timely submission, you will not be liable to such Dentist for the amount which would have been payable by Delta Dental, provided you advised the Dentist of your eligibility for benefits at the time of treatment.

2. **Weekly Income Benefit Claims**

   Be sure to notify the Fund Office if you are sick or injured and are unable to work. The Fund Office will send you a claim form. Have your Doctor complete the form. Then send the completed form to the Fund Office as soon as possible. Benefits are not payable until you apply for and submit the required information.

3. **Life Insurance, Dependent Life, and Accidental Death and Dismemberment Benefit Claims**

   In the event of your death, your beneficiary should call the Fund Office for help in filing a claim. You should contact the Fund Office about the Dependent Life benefit if your Dependent dies or if you have an accident that makes you eligible for Accidental Death and Dismemberment benefits.

Section 16.02 Claim Decisions and Benefit Payment

Timing of Claim Decisions

The Plan will notify you of its initial decision in the timeframes below:

1. **Urgent Care Claims.** Urgent care claims are those claims that require notification (such as an Emergency hospitalization) or preauthorization or precertification prior to receiving medical care and where a delay in treatment could seriously jeopardize your life or health, or your ability to regain maximum function or, in the opinion of a Physician knowledgeable about your medical condition, could cause severe pain that cannot be managed without such care or treatment.

An urgent care claim will be resolved as soon as required by your medical condition but no later than 24 hours after the necessary information is provided. If an urgent care claim is filed improperly or if more information is needed, you will be notified about how to properly file the claim or what information is needed within 24 hours after the claim was received. If more information is needed, you will have 48 hours to provide the information. Within 48 hours of receiving the information or, if no additional information is provided, at the end of the period to provide the information, a determination will be made on the claim. If you request more than the 48 hours to provide the additional information, the request will be considered in the context of the urgency for a determination.

Notice of the benefit determination may be made in writing, electronically or orally depending on the circumstances. If your claim is denied in whole or in part you will be notified of the specific reason(s) for the denial with a reference to the applicable section of this Summary Plan Description and any protocol or guidelines used in making the determination. You will also be notified about any medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the determination without regard to whether the advice was relied upon. If your claim was denied because of insufficient information you will be told what information was missing and why that information was necessary. You will be provided a description of the Plan's review procedures and time limits for such procedures including the time for filing an appeal (180 days), the time in which a determination on the appeal must be made (generally 24 hours). You will also be provided with information about your right to request an expedited external review.

If you request an extension of an approved ongoing course of treatment (treatment approved for a specific period of time or a set number of treatments) and your request for an extension meets the definition of an urgent claim then a determination will be made within 24 hours, provided the request is made at least 24 hours before the end of the approved treatment. If your request is made less than 24 hours before the end of the approved treatment then your request will be treated as any other urgent care claim. If you request an extension of an approved course of treatment in non-urgent circumstances, then your claim will be treated as a pre-service or post-service claim, whichever is applicable.

2. **Pre-service claim.** Pre-Service Claims are those claims that require preauthorization or precertification prior to receiving care but are not urgent care claims. You will be notified in writing of the determination for a pre-service claim as soon as possible but no later than 15 calendar days of receipt of the initial claim. If a pre-service claim is filed improperly you will be notified within 5 days after the claim was received of how to properly file the claim. If the initial claim does not contain all the necessary information or if for other reasons beyond the control of the Fund the claim cannot be resolved within the15 day period then the Fund can extend the time period for an additional 15 days. The time to resolve your claim can be extended for only 1 additional 15-day period. The period of time to make a determination, however, may be delayed if the Fund requests additional information from you.

   If there is a need to extend the time period to resolve your claim you will receive a notice of the extension explaining the standards for entitlement to the benefit, why an extension is needed (what issues are unresolved), and what, if any, additional information is needed. If additional information is needed you will have at least 45 days to supply the information.

The time provided for you to provide this additional information extends the period to reach a determination on your claim.

3. **Post-Service Health claims** will be determined (approved or denied in whole or in part) within 30 days of receipt of the claim. The time for deciding the claim may be extended by fifteen (15) days, upon notice to the claimant prior to the expiration of 30 days. If a claim cannot be processed due to insufficient information, the time period for making the decision will be delayed. The Plan will notify the claimant of the missing required information and the claimant will then have 45 days to provide the additional information. The claimant will be notified of the decision within 15 days of the earlier of the date the claimant responds to the request or the end of the 45-day period. If the claimant does not provide the information within the 45-day period, then the claim will be decided on the basis of information available to the Plan and may be denied.

4. **Weekly Income Benefit claims** will be decided (either approved or denied) within 45 days of receipt of the initial claim. If additional time is required to make a determination on the claim (for reasons beyond the control of the Plan), the Plan will notify the Participant within this time. The Plan may extend this 45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, the Plan will notify the Participant that an additional 30 days is necessary. In some instances the Plan may require additional information to process and make a determination on the claim. If such information is required, the Plan will notify the Participant that additional information is required within 45 days of receiving the Participant's request. The Participant then has up to 45 days in which to submit the additional information. If the Participant does not provide the information within this time, then the claim will be decided on the basis of information available to the Plan and may be denied.

5. **Claims for Life Insurance, Dependent Life, and Accidental Death and Dismemberment Insurance Benefits** will be decided within 90 days after the insurance company receives the claim. If circumstances require an extension of time for processing the claim, the claimant will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the insurance company expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

6. **Claims for Dental, and Life Insurance Benefits** will be decided by the insurer, and their turnaround times and extension provisions will apply.

Section 16.03 If a Claim is Denied

If your medical claim is denied (in whole or in part), the Plan will:

1. Notify you of its denial of your claim within the timeframes described above, and
2. Provide you with a notice about that denial that includes the following information:
    a. The specific reason or reasons for the decision;
    b. Reference to the Plan provisions on which the decision was based;
    c. A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;

d. A copy of the Plan's appeal review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim; and

e. Your right to file an external appeal.

In addition, for **health care** and **weekly income benefit** claims the notice will include:

1. A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and

2. A copy of the scientific or clinical judgment, or a statement that a copy is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

Section 16.04 Appealing a Denied Claim to the Board of Trustees

1. **Right to Appeal**

If your claim is denied in whole or in part or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. However, you must fully exhaust the Plan's appeals procedures before you can file a lawsuit under ERISA, the federal law governing employee benefits.

In general, you should send your written request for an appeal addressed to the Board of Trustees at the Fund Office as soon as possible. If your claims is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your written appeal within 180 days from the date of a decision for medical or weekly income benefit claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Fund Office authorizing this representative. Your written request for an appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

a. Submit additional materials, including comments, documents, records, and information relating to the claim for benefits; and

b. Request an opportunity for reasonable access to review and make copies of all relevant documents, records or other information free of charge. Documents, records, and other information that is relevant to your claim may include:

   1) Documents, records, and information that the Plan relied upon, considered, or generated in its review of your claim;

   2) Documents, records, and information that was submitted to the Board of Trustees for the claims review;

   3) Documents, records, and information that shows that the Plan made the claims decision consistently and according to the Plan documents; or

   4) Documents, records, and information that may constitute a statement of Plan policy or guidance regarding your benefit.

2. **Internal Appeal**

If you file your appeal on time and follow all required procedures, then your claim will be reviewed by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor the subordinate of that individual. The appeal will be a full and fair review that takes into account all comments, documents, and other information submitted, without regard to whether such information was submitted or considered in the initial benefit determination. This review will be made independent of the original decision.

In deciding an appeal of any initial adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, or other item is Experimental or Investigative, not Medically Necessary, or not appropriate, the appropriate named fiduciary will:

a. Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment;

b. Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of such individual; and

c. The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The Plan will notify you, in writing, of the decision on any appeal.

3. **Internal Appeal Timeframes**

The Plan's determination of its decision will be made within the following timeframes:

a. **Post-Service Health Care and Weekly Income Benefit Claims.** The Board of Trustees or its committee must make a benefit determination on an appeal pertaining to post-service and Weekly Income Benefit claims no later than the date of the Board of Trustees' quarterly meeting that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination must be made no later than the date of the second quarterly meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting following the Plan's receipt of the request for review. If such an extension is necessary the Plan must provide the claimant with a notice of extension describing the special circumstances and date the benefit determination will be made. The Fund Administrator must notify the claimant of the benefit determination no later than five (5) calendar days after the benefit determination is made.

b. **Non-urgent pre-service claims.** The rules are the same except that the decision on your appeal will be issued within 30 calendar days of the receipt of the appeal.

c. **Urgent Care Claims.** This appeal may be requested by you, your Physician, or the Hospital by contacting the Fund Office. his appeal does not need to be in writing, however, you can provide whatever written support you or your Physician consider appropriate. On appeal, to the extent the matter involves a question requiring medical judgment, the Fund Office will request two Physicians, knowledgeable in the field, who are neither the same Physician nor the subordinate of the Physician, who made the original recommendation, to decide the appeal. If these two Physicians do not agree, then the matter is referred to another Physician for review. The Trustees will issue a determination on the appeal within 72 hours either in writing or electronically. Determinations on appeal will be made within 72 hours, except that if, when the appeal is filed, the claim no longer meets the definition of urgent care (for example if it is now post-service) then the appeal will be handled under the procedures and time periods that are appropriate based on the current status of the claim.

The decisions as to medical necessity or medical appropriateness in connection with an urgent care claim generally do not deal with eligibility for coverage, or other limitations in the Plan such as the exclusion for work related injuries, or limits in the Plan on the number of days of coverage nor do they make a determination as to the Deductible or co-payment. The final determination as to the payment on your claim will be made by the Fund after services are rendered.

4. **Information Requirements**

When the Plan notifies you of its determination on your appeal, it will provide:

a. The specific reason or reasons for the adverse appeal review decision, including reference to the Plan provisions on which the decision was based;

b. A statement notifying you that you have the right to request a free copy of all documents, records and relevant information;

c. A statement informing you of your right to an external appeal;

d. A statement that you may bring a civil action suit under ERISA after you have exhausted the Plan’s appeal procedures;

e. A copy of any internal rule, guideline, protocol or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and

f. A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment or similar exclusion or limit.

If the adverse determination on your claim was based in whole or in part on a medical judgment then the Trustees will consult with an appropriately trained health care professional with experience in the relevant field of medicine who was not consulted in making the initial determination on your claim and who is not a subordinate of the person consulted for the initial determination.

Section 16.05 External Appeal

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

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

2. **Preliminary review**

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

a. You or your Dependent (the claimant) is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

b. The adverse benefit determination or the final adverse benefit determination related to a failure to meet the requirements for eligibility under the terms of the plan (e.g., whether you worked sufficient hours during the eligibility period);

c. The plan's internal appeal process was exhausted unless exhaustion is not required as set out in this procedure; and

d. The claimant provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a written notification. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notification will also describe the information or materials needed to make the request complete. You or the claimant will be allowed to perfect the an incomplete request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**

The Plan will assign an Independent Review Organization (IRO) accredited by URAC or similar nationally-recognized accrediting organization to conduct the external review and will take action against bias and to ensure independence by contracting with at least three (3) IROs and rotate claims assignments among them. In addition, the IRO will not be eligible for any financial incentives based on the likelihood that it will support the denial of benefits. If you would like information regarding the IROs with which the Fund contracts, you may contact the Fund Office.

4. **The External Review Process**

The assigned IRO will:

a. Utilize legal experts where appropriate to make coverage determinations under the plan;

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

c. Within five business days after the date of assignment of the IRO, the Plan will provide the assigned IRO with the documents and any other information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination;

d. Within ten business days following the date of receipt of notice from the IRO that it has received the request for external review, you or the claimant may submit in writing additional information for the IRO to consider. The IRO may, but is not required to, accept and consider additional information submitted after ten business days;

e. Upon receipt of any information from you or the claimant, the assigned IRO will forward the information to the plan within one business day. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination. Reconsideration by the plan, however, will not delay the external review. The external review will be terminated as a result of the reconsideration only if the plan decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan will provide you or the claimant and the assigned IRO with written notice of its decision and the assigned IRO will terminate the external review;

f. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided by the Fund and you or the claimant, to the extent the information or documents are available and the IRO considers them appropriate, the assigned IRO will consider the following:

   1) The claimant's medical records;

   2) The attending health care professional's recommendation;

   3) Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the claimant's treating provider;

   4) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

5) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

6) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

g. The assigned IRO will provide written notice of the final external review decision within 45 days after it receives the request for the external review and will deliver the notice of final external review decision to the claimant and the plan within one business day after making the decision. The assigned IRO's decision notice will contain:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

6) A statement that judicial review may be available to the claimant; and

7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

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

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

6. **Expedited External Review**

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

a. An adverse benefit determination involving a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

b. A final internal adverse benefit determination and the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above and will immediately send the claimant a notice of its eligibility determination. Upon a determination that a request is eligible for external review the plan will assign an IRO and provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. The assigned IRO will provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the plan.

Section 16.06 Legal Action

You may not file legal action to recover benefits against the Plan or any other related party until you have exhausted the internal and external claim appeal procedures.

Section 16.07 Sole Authority on Plan Benefits

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

No action at law or in equity or otherwise may be brought on any claim or other matter whatsoever against the Plan, the Administrator, the Trustees, or any of them, unless all of the required claim procedures and claim appeal procedures under Article XVI of the Plan have been followed and exhausted, nor can such action be brought unless brought within two years from the expiration of the time within which proof of loss is required to be furnished or within the maximum time permitted under the applicable provisions of ERISA.

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

Article XVII. Coordination of Benefits

The Plan has been designed to help you pay for your health care expenses, including medical, prescription drug, vision and dental. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or a covered Dependent have under other health care plans.

This Plan will always pay either its regular benefits in full, or a reduced amount that, when added to the benefits payable by the other plan(s), will equal this Plan's total "allowable expenses." However, no more than the maximum benefits payable under this Plan will be paid.

Other Plan

The term "other plan" refers to any plan providing benefits or services for actual expenses, where benefits or services are provided by:

1. Any group insurance;
2. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, health maintenance and preferred provider organizations, Participant benefits organization plans, or any other arrangement of benefits for individuals of a group; or
3. Any coverage under governmental programs, and any coverage required or provided by any statute.

The term "other plan" will be considered separately for each plan and also between that part of any plan that applies to coordination of benefits provisions and that part which does not.

Section 17.01 Order of Payment

The Plan allows an individual to be covered as both a Participant and as a Dependent of a Participant, as well as a Dependent of more than one Participant. The Plan will be primary for an individual in his/her capacity as a Participant and secondary for his/her capacity as a Dependent. When an individual is a Dependent of more than one person, the "birthday rule" described below will apply.

If you or your Dependent(s) is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefit payable does not exceed 100% of the allowable expense incurred.

These are the Plan's rules for determining which plan is the primary plan:

1. A plan that does not have a coordination of benefits rule is always primary; and
2. A plan that covers an individual as a Participant or Retiree is primary before a plan that covers the person as a Dependent.

3. If a Dependent child is covered under this plan as a Dependent child and another plan through the child's employment or the employment of the child's spouse (Employment Related Plan) then the Employment Related Plan is primary over this plan.

4. If a Dependent child is covered under more plans through more than one parent (or step-parent), the following rules determine which plan is primary:

   If the parents are married:

   a. The plan that covers the parent whose birthday (month and day) occurs earlier in the calendar year is primary;

   b. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary; or

   c. If the other plan does not use the "birthday rule" and as a result, the plans do not agree on the order of benefits, the rules of the other plan determine the order of benefit payments.

   d. If the rules still do not establish an order of payment, the plan that has covered the Dependent for the longer period will pay benefits first.

   Where there is a court order or State agency order (such as a Qualified Medical Child Support Order (QMCSO)) that establishes which parent has legal responsibility for the child's medical expenses, the plan covering the Dependent child of the parent who has legal responsibility is primary.

   If the parents are not married and there is no court order or State agency order that establishes which parent has legal responsibility for the child's medical expenses, then the

   a. Plan of the parent with custody is primary; then

   b. The plan of the step-parent with custody; then

   c. The plan of the parent not having custody; then

   d. The plan of the stepparent without custody.

5. If the above provisions are in conflict with the Coordination of Benefit rules of the other plan or if no other provision applies, the plan that has covered the individual for the longest period is primary, except when:

   a. One plan covers a claimant as a laid-off or a retired Participant (or a Dependent of such a Participant), in which case the plan that covers the claimant as an Active Participant or Dependent of an Active Participant will pay its benefits before the plan that covers the claimant as a laid-off or retired Participant or the Dependent of such a Participant; or

   b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. This Plan will also apply coordination when the primary plan is designed so that it pays a minimal amount and then, if there is other coverage, only pays amounts not paid by a secondary or tertiary plan. In situations where this Plan is secondary and the primary plan pays less when there is secondary coverage than when it is the only coverage, this Plan will only pay the amount you or your Dependent's other plan would not have paid had it been

the only plan providing coverage. **For example:** The other plan pays the first $1,000 at 100% and then pays the remainder at 80% except that if there is secondary coverage the other plan only pays the amounts above $1,000 that are not covered by a secondary plan. In this situation, this Plan will only pay up to 20% of the amount above $1,000. This rule takes precedence over any Coordination of Benefit rule to the contrary in this Plan or the other plan.

Section 17.02 Payment Provisions

When this Plan is secondary and the Fund pays reduced benefits, only the reduced amount is charged against the payment limits of the Plan. If another plan pays benefits that should have been paid by this Plan under the coordination of benefits provisions, the Fund may pay the other plan any amount due. Any amounts paid to another plan for this reason are considered benefits under this Plan. In addition, if the Fund makes payments it is not required to pay, it may recover and collect those payments from you, your Dependents, or any organization or insurance company that should have made the payment.

Section 17.03 Coordination of Benefits with Medicare

Medicare consists of four programs:

1. The first part is officially called “Hospital Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part A of Medicare. It primarily covers Hospital benefits, although it also provides other benefits.
2. The second part is officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part B of Medicare. It primarily covers a Doctor’s services, although it, too, covers a number of other items and services.
3. The third part is “Medicare Advantage,” sometimes called Medicare Part C, and is the managed care program under Medicare.
4. The fourth part is prescription drug coverage, which is commonly referred to as Part D of Medicare.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you are still actively employed and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B of Medicare. **You must enroll in Part B to receive full benefits under this Plan when this Plan is secondary to Medicare (generally after you retire).**

1. **Coordination with Medicare is Mandatory**

   If you retire and are age 65 or disabled, any benefits payable to you or your Dependents under any portion of this Plan will be reduced by the amount of any benefits or other compensation to which you are entitled under any federal law, rules, or regulations

constituting a governmental health plan, such as Medicare. Benefits will similarly be reduced if you or your Dependents are eligible for Medicare as your primary plan, regardless of whether or not you have made application for such benefits or compensation.

For purposes of this provision, if you or your Dependents are entitled to benefits or other compensation under Medicare and you have not applied for both Part A and Part B of Medicare, the Plan will determine the allowable expense applicable under the Plan and pay 20% of the expense.

The Plan will not apply coordination of benefits provisions to Medicaid coverage.

Section 17.04 Information Gathering

Participants must notify the Plan whenever there is a change in coverage. To implement the provisions in this coordination of benefits section, the Trustees may release or obtain any information necessary. Anyone claiming benefits under this Plan must provide any information necessary to implement the coordination of benefits provisions or to determine their applicability.

Section 17.05 Privacy Policy

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended, the Plan protects the confidentiality and security of your private health information. You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

This Plan and the Plan Sponsor will not use or further disclose your protected health information except as necessary for treatment, payment, health plan operations, and Plan administration or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan hires professionals and other companies to assist in providing health care benefits. The Plan requires these entities, called "Business Associates" to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your protected health information include the right to:

1. See and copy your health information;
2. Receive a notice of any breach of your health information;
3. Amend your health information under certain circumstances; and
4. File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

If you need a copy of the Privacy Notice, please contact the Fund Office.

1. **Breach Notification Rights for Unsecured Protected Health Information under HIPAA**

   The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Plan Sponsor to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Plan Sponsor is required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Plan Sponsor to provide notification to the media.

   For purposes of this section, a breach means the acquisition, access, use, or disclosure of protected health information in a manner not permitted under HITECH, which compromises the security or privacy of the protected health information.

   If your unsecured PHI is breached, the Plan Sponsor will notify you without unreasonable delay and in no case no later than 60 calendar days after discover of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Fund up to date with your current mailing address.

   Under HIPAA, you have a statutory right to file a complaint with the Plan Sponsor or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Plan Sponsor has improperly followed the breach notification process.

Article XVIII. Subrogation

If a covered individual's Injury or Illness was caused by the action or inaction of another person or party, that person or party may be responsible for your hospital or medical bills. Automobile accident Injuries or personal Injury suffered on another's property are examples.

The Fund generally does not pay for claims where a third party has liability or for claims that are for work-related Injuries or Illness. Since collecting payments for these expenses from the third party may take a long time, the Fund will provide covered benefits, but the Fund must be repaid from any settlement, judgment award or claim the covered individual may receive. When the Fund does pay for these claims, the Fund is fully subrogated to any and all claims, rights of recovery and causes of action a Participant, Retiree or Dependent (covered individual) has against another party for payment of any Medical Expense Benefits and/or Weekly Income Benefits paid under this Plan.

The Participant or Retiree and, where applicable, any non-minor Dependent (the covered individual) will be required to sign a form, which acknowledges the Fund's right to reimbursement and verifies that the Participant or Retiree and any Dependent will help the Fund secure its rights. The form must be completed before the Fund will make payments on behalf of the covered individual. If the individual has retained an attorney to recover from the third party or insurer, then the attorney must also acknowledge in writing the Fund's right to reimbursement and subrogation.

If a covered individual brings a liability claim against a third party, benefits payable under the Fund must be included in the claim. By accepting benefits from the Fund, Participants, Retirees and Dependent specifically acknowledge and agree that, as set out in the Supreme Court's 2006 opinion in Sereboff v. Mid Atlantic Medical Services, the Fund is granted an equitable lien in the proceeds of any payment, settlement, judgment or other recoveries from any third party (including any tort feasor or insurer) up to the amounts paid by the Fund. This is a first right of reimbursement and once payment is made to or on behalf of a Participant, Retiree or Dependent the Fund is granted a lien that can be satisfied from any identifiable funds in the possession or control of the covered individual or the agent or representative thereof. When the claim is resolved, the covered individual and his or her attorney (if the attorney is holding the monetary recovery) must hold any monetary recovery in constructive trust and promptly reimburse the Fund for the benefits provided, up to the amount of the monetary recovery. The covered individual and the attorney (if the attorney is holding the monetary recovery) will be fiduciaries with respect to the monetary recovery.

In addition, the Fund is granted a specific and first priority right to reimbursement in any recovery regardless of the manner in which the recovery is structured or worded and regardless of whether the covered individual has been "made whole" by the settlement. The Fund's reimbursement will not be reduced by attorney's fees, absent consent of the Board of Trustees. In addition to its right to reimbursement, the Fund is subrogated to the covered individual's claim and may therefore make a claim or bring any action against such third party to recover any benefits paid on behalf of the covered individual by the Fund.

Participants, Retirees and Dependents are legally obligated to avoid doing anything that would prejudice the Fund's right of reimbursement and subrogation. However, the Fund will be entitled to recover in accordance with these rules, even if the covered individual does not sign or return its forms. Failure to cooperate may result in disqualification from receipt of future benefits from the Fund for the Participant or Retiree and his or her Dependents.

In addition, by accepting benefits from this Fund, Participants, Retirees and Dependents specifically agree if the covered individual does not reimburse the Fund from the third party recovery then, the Fund may offset any future benefits otherwise payable to that individual with interest of 10 percent per annum. If the Fund prevails in a lawsuit to enforce its Reimbursement and Subrogation Agreement and/or these rules, the Fund will be entitled to recover benefits paid on your or your Dependent's behalf, together with interest at 10 percent per annum plus reasonable attorney's fees and costs.

Article XIX. Important Plan Information

1. **Plan Name**

   The Plan is known as the Iron Workers St. Louis District Council Welfare Plan.

2. **Identification Numbers**

   The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service (IRS) is 43-0684998. The Plan number assigned to this Plan by the Board of Trustees per IRS instructions is 501.

3. **Plan Fiscal Year**

   The financial records of this Plan are based on a fiscal year, which begins November 1 and ends October 31. Annual benefit periods are based on the calendar year, which begins on January 1 and ends December 31.

4. **Plan Sponsor and Plan Administrator**

   A Board of Trustees is responsible for the operation of this Plan. Although the Trustees are legally designated as the Plan Sponsor and Plan Administrator, they have delegated certain administrative responsibilities to other individuals and organizations.

   The Board of Trustees consists of Employer and Union representatives selected by the Employers and Union who have entered into collective bargaining agreements that relate to this Plan. If you want to contact the Board of Trustees, you may use the address and phone number of the Fund Office below:

   Board of Trustees
   Iron Workers St. Louis District Council Welfare Plan
   13801 Riverport Drive, Suite 401
   Maryland Heights, Missouri 63043
   Telephone Number: 1-877-597-8704
   Facsimile: 314-739-1105

The Trustees of this Welfare Plan are:

Union Trustees	**Employer Trustees**
Mr. Shane Austin Iron Workers Local No. 46 2888 East Cook Street Springfield, IL 62703	Mr. Steve Halverson Halverson Construction Co., Inc. 620 North 19th Street Springfield, IL 62702
Mr. John Davis Iron Workers Local No. 782 2424 Cairo Road Paducah, KY 42001	Mr. Dennis Hellenberg Lin-Berg Construction 1000 North Main Street Mt. Vernon, IN 47620
Mr. Steve Dowell Iron Workers Local No. 577 16452 Highway 34 West Burlington, IA 52655	Mr. Bill Kroeger Associated General Contractors of St. Louis 6330 Knox Industrial Dr., Suite 200 St. Louis, MO 63139
Mr. Robert Garmoe Iron Workers Local No. 321 1315 West Second Street Little Rock, AR 72201	Mr. Ronald Mikel Area Bargaining Unit 1224 N. Elson Kirksville, MO 63501
Mr. Tommy Garrett Iron Workers Local No. 103 5313 Old Booneville Highway Evansville, IN 47715	Mr. Richard Pengress West KY Construction Employers 430 Weidlocher Lane Anna, IL 62906
Mr. Thomas McNeil Iron Workers Local No. 396 2500 59th Street St. Louis, MO 63110	Mr. Scott Reiman PJR & Associates, Inc. Post Office Box 52 Campbell Hill, IL 62916
Mr. Dan O'Sullivan Iron Workers Local No. 392 2995 Kingshighway East St. Louis, IL 62201	Mr. Boyed Sanders Boyed Sanders Construction, Inc. 14 Gingerbread Lane Conway, AR 72032

5. **Administrator**

BeneSys, Inc.
13801 Riverport Drive, Suite 401
Maryland Heights, MO 63043

6. **Fund Counsel**

Schuchat, Cook & Werner
The Shell Building, Second Floor
1221 Locust Street, 2nd Floor
St. Louis, MO 63103

7. **Fund Consultant**

The Segal Company
101 N. Wacker, Suite 500
Chicago, IL 60606

8. **Agent for Service of Legal Process**

If legal disputes involving the Plan arise, service of legal process may be made upon the Administrator or any individual Plan Trustee at the Fund Office.

9. **Parties to the Collective Bargaining Agreement**

This Plan is maintained pursuant to collective bargaining agreements between Employers and the Union. Upon written request, the Fund Office will provide you with a copy of the collective bargaining agreement under which you are covered. The Fund Office will also provide, upon written request, information as to whether a particular employer is participating and, if so, the name and address of the employer. The collective bargaining agreements specify the amount of contributions, due date of employer contributions, and type of work for which contributions are payable.

10. **Plan Funding**

All Plan benefits, except life insurance, dependent life, accidental death and dismemberment, and dental, which are insured plans, are paid directly from accumulated assets of the Fund. Employer contributions, self-payment contributions, and investment earnings finance the Plan's benefits. All employer contributions and self-payments are paid to the Fund subject to the provisions of collective bargaining agreements. The agreements specify the amount of contributions, due date of contributions, type of work for which contributions are payable, and the geographic area covered by the labor contract. A portion of Fund assets are also allocated for reserves to meet future liabilities and to carry out the objectives of the Plan.

All contributions to the Plan are made by employers in accordance with their collective bargaining agreements with the following local unions:

Iron Workers Local 392
2995 Kingshighway
East St. Louis, IL 62201

Iron Workers Local 577
Box 306 E-1
Burlington, IA 52655

Iron Workers Local 782
1115 Broadway
Paducah, KY 42001

Iron Workers Local 321
1315 West Second Street
Little Rock, AR 72201

Iron Workers Local 396
2500 59th Street
St. Louis, MO 63110

Iron Workers Local 46
2888 East Cook Street
Springfield, IL 62707

Iron Workers Local 103
5313 Old Boonville Highway
Evansville, IN 47711

11. **Plan Type**

The Plan is a welfare benefits plan providing self-funded and fully insured medical, prescription drug, dental, and vision benefits. This Plan also provides insured Weekly Income, Life Insurance and Accidental Death & Dismemberment Benefits.

12. **Eligibility Requirements**

The Plan's requirements with respect to eligibility for benefits are described in this booklet. Circumstances that may cause a Participants to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of employment and you are not vested in the benefits described in this booklet.

13. **Severability Clause and Conformity with the Law**

Should any provision of the Plan or this Plan document or any amendment thereto be deemed or held to be unlawful, or unlawful as to any person or instance, such facts will not adversely affect the other provisions herein and therein contained or the application of those provisions to any other person or instance, unless such illegality will make impossible or impracticable the functioning of the Plan.

To the extent permitted by law, the Trustees will not be held liable for any act done or performed in pursuance of any provisions hereof prior to the time that such act or provision is held unlawful by a court of competent jurisdiction.

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

14. **Examinations**

The Trustees will have the right and opportunity:

a. To employ a Doctor to examine the person whose Injury or Illness is the basis of a claim hereunder when and so often as they may reasonably require during the pendency of a claim hereunder; and

b. To examine any and all Hospital or medical records relating to a claim under this Plan; and

c. To make an autopsy in case of death, provided an autopsy is not forbidden by law.

15. **Workers' Compensation Not Affected**

This Plan is not issued in lieu of, nor does it affect any requirement for, coverage by any Workers' Compensation Law, Occupational Disease Law or similar laws.

16. **Release of Information**

To the extent consistent with applicable State and Federal law and subject to the rules and regulations that govern the Plan, an Eligible Participant making application for benefits will be required by the Plan to authorize any Doctor, Hospital, employer, government agency or any other person, corporation or organization having relevant health related information, which may be required for a proper determination of the claim by the Plan, to

release such information to the Plan. Each Participant, Retiree, and Dependent will also authorize the Plan to release relevant health related information to third parties, if necessary to provide medical services, or to facilitate the payment of benefit claims hereunder, provided, however, no authorization will be required if such authorization would violate applicable State and Federal laws. The information will be requested for the purposes of treatment, payment and plan administration and the authorization is intended to comply with all the requirements of the Administrative Simplification rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By making a claim for benefits an individual will be deemed to have authorized a release of information pursuant to this section.

17. **Right to Recovery**

Whenever the Trustees pay benefits that exceed the amount of benefits that should be paid under the terms of this Plan, the Trustees will have the right, to the greatest extent allowed by law, to recover the wrongfully paid benefits from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of a Participant, Retiree, or Dependent, the Plan, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments or institute legal action to collect the overpayment.

To the extent an overpayment is made, any person, or agent for such person, benefiting from the overpayment will be deemed to hold the excess payment or the benefit received as a result of the excess payment in an equitable and constructive trust for the benefit of the Fund.

18. **Misrepresentation or Falsification of Claim**

If any individual knowingly misrepresents or falsifies any information or any matters in connection with a claim filed for Plan benefits, the Trustees may, in their sole discretion, deny all or part of the benefits that might otherwise be due in connection with the claim. If benefits are paid and it is later determined that they were paid as a result of a misrepresentation or false information then the Trustees may, in their sole discretion, withhold future benefits to collect amounts paid in error.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Plan may also obtain reimbursement of interest, professional fees incurred and other damages related to that overpayment.

Except as the context may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders, unless the context requires otherwise. Any reference to the singular may also apply to the plural and vice versa, unless the context requires otherwise or the result would be irreconcilable.

19. **Governing Law**

All questions pertaining to the validity and construction of the Trust Agreement, the Plan, and of the acts and transactions of the Trustees or of any matter affecting the Fund will be determined under Federal law where applicable Federal law exists. Where no applicable Federal law exists, the laws of the State of Missouri will apply.

20. **Trustee Authority and Interpretation**

The Trustees will have the power and authority to increase, decrease, or change benefits, or change eligibility rules or other provisions of the Plan of benefits as may in their sole and unrestricted discretion be proper or necessary for the sound and efficient administration of the Fund, provided that such changes are not inconsistent with the law or with the provisions of this Plan or with the provisions of the Trust Agreement.

The Trustees will have the power to construe this Plan Document, the Trust Agreement, the procedures and regulations of the Plan, and other Plan documents. The Trustees' interpretation will be binding on all involved parties hereto, including but not limited to eligible Participants, Retirees, Dependents, and beneficiaries of Participants and Retirees. The decisions of the Trustees will be given judicial deference in any court proceeding regarding benefits of this Plan, unless they are found to be arbitrary or capricious.

The Trustees may amend this Plan in accordance with the procedures set forth in the Trust Agreement, which amendment will be reduced to writing and may be effective prospectively or retrospectively. All amendments are subject to the limitations of the Trust Agreement and the applicable law and administrative regulations. Participants, Retirees, and their Dependents of the Plan will be notified in writing of any Plan amendments.

21. **Payment of Benefits**

Benefits are payable to the Participant, or Retiree whose Injury or Illness or whose Dependent's Injury or Illness is the basis for a claim under the Plan, except that:

a. In the event of the Participant's (or Retiree's) death, any applicable death benefits will be payable in accordance with the payment provisions as described in the Summary of Benefits;

b. In the event that an unpaid Hospital bill, Doctor's bill, or bill from any other provider providing medical services or supplies that are covered by this Plan is submitted to the Trustees, the payment may be made directly to the Hospital, Doctor, or provider;

c. To the extent that a Participant or a Participant's Dependent, or a Retiree or a Retiree's Dependent, has filed a written assignment to make payment directly to a provider of medical services or supplies, payments will be made in accordance with the assignment. No other assignment of any present or future right, interest, or benefit under this Plan will bind the Trustees without their written consent thereto;

d. Benefits payable for any loss will be paid upon receipt of written proof covering the occurrence, character, and extent of the event for which claim is made, provided such proof is provided within the time limitations shown in the Claims and Appeals section of this document;

e. Subject to proof of loss, Weekly Income Benefits will be paid each week during the continuance of the period for which benefits are payable;

f. If any individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed for that individual, the Trustees may, at their option, make such payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of such individual. If the individual should die before all amounts due and payable have been paid, the Trustees may, at their option, make such payment to the executor, administrator or personal representative of the individual's estate or to the individual's surviving spouse, parent, child or children, or to any other person or persons who, in the Trustees' opinion, are entitled thereto; and

g. Any payments made by the Trustees in accordance with these provisions will fully discharge the liability of the Trustees to the extent of such payment.

22. Payment of Benefits on Plan Termination

Participants (and Retirees) are not vested in the benefits provided by this Plan. The Trustees may terminate this Plan of Benefits under certain circumstances, for example, if future collective bargaining agreements and participation agreements do not require employer contributions to the Plan.

If it should happen that the Plan is terminated, benefits for Covered Charges incurred before the termination date fixed by the Trustees will be paid as long as the Plan's assets are more than the Plan's liabilities.

Full benefits may not be paid if the Plan's liabilities are more than its assets.

If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement. In no event will assets be paid to or recoverable by any contributing employer, association, or labor organization.

23. Official Plan Documents Govern

This booklet is intended to be written in clear, understandable, and informal language and contains the majority of the specific descriptions of the self-insured benefits. This document, along with the wrap Plan document, constitutes the Plan Document under ERISA. You should refer to the underlying insurance agreements for more information on the insured benefits. Other important Plan Documents include the Agreement and Declaration of Trust and the collective bargaining agreements.

Article XX. Statement of ERISA Rights

As a Participants in the Iron Workers St. Louis District Council 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 are entitled to the rights described in this section.

1. **Receive Information About Plan and Benefits**

   You have the right to:

   a. Examine, without charge at the Administrator's Office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts, applicable 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 (EBSA).

   b. Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts, applicable collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

2. **Continue Group Health Plan Coverage**

   You also have the right to:

   a. Continue healthcare 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. The Fund Office will provide you with the rules governing your COBRA Continuation Coverage rights.

   b. Reduce or eliminate exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the Plan when:

      1) You lose coverage under the Plan, including the loss of coverage due to reaching the Plan's lifetime maximum;

      2) You become entitled to elect COBRA Continuation Coverage; or

      3) Your COBRA Continuation Coverage ceases.

   You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

3. **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 Participant benefit plan. The people who operate the 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.

4. **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 the Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures. 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 you believe that Plan fiduciaries have misused the Plan's money, or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. **Assistance with Questions**

If you have any questions about the Plan, you should contact the 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 Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) at:

National Office

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
866-444-3272

Nearest Regional Office

Employee Benefits Security Administration
Kansas City Regional Office
2300 Main St, Ste. 1100
Kansas City, MO 64108
816-285-1800

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the web site of the EBSA at **www.dol.gov/ebsa**.

Article XXI. Definitions

The following are definitions of specific words and terms used in this SPD that may be helpful in understanding covered or excluded services.

1. **Active Participant/Participant**

   An Active Participant is an employee who is eligible for benefits as a result of employer contributions.

   A Participant is anyone covered by the Plan.

2. **Allowed Amount**

   The Allowed Amount is the maximum amount on which payment is based for covered health care services. This may be a negotiated amount or any usual, customary and reasonable item of expense for medical care or treatment that is covered under at least one of the plans covering the eligible person for whom a claim is made.

3. **Covered Charges**

   Covered Charges means the Allowed Amount for Medically Necessary services, supplies and treatments, which are:

   a. Covered under this Plan;

   b. For medical conditions covered under this Plan; and

   c. Are in accordance with accepted standards of medical practice.

4. **Dentist**

   Dentist means a person who is licensed to practice dentistry or perform oral surgery in the state in which he is practicing, and who is acting within the scope of that license. For the purpose of this definition, a Doctor will be considered to be a Dentist when he performs a covered dental service and is operating within the scope of his license.

5. **Dependent**

   Dependent means any one of the following individuals:

   a. The Participant's or Retiree's lawful spouse;

   b. The Participant's or Retiree's child who is younger than age 26. A person qualifies as a child under the Plan if he or she is related to the Participant or Retiree in one of the following ways:

      1) A natural child;

      2) A step-child;

3) An adopted child (an adopted child will be considered to be adopted from the date of placement in the physical custody of the adoptive parent). Coverage for an adopted child will be on the same basis as other Dependents, including necessary treatment of medical conditions that existed prior to the date of placement. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement;

4) A foster child who has been placed with the Participant or Retiree by an authorized placement agency or court judgment, decree or order;

5) A child is also considered to be a Dependent if the Participant or Retiree is a legal guardian for said child, provided that the child depends on the Participant or Retiree for more than one-half of the child's support and such child maintains a principal residence with the Participant or Retiree and is a member of the Participant's or Retiree's household for the entire year; and

6) A child who is named as an alternate recipient under a Qualified Medical Support Order (QMCSO).

c. An unmarried child whose coverage would otherwise end due to reaching age 26 will continue to be considered a Dependent if all of the following apply:

1) The child is Dependent upon the Participant or Retiree for more than one-half of the his or her support for the calendar year and maintains a principal residence with the Participant or Retiree for more than one-half of the calendar year;

2) The child is permanently and totally disabled, which means the child is unable to engage in any gainful activity by reasons of a medically determined physical or mental impairment that is expected to result in death or last for a continuous period of twelve months or more;

3) The child became disabled prior to reaching age 26 and, as of the date of disability, the child was covered under the Plan;

4) Written evidence of the disability is sent to the Fund Office within 31 days after the child reaches age 26; and

5) Proof that the child continues to be so disabled is sent to the Fund Office from time to time as requested.

d. The Participant's or Retiree's child for whom the Participant or Retiree has been appointed legal guardian (as described in (b), or unmarried disabled child who has reached age 26 (as described in (c)), and who does not live with the Participant or Retiree, provided that there is a court order requiring the Participant or Retiree to provide health and welfare coverage, or provided that:

1) The child's parents are divorced or legally separated under a decree of divorce or separate maintenance;

2) One of the child's parents can claim the child as a tax Dependent; and

3) The child is in the custody of, and resides with, one or both parents for more than one-half of the calendar year.

6. **Doctor**

Doctor means a person who is licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy, or a person who is a licensed Dentist, Oral Surgeon, Podiatrist, Midwife, Chiropractor, Masters of Social Work (MSW) or Licensed Clinical Social Worker (LSW) who is practicing within the scope of his or her profession. For purposes of the Plan, the term "Doctor" does not include you, or any person who is related to you by blood or marriage, or who normally resides in your home, even if he or she otherwise satisfies the above-described requirements.

7. **Employee/Active Employee**

An Employee is an individual who is eligible for benefits according to the standards shown in the eligibility rules.

An Active Employee is one whose eligibility is maintained through employer contributions.

8. **Experimental or Investigative**

The use of any treatment, procedure, facility, equipment, drug, device, or supply not yet generally recognized as accepted medical practice and any items requiring Federal or other governmental agency approval for which approval had not been granted at the time such service or supply was rendered or provided.

Experimental or Experimental Procedure means:

a. Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is meant to investigate and is limited to research;

b. Techniques that are restricted to use at centers that are capable of carrying out disciplined clinical efforts and scientific studies;

c. Procedures which are not proven in an objective way to have therapeutic value or benefit; and

d. Any procedure or treatment whose effectiveness is medically questionable.

The exclusion of coverage for Experimental procedures does not apply to in-network "routine patient costs" incurred by a "qualified individual" in connection with participation in an "approved clinical trial" (see Section 10.03 item 30 on page 43 for coverage in connection with a clinical trial).

9. **Habilitation Services**

Habilitation Services means health care services that help a person keep, learn or improve skills and functioning for daily living. The Plan may cover some Habilitation Services as set out in this SPD.

10. **Hospital**

Hospital means an institution that meets the following criteria:

a. Is primarily engaged in providing, by or under the supervision of Doctors, inpatient diagnostic surgical and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick persons;

b. Maintains clinical records on all patients;

c. Has bylaws in effect with respect to its staff of Doctors;

d. Has a requirement that every patient be under the care of a Doctor;

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

f. Has in effect a Hospital utilization review plan; and

g. Is licensed pursuant to any state or agency of the state responsible for licensing Hospitals.

Unless specifically provided, the term Hospital does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facilities operated exclusively for treatment of the aged or drug addicts. It does not mean any institution that makes a charge that you are not required to pay.

11. **Illness**

Illness means a related sickness, disorder or disease. Only non-employment related Illnesses are considered.

12. **Injury**

Injury means physical damage to a person's body caused by an accident and independent of all other causes. Only non-employment related Injuries are considered for benefits under this Plan, except under the AD&D benefit.

13. **Medically Necessary**

Medically Necessary means any health care services, supplies, treatment, or Hospital confinement (or part of a Hospital confinement) which:

a. Is essential for the diagnosis, prevention or treatment of the Injury or Illness for which it is prescribed or performed;

b. Meets generally accepted standards of medical practice; and

c. Is ordered by a Doctor.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the expense a Covered Charge.

14. **Medicare Benefits**

Medicare Benefits means benefits for services and supplies, which the eligible person receives or is entitled to receive under Medicare Parts A or B.

15. **Mental Health Treatment**

Mental Health Treatment means inpatient and outpatient treatment for a mental health disorder, which is any Illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Mental health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by an M.D., or Ph.D. who is a Psychiatrist, or Psychologist or by a Masters of Social Work (MSW) or Licensed Clinical Social Worker (LSW).

16. **Owner-operator**

An individual who works, or previously worked (alumni) as an ironworker will not be considered a Participant and will be considered an owner if he or she is:

a. A partner (at any percentage) of a business, which is a Contributing Employer;

b. The sole proprietor of a business, which is a Contributing Employer;

c. The president or a shareholder (of any number of shares) of a corporation, which is a Contributing Employer;

d. An immediate family member of an individual described in (a), (b), or (c) above; or

e. Anyone else whose ownership would, in the opinion of the Trustees, jeopardize the tax exempt status of the Fund or violate the provisions of ERISA.

Any individual who meets the definition of owner, except one whose ownership status would, in the opinion of the Trustees, jeopardize the tax exempt status of the Fund or violate the provisions of ERISA, may elect to participate. An individual who elects to participate must report and pay contributions on an average of 142 hours a month, with a minimum of 425 hours in any calendar quarter, and on actual hours worked with the tools if they exceed 425 hours in any calendar quarter. To maintain eligibility for a quarter, the individual must have reported and paid contributions for a minimum of 425 hours in each quarter of the accrual period which is the two consecutive quarters prior to the benefit period.

17. **Rehabilitation Services**

Rehabilitation Services means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. The Plan may cover some Rehabilitation Services as set out in this SPD.

18. **Totally Disabled or Total Disability**

Totally Disabled or Total Disability, unless otherwise specifically defined, refer to disability resulting solely from a bodily Injury or sickness that prevents a Participant from engaging in any occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health and the person is eligible for Social Security disability benefits. A copy of the Social Security Administration Award is required for proof of Total Disability. Disability for purposes of this Welfare Plan may not be the same as for pension or other benefits.

19. **Usual, Customary and Reasonable (UCR)**

The Usual, Customary and Reasonable (UCR) fee or charge for the services rendered and the supplies furnished in the area that such services are rendered or supplies are furnished, provided such services and supplies are recommended and approved by a Doctor or surgeon other than an eligible person.

UCR charges are based on data obtained from sources, such as MEDICODE, HIAA, and other schedules for relevant zip code areas at a percentile that the Trustees adopt.

A charge is considered to be:

a. ***Usual*** if it is the fee charged by a provider to the majority of patients for a given service, supply, medication, or equipment;

b. ***Customary*** if it is the fee charged by the majority of providers within the same general geographic area for similar care; and

c. ***Reasonable*** if the fee charged is based on the nature and severity of the condition being treated.

Should you require surgery, you should ask your Doctor to submit the surgical procedure codes and his or her fee to the Fund Office in advance of the surgery. You will then be advised if the Doctor’s fee is greater than the UCR charge. This way you are aware, in advance, if there are any amounts that exceed the UCR charge amounts for which you will be held responsible and whether the procedure is covered.

Article XXII. Reciprocity

Section 1. Purpose

Eligibility is continued for health, welfare and insurance benefits for Employees who would otherwise lose eligibility for benefits because their employment is divided between Local Union jurisdictions and in some cases such Employees may not have sufficient hours of contributions in one Fund to be eligible for benefits because of the division of hours and contributions among such Funds. The Welfare Fund participates in both Point-of-Claim and Money-Follows-The-Man Reciprocity.

Section 2. Definitions

1. "Employee" will mean any employee on whose behalf payments are required to be made to a Cooperating Fund by an Employer pursuant to a collective bargaining agreement or other written agreement with a Local Union or District Council of the International Association of Bridge, Structural and Ornamental Iron Workers.
2. "Employer" will mean any employer signatory to a collective bargaining agreement or other written agreement providing for contributions to a Cooperating Fund.
3. "Cooperating Fund" will mean any Health, Welfare or Insurance Fund, which by resolution of the Board of Trustees, has approved participation in and executed the Iron Workers International Health and Welfare Reciprocal Agreement.
4. ("Home Fund." Each Employee who has Employer contributions made on his behalf to one or more of the Cooperating Funds will have a determined Home Fund. In the absence of evidence substantiating a claim to the contrary, the following rules will be used in determining an Employee's Home Fund:
    a. If the Employee is a member of a local union and he has established eligibility in a Health and Welfare Fund in which his local union participates, that Fund will be his Home Fund.
    b. If an Employee is not a member of a local union or if he has not established eligibility in a Health and Welfare Fund, his Home Fund will be that Cooperating Fund which has received the largest amount of contributions on his behalf in the preceding twelve month period.

Section 3. Point-of-Claim Reciprocity

3.1. Transfer of Contributions

a. Employment in Other Than Home Fund Jurisdiction: If an Employee is working in the jurisdiction of a Cooperating Fund other than his Home Fund, and he is not eligible for benefits from that Cooperating Fund, he will continue to file all claims incurred with his Home Fund for so long as he remains eligible in his Home Fund. If he is not eligible in his Home Fund, but is eligible in another Cooperating Fund, such claim will be filed with that Cooperating Fund. If the Employee is not eligible in any

Cooperating Fund, then the claim will be filed with his Home Fund, which will contact the other Cooperating Funds in whose jurisdiction the Employee worked to determine if a transfer of contributions will reinstate the Employee's eligibility in his Home Fund at the time the claim was incurred. If such a transfer will make the Employee so eligible in his Home Fund the contributions will be transferred in accordance with the following paragraph (b).

b. Transfer of Contributions to Home Fund:

1) Upon a request by a Home Fund to another Cooperating Fund in whose jurisdiction an Employee has worked, the Cooperating Fund will, subject to the conditions of Section 3(a) of this Section, transfer all Employer contributions made on the Employee's behalf back to his Home Fund. The amount of contributions transferred will be based on all of the Employee's hours of work up to and including the month in which the claim was incurred during the eligibility period set forth in the Home Fund's Plan. Such hours, will be multiplied by the contribution rate of the transferring Co-operating Fund. Upon transfer of hours and contributions, such hours transferred will not be used for determining future eligibility for the Employee under the Cooperating Fund's rules.

2) Hours and contributions will first be transferred from the Cooperating Fund in whose jurisdiction the Employee was working when the claim was incurred. If those hours and contributions do not result in establishing the Employee's eligibility on the basis of hours, then contributions will be transferred from all other Cooperating Funds in reverse order of employment until such eligibility is established within the Home Fund's eligibility period.

3) Upon the transfer of contributions by a Cooperating Fund in connection with an Employee's claim, the hours represented by such contributions transferred will not be included in a determination of eligibility for benefits for that Employee under that Cooperating Fund's rules. However, subsequent hours worked, but not transferred, in the jurisdiction of the Cooperating Fund will be used in the determination of such an Employee's eligibility for benefits.

3.2. Designation of New Home Fund

If an Employee changes his membership from one Local Union to another Local Union, his Home Fund will be the Health, Welfare or Insurance Fund in the jurisdiction of his new Local Union. Claims incurred by such an Employee will be filed with his new Home Fund if he is eligible under the new Home Fund. If he is not eligible in his new Home Fund, but is eligible in his prior Home Fund, such claims will be filed with his prior Home Fund. If he is not eligible in either his new Home Fund or the prior Home Fund, but would be eligible in the new Home Fund if contributions were transferred from his prior Home Fund, the contributions will be transferred in accordance with Section 3.3 to the new Home Fund as designated.

3.3. Transfer of Contributions to New Home Fund

Upon a request from a new Home Fund to a prior Home Fund, the prior Home Fund will transfer employer contributions made on the Employee's behalf to the new Home Fund. The amount of contributions transferred will be based on the Employee's actual hours of work during the period that will establish his eligibility in the new Home Fund for the claim he has incurred. However, such hours will be limited to those worked after the date on which such Employee lost eligibility in his prior Home Fund. In any event, such hours will not include hours that an Employee may have to his credit in any "hour bank" arrangement. Such hours will be multiplied by the contribution rate to be transferred. The transfer of hours and contributions will be made within thirty (30) days of the date requested by the Home Fund or the new Home Fund.

Section 4. Money-Follows-The-Man Reciprocity

4.1. Employee Authorization

If contributions are or will be made on an Employee's behalf to a Cooperating Fund participating in Money-Follows-The-Man Reciprocity, he may, provided his Home Fund also participates, file a request with the Cooperating Fund that such contributions be transferred to his Home Fund on his behalf. Such request will be made in writing on a form approved by the respective Funds, which is signed and dated by the Employee. Said request form will release the Boards of Trustees of the respective Funds from any liability or claim by an Employee, or anyone claiming through him, that the transfer of contributions may not work to his best interest. Said completed request form will be filed by the Employee with the Cooperating Fund within sixty (60) days following the beginning of his employment within the Cooperating Fund's jurisdiction, provided however, that the Board of Trustees of the Cooperating Fund may, at its discretion, grant an extension of that sixty (60) day period for special circumstances.

If the Employee does not file a timely request form with the Cooperating Fund, he will be treated as electing not to authorize a transfer of contributions and the Point-of-Claim provisions of the Cooperating Fund's Plan will apply to the Employee.

4.2. Transfer of Contributions

Upon receipt of a timely and properly completed request for a transfer of contributions to the Employee's Home Fund, the Cooperating Fund will collect and transfer to the Employee's Home Fund the contributions required to be made to the Cooperating Fund on the Employee's behalf. Said contributions will be forwarded to the Employee's Home Fund within sixty (60) calendar days following the calendar month in which the contributions were received. The contributions so transferred will be accompanied by such records or report, which are necessary or appropriate. The Cooperating Fund will transfer the actual dollar amount of contributions received regardless of any difference in the contribution rates between the Funds.

Section 5. Eligibility

The Board of Trustees of each Home Fund will be responsible for determining whether an Employee is eligible to receive benefits under the Home Fund's plan based on the Home Fund's eligibility rules and a uniform application of how such transferred contributions should be credited.