Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust

Plan Document and
Summary Plan Description for Active Metal Building Employees

January 1, 2016

Iron Workers District Council of Southern Ohio & Vicinity
Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156
Benefit Trust Office: (937) 454-1744 or (800) 331-4277

Mailing Address:
P.O. Box 398
Dayton, OH 45401-0398

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This Summary Plan Description has been prepared for active Metal Building Participants of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust. The Trustees reserve the right to interpret, amend, or terminate the Plan at any time. The benefits provided by this Plan are not vested and can be modified and/or eliminated by the Board of Trustees at any time.

Disclaimer: *Your employment under the Metal Building and Canopy Agreement requires employer contributions to the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust that are <u>less</u> than the employer contributions required under other collective bargaining agreements covering journeymen, apprentices, and other classifications of ironworkers. As a result, eligible Metal Building Agreement employees are <u>not</u> entitled to the benefits provided to ironworkers employed under the other collective bargaining agreements.*

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Introduction

The Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust is pleased to provide you with this Plan Document and Summary Plan Description, which contains benefits information for employees working under the **Iron Workers District Council of Southern Ohio and Vicinity Metal Building and Canopy Agreement**. This document serves as the Plan Document. The benefits described in this booklet are generally effective January 1, 2016 but your effective date will depend on when you meet the eligibility requirements. This Plan Document and Summary Plan Description document replaces and supersedes any prior Plan Document and Summary Plan Description.

The Plan provides coverage for Active Participants and their Dependents only. **The Plan provides medical and prescription benefits only.** The Plan has contracted with a third party to administer medical and prescription drug benefits. Please refer to the latter part of this booklet for details of the third party administrator.

It is the Trustees' goal to maintain a financially stable Fund while providing adequate health care coverage to you and your family. The Fund has implemented some cost-saving methods such as medical Deductibles and out-of-pocket maximums to ensure that we can meet your current and future health care needs. You can do your part in helping the Fund manage health care costs by:

If you have questions about how the Plan works, please call or write:

Benefit Trust Office
1470 Worldwide Place
Vandalia, OH 45377-1156
(937) 454-1744 or (800) 331-4277

Benefit Trust Office Mailing Address:
P.O. Box 398
Dayton, OH 45401-0398

- **Visiting Network Providers –** Network Providers and participating Providers, including Hospitals, Physicians, and other health care Providers, charge negotiated, reduced rates. In addition, for Active Participants and Dependents, the Plan pays a higher percentage when you use a Network Provider.
- **Examining Emergency Treatment Alternatives –** In the event of an Emergency, the most important consideration is to seek medical care, especially in a life-threatening situation. However, in some cases, you can obtain the same level of care at a Physician's office or an urgent care facility as is available in an emergency room. Keep your Physician's telephone number easily accessible and locate the nearest facility so you will be prepared in case of an Emergency.
- **Requesting Generic Medications –** Often medications come in two forms: generic and brand name. Generic medications have to meet the same quality standards for pureness and effectiveness, but can cost much less than their brand name equivalent. Check with your Physician to see if a generic medication is appropriate for you.
- **Using the Mail Order Program –** The mail order program is a convenient way to have maintenance medications delivered to your home. When you use the mail order program, you pay less for a larger supply of medication.

We have organized this booklet in an easy-to-understand format with the following sections:

- **Life Events –** Details how your benefits are affected by the different events that can occur in your life.
- **How to File a Claim –** Gives you a step-by-step process for filing claims, including what you need to do if a claim is denied.
- **Definitions –** Defines important terms used throughout this SPD.

In addition, this booklet includes the following inserts:

- Schedule of Benefits, which includes a summary of coverage available under the Plan; and
- Contact Information, which includes phone numbers and Web sites for organizations providing services under this Plan.

We urge you to read this information and, if you are married, share it with your spouse. Also please keep this booklet with your important papers so you can refer to it when needed.

Sincerely,
Board of Trustees

Eligibility Requirements

Initial Eligibility

You become eligible for coverage under the Plan if you:

1. Perform work under the Metal Building and Canopy Agreement in the jurisdiction of an Iron Workers Local Union that participates in the Plan pursuant to such Agreement (i.e., Covered Employment); **and**
2. Complete at least 1,000 hours of such work under the Metal Building and Canopy Agreement during a 12-consecutive calendar month period, with some hours worked in the first month of the 12-month period.

Active Participants are eligible for:
- Medical Benefits;
- Prescription Drug Benefits;

In order to receive benefits, the Benefit Trust Office must receive your completed enrollment card with your list of Dependents and your Beneficiary. Claims may be denied or payments may be delayed if you have not submitted your enrollment card to the Benefit Trust Office.

Apprentices are eligible for coverage after 500 hours of work in Covered Employment under the Metal Building and Canopy Agreement during a five-consecutive month period, provided some hours are worked in the first month of the five-month period.

When Coverage Begins

Coverage begins on the first day of the second month after you meet the eligibility requirements, which is your Effective Date for benefits.

If you are an Active Participant, you should have all of your pay stubs in case you have to verify eligibility for benefits.

Participant Example

Pat begins work on March 1, 2016 and completes 1,000 hours of work in Covered Employment prior to March 1, 2017. He will be eligible for benefit coverage beginning April 1, 2017.

Apprentice Example

Chris is an apprentice who begins work on March 1, 2016 and completes 500 hours of work in Covered Employment prior to August 1, 2016. He will be eligible for benefit coverage beginning September 1, 2016.

Continuing Eligibility

Once you become eligible, you must continue to work under the Metal Building and Canopy Agreement a minimum of 270 hours within three-consecutive-month periods as described in the following table to continue your eligibility.

The Fund Must Receive at Least 270 Hours Reported for the Months of…	To Be Eligible for Coverage in…
September, October, November	January, February, March
October, November, December	February, March, April
November, December, January	March, April, May
December, January, February	April, May, June
January, February, March	May, June, July
February, March, April	June, July, August
March, April, May	July, August, September
April, May, June	August, September, October
May, June, July	September, October, November
June, July, August	October, November, December
July, August, September	November, December, January
August, September, October	December, January, February

Example

Pat's Employer contributes on his behalf for 270 hours worked during July, August, and September. Pat is eligible for coverage for November, December, and January.

If you have not worked the required number of hours for eligibility, you may be able to continue coverage by electing COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

When Eligibility Ends

When coverage ends, you or your eligible Dependents may be eligible to continue coverage by electing COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

Coverage ends on the earliest of the following:

- The date you die;
- The last day of the fourth month following the last three-consecutive-month period during which you met the eligibility requirements for continuing eligibility through hours of work completed;
- If you are making COBRA premium payments, at the end of the last day that you are entitled to COBRA Continuation Coverage or the last day of the month for which a correct and timely COBRA payment was received; or
- The day the Plan is terminated.

When Coverage Ends Example

Pat worked 270 hours in April, May, and June, but no hours in July, August, or September. His coverage ends the last day of October.

If your Local Union bargaining unit withdraws from the Benefit Plan, your eligibility will end on the last day for which contributions are required to be made to the Plan under the terms of the Metal Building and Canopy Agreement between the Employer and the withdrawing Local Union.

If you are eligible for continued coverage based on the Family and Medical Leave Act (FMLA) or the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA), you may continue coverage as required by FMLA and USERRA. The required payments must be made by you (USERRA leave) or your Employer (FMLA leave) on a timely basis.

Special Termination Provisions

You will no longer be eligible for coverage under the Plan if you become employed in the building trades by an employer who is not required to make contributions to the Plan on your behalf under the Metal Building and Canopy Agreement (either directly or indirectly through a reciprocity agreement). Your coverage and that of your Dependents will end on and after the day you work in such employment. You may be eligible to elect COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

You will lose eligibility for coverage for yourself and your eligible Dependents, if you:

- Become employed by an employer in the building trades who is not required to make contributions to this Plan on your behalf under the Metal Building and Canopy Agreement; or
- You are no longer available for work at the trade in the jurisdiction of a participating Local Union for a Contributing Employer under the Metal Building and Canopy Agreement.

Reinstatement of Eligibility

If your eligibility ends under the Plan and you return to work for a Contributing Employer under the Metal Building and Canopy Agreement:

Within 24 months following the last day you were previously eligible for coverage, you will become eligible again under the active Plan if you have 270 hours within three consecutive months. At least one hour must be in the first month. You will become eligible the first day of the fifth month.

Example

After not having coverage for 18 months, Pat returns to Covered Employment and works 300 hours in January, February and March. He is eligible for coverage again on May 1.

After 24 months from the day after your eligibility ended, you must work 500 hours within a five-consecutive-month period to be eligible for coverage on the first day of the seventh month. At least one hour must be worked in the first month.

Example

Jon was not eligible for coverage for 2½ years before returning to Covered Employment. After working 750 hours from January through May, he becomes eligible for coverage again on July 1.

You must satisfy the initial eligibility requirements as described in the ***Eligibility Requirements*** section if you were classified as:

- A member whose coverage was terminated due to work in a non-union capacity.

Dependent Eligibility

Eligible Dependents include your:

- Legal spouse;
- Children up to the end of the month in which they reach the age of 26; and
- Unmarried children for whom you or your covered spouse are

The Trustees require proof of Dependent status, including birth certificates, guardianship papers, marriage certificates, adoption decrees, paternity decrees, support agreements, divorce decrees, federal tax returns.

required to provide medical coverage for under a divorce decree, paternity judgment, or Qualified Medical Child Support Order (QMCSO), and who otherwise meet the eligibility requirements of a Dependent child.

Children include:

- Your own children;
- Stepchildren; and
- Legally adopted children, or children who have been placed with you for adoption and for whom legal adoption proceedings have been initiated.

Children also means children who meet all of the following conditions during the calendar year:

- Have their legal residence with you;
- Are related to you or your spouse by blood as brother, sister, niece, nephew, or grandchild; and
- Whose legal parents are both deceased or who have been court-ordered guardianship Dependents of yours or your spouse's for no less than five consecutive years. In the case of a child for whom you are the legal guardian, the child must maintain a principal residence with you for the entire year. You must submit copies of the guardianship order to the Benefit Trust Office.

You must have your Dependents listed on your Enrollment Card or you must add your Dependents on an Enrollment Card and submit the card and supporting documentation to the Benefit Trust Office. Eligible Dependents do not include Dependents who are in the uniformed services on a full-time basis.

When Dependent Coverage Begins

Dependent coverage begins on the same date your eligibility begins, or if applicable, a later date such as the date you acquire an eligible Dependent, four months prior to the date Dependent documentation is received and verified, or as specified in a Qualified Medical Child Support Order.

When Eligibility Ends

Your eligible Dependent's eligibility will end on the earliest of the following:

- The date your eligibility under the Plan ends;
- The date your Dependent dies;
- The date your Dependent no longer meets the Plan's definition of a Dependent (please see preceding page for definition of a Dependent);
- The date the Plan is modified to terminate Dependent benefits;
- The date the Plan terminates;
- For a covered spouse, the day you become legally divorced or your marriage is legally dissolved;
- The date specified in a Qualified Medical Child Support Order (QMSCO), a court order that establishes who will provide health care for the child; or
- If your Dependent has COBRA Continuation Coverage, at the end of the last day of the period in which your Dependent's COBRA Continuation Coverage period ends.

If both parents are covered as Metal Building Participants under the Plan, then the natural or adopted children are covered under the parent with the birthday that occurs earlier in the year. If that parent loses eligibility under the

Plan, but the other parent maintains eligibility, then the children will be covered under the parent who maintains eligibility.

If your eligible Dependent's coverage ends, your eligible Dependent may be eligible for COBRA Continuation Coverage as described in the *COBRA Continuation Coverage* section.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment

If you were eligible to enroll under this Plan and declined this Plan's coverage because you were covered under a group health plan, Medicare, or health insurance coverage (as defined under ERISA Section 701(f)(1)(A) which is referred to as "Other Coverage"), and lose the Other Coverage because:

- Of termination of employment;
- Of a reduction of hours of employment;
- Of termination of the Other Coverage;
- Of termination of Employer contributions toward coverage;
- Of the exhaustion of COBRA continuation coverage;
- Of the exhaustion of applicable lifetime benefits under the coverage;
- An individual ceases to be a Dependent under the Plan;
- The plan terminates a benefit package option;
- Your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's service area (and there is no other coverage available under the other plan);
- The plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for part time employees);
- Of lay off; or
- Of death or divorce from your spouse.

You or your Dependents will be permitted to enroll during a special enrollment period. Enrollment must be supported by written documentation of the termination of the Other Coverage (including the effective date of termination). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. Notice of the intent to enroll must be provided to the Benefit Trust Office within 31 days of the event, with coverage to be effective on the date the Other Coverage terminates.

If you or your Dependents declined coverage during another group health plan's initial enrollment period, because you were covered under this Plan, you may have a special enrollment opportunity to obtain health care coverage from that plan when coverage under this Plan ends. Generally, the other group health plan must receive your request for special enrollment within 30 days of the date your coverage ends under this Plan.

If your Dependent children are eligible for coverage under Medicaid or a State Children's Health Insurance Program, and they declined enrollment in this Plan due to this Other Coverage, you have the special enrollment opportunity to obtain health care coverage from this Plan when coverage under one of these programs ends. You must provide notice of the loss of Medicaid or State Children's Health Insurance Program coverage within 60 days to the Benefit Trust Office in order to enroll the Dependents in this Plan. Additionally, in the event that the State Children's Health Insurance Program decides to provide a subsidy for coverage of Dependents under this Plan, the Plan will allow enrollment of the children as long as notice is provided within 60 days.

COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary extension of coverage under the Trust.

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This section gives only a summary of your COBRA Continuation Coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Benefit Trust Office.

If you have a newborn child, adopt a child, or have a child placed with you for adoption or legal guardianship (for whom you have financial responsibility) while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Benefit Trust Office in writing of the birth or placement and provide a completed enrollment card and other necessary documentation (i.e., birth certificates, legal documents) to have this child added to your coverage. Children born, adopted, or placed for adoption or legal guardianship as described above have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA Continuation Coverage. Like all qualified Beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

COBRA Continuation Coverage in General

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. COBRA Continuation Coverage must be offered to each person who is a qualified Beneficiary. You, your spouse, and your Dependent children could become qualified Beneficiaries if coverage under the Plan is lost because of a qualifying event. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for this coverage.

Type of coverage. If you choose COBRA Continuation Coverage, you will be entitled to the same type of coverage you had before the event that triggered COBRA.

Cost of coverage. Under the Plan, qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Participants and Dependents (including both the Fund's share and the Participant's share, if any) plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Fund is permitted to charge the full cost of coverage for similarly situated Participants and Dependents (including both the Fund's share and the Participant's share, if any) plus an additional 50% for COBRA family members that include the disabled person for the 11-month disability extension period.

Qualifying Events

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

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

If you are the spouse of a Participant, you become a qualified Beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happen:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason, other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits under Part A, Part B, or both. (Becoming entitled to Medicare means that you were eligible for Medicare benefits *and* enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment.); or;
- You become divorced or legally separated.

Your Dependent children become qualified Beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happen:

- The parent-Participant dies;
- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment ends for any reason, other than the parent-Participant's gross misconduct;
- The parent-Participant becomes entitled to Medicare benefits. (The parent-Participant becoming entitled to Medicare means that the parent-Participant was eligible for Medicare benefits *and* enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment.);
- The parents become divorced or legally separated; or
- The child loses Dependent status under the Plan.

If a Participant's Dependent child is covered by a Qualified Medical Child Support Order (QMCSO), the Dependent child will be offered the same COBRA rights as other Dependents if coverage ends for any of the above reasons. Notices will be sent to such a Dependent in care of the custodial parent.

If you enter service in the uniformed services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, you are entitled to elect continuation coverage under USERRA for yourself and your Dependents. The Plan administers continuation coverage under USERRA in the same manner as COBRA Continuation Coverage and treats your entry into service as a qualifying event (reduction in hours or termination of employment); you may elect this coverage regardless of any coverage provided by the military or government. This Plan will pay primary benefits before the military/government pays, except for service-related disabilities. Under USERRA, you are eligible to continue coverage for up to 24 months.

You must give your employer notice of your entry into service. In addition, you have certain reemployment rights under USERRA upon your return to work after service. You should refer to the Section entitled *Serving in the Uniformed Services* on page __ or contact the Benefit Trust Office for more information about USERRA.

When COBRA Continuation Coverage Is Available

The Plan will offer COBRA Continuation Coverage to qualified Beneficiaries only after the Benefit Trust Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, the Employer will generally provide the information to the Benefit Trust Office.

Electing COBRA Continuation Coverage

To elect COBRA Continuation Coverage, you must complete an Election Form and furnish it according to the directions on the form. Each qualified Beneficiary has a separate right to elect COBRA Continuation Coverage. For example, both you and your spouse may elect COBRA Continuation Coverage, or only one of you. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified Beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in the loss of the right to elect

COBRA Continuation Coverage under the Plan. A qualified Beneficiary may change a prior rejection of COBRA Continuation Coverage any time until that date.

Employer Must Give Notice of Some Qualifying Events

When the qualifying event is the end of employment or reduction of hours of employment, death of the Participant, or the Participant's becoming entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), the Employer must notify the Benefit Trust Office of the qualifying event within 30 days of any of the events.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Benefit Trust Office. You are required to notify the Benefit Trust Office within 60 days after the qualifying event occurs. You must send this notice to:

Iron Workers District Council of Southern Ohio & Vicinity
Benefit Trust Office
ATTN: COBRA
P.O. Box 398
Dayton, OH 45401-0398

Your notice should be accompanied by supporting legal documents in their entirety and include all attachments (i.e., notice of a divorce should include a journalized copy of the divorce decree from the court with all attachments). However, because notice is required within 60 days after a qualifying event, it is permissible to provide the supporting legal documentation separate from the notice of the qualifying event.

How COBRA Continuation Coverage Is Provided

Once the Benefit Trust Office receives notice that a qualifying event has occurred, you will receive a termination of coverage letter that details your ability to continue coverage under COBRA Continuation Coverage.

A complete packet of COBRA information will be provided to you and each of your qualified Beneficiaries when you have a COBRA qualifying event. COBRA Continuation Coverage will be offered to each qualified Beneficiary. Covered Participants may elect COBRA Continuation Coverage on behalf of their spouses and parents may elect COBRA Continuation Coverage on behalf of their children.

Length of COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, the Participant's entitlement to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both), divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a maximum of 36 months, depending on the reason for the continuation of coverage.

When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the Participant became entitled to (qualified for *and* enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified Beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. However, the covered Participant's maximum coverage period will be 18 months. For example, if a covered Participant becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA Continuation Coverage lasts for up to a total of 18 months. This 18-month period of COBRA Continuation Coverage can be extended in two ways, as explained below. If you are continuing coverage under a USERRA leave, your coverage lasts for a total of 24 months.

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Benefit Trust Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of coverage.

You must make sure that the Benefit Trust Office is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA Continuation Coverage. You must also notify the Benefit Trust Office within 30 days of the date that the Social Security Administration determines that you or your Dependents are no longer disabled. You must send this notice to the Benefit Trust Office at the address listed in the *You Must Give Notice of Some Qualifying Events* section above.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, your spouse and Dependent children may receive up to an additional 18 months of COBRA Continuation Coverage, up to a maximum of 36 months, if you give notice of the second qualifying event to the Plan within 60 days of the event. This extension is available to your spouse and Dependent children if:

- The Participant or the former Participant dies;
- The Participant or the former Participant becomes entitled to Medicare benefits (qualified for *and* enrolled in coverage under Part A, Part B, or both);
- The Participant or the former Participant gets divorced or legally separated; or
- The Dependent child no longer meets the definition of a Dependent child under the Plan.

The extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In all of these cases, you must make sure that the Benefit Trust Office is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Benefit Trust Office at the address listed in the *You Must Give Notice of Some Qualifying Events* section above.

When COBRA Continuation Coverage Ends

COBRA Continuation Coverage will end at the conclusion of your period of coverage (e.g., 18 months, 29 months, 36 months, or 24 months for coverage under a USERRA leave), as determined by the type of qualifying event you experience. In addition, COBRA Continuation Coverage may also end upon any of the following dates for the reasons described:

- The date the Plan ceases to provide a group health care plan for all Participants;
- The date you cease to timely pay the required premium payment for continuation of your health care coverage;
- The date you become entitled to Medicare; or

- The date you become covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that you or your eligible Dependents might have.

Making Payments for COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you do not have to send any payment for COBRA Continuation Coverage with the Election Form. However, you must make your first payment for COBRA Continuation Coverage within 45 days after the date your Election Form is returned to the Benefit Trust Office. (This is the date the Election Form is post-marked, if mailed.) If you do not make your first payment for COBRA Continuation Coverage within those 45 days, you will lose all COBRA Continuation Coverage rights under the Plan.

Your first payment must cover the cost of COBRA Continuation Coverage from the time your coverage under the Plan would have otherwise ended up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Benefit Trust Office to confirm the correct amount of your first payment.

After you make your first payment for COBRA Continuation Coverage, you will be required to pay for COBRA Continuation Coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA Continuation Coverage are due prior to the first day of the month for which payment is made. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. Self-payments for COBRA Continuation Coverage should be sent to:

Iron Workers District Council of Southern Ohio & Vicinity
Benefit Trust Office
1470 Worldwide Place
Vandalia, OH 45377-1156

Mailing Address:
ATTN: COBRA
P.O. Box 398
Dayton, OH 45401-0398

Grace Periods for Periodic Payments

Although periodic payments are due on the date described above, you will be given a grace period of 30 days to make each periodic payment. You should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA Continuation Coverage, as described in the previous information. Your COBRA Continuation Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and you submit a claim within that period, you may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA Continuation Coverage under the Plan.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost

less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the Benefit Trust Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA's Web site at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through the EBSA's Web site.). For more information about the Marketplace, visit www.HealthCare.gov.

Life Events At-a-Glance

Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different lifestyle changes occur after you become a Participant.

Getting Married

When you get married, your spouse is eligible for Medical and Prescription Drug coverage if you are an Active Participant. Once you provide the required information, coverage for your spouse begins on the later of the date of your marriage or six months prior to the date the information is processed by the Benefit Trust Office.

If your spouse is covered under another group insurance plan, you must report the other coverage to the Benefit Trust Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage; benefits for your spouse under this Plan will be paid after any benefits are payable from your spouse's plan.

When you get married, provide the Benefit Trust Office with:

- A new enrollment card listing all eligible Dependents.
- A copy of your marriage certificate.
- Your spouse's date of birth and social security number.
- A copy of your spouse's insurance information, if he or she is covered under another plan.

Adding a Child

Your natural born child will be eligible for coverage on his or her date of birth. If you have guardianship for a child, adopt a child, or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent (please see the *Dependent Eligibility* section). Stepchildren are eligible for coverage on the date of your marriage. Once you provide any required information, coverage for your child will begin. However, if required information is not received in a timely manner, coverage will only go back a maximum of six months from the date the information is processed by the Benefit Trust Office. The child must meet the Dependent eligibility requirements (please see the *Dependent Eligibility* section).

When you add a child, provide the Benefit Trust Office with:

- A new enrollment card listing all eligible Dependents.
- When you add a stepchild, you must submit a copy of your spouse's divorce decree to establish if there is other coverage for that child.
- A copy of the child's birth certificate, social security number, adoption papers, court order and your marriage certificate.
- A copy of your child's other insurance information, if he or she is covered under another plan.

Getting Divorced

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as a Dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must** notify the Benefit Trust Office **within 60 days** of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage. You will be held responsible for any overpayment of claims if you do not notify the Benefit Trust Office of your divorce.

This Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and provides benefits for eligible Dependents, as determined by the order. A Qualified Medical Child Support Order (QMCSO) is a court order or administrative order, which has the force of law pursuant to the state's administrative procedure, relating to child support that provides for a child's coverage under the Plan. A copy of the Plan's QMCSO qualification procedures and a sample is available, free of charge, at the Benefit Trust Office.

If you divorce, provide the Benefit Trust Office with:

- A new enrollment card listing all eligible Dependents.
- A copy of your divorce decree.
- If you have children for whom you do not have custody, a copy of any QMCSO.

If your spouse wants to continue coverage, he or she must:

- Contact the Benefit Trust Office; and
- Enroll for COBRA Continuation Coverage.

Losing Eligibility

A detailed description of the requirements needed to continue eligibility is shown in the *Eligibility Requirements* section. If you are an Active Participant and your eligibility ends under the Plan, you can become eligible again by meeting the reinstatement of eligibility requirements as described in the *Eligibility Requirements* section. When your coverage ends, you may be eligible to continue coverage by electing COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he or she reaches age 26. You must notify the Benefit Trust Office when your child is no longer eligible for coverage. You will be held responsible for any overpayment of claims if you do not notify the Benefit Trust Office at the time your child is no longer eligible. Your child may elect to continue coverage by making COBRA self-payments for up to 36 months.

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA Continuation Coverage. Within 60 days of losing eligibility for coverage, he or she must:

- Contact the Benefit Trust Office.
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.

In the Event of Your Death

If you die while an Active Participant your spouse and/or eligible Dependents may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary premium payments (please see the *COBRA Continuation Coverage* section).

In the event of your death, your spouse or Beneficiary should:

- Notify the Benefit Trust Office.
- Provide the Benefit Trust Office with a certified copy of your death certificate.
- If your Dependents want to continue coverage under the Plan, they must enroll for COBRA Continuation Coverage.

When You Leave Covered Employment

You may continue health care coverage through COBRA Continuation Coverage as described in the *COBRA Continuation Coverage* section.

If You Move

To protect your family's rights, you should keep the Benefit Trust Office informed of any changes in the addresses of you and any family members. You should also keep a copy, for your records, of any notices you send to the Benefit Trust Office.

Keep the Benefit Trust Office informed of address changes

Serving in the Uniformed Services

If you serve in the military (active duty or inactive duty training) or certain types of service in the National Disaster Medical System, you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage means Medical and Prescription Drug coverage provided under the Plan.

If you serve in the military:
- Notify your Employer, Local Union, and the Benefit Trust Office.
- Make self-payments if you wish to continue your coverage.

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;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

Uniformed services means the:
- United States Armed Forces;
- Army National Guard;
- Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- Commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or emergency.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you must pay your share, if any, of the cost of coverage. If your service continues for 31 days or more, you may elect to continue coverage under the Plan by making monthly COBRA premium payments. To continue coverage, you or your Dependents must pay the required premium payment. You need to notify the Benefit Trust Office at least 30 days before the date you will leave for the military.

Continuation Coverage under USERRA will be administered in the same manner as COBRA Continuation Coverage, except that, if you elect USERRA Continuation Coverage it will continue for 24 months for you and your Dependents if you elect to cover your Dependents. If you do not elect to continue coverage under USERRA, your coverage will end when you enter military service, and your eligible Dependents may continue coverage under the Plan by electing and making self-payment for COBRA Continuation Coverage.

Your USERRA coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- Twenty-four consecutive months after your coverage would have otherwise ended.

Reemployment
Following your discharge from service, you have reemployment rights under USERRA. Such reemployment includes your right to elect reinstatement in health care coverage under this Plan.

However, your USERRA coverage will end the earliest day:

- Your coverage would otherwise end as described above;

- The date the Plan ends;
- The date you no longer meet the eligibility requirements for USERRA leave;
- Your premium payment is due and unpaid; or
- You again become covered under the Plan.

You need to notify the Benefit Trust Office when you enter the military and when your service ends. For more information about continuing coverage under USERRA, contact the Benefit Trust Office.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with any Contributing Employer under this Plan in accordance with USERRA. Additionally, you may report for work to your Local Union to satisfy the reemployment. Reemployment includes the right to elect reinstatement in the existing health coverage under this Plan without satisfying the reinstatement enrollment requirements. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to report to work for a Contributing Employer or Local Union;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to report to work for a Contributing Employer or Local Union; or
- More than 180 days, you have up to 90 days after discharge to report to work for a Contributing Employer or Local Union.

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 or make yourself available for work for a Contributing Employer or report to your Local Union. If you do not report to work within the required timeframes, you must again meet the reinstatement eligibility requirements to be eligible for coverage. Additionally, your coverage will be reinstated upon the date you make yourself available for work as verified by your Local Union.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks in a 12-month period of unpaid leave for your serious illness, to care for a child after the birth, adoption, or placement for adoption of a child, or to care for your seriously ill spouse, parent, or child. In addition, when you are the spouse, son, daughter, parent or next of kin of a service member, the FMLA allows you to take up to 26 weeks in a 12-month period to care for the covered service member who has a serious injury or illness that was incurred in the line of duty while serving in the armed services. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for the length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave. You and your Employer must meet certain requirements for you to be eligible for FMLA leave. Contact your Employer if you are considering FMLA leave to see if you qualify.

When You Retire

If you are an Active Participant and lose eligibility for active coverage due to retirement, you may be eligible for COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

When you retire:

- Notify the Benefit Trust Office in advance of your retirement.
- If you want to continue coverage under the Plan, enroll for COBRA Continuation Coverage.

Returning to Work

If your eligibility ended and you start working again for an Employer who contributes to the Fund under the Metal Building and Canopy Agreement, your coverage will be reinstated (please see the *Eligibility Requirements* section).

If you return to work under the Metal Building and Canopy Agreement following a military leave of absence, your coverage will be reinstated as described in the *Serving in the Uniformed Services (For Active Participants)* section.

Medical Benefits

(For Active Participants and Dependents)

The Plan offers comprehensive health care coverage to help you and your eligible Dependents stay healthy and the Plan helps provide financial protection against catastrophic health care expenses. This section describes how the Plan works for Active Participants and eligible Dependents.

How the Plan Works

Preferred Provider Organization (PPO)

For Active Participants and Dependents, to help manage certain health care expenses, the Plan contains a cost management feature – the Preferred Provider Organization (PPO) Network. A PPO is a network of Physicians and Hospitals that have agreed to charge negotiated rates. When you use a Network Provider, you save money for yourself and the Plan because the Network Provider has agreed to charge a discounted dollar amount.

Preferred Provider Organization (PPO)
A PPO is a network of health care Providers who have agreed to charge negotiated rates. Since Network Providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use Network Providers.

It is your decision whether or not to use a Network Provider. You always have the final say about the Physicians and Hospitals you and your family use. To encourage you to use Network Providers whenever possible, the Plan pays a higher percentage of Covered Expenses when you use a Network Provider. If you have questions, or need a listing of Physicians and Hospitals that participate in the PPO Network (provided free of charge), please see the *Contact Information* insert for PPO contact information.

Please keep in mind that when you visit a PPO Network Hospital, the Physicians and other health care Providers in the Hospital may not belong to the PPO Network, and vice versa.

The Plan pays different levels of benefits, based on whether you use a Network or Non-Network Provider, as listed on the *Schedule of Benefits* insert to this booklet. For a listing of the services and supplies covered under the Plan, please see the *Covered Medical Expenses* section.

Once your Coinsurance amounts for Covered Expenses (including the Deductible) reach the out-of-pocket maximum during the calendar year, the Plan pays 100% of remaining Maximum Allowable Amounts for Covered Services for the rest of that year up to any specific benefit maximums. **You must show your ID card each time you receive medical care; otherwise, your expenses may be paid as Non-Network expenses, even if you use a Network Provider. Services you obtain from any Provider other than a Network Provider, which are not precertified or Emergency Care, are considered Non-Network.**

Note that some expenses may be covered differently or may be subject to different benefit maximums. See the *Schedule of Benefits* insert to this booklet for more information.

Deductible

The calendar Deductible is the amount of Covered Expenses that you pay each calendar year before the Plan begins to pay benefits for Network and Non-Network Provider services. Network and Non-Network Deductibles are separate and amounts do not apply toward each other. In addition, flat dollar Copayments do not apply toward the Deductible.

Out-of-pocket expenses for covered medical services are limited. The out-of-pocket maximum includes your annual Deductible.

The Deductible applies to each Covered Person each calendar year. The family Deductible is met once two or more covered members of a family meet the family maximum amount as listed on the *Schedule of Benefits* insert to this booklet. Once an individual Deductible is met, no further Deductibles are required for that year on that individual. Once the family Deductible is met no further Deductibles are required for that year.

Normally, the individual Deductible is applied to each member of the family. However, if two or more covered members of a family are injured in the same accident, the medical expenses that result from the accident will be combined and only one Deductible will apply to all expenses incurred because of that accident.

Any amounts applied to a Deductible for expenses incurred during the last three months of the calendar year will also be applied to meet the next calendar year's Deductible, but not the next calendar year's out-of-pocket maximum.

Services Not Available within the Service Area

If you or your Dependents require treatment that is not available from a Network Provider within the service area, the Plan will cover that treatment from a Non-Network Provider subject to the same Copayments that apply for Network Providers. The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Plan's third party administrator, when you obtain precertification and are required to travel more than 75 miles from your residence because of services not being available within the Network. The Plan's assistance with travel expenses includes transportation to and from the nearest Network Provider facility, lodging, and meals. You must submit itemized receipts for transportation, meals, and lodging expenses that are satisfactory to the Plan's third party administrator when claims are filed. You will not be required to pay more for medical services than if the services had been received from a Network Provider within the service area.

Precertification and Case Management

Health care management is designed to promote the delivery of cost-effective medical care to all by reviewing the use of appropriate procedures, setting (place of service), and resources through case management and precertification. If you have any questions about health care management or to determine which services require precertification, call the precertification telephone number on the back of your ID card or on the *Contact Information* insert.

If you need to be hospitalized:

- Ask your Physician to refer you to a Network Hospital.
- Contact the Plan's third party administrator for precertification.
- Inform your supervisor that you will be away from work.
- Bring your medical ID card to the Hospital.

Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. It is a confirmation of Medical Necessity only.

Precertification means that you obtain approval before receiving certain procedures or services. Services that require precertification include Hospital stays, inpatient Mental Health and/or Substance Abuse treatment, durable medical equipment, or certain diagnostic tests. Most Providers know which services require precertification and will obtain any required precertification. However, it is a good idea to check with your Provider to ensure he or she has obtained precertification when necessary.

Make the Call
If your Physician recommends hospitalization, you must call the Plan's third party administrator to get your stay precertified. If you do not make this call, benefits may be reduced or denied.
If you receive Emergency hospitalization, you or a family member must call the Plan's third party administrator no later than 24 hours after the Hospital admission. The telephone number is listed on the back of your ID card or on the Contact Information insert.

You may designate an authorized representative to act on your behalf for a specific precertification request. The authorized representative can be anyone who is 18 years or older. Inpatient admissions following Emergency Care do not require precertification. However, you must notify the Plan's third party administrator or verify that your Physician has notified the Plan's third party administrator within 24 hours or as soon as possible within a reasonable period. For childbirth admissions, precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Coinsurance and Copayment

Once you or your family has met the Deductible, the Plan pays a percentage of Covered Expenses, called Coinsurance. The amount the Plan pays depends on the type of Covered Expense as listed on the *Schedule of Benefits* insert to this booklet. Your payment is the remaining percentage of Covered Expenses. For certain services, you a pay a flat dollar amount called a Copayment.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum listed in the Schedule of Benefits is the most you pay for covered essential health benefits received from PPO Network or Out-of-Network Providers related to Plan deductibles, coinsurance, and copayments during a plan year before the Plan begins to pay 100% of any additional PPO Network or Out-of-Network Provider covered medical expenses. This limit never includes your premium, balance-billed charges or health care your Plan does not cover. If your Coinsurance payments toward Covered Expenses reach the out-of-pocket maximum (including the Deductible), the Plan pays 100% for most additional Covered Expenses for the rest of the calendar year to the extent required by law. Network and Non-Network out-of-pocket maximums are separate and amounts do not apply toward each other.

The Plan will apply the individual out-of-pocket maximum to each individual member of a family. This means that an individual will never have to pay more than the individual out-of-pocket maximum in the Schedule of Benefits, even if the family out-of-pocket maximum has not yet been met.

The following expenses and Copayments do not apply to the out-of-pocket limit:

- Charges not considered covered medical expenses;
- Charges made after the maximum benefit has been received or paid;
- Amounts above the Maximum Allowable Amount;
- Physician Office Services;
- Urgent Care Services;
- Prescription Drug Benefits; and
- Non-Network Human Organ and Tissue Transplant Services (HOTT).

Specific Benefit Maximums

You and each eligible Dependent can receive medical benefits up to the specific benefit maximums listed on the *Schedule of Benefits* insert to this booklet.

Maximum Allowable Amount

The Maximum Allowable Amount is the PPO's negotiated rate for Covered Services with Network Providers. The Plan pays the same rate to Non-Network Providers as well. When you use a Non-Network Provider, you are responsible for paying the difference between the Maximum Allowable Amount and the Non-Network Provider's charge, if applicable.

The Maximum Allowable Amount for a Covered Service is determined using internally developed criteria and industry accepted methods and fee schedules that are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

Maximum Allowable Amount
The Maximum Allowable Amount is the PPO's negotiated rate for Covered Services with Network or participating Providers. The PPO pays the rate to Non-Network Providers as well. When you use a Non-Network Provider, you are required to pay any Copayments, Coinsurance, and Deductibles and any amounts that exceed the Maximum Allowable Amount. The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible because of its agreement with the Plan's third party administrator.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that is payment in full under the Network Provider's participation agreement for a service or product. For a Non-Network Provider, even if the Provider has a participation agreement, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers. If there is not a negotiated amount, the Plan's third party administrator has discretionary authority to establish the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount as determined by the Plan's third party administrator after consideration of industry cost, reimbursement, utilization data, and other factors the Plan's third party administrator considers appropriate.

You are required to pay any Copayments, Coinsurance, and Deductibles and any amounts that exceed the Maximum Allowable Amount on Non-Network Provider services. The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible because of its agreement with the Plan's third party administrator.

Medically Necessary or Medical Necessity

The Plan pays benefits only for services and supplies that are Medically Necessary or based on Medical Necessity. In general, Medically Necessary means only those services, treatments, or supplies provided by a Hospital, a Physician, or other qualified Provider of medical services or supplies that are required, in the Trustees' judgment (based on the opinion of a medical professional), to identify or treat an injury or sickness. The services, treatment, or supplies must be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided to the patient and that cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);

- Cost-effective compared to alternative interventions, including no intervention (cost effective does not mean lowest cost);
- Not Experimental;
- Not primarily for the convenience of the patient, the patient's family, or the Provider; and
- Not otherwise listed as an exclusion under the Plan.

Your Responsibility

It is important to remember that the Plan is not designed to cover every health care expense. The Plan pays charges for Covered Expenses, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician — not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

Choosing a Physician

You save money for yourself and the Plan when you use a Physician who participates in the Plan's Network. One way to find a Physician is to ask around. Ask a family member, friend, or co-worker if they have the name of a Physician they would recommend. Before visiting a Physician, you should contact the Plan's third party administrator (please see the *Contact Information* insert) to ensure your Physician is in the Network.

Here are some questions you may want to ask the Physician(s) you are thinking about making an appointment with:

Are you accepting new patients?

What is your treatment style?

Are you board certified? If so, in what specialties? (Any Physician with a license can practice in any specialty. Board certification is your assurance that the Physician has appropriate training for the specialty.)

At which Hospitals do you admit patients for major health care needs? Does the Hospital belong to the PPO Network? Do the Hospital technicians (for example, for Laboratory tests and X-rays) belong to the PPO Network?

What are your office hours?

On average, how long do patients have to wait to make an appointment?

During an appointment, on average, how long is the wait in your waiting room?

Medical Covered Expenses

Covered medical expenses, see *Covered Medical Expenses (For Active Participants and Dependents)* section.

Medical Expenses Not Covered

You should be aware that not every medical expense is covered by the Plan. For a list of expenses not covered by the Plan, please see the *General Plan Exclusions* section.

Covered Medical Expenses

(For Active Participants and Dependents)

This section includes Covered Expenses for Active Participants and Dependents.

Covered medical expenses or Covered Services are services and supplies that are Medically Necessary and not Experimental or Investigational. If a charge is more than the Maximum Allowable Amount, only the Maximum Allowable Amount will be considered a Covered Expense. **Please keep in mind that charges relating to Covered Expenses will be paid according to the Plan's Deductibles, benefit maximums, out-of-pocket limits, and Maximum Allowable amounts as listed on the *Schedule of Benefits* insert to this booklet.**

Your health coverage is provided through an administrative services arrangement between the Fund and its third party administrator. In order for you to understand the terms and conditions of your coverage, the third party administrator provides you with a separate Certificate of Coverage and Benefits, as well as a Benefits Chart, describing your health care coverage (hereinafter collectively referred to as the "Certificate"). The Certificate is incorporated herein by reference. Should you need another copy of the Certificate, please contact the Fund or the third party administrator. Please read these materials carefully and keep them in a safe place.

Prescription Drug Benefits

(For Active Participants and Dependents)

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan provides prescription drug benefits to all Eligible Participants.

This section includes information on prescription drug coverage for Active Participants and Dependents.

When you need a short-term medication filled (for example, an antibiotic or cold remedy), it is best to use the retail Pharmacy program. If you take medication on a long-term basis (maintenance medications), it is usually best to use the mail order program. Precertification may be required for certain medications. For a list of medications that require precertification, please see the *Contact Information* insert for the Plan's third party administrator.

If you have your prescriptions filled at a Pharmacy that is not part of the network or you do not present your ID card to the pharmacist, you will not receive discounted medication prices.

Retail Pharmacy Program

The Plan has contracted with the Plan's third party administrator's network of participating pharmacies (as listed in the *Contact Information*.) It is always your decision where you have prescriptions filled, but when you use participating pharmacies, you save money for yourself and the Plan because participating pharmacies have agreed to charge discounted rates for prescription drugs. If you use a non-participating Pharmacy or do not show your ID card when having your prescription filled, the Plan still provides coverage, but the amount you pay may be more because you do not receive your prescription at discounted prices.

You save money by using network pharmacies because these pharmacies have agreed to charge discounted rates. To find a participating Pharmacy, please see the *Contact Information* insert.

You need to meet a prescription drug Deductible, as listed on the *Schedule of Benefits* insert to this booklet, before the Plan begins to pay benefits for covered prescription drugs provided at a retail Pharmacy. This prescription drug Deductible is separate from any other Plan Deductible.

There is an Annual Prescription Drug Out-of-Pocket Limit, which is listed on your *Schedule of Benefits.* When you meet your Annual Prescription Drug Out-of-Pocket Limit (including your prescription drug Deductible), the Plan will pay 100% of your remaining allowable prescription drug costs during the year. The prescription drug Annual Prescription Drug Out-of-Pocket Limit is separate from the Annual Medical Out-of-Pocket Limit.

Through the retail Pharmacy program, you may receive up to a 30-day supply. When filling a prescription, simply present your prescription drug ID card and, once you have met your Deductible, pay the applicable Copayment. The amount you pay depends on the Pharmacy you use and whether you have your prescription filled with a generic formulary, brand name formulary, or non-formulary medication. For the Plan's Copayments, see the *Schedule of Benefits* insert to this booklet.

If you visit a non-participating Pharmacy, you are responsible for payment of the entire amount charged by the Pharmacy and then you must submit a prescription drug claim for reimbursement. To obtain a claim form, please see the *Contact Information* insert. You must complete the top section of the form and ask the non-participating Pharmacy to complete the bottom section. If the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit it to the Plan's third party administrator. The itemized receipt must show:

- Name and address of the non-participating Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;

- Name of the medication;
- Cost of the prescription; and
- Quantity of each covered medication or refill dispensed.

You are responsible for the amounts listed on the *Schedule of Benefits* insert to this booklet. This is based on the Maximum Allowable Amount.

Mail Order Program

The Plan also offers a mail order program for your long-term, or maintenance, prescription drug needs. Maintenance medications are often prescribed for heart disease, high blood pressure, asthma, etc. Through the mail order program, you receive up to a 90-day supply. With the mail order program, you receive a larger supply of medication at one time and enjoy the convenience of having the medication sent directly to your home.

To place an order, complete an *Order and Patient Profile Form*, which is available by contacting the Plan's third party administrator as listed on the *Contact Information* insert. You will need to complete the patient profile information only once. You may mail the written prescription from your Physician, have your Physician fax the prescription to the Plan's third party administrator, or your Physician may phone in the prescription. You will need to submit the applicable Copayment amounts when you request a prescription or refill. The amount you pay depends on whether you have your prescription filled with a generic formulary, brand name formulary, or non-formulary medication. For the Plan's Copayments, see the *Schedule of Benefits* insert to this booklet. For more information about how to use the mail order program, please see the *Contact Information* insert for the Plan's third party administrator's information.

Generic and Brand Name Medications

Almost all prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness.

> **Generic or Brand Name**
> While the Plan covers generic and brand name medications, you pay a higher Copayment amount when you receive a brand name medication.

When you receive a brand name medication, you generally pay more because they are more expensive. When you or your Dependents need a prescription, you may want to ask your Physician whether a generic medication can be substituted for a brand name medication.

In general, using generic medications will help control the cost of health care while providing quality medications – and can be a significant source of savings for you and the Plan. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

Formulary Versus Non-Formulary Medications

There are often several types of medications that can be used to treat the same condition. To ensure high-quality care and to help manage costs, the prescription drug program has a formulary that lists preferred drugs. The Plan's formulary includes most generic medications and brand name medications that are either more effective than others in their class or as effective as and less costly than similar medications. You are responsible for a higher Copayment amount for non-formulary medications.

When you or your Dependents need a prescription, you may want to ask your Physician whether a formulary medication can be substituted for a non-formulary medication. For information about the drug formulary, please see *Contact Information* insert for the Plan's third party administrator's information.

Prescription Drug Covered Expenses

Covered Services include only:

1. Prescription Legend Drugs;
2. Specialty Drugs;
3. Injectable insulin and syringes used for administration of insulin;
4. Oral Contraceptive Drugs, including injectable contraceptive Drugs and patches, are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the "Preventive Care" benefit.
5. Certain supplies and equipment obtained by mail service or from a network Pharmacy (such as those for diabetes and asthma, excluding diabetic test strips) are covered without any Copayment. Contact the Plan's third party administrator to determine approved covered supplies. If certain supplies, equipment, or appliances are not obtained by mail service or from a network Pharmacy then they are covered as medical supplies, durable medical equipment, and appliances instead of under your prescription drug benefits;
6. Injectables;
7. Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These service will be covered under the "Preventive Care" benefit.
8. Orally administered cancer Drugs. As required by Ohio law, your cost-share (e.g., Copayment, Deductible or Coinsurance) will not be more than $100 per Prescription Order.
9. Immunizations required by the "Preventive Care" benefit.
10. Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

The Plan's third party administrator offers a therapeutic substitution of drugs program. This is a voluntary program designed to inform members and Physicians about formulary or generic alternatives. You and your prescribing Physician may be contacted to make you aware of formulary or generic drug substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For a list of therapeutic drug substitutes that have been identified, call the Customer Service number on the back of your ID card or please see the *Contact Information* insert.

Prescription Drug Expenses Not Covered

In addition to any general Plan exclusions or limitations (please see the *General Plan Exclusions* section), benefits are not paid for:

1. Drugs, devices, products, or Prescription Legend Drugs with over the counter equivalents and any drugs, devices, or products that are therapeutically comparable to an over the counter drug, device, or product. This exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care Services" benefit under federal law with a Prescription.
2. Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.
3. Off label use, except as otherwise prohibited by law or as approved by the Administrator or the PBM.

4. Drugs in quantities exceeding the quantity prescribed or for any refill dispensed later than one year after the date of the original prescription order.
5. Charges for the administration of any drug.
6. Drugs not approved by the FDA.
7. Charges for the administration of any drug.
8. Drugs consumed at the time and place where dispensed or where the prescription order is issued, including, but not limited to, samples provided by a Physician. This does not apply to drugs used in conjunction with a Diagnostic Service, chemotherapy performed in the office, or drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
9. Any drug that is primarily for weight loss.
10. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law) except for injectable insulin.
11. Drugs in quantities that exceed the limits established by the Plan or which exceed any age limits established by the Plan.
12. Drugs for the treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
13. Drugs in quantities which exceed the limits established by the Plan.
14. Human Growth Hormone for children born small for gestational age. It is only a Cove red Service in other situations when allowed by the Plan through Prior Authorization.
15. Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
16. Treatment of Onychomycosis (toenail fungus).
17. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Administrator for additional information on these Drugs.
18. Refills of lost or stolen medications.
19. Any drug that is primarily for cosmetic purposes (including, but not limited to, preserving, changing, or improving appearance, such as changing the appearance or texture of skin).
20. Fertility drugs.
21. Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. “Clinically equivalent” means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card.

    If you or your Physician believe you require continued coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the Administrator or the PBM. The Plan will cover your current Prescription Drug only if the Administrator or the PBM agrees that it is Medically Necessary and appropriate over its clinically equivalent alternative. Continued coverage of the Prescription Drug will be subject to periodic review by the Administrator.

The Plan is the final authority for determining what medications are covered. No additional prescription drug benefits will be paid except as otherwise specified as covered by the Plan.

General Plan Exclusions

The following list of exclusions applies to all such charges, unless an exception is stated, and applies to all benefits provided under the Plan. In addition to the exclusions listed under each benefit section, no benefits are payable under the Plan for:

1. Any procedure, equipment, service, or supply that is not determined to be Medically Necessary or that does not meet the Plan's third party administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Any procedure, equipment, service, or supply received from an individual or entity that is not a Provider as defined by the Plan or recognized by the Plan's third party administrator on behalf of the Plan.

3. Any Experimental or Investigational procedure, equipment, service or supply, or related to such, whether incurred before, in connection with, or subsequent to the Experimental or Investigational service or supply, as determined by the Plan or the Plan's third party administrator on behalf of the Plan.

4. Any condition, disease, defect, ailment, or injury arising out of and/or in the course of employment for wage or profit, or covered under any Workers' Compensation act or other similar law, regardless of whether:

    a. You receive the benefits in whole or in part;

    b. You claim the benefits or compensation; or

    c. You recover from any third party.

5. Any benefit provided through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under the Plan will be coordinated with such governmental units to the extent required under existing state or federal laws.

6. Any condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

7. Any care required while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state, or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

8. Any illness or injury that occurs as a result of any act of war, declared or undeclared, or while serving in the armed forces.

9. Any prescription drug expenses you are responsible for under other coverage with other carriers or health plans.

10. Any membership, administrative, or access fee charged by Physicians or other Providers, including, but not limited to, fees charged for educational brochures or calling a patient to provide test results.

11. Any court-ordered testing or care unless Medically Necessary and certified by the Plan or the Plan's third party administrator on behalf of the Plan;

12. Any expense that you have no legal obligation to pay in the absence of this or like coverage.

13. Any procedure, equipment, service, or supply received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

14. Any procedure, equipment, service, or supply prescribed, ordered, referred by, or received from a member of your immediate family (i.e., parent, child, spouse, sister, brother, or self).

15. Completion of claim forms or charges for medical records or reports unless otherwise required by law.

16. Missed or canceled appointments.

17. Mileage costs or other travel expenses, except as certified by the Plan or the Plan's third party administrator on behalf of the Plan.

18. Which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a member had applied for Part A and/or Part B, except, as specified elsewhere in this Plan or as otherwise prohibited by federal law.

19. Charges in excess of the Maximum Allowable Amount.

20. Charges incurred before the Effective Date of coverage.

21. Charges incurred after the termination date of this coverage except as specified elsewhere in this Plan.

22. Any procedures, services, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape, or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest, or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under the Plan. Other reconstructive services are not covered except as otherwise required by law.

23. Any procedure, equipment, service, or supply to maintain or preserve the present level of function or prevent regression of functions for an illness, injury, or condition that is resolved or stable.

24. Custodial, Domiciliary, Long-Term or Convalescent Care whether or not recommended or performed by a professional.

25. Foot care to improve comfort or appearance including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including, but not limited to, foot care diagnosis of diabetes or for impaired circulation to the lower extremities.

26. Any treatment for teeth, gums, or tooth related service except as otherwise specified as covered by the Plan.

27. Weight loss or weight loss programs whether or not they are under medical or Physician supervision or for medical reasons. Weight loss programs include, but are not limited to, commercial weight loss programs such as Weight Watchers, Jenny Craig, LA Weight Loss or fasting programs.

28. Bariatric surgery, regardless of its proposed purpose. This includes, but is not limited to, roux-en-y (rny), laparoscopic gastric bypass surgery, other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small

intestine extending from the duodenum), gastroplasty (surgical procedures that decreases the size of the stomach), or gastric banding procedures.

29. Treatment related to or in connection with gender dysphoria, including sex transformation surgery and related services or the reversal thereof.

30. Marital counseling or personal growth counseling.

31. Routine vision examinations except as otherwise specified as covered by the Plan.

32. Routine hearing care except as otherwise specified as covered by the Plan.

33. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specified as covered by the Plan. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery or for soft contact lenses due to a medical condition.

34. Hearing aids or examinations for prescribing or fitting them except as otherwise specified as covered by the Plan.

35. Any procedure, equipment, service, or supply primarily for educational, vocational, or training purposes except otherwise specified as covered by the Plan.

36. Reversal of sterilization.

37. Artificial insemination, fertilization (such as invitro or gift), procedures, or testing related to fertilization, infertility drugs, or related services following a diagnosis of infertility.

38. Personal hygiene, environmental control, or convenience items including, but not limited to, air conditioners, humidifiers, physical fitness equipment, personal comfort and convenience items during an Inpatient stay (including, but not limited to daily television rental, telephone services, cots or visitor's meals), charges for failure to keep a scheduled visit or non-medical self-care (except as otherwise stated), and purchase or rental of supplies for common household use (such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program).

39. Telephone consultations or consultations via electronic mail or internet/Web site except as required by law or as otherwise certified.

40. Care received in an emergency room that is not Emergency Care.

41. Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation, radial keratotomy, keratomileusis, or excimer laser photo refractive keratectomy.

42. Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal, and complications. This exclusion does not apply for left ventricular assist devices (LVAD) when used as a bridge to a heart transplant.

43. Any procedure, equipment, service, or supply related to alternative or complementary medicine. Such services include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reike therapy, herbal, vitamin, or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (best), and iridology (study of the iris).

44. Expenses incurred at a health spa or similar facility.

45. Self-help training and other forms of non-medical self-care except as otherwise specified as covered by the Plan.

46. Research studies or screening examinations except as otherwise specified as covered by the Plan.

47. Stand-by Physician charges.

48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

49. Private duty nursing services rendered in a Hospital or Skilled Nursing Facility.

50. Private duty nursing services except when provided through home care services benefit.

51. Drugs quantities that exceed Plan limits.

52. Any new FDA approved drug product or technology (including, but not limited to, medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to, pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. The Plan may, at its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.

53. Treatment or service not prescribed by a Physician.

54. Charges for books and supplies for music and/or art therapy.

55. Surgery performed for the removal of excess fat in any body area or resection of excess skin or fat following weight loss or pregnancy.

56. Treatment or service in connection with or to rule out the pregnancy of a Dependent child, except as required under the Patient Protection and Affordable Care Act of 2010 (ACA).

57. Expense incurred for donation or transplant of an organ or tissue when the recipient is not covered under this Plan.

58. Nicotine gum or Nicorette whether or not prescribed by a Physician.

59. Treatment of injury received or sickness contracted as a result of committing or attempting to commit a criminal act.

60. Injuries resulting from travel on any type of non-commercial aircraft.

How to File Claims and Appeals

Medical Claims

When you receive medical treatment, you must present your identification (ID) card at the time of your visit. All Network Providers submit claim forms for you. Benefits will then be paid directly to the Physician or Hospital providing the services. You will receive an explanation of benefits for all claims received. Your ID card provides the group and identification number the Provider will need to submit your claim. While it is preferred that all claims be submitted electronically, paper claims may be mailed to the address in the *Contact Information* insert.

> Claims should be filed within 90 days of the date services are received or your claim may be denied. No notice of an initial claim can be submitted later than one year after the 90-day filing period.

You should file your initial claim for Plan benefits **within 90 days** after the date you received treatment. Otherwise, your claim may be denied. 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.

> If you or an eligible Dependent has coverage under more than one health care plan, benefits are coordinated (see the *Coordination of Benefits* section).

Prescription Drug Claims

Each time you need a prescription, be sure to present your identification card. Network pharmacies and most non-network pharmacies will submit claims electronically. If you visit a non-network Pharmacy and need to submit a claim form, you can submit the claim to the address shown in the *Contact Information* insert.

> With each claim be sure to attach an itemized statement that includes:
> - Patient name;
> - Date of service;
> - Itemized charges;
> - Procedure codes;
> - Diagnosis;
> - Receipts (if applicable); and
> - Provider's name, address, phone number, and tax ID number.

Claims Procedures

In this section, the term Benefit Trust Office means the office or organization designated by the Trustees for handling claims. A claimant is an individual claiming a benefit under the Plan.

Claim Filing Procedures

A person must go through both levels of appeal with the Plan's third party administrator before they are allowed a voluntary level of appeal to the Board of Trustees.

For the Plan to pay benefits, a claim must be filed with the Benefit Trust Office or insurance carrier, depending on the type of claim, in accordance with the procedures described in this section. A claim can be filed by a Participant, eligible Dependents, or by someone authorized to act on behalf of the Participant or eligible Dependents. Please remember:

- A claim is considered filed on the date it is received, even if the claim is incomplete.
- A claim is a request for Plan benefits, normally because the claimant has incurred a Covered Expense. A request for confirmation of Plan coverage is not a claim if the expense has not yet been incurred, unless the Plan requires precertification as a condition of payment. A general inquiry about eligibility or coverage when no expense has been incurred is not a claim, nor is presenting a prescription to a Pharmacy.
- Claims must be filed within **90 days** of the date the claim was incurred.

- A claimant may designate another person as his or her authorized representative for purposes of filing a claim. Except in the case of an urgent care claim, the designation must be in writing, and, unless the precertification states otherwise, all notices regarding the claim will be sent to the authorized representative and not to the claimant.

A routine assignment of benefits so that the Plan will pay the Provider directly is not a designation of the Provider as the authorized representative.

Claim Processing Time Periods

The amount of time the Plan can take to process a claim depends on the type of claim. A claim is one of the following categories:

Pre-Service Claim – A pre-service claim is a request for precertification of a health care (i.e., Medical or Prescription Drug) treatment or supply that requires approval in advance of obtaining the care.

Urgent Care Claim – An urgent care claim is a pre-service claim where if normal time periods were applied for making non-urgent care determinations could seriously jeopardize the claimant's life, health, or ability to regain maximum function or that could subject the claimant to severe pain that cannot be adequately managed with the proposed treatment. (Urgent care claims should be filed with the Plan's third party administrator.)

Concurrent Care Claim – A concurrent care claim is also a type of pre-service claim. A claim is a concurrent care claim if a request is made to extend a course of treatment beyond the period or number of treatments previously approved.

Post-Service Claim – A post-service claim is a claim in which the claimant has already received the health care (i.e., Medical or Prescription Drug) treatment or supply for which payment is now being requested. Most claims are post-service claims.

Because there are a few circumstances in which the Plan determines eligibility for benefits based on precertification of the treatment, pre-service, urgent care, or concurrent care claims do not occur often.

If all the information needed to process the claim is provided, the claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are:

Pre-Service Claims – 15 days.

Urgent Care Claims – 72 hours.

Concurrent Care Claims – 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours before the end of the already precertified treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

Post-Service Claims – 30 days.

When Additional Information Is Needed

If additional information is needed from the claimant, Physician, or Provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is the claimant's responsibility to see that the missing information is provided. The normal processing period will be extended by the time it takes the claimant to provide the information, and the time period will start to run once the information has been received. If the claimant does not provide the missing information within 45 days (48 hours for an urgent care claim), a decision will be made on the claim without it, and the claim could be denied as a result.

Extension of Time for Decision on Claim

The time periods above may be extended if an extension is necessary due to matters beyond the Plan's control (but not including situations where additional information is requested from the claimant or Provider). The claimant will be notified before the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not last more than:

- **Pre-Service Claims –** 15 days.
- **Post-Service Claims –** 15 days.

Claim Denials

If all or a part of the claim is denied after all requested, necessary information from the claimant is received, the claimant will be sent a written notice giving the reason(s) for the denial. The notice will include:

- Reference to the Plan provisions on which the denial was based;
- A description of the appeal procedures and the applicable time limits for following the procedures;
- If applicable, a description of any additional material or information necessary for the claimant to perfect the claim and the reason such information is necessary;
- In cases where the Plan relied upon an internal rule, guideline, protocol, or similar criterion to make the decision, the notice will state that the specific internal rule, guideline, protocol, or criterion will be provided to the claimant free of charge upon request;
- If the decision was based on Medical Necessity or if the treatment was Experimental, the notification will include a statement that the explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;
- For urgent care claims, a description of the Plan's expedited review process will be provided; and
- A statement concerning the claimant's right to bring a civil action under Section 502(a) of ERISA following an appeal.

Claim Appeal Procedure

Appeal of Adverse Benefit Determinations

Our procedures contain two (2) mandatory levels of appeal. After exhaustion, the Claimant may bring a civil action under Section 502(a) of ERISA. We also provide for a voluntary appeal as described below.

- **Claims Adjudicated by the Plan's third party administrator.**

- **First Level Appeal**:

  With respect to those claims adjudicated by the Plan's third party administrator, the Claimant is required to appeal any adverse benefit determination directly to the Plan's third party administrator in accordance with these procedures.

- **Second Level Appeal:**

  Once the Claimant receives the Plan's third party administrator determination on such appeal, the Claimant has the right to a second-level external review through an Independent Review Organization (IRO), if certain criteria are met. The request for external review must be made within four (4) months from the Claimant's receipt of the adverse benefit determination from the Plan's third party

administrator. The Claimant may be eligible to have a decision reviewed through the external review process if the following criteria are met:

- The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;

- The mandatory internal appeal process has been exhausted unless under applicable law you are not require to exhaust the internal appeal process (for example, when your claim is entitled to expedited external review and you request an expedited external review to proceed simultaneously with an urgent internal appeal, or if you do not receive a timely internal appeal decision);

- The Claimant is or was covered under the Plan at the time the service was requested, or, in the case of retrospective review, was covered under the Plan when the service was provided, and;

- The Claimant has provided all of the information and forms necessary to process the external review.

The external review will be conducted by an IRO accredited by a nationally recognized accrediting organization. The Claimant will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review the claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The IRO conducting the review will be provided with a copy of the records that are relevant to your medical condition and the external review. The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

External Review for Non-Urgent Care Claim Appeals

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the interview. The IRO will notify the Claimant and give the Claimant ten (10) business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision.

Expedited External Review for Urgent Care Claim Appeals

The Claimant may request an external review for urgent care claims at the same time the Claimant requests and expedited internal appeal of an urgent claim.

An expedited review may be requested if the Claimant's condition, without immediate medical attention, could result in serious jeopardy to the Claimant's life or health or the Claimant's ability to regain maximum function; or the Claimant has received a final internal appeal denial concerning 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.

If the Claimant's request for external review is complete and the Claimant is eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision.

If the IRO grants the appeal, then the IRO's decision is final and binding. However, if the IRO denies the appeal, a voluntary appeal is available whereby the Claimant may then appeal any such adverse determination to the Fund's Board of Trustees as described below.

Appeals to the Plan's third party administrator should be addressed as follows:

Anthem Blue Cross and Blue Shield
Attn: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

- **Voluntary Appeal**.

Once you have filed your appeal through the Plan's third party administrator and the IRO contracted by the Plan's third party administrator as detailed above, and you have been denied at both levels of review, you have the right to file a lawsuit in federal court. However, prior to initiating federal court action you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing of the Notice of Final Decision on your appeal.

The Board of Trustees will review the appeal at their next scheduled bi-monthly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

(i) The Plan will not assert a failure to exhaust administrative remedies;

(ii) The Plan agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;

(iii) The Plan requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

(iv) You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

a. A statement that using this procedure will have no effect on your right to receive other benefits under this Plan.
b. A statement that you have the right to have a personal representative with regard to your claim.
c. A notice of any circumstances which may impair the impartiality of the Board of Trustees.

(v) The Plan will not impose any fees or costs on you as part of this voluntary appeal process.

In the event that the denial is upheld, you will receive a written notice which includes the following:

- The specific reason for the denial;
- The sections of the Plan upon which denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affect your claim, if applicable; and
- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

- **Decision on Appeal to Be Final**

  The decision by the Board of Trustees, the Plan's third party administrator, or any insurer or other vendor, as applicable, on appeals shall be final, binding and conclusive and will be afforded the maximum deference permitted by law unless found by a court of competent jurisdiction to be arbitrary and capricious. **The mandatory levels of appeal must be exhausted before any legal action is brought. Any legal action must be commenced within one (1) calendar year after these claims' review procedures have been exhausted.**

Benefit Payment to an Incompetent Person

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent. In this event, the Trustees may make such payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which they were paid if they are paid:

- Directly to the person;
- To the legally appointed guardian or conservator of such person;
- To any spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of the person; or
- By the Trustees directly for the support, maintenance, and welfare of the person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Plan, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

Coordination of Benefits

When members of a family are covered under more than one group benefit plan, there may be instances of duplication of coverage – two plans paying benefits for the same medical expenses. The Coordination of Benefits (COB) provision coordinates the benefits payable by this Plan with similar benefits payable under other plans**.**

All benefits provided under this Plan are subject to Coordination of Benefits except Prescription Drug Benefits.

This Plan follows rules established by law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills. When you or your family members are covered by another group plan in addition to this one, this Plan will follow Coordination of Benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan. This Plan pays for health care only when you follow its rules and procedures. If its rules conflict with those of another plan, it may be impossible to receive benefits from both plans and you will be forced to choose which plan to use.

The Plan will coordinate its benefits with any plan providing health benefits or health services, including, but not limited to:

- Group, blanket or franchise insurance coverage;
- Group practices and other group pre-payment coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- Any coverage under governmental programs such as Medicare;
- Vehicle Insurance (including but not limited to, uninsured/underinsured, no-fault, medical payment and similar policies or coverage);
- School sponsored insurance;
- Casualty and liability insurance; and
- Excess insurance.

When a claim is made, the primary plan pays its benefits without regard to any other plan. Vehicle insurance including, uninsured/underinsured, medical payment coverage, no-fault, and similar policies or coverage, as well as casualty, liability and excess insurance coverages are always primary.

This Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- Medicaid;
- Group Hospital indemnity plans that pay less than $100 per day;
- School accident coverage; and
- Some supplemental sickness and accident policies.

When this Plan is primary, it will pay the full benefit allowed by this Plan as if you had no other coverage. When this Plan is secondary, payments will be based on the balance left after the primary plan has paid. It will pay no more than that balance. In no event will this coverage pay more than it would have paid if it had been primary.

This Plan's secondary benefits will be limited if, under this Plan's Coordination of Benefits rules:

- This Plan's coverage is secondary; and
- The primary plan includes a provision that results in the primary plan paying a lesser benefit when there is secondary coverage.

In this situation, as the secondary payer, this Plan will limit benefits to no more than the lesser of the:

- Difference between the amount that the Covered Person's primary plan would have paid if the primary plan had been the only plan providing coverage and the total amount of covered charges; or
- Amount that this Plan would have paid had this Plan's coverage been primary.

This rule takes precedence over any contrary provision in the primary plan and applies whether the coverage under the primary plan is provided through a sub-plan, wrap-around plan, or any other designation.

This Plan will pay:

- Only for expenses that are Covered Services;
- Only if you have followed all of this Plan's requirements; and
- No more than the allowable expenses. If this Plan's allowable expense is lower than the primary plan's, then the primary plan's allowable expense will be used unless a Provider has agreed to accept this Plan's allowable expense as payment in full. The allowable expense may be less than the actual bill.

Which Plan Is Primary

To decide which plan is primary, consider both the coordination provisions of the other plan and which member of your family is the patient. The primary plan will be determined by the first of the following that applies:

1. **Non-Coordinating Plan –** If you have another group coverage that does not coordinate benefits that plan will always be primary.

2. **Insured/Participant –** The plan that covers the patient as the insured is primary to the plan that covers the person as a dependent; except, if that person is also a Medicare Beneficiary and because of Medicare regulations, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent.

3. **Children (parents divorced or separated) –** If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, this Plan follows the birthday rule. If neither of these rules apply, the order will be determined as follows:
   - The plan of the parent with custody;
   - The plan of the spouse of the parent with custody;
   - The plan of the parent not having custody; and
   - The plan of the spouse of the parent not having custody.

4. **Children and the Birthday Rule –** When your children's health care expenses are involved, the birthday rule is followed. The birthday rule uses the month and day of a birthday; it excludes the year of birth. The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If the parents' birthdays are the same, then whichever parent's plan has been in effect longer is primary. If a dependent child has coverage under this plan and also has coverage as a dependent under a spouse's plan, then the plan that has covered that dependent child for the longer time period will be primary and the plan that has covered the dependent for the shorter time period will be secondary; however, if the dependent child's

coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule.

5. **Active Employment vs. Layoff or Retirement –** The plan that covers the person as an active participant (or that participant's dependent) is primary to another plan that covers that person as a laid off participant or a retiree (or that person's dependent). This rule does not supersede rule 2, insured vs. Dependent.

6. **State or Federal Continuation Coverage –** When the person's coverage is provided under a right of continuation under federal law (i.e., COBRA) or state law, any other plan covering that person will be primary to the plan covering the person under such continuation provision.

7. **Length of Time Covered by the Plan –** The plan that has covered the person for the longer period is primary to another plan.

8. **Other Situations –** For all other situations not described above, the order of benefits will be determined in accordance with the NAIC rule on Coordination of Benefits.

Right to Information and Recovery

Certain facts are needed to apply COB rules. The Benefit Trust Office has the right to decide which facts are needed. This Plan may get needed facts from or give them to any other organization or person. The Plan need not tell you, or get your consent to do this. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan and this Plan will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments made by this Plan is more than should have been paid under this COB provision, this Plan may recover the excess. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services. The Plan reserves the right to offset any amounts paid in error from any pending or future claims.

Subrogation

Subrogation is substitution of the Fund to your or your Dependent's legal right to collect damages from a third party.

The Plan will exercise its right of subrogation and recovery if you as a Participant, or your Dependents (hereinafter referred to a "Covered Person(s)") are paid any benefits, including hospital, surgical, and/or medical benefits, due to illness, injury, or any other loss for which another person or entity is or may be legally responsible. This would include, but not be limited to, a loss, injury or illness compensable under workers' compensation system and/or due to medical malpractice, negligence, tortious and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's advancement of benefits in this context, you and your covered dependents agree to the terms set forth herein.

Subrogation means that the Plan can regain from the person who caused the loss, illness or injury, or that person's insurance company, the benefits the Plan paid on your behalf for that loss, injury or illness, including but not limited to, claims compensable under state Workers' Compensation laws, medical malpractice, negligence, tortious and/or criminal conduct by a third party. The Plan is subrogated to all rights of recovery of you and your Dependents regardless of whether you or your Dependents obtain a full or partial recovery from such person, entity, or any other available source, including, but not limited to, the insurer of such person or entity, the Participant's, or your Dependent's insurer including coverage for medical payments, underinsured and/or

uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance, or the workers' compensation system, or any other source (each of the aforementioned hereinafter collectively referred to as "Responsible Person(s)"). Such recovery includes, but is not limited to, court judgments, administrative or agency orders, private settlements, and all monies however characterized, or any other payments.

The full amount of the benefits paid by the Plan will be recovered by the Plan without regard to any collateral source of recovery. The Plan's subrogation interest will take priority over any and all rights of recovery held by you or your Dependents against such person, entity or other coverage arising out of the event that triggered the Plan's payment of benefits. The Plan's subrogation interest will apply regardless of whether you or your Dependents have been or will be made whole and regardless of whether you or your Dependents have incurred fees or costs to obtain a recovery from any person, entity, or other coverage, the "make whole" rule will not apply. Further, the Plan expressly rejects and otherwise prohibits application of the "make whole" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights. Additionally, the Plan expressly rejects, disclaims and otherwise prohibits application of the "common fund" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claims still held by you or your Dependents, the Plan's subrogation claim shall be first satisfied before any part of the recovery is applied to your claim, your attorney fees, other expenses or costs. You and your Dependents will be solely responsible for all attorney's fees and costs incurred in the pursuit of the recovery.

Your claims and benefits payments will normally continue to be paid in the same way as they always have been. However, you or your Dependents will have certain responsibilities to the Plan. When you or your Dependents submit a claim for injuries, the Benefit Trust Office will have you complete a form requesting information as to how the injuries occurred and the identity of any potentially responsible third parties. At the request of the Benefit Trust Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Plan's right of subrogation, and if any of your acts or omissions to act compromise this right of subrogation, the Plan will seek reimbursement of all appropriate benefits paid on behalf of you and your eligible Dependents directly from you. **Specifically, the Covered Person(s) shall complete all paperwork deemed necessary by the Benefit Trust Office to protect the Plan's subrogation interests, including the signing of the Plan's subrogation and reimbursement agreement; failure to do so entitles the Plan to deny coverage for the subject loss, injury or illness**.

The Covered Person will do nothing to impair or negate the Plan's right of subrogation and will fully cooperate with the Benefit Trust Office. In the event the Plan has a subrogated interest or right of recovery, you will not release any party, person, corporation, entity, insurance company, insurance policy, or funds that may be liable or obligated to you for the acts or omissions of any person or entity without the written approval of the Plan. If the covered Person performs any act or fails to act, fails to reimburse the Plan in the full amount of benefits of whatever nature that they were paid by the Plan, or otherwise compromises the Plan's rights, the Plan may immediately seek recovery of all benefit amounts paid by any available means, including legal action. The Plan shall also have the right to offset any future benefit payments that would otherwise be payable to or on behalf of the Covered Person, to the extent of its lien. These offset benefits shall be permanently forfeited by the Covered Person and the Covered Person shall be legally responsible for any unpaid amounts.

In the event that you or your Dependents pursue a claim against any person, entity, or other coverage, you and your Dependents must agree to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan will be legally presumed to be included in such claim. In the event you or your Dependents do not pursue a claim against any person, entity, or other coverage, the Plan will have the right to pursue, sue, compromise, or settle any such claims in your or your Dependent's name and to execute any and all documents necessary to pursue the claim.

The Covered Person assigns to the Plan any and all claims, demands and contractual rights the Covered Person has or may have against Responsible Person(s) arising from or related in any way to the Covered Person's loss,

injury or illness, and agrees that the Plan is substituted in the place of the Covered Person against such Responsible Person(s) to the extent of the amount paid by the Plan as a result of such loss, injury or illness. This entitles the Plan to make claim or file suit in the name of the Covered Person. The Covered Person agrees that the Plan shall hold a lien against any amounts the Covered Person receives, will receive or has available from any source as a result of the loss, injury or illness to the extent of benefits paid by the Plan. The Covered Person agrees that the Plan may at any time notify or otherwise communicate with the Responsible Person(s) and the Covered Person's attorney and release information relative to the loss, injury or illness. The Covered Person agrees to promptly make claims against the Responsible Person(s), and if necessary, to commence and prosecute a lawsuit against such Responsible Person(s) with all due diligence. Any recipient of settlement proceeds or assets collected from judgments are subject to the imposition of a constructive trust.

Constructive Trust

A Participant, or Dependent, or his attorney who receives any recovery (whether by judgment, settlement, compromise or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision or otherwise make restitution to the Plan. A Participant, or Dependent, or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Participant, or Dependent, or his attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Reimbursement

As a Covered Person, you and your Dependents agree to reimburse the Plan for any money recovered from any person, entity, or other coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. The Plan has the right to be reimbursed in an amount equal to the amount of medical benefits paid hereunder, regardless of whether you or your Dependents obtain a full or partial recovery from such person, entity, or other coverage. The Plan will be reimbursed on a first priority basis, regardless of whether or not you or your Dependents have been or will be made whole and regardless of whether you or your Dependents have incurred fees or costs to obtain a recovery from any person, entity, or other coverage. The "make-whole" rule will not apply.

In the event you or your Dependents settle, recover, or are reimbursed by any person, entity, or other coverage, you or your Dependents will hold any such money in Trust for the benefit of the Plan. You or your legal representative must hold in Trust for the Plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses, or costs) to be paid to the Plan immediately upon your receipt of the recovery. You must reimburse the Plan in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire, regardless of whether funds recovered are used to repay benefits paid by the Plan. If you fail to hold money you receive in Trust for the benefit of the Plan, you or your Dependents will be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

The Plan will provide benefits at the onset, but you will be asked to execute and deliver such documents or take other action as is necessary to assure the Plan's rights should your lost wages claim prove successful.

Recovery of Payments and Overpayments

In the event that you or your Dependent receives a payment you are not entitled to, or an overpayment of benefits, for any reason including but not limited to an administrative or clerical error, misrepresentation, fraud, or you fail to reimburse the Plan for payments made to you whereby the Plan is entitled to reimbursement including but not limited to subrogation, the Plan shall have the right to request immediate repayment of the payment or

overpayment, and if you or your Dependent is unwilling or unable to repay such amount within thirty (30) days or reach a repayment schedule agreeable to the Plan regarding such amount, the Plan shall have the right to offset future benefits due to you or your Dependent under the Plan. In addition to any other remedy, the Trustees may collect any such payment or overpayment by suit, arbitration or such other remedy as law or equity may provide including the placement of an equitable lien and/or constructive trust on the payment or overpayment. Anyone who does not immediately tender the payment or overpayment to the Plan will be deemed to hold such monies in constructive trust for the Plan, because such person is not the rightful owner of the payment or overpayment and should not be in possession of such amount. These provisions do not limit the Plan's right to recover such erroneous payment or overpayment by any other lawful means.

You and your Dependent shall furnish, at the request of the Trustees, any information or proof reasonably required to determine your benefit rights. If you or your Dependent makes a willfully false statement or furnishes fraudulent information or evidence, the Trustees shall have the right to recover immediately all benefit payments made in reliance on any false or fraudulent statement, information or evidence submitted by a claimant, including withholding of material fact.

Rescission of Benefits

In accordance with the Patient Protection and Affordable Care Act, the Fund will only "rescind," or cancel, or discontinue coverage retroactively in cases where a Participant or the Participant's eligible dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Fund. If the Fund seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a participant's failure to timely pay premiums is not a rescission.

HIPAA Privacy Policy

Neither the Plan nor any of the providers of benefit programs covered under HIPAA discriminate against any Participant or Dependent on the basis of health related status which refers to medical condition, claims experience, receipt of health care, genetic information or disability. By discriminate the Plan means exclusion from coverage, eligibility rules, or higher premiums but does not mean setting limitation on amount level, or nature of benefits or coverage, nor limitation on amount of premium that may be charged, nor preexisting condition exclusions in conformity with HIPAA. The Plan and the carriers it retains to provide benefits coverage either do not have preexisting condition exclusions or if such exclusions exist they comply with the terms of HIPAA.

FEDERAL REGULATIONS REQUIRE YOUR HEALTH PLAN TO FOLLOW PROCEDURES TO PROTECT YOUR PRIVACY – SPECIFICALLY, THE PRIVACY OF YOUR HEALTH INFORMATION WITHIN THE CONTROL OF THE PLAN

When you read this notice that the Plan is required to provide to you under the rules, please pay close attention to the following points:

- The rules allow the Plan to use and disclose your health information:
  - To pay claims; and
  - To administer the Plan.

Unless you object, the rules allow the Plan to communicate orally, electronically and by other means about the status of your claims and your eligibility for benefits with your spouse if you are married.

For example:

The Benefit Trust Office may discuss:

- *Your claims* electronically, over the telephone or in person *with your spouse*.
- *Your spouse's claims* electronically, over the telephone or in person *with you*.

As parents or guardians, you and your spouse will generally have continuing access to information regarding your minor children.

The Fund will assume the person contacting them is involved with an individual's care if the person can identify the provider name and date of service.

If you do not wish to have the Benefit Trust Office discuss your protected health information with your spouse, you must complete the form on the next page and send it to the Benefit Trust Office. The form will take effect when the Benefit Trust Office receives it.

Privacy Request

To: Privacy Official

The Benefit Trust Office does not have my permission to discuss my protected health information, including eligibility and claims status, with the person checked below unless I specifically authorized such a discussion in writing:

☐ My Spouse Name: _____ Date of Birth:_____

Participant Name: _____ Social Security Number: _____

Signature: _____ Date: _____

Privacy Notice

Section 1: Purpose of This Notice and Effective Date

This Notice Describes:

1. How medical information about you may be used and disclosed; and
2. How you may obtain access to this information.

Please review this information carefully.

Effective date. The effective date of this updated Notice is January 1, 2016.

This Notice is required by law. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),

2. Your rights to privacy with respect to your PHI,

3. The Plan's duties with respect to your PHI,

4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services, and

5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written or electronic form.

PHI refers to your health information held by the Plan.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization or the opportunity to object in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

- ***To the Plan's Trustees.*** The Plan will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor is the Board of Trustees. The Plan Sponsor has amended its Plan Documents to protect your PHI as required by Federal law. For example, the Plan may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

  - Treatment,
  - Payment, or
  - Health care operations.

The Plan does not need your consent or authorization to release PHI when:

- you request it,
- a government agency requires it,
- Trustees are required to review it, or
- the Plan uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example:*** The Plan discloses to a treating physician the name of your family physician so that the treating physician may ask for your X-rays from the family physician.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
Health Care Operations keep the Plan operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

In general, the Plan does not need your consent to release your PHI if required by law or for public health and safety purposes.

1. ***When required by law.***
2. ***Public health purposes.*** To an authorized public health official if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).
7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:

a. identifying or locating a suspect, fugitive, material witness or missing person, and

b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

13. ***Specialized Government Functions.*** When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. Any revocation of any authorization must be in writing. The authorization form that you would use describes how to revoke an authorization. A revocation is not effective unless it is received by the Privacy Official.

Other Uses or Disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the Plan for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the Board of Trustees.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures and Receipt of PHI

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Official determines it to be unreasonable.

In addition, the Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI or to receive communications of PHI by alternative means or at alternative locations. Make such requests to the Benefit Trust Office:

1470 Worldwide Place
Vandalia, OH 45377-1156

Protected Health Information (PHI): includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form of the PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer:

Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Plan and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to make a written request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

If you disagree with the record of your PHI, you may amend it.
If the Plan denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your written request to amend PHI to the following officer:

Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI. The Plan does not have to provide you with an accounting of disclosures related to treatment, payment or health care operations or disclosures made to you or authorized by you in writing.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain an additional paper copy of this Notice, contact the following officer:

Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Benefit Trust Office.

You may designate a personal representative by completing a form that is available from the Benefit Trust Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the plan. In addition, the Fund will consider a parent or guardian as the personal representative of an un-emancipated minor unless applicable law requires otherwise. A spouse or a parent recognized as a personal representative may act on an individual's behalf, including requesting access to their PHI. Spouses and un-emancipated minors may, however, request that the Plan restrict information that goes to family members as described above at the beginning of Section 3 of this Notice.

Section 4: The Plan's Duties

Maintaining Your Privacy

This notice is written to inform you of the Plan's obligation to maintain the privacy of your PHI.

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and

privacy practices.

This Notice is effective beginning on January 1, 2016 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

The Plan must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your written authorization,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services, pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Final HIPAA Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act generally referred to as the HIPAA Final Rule, are as follows:

- You have the right to be notified of a data breach relating to your unsecured health information.
- You have the right to ask for a copy of your electronic medical record in an electronic form provided the information already exists in that form.
- To the extent the Plan performs any underwriting, the Plan cannot disclose or use any genetic information for such purposes.
- The Plan may not use your PHI for marketing purposes or sell such information without your written authorization.

Section 6: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the privacy officer:

Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156

You have the right to file a complaint if you feel your privacy rights have been violated.
The Plan may not retaliate against you for filing a complaint.

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Plan will not retaliate against you for filing a complaint.

Section 7: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the privacy officer at the Benefit Trust Office:

Board of Trustees of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust
1470 Worldwide Place
Vandalia, OH 45377-1156

Section 8: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

HIPAA Security

The Plan and the Plan Sponsor agree to comply with the Security Regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160, 162, and 164 (the "Security Regulations"). The Security Regulations are incorporated herein by references, and, unless defined otherwise in the Plan in a way not inconsistent with the Security Regulations, all capitalized terms herein shall have the definition given to them by the Security Regulations. These provisions shall apply to that Electronic Protected Health Information ("ePHI") created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan except, as provided in the Security Regulations, for ePHI (1) disclosed to the Plan Sponsor consistent with the provisions set forth in 45 CFR section 164.504(f)(1)(ii) or (iii), or (2) as authorized under the provisions set forth in 45 CFR section 164.508. To the extent any other terms of the Plan should conflict with the following provisions, the following provisions shall control.

The Plan Sponsor is required to and shall, in accordance with the Security Regulations:

(a) Implement Administrative, Physical, and Technical Safeguards (each as defined in 45 CFR § 164.304) that reasonably and appropriately protect the Confidentiality, Integrity, and Availability (each as defined in 45 CFR § 164.304) of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(b) Ensure that the adequate separation required 45 CFR section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures. In general, the required adequate separation means that the Plan Sponsor will use ePHI only for Plan administration functions it performs for the Plan.

(c) Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect information, including those security measures that are required pursuant to the HITECH Act.

(d) Obtain signed business associate agreements from the Plan's business associates that are updated to reflect the changes imposed by the HITECH Act.

(e) Report to the Plan any Security Incident of which it becomes aware, and to make such other reports, notices, and/or disclosures that are required pursuant to HITECH Act's Breach Notification Requirements.

Important Information About the Plan

Plan Name

The name of the Plan is Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Plan for Active Metal Building Employees.

Plan Year

The records of the Plan are kept separately for each Plan year. The Plan year is February 1 through January 31.

Board of Trustees

A Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of contractor and union representatives selected by the contractor associations and the local unions. If you wish to contact the Board of Trustees, use the address and phone number at the beginning this booklet. The Trustees of this Plan as of January 1, 2016 are:

Union	Employer
Ralph Copley Iron Workers Local Union No. 22 5600 Dividend Rd., Suite A Indianapolis, IN 46241-4302	Curtis Sattison F.A. Wilhelm Construction Co. 3914 Prospect Street Indianapolis, IN 46203-2344
Dave Baker Iron Workers Local Union No. 44 1125 Victory Place Hebron, KY 41048-8293	Mark Douglas Ben Hur Construction Company 3250 Profit Drive Fairfield, OH 45014-4238
Tommy Carrier Iron Workers Local Union No. 70 2441 Crittenden Drive Louisville, KY 40217-1813	Mark Bishop Huelsman Sweeney Const. Co., Inc. P.O. Box 188 Sellersburg, IN 47172-0188
Ron Starkey Iron Workers Local Union No. 147 1211 West Coliseum Boulevard Fort Wayne, IN 46808-1227	Robert Fruchey Don R. Fruchey, Inc. 5608 Old Maumee Road Fort Wayne, IN 46803-1733
Neal Amburgey Iron Workers Local Union No. 172 2867 South High Street Columbus, OH 43207-3641	Craig Wanner Wanner Metal Worx Inc. 525 London Road Delaware, OH 43015-2849
Jeffrey S. Bush, Sr. Iron Workers Local Union No. 290 606 Hillrose Avenue Dayton, OH 45404-1543	John Hesford SOFCO Erectors, Inc. 10360 Wayne Avenue Cincinnati, OH 45215-1129
Robert Kara Iron Workers Local Union No. 292 3515 Boland Drive South Bend, IN 46628-4303	Ronald Fisher 234 N. Elmer Street Griffith, IN 46319-2741
Robert Thornton, II Iron Workers Local Union No. 301 2425 Hampshire Drive Charleston, WV 25312-1315	Willard Casto Kanawha Valley Builders Association 653 Fore Drive Charleston, WV 25312-6263
Rob Barker Iron Workers Local Union No. 372 4958 Winton Ridge Lane Cincinnati, OH 45232-1617	Berney McGee 274 Shadow Wood Court Loveland, OH 45140-9337
Kevin Libby Iron Workers Local Union No. 769 2151 Greenup Avenue Ashland, KY 41101-7714	Doug Moffitt C & L Construction P.O. Box 6726 Charleston, WV 25362-0726
Bradley C. Winans Iron Workers Local Union No. 787	Clinton Suggs Parkersburg-Marietta Cont. Association

Union	Employer
303 Erickson Boulevard Parkersburg, WV 26101-6687	2905 Emerson Avenue Parkersburg, WV 26104-2518

Plan Sponsor and Fund Administrator

The Board of Trustees is both the Plan Sponsor and Fund Administrator.

Identification Numbers

The number assigned to this Plan is 502. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 31-0557391.

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents may also be served upon any individual Trustee.

Source of Contributions

Employer contributions are received and held in Trust by the Trustees pending payment of benefits and administrative expenses. Contributions are determined by the provisions of the Metal Building and Canopy Agreement in force with one or more of the Local Unions affiliated with the Iron Workers District Council of Southern Ohio & Vicinity. The Metal Building and Canopy Agreement requires contributions to the Plan at fixed rates per hour worked for Employers.

The Benefit Trust Office issues each Participant a quarterly statement that includes the name of his employer and the hours of work reported. Upon written request, you may receive information as to whether a particular employer or organization has entered into the Metal Building and Canopy Agreement with the Fund or obtain a copy of the Metal Building and Canopy Agreement. You are entitled to participate in this Plan if you work under the Metal Building and Canopy Agreement and if your employer makes the required contributions to the Fund on your behalf.

Note: Contributions made by Employers are not deductible on the Participant's income tax return.

Plan Type

The Plan, considered a Welfare Plan, is maintained for the purpose of providing Medical and Prescription Drug Benefits only. The Plan benefits are as listed on the *Schedule of Benefits* insert to this booklet.

Insurance Companies/Vendors

Medical benefits (Active) are processed by:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Prescription drug benefits (Active) are processed by:

Express Scripts
P.O. Box 66558

St. Louis, MO 63166-6558

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. The Fund's assets and reserves are managed by professional asset managers selected by the Board of Trustees.

Eligibility

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet. The Fund Administrator has broad discretion to determine eligibility for benefits and interpret Plan language. The Fund Administrator's decisions will receive judicial deference in any court or administrative proceeding to the extent they do not constitute an abuse of discretion. Participation in the Plan or eligibility for benefits is not a guarantee of employment.

Claim Procedures

The procedures to follow for filing a claim for benefits are listed in the *How to File Claims and Appeals* section of this booklet. If all or any part of a claim is denied, you have the right to request that the Board of Trustees review the matter and that the matter be submitted to a hearing.

Plan Amendment or Termination

This Plan may be amended, changed, or discontinued at any time without the consent of any Covered Person by a majority vote of those Trustees present and voting at a meeting where a quorum is present. An amendment may be effective prospectively or retroactively and is subject to the limitation of the Trust Agreement and to applicable law and administrative regulations.

If the Plan is modified or terminated, you will be notified in writing or as required by law. The Trust may be terminated because of the expiration of all Collective Bargaining Agreements requiring payment of contributions to the Fund, or for any other reason deemed necessary by the Trustees.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a Plan for dissolution adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any contributing employer, association, or labor organization.

Notices under Federal Law

Maternity or Newborn Infant Coverage

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

Women's Health and Cancer Rights Act

The Plan, when providing medical and surgical benefits with respect to a mastectomy will provide, in the case of a Participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, and coverage for prostheses and physical complications at all stages of the mastectomy, including lymphedemas. Such coverage is subject to the Plan's annual deductibles and coinsurance provisions.

Mental Health Parity and Addiction Equity Act of 2008

To the extent the applicable medical plan provides mental health and substance abuse benefits, it will not place financial requirements, such as co-pays and deductibles, and treatment limitations, such as visit limits, on mental health or substance use disorder benefits that are more restrictive than the predominant requirements or limitations applied to substantially all medical and/or surgical benefits. Such coverage shall be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

ERISA Rights

As a Participant in the 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 following rights.

Receive Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Benefit Trust Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Participant Benefit Plan. The people who operate your Plan, called fiduciaries of the Plan,

have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description and Plan Document 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 Fund 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 Fund Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund 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 Fund Administrator, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

Nearest Regional Office:
Employee Benefits Security Administration
Cincinnati Regional Office
1885 Dixie Highway, Suite 210
Ft. Wright, KY 41011-2664
(859) 578-4680

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210-0001
(866) 444-3272

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

Definitions

Active Participant: Participant who is either actively employed in Covered Employment or available for employment in the trade with a Contributing Employer signatory to the Metal Building and Canopy Agreement.

Authorized Service: Covered Service rendered by any Provider other than a Network Provider that has been authorized in advance to be paid at the Network level.

Benefit Period: Period that benefits for Covered Services are payable under the Plan as listed on the *Schedule of Benefits* insert to this booklet. If your benefits end earlier, the Benefit Period ends at the same time.

Brand Name Drug: Initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name or under the drug's chemical name (generic).

Copayment or **Coinsurance:** Specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services as listed on the *Schedule of Benefits* insert to this booklet for which you are responsible. The Copayment or Coinsurance does not apply towards any Deductible.

Continuation Coverage: Opportunity offered to Participants and their Dependents for a temporary extension of health coverage in certain instances where coverage under the Plan would otherwise end.

Contributing Employer: Employer who is obligated pursuant to the Metal Building and Canopy Agreement to contribute to the Trust.

Covered Employment: Work that is covered by the Metal Building and Canopy Agreement between a Contributing Employer and a participating Local Union of the International Association of Bridge, Structural and Ornamental Iron Workers.

Covered Person: Participant, eligible Dependent, or qualified Beneficiary who meets all the requirements for coverage pursuant to the Plan's eligibility rules.

Covered Service or **Covered Expense:** Services, supplies, or treatment as described by the Plan that are performed, prescribed, directed, or authorized by a Provider. To be a Covered Service or Covered Expense, the service, supply, or treatment must be:

- Medically Necessary or otherwise specifically included as a Plan benefit;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under the Plan is in force;
- Not Experimental or Investigational or otherwise excluded or limited by the Plan; and
- Authorized in advance when precertification is required by the Plan.

A charge for a Covered Service is incurred on the date the service, supply, or treatment is provided.

Custodial Service or **Custodial Care** or **Long-term Care:** Services or care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury but care that cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises, or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible: Dollar amount of Covered Services, as listed on the *Schedule of Benefits* insert to this booklet, for which you are responsible to pay before benefits are paid under the Plan each Benefit Period.

Dependent: includes your:

Eligible Dependents include your:

- Legal spouse;
- Children up to the end of the month in which they reach the age of 26; and
- Unmarried children for whom you or your covered spouse are required to provide medical coverage for under a divorce decree, paternity judgment, or Qualified Medical Child Support Order (QMCSO), and who otherwise meet the eligibility requirements of a Dependent child.

Children include:

- Your own children;
- Stepchildren; and
- Legally adopted children, or children who have been placed with you for adoption and for whom legal adoption proceedings have been initiated.

Children also means children who meet <u>all</u> of the following conditions during the calendar year:

- Have their legal residence with you;
- Are related to you or your spouse by blood as brother, sister, niece, nephew, or grandchild; and
- Whose legal parents are both deceased or who have been court-ordered guardianship Dependents of yours or your spouse's for no less than five consecutive years. In the case of a child for whom you are the legal guardian, the child must maintain a principal residence with you for the entire year. You must submit copies of the guardianship order to the Benefit Trust Office.

You must have your Dependents listed on your Enrollment Card or you must add your Dependents on an Enrollment Card and submit the card and supporting documentation to the Benefit Trust Office.

Diagnostic Service: A test or procedure performed when you have specific symptoms to detect or to monitor a certain disease or condition. A Diagnostic Service also includes a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed as Covered Services.

Domiciliary Care: Care provided in a residential institution, treatment center, halfway house, or school because your own home arrangements are not available or are unsuitable, and consist chiefly of room and board, even if therapy is included.

Effective Date: The date your coverage begins under the Plan. A Dependent's coverage under the Plan begins on your Effective Date, if eligible. No benefits are paid for services and supplies received before your Effective Date or after your termination date.

Eligible Participant or **Eligible Employee:** An individual who has met the Plan's eligibility requirements and is entitled to benefits at the time a claim is incurred.

Emergency: An accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care: Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or stabilize an individual in an Emergency.

Experimental: Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition that, as determined by the Plan's third party administrator and/or the Plan, meets one or more of the following criteria:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or other licensing or regulatory agency, and such final approval has not been granted; or
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not considered Experimental based on the criteria above may still be considered Experimental by the Plan's third party administrator. In determining whether a service is Experimental, the Plan's third party administrator will consider the information described below and assess whether:

- Scientific evidence is conclusory concerning the effect of the service on health outcomes;
- Evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- Evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- Evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Plan's third party administrator to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental under the above criteria may include one or more items from the following list, which is not all inclusive:

- Published authoritative, peer-reviewed medical, or scientific literature, or the absence thereof;
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals or facilities, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Medical records; and
- The opinions of consulting Providers and other experts in the field.

While the Plan's third party administrator and/or the Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental under the Plan, the Trustees reserve the right to determine Plan benefits.

Generic Drugs: Drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark, which means a drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent. Generic Drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug.

Illness or **Sickness:** A condition in which a person is unable to function in the person's normal capacity due to bodily organ malfunction or any temporary ailment, including pregnancy.

Immediate Relative: Covered Person's spouse, parent, child, brother, or sister by blood, marriage, or adoption.

Injury: Any damage to a body part resulting from an external trauma.

Inpatient: A Participant who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Participant who is placed under observation for fewer than 24 hours.

Late Enrollee: An individual whose enrollment under the Plan is a Late Enrollment.

Late Enrollment: Enrollment other than on the:

- Earliest date on which Plan benefits can become effective; or
- Date of an event that qualifies for special enrollment.

Maximum Allowable Amount: The negotiated rate for Covered Services with participating or Network Providers. The Plan pays the same rate to non-participating Providers as well.

When you use a non-participating Provider, you are responsible for paying the difference between the Maximum Allowable Amount and the non-participating Provider's charge, if applicable.

The Maximum Allowable Amount for a Covered Service is determined using internally developed criteria and industry accepted methods and fee schedules that are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply.

For a participating Provider, the Maximum Allowable Amount is equal to the amount that is payment in full under the Network Provider's participation agreement for a service or product. For a non-participating Provider, even if the Provider has a participation agreement, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with participating Providers. If there is not a negotiated amount, the Fund Administrator has discretionary authority to establish the Maximum Allowable Amount for a Non-Network Provider facility.

Medically Necessary or **Medical Necessity:** In general, Medically Necessary means only those services, treatments, or supplies provided by a Hospital, Physician, or other qualified Provider of medical services or supplies that are required, in the Trustees' judgment (based on the opinion of a medical professional), to identify or treat an injury or sickness. The services, treatment, or supplies must be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the patient's condition, illness, disease, or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting, or level of service that can safely be provided to the patient and that cannot be omitted, consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention (cost-effective does not mean lowest cost);
- Not Experimental or Investigational;
- Not primarily for the convenience of the patient, patient's family, or Provider; and
- Not otherwise listed as a Plan exclusion.

The Plan only pays benefits for services and supplies that are Medically Necessary or based on Medical Necessity.

Mental Health Disorder: A condition that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical cause.

Network Provider: A Provider who has entered into a contractual agreement or is otherwise engaged by the Plan's third party administrator, or with another organization that has an agreement with the Plan's third party administrator or the Fund, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

Non-Network Provider: A Provider who has not entered into a contractual agreement with the Plan's third party administrator or the Fund for the Network associated with the Plan. Providers who have not contracted or

affiliated with the Plan's third party administrator's or the Fund's designated subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Outpatient: A Participant who receives services or supplies while not an Inpatient.

Participant or **Participating Employee:** A person whose employment is covered by the Metal Building and Canopy Agreement between a Contributing Employer and a participating Local Union of the International Association of Bridge, Structural and Ornamental Iron Workers.

Plan: Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust Metal Building Plan.

Prescription Legend Drug: Medicinal substance, dispensed for Outpatient use. It is required, under the Federal Food, Drug & Cosmetic Act, to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications that contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under the Plan.

Provider: Duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan's third party administrator or the Plan approves. To the extent required by the Patient Protection and Affordable Care Act of 2010 (ACA), if a service is covered under the Plan, the Plan will not discriminate based on the license or certification of the individual providing the service, if the individual is licensed to provide such services in the state in which the services are performed and the individual is acting within the scope of that license. Providers include, but are not limited to, the following persons and facilities:

- **Alcoholism Treatment Facility:** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternate Care Facility:** A non-Hospital health care facility, or an attached facility designed as free standing by a Hospital, that the Plan's third party administrator or the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility:** A facility Provider, with an organized staff of Physicians, which:
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations, and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Certified Nurse Midwife**
- **Certified Registered Nurse Anesthetist (C.R.N.A.)**
- **Dialysis Facility:** A facility Provider that mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or home care basis.
- **Drug Abuse Treatment Facility:** A facility that provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency:** A facility that:
    - Provides skilled nursing and other services on a visiting basis in the Subscriber's home; and

- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility:** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances in the home as Home Infusion Therapy for Total Parental Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice:** A facility Provider that provides medical, social, psychological and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals.
- **Hospital:** An institution which maintains an establishment for the medical or surgical care of bed patients for a continuous period longer than twenty-four hours and which:
  - Is open to the general public twenty-four hours each day for Emergency Care; and
  - Has a minimum of ten patient beds; and
  - Has an average of two thousand patient days per annum; and
  - Has an on-duty registered nurse twenty-four hours each day; and
  - Is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.
- **Laboratory (Clinical)**
- **Licensed Practical Nurse (L.P.N.)**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility:** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy:** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist**
- **Physician:** One of these professionals licensed under applicable State laws:
  - Doctor of Medicine (M.D.)
  - Doctor of Osteopathy (D.O.)
  - Podiatrist or Surgical Chiropodist (D.P.M. or D.S.C.)
  - Dental Surgeon (D.D.S.)
  - Chiropractor (D.C.)
  - Doctor of Optometry (O.D.)
- **Psychiatric Hospital:** A facility which, for compensation of its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorder. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist:** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital:** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level

of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Registered Nurse**
- **Respiratory Therapist**
- **Skilled Nursing Facility:** A Provider constituted, licensed, and operated as set forth in applicable state law, which:
    - Mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
    - Provides care supervised by a Physician;
    - Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
    - Is not a place primarily for care of the aged, Custodial or Domiciliary Care, long-term care, or treatment of alcohol or drug dependency; and
    - Is not a rest, educational, or Custodial Provider or similar place.
- **Social Worker (licensed)**
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Medical Supplies**
- **Urgent Care Center:** A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Medical Child Support Order: A Qualified Medical Child Support Order (QMSCO) is a court order that requires a Participant to provide medical coverage for his or her children called "Alternate Recipients" even if they do not otherwise meet the group health plan's eligibility requirements. These QMSCOs are generally issued in situations involving divorce, legal separation, or paternity disputes. The terms of a Qualified Medical Child Support Order are defined under ERISA Section 609(a).

Substance Abuse: A condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

Trust or **Fund:** The Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust, as defined in the Agreement and Declaration of Trust.

Active Participants and Dependents Schedule of Benefits

	PPO Network	Out-Of-Network
Medical Benefit		
Annual Deductible		
Individual	$3,100	$6,200
Family	$6,200	$12,400
Coinsurance (% the Plan Pays)	65%	50%
Copays		
Preventive Care (% the Plan Pays)	100%	50%
Primary Care Physician (Your Copay/Coinsurance)	$40	50%
Specialist (Your Copay/Coinsurance)	$40	50%
Urgent Care Copay	$50	$50
Emergency Room Copay (Copayment waived if admitted, then inpatient coinsurance applies)	$300	$300
Annual Medical OOP Limit (includes deductible)		
Individual	$6,200	$12,400
Family	$12,400	$24,800
Prescription Drug Benefit		

	PPO Network	Out-Of-Network
Annual Deductible		
Per Person	$50	$50

	PPO Network	Out-Of-Network
Copays/Coinsurance (Generic/Formulary/Non-Formulary)		
Retail – Maximum Supply 30 Days	$10/$35/$55	50% ($40 minimum)
Mail Order – Maximum Supply 90 Days	$20/$70/$110	Not Covered
Specialty	25% ($150 maximum)	50% ($40 minimum)
Annual Prescription Drug OOP Limit (includes deductible)		
Individual	$650	*N/A*
Family	$1,300	*N/A*
Medical and Prescription Drug OOP Limit for 2016		
Individual	$6,850	*N/A*
Family	$13,700	*N/A*

Contact Information

If You Need Information About ...	Contact ...
▪ Locating a Network Provider (Active)	Anthem Blue Cross and Blue Shield (800) 887-6055 www.anthem.com
▪ Medical Claims (Active)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187 (800) 887-6055 www.anthem.com
▪ Mental Health and Substance Abuse Precertification (Active)	Anthem Blue Cross and Blue Shield (800) 788-4003 www.anthem.com
▪ Prescription Drug Program	Mail-Order: Express Scripts P.O. Box 66558 St. Louis, MO 63166-6558 800-962-8192 www.anthem.com

NOTE: Unwritten communications such as personal conversations with a Trustee, the Union, an Employer, or Plan employees shall not be relied upon to change the terms of the written documents.