Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust

Plan Document and
Summary Plan Description

February 1, 2015 Edition

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

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This Summary Plan Description has been prepared for active and retired 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.

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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 updated Plan Document and Summary Plan Description (SPD), which contains current benefits information. This SPD serves as the Plan Document. The benefits described in this booklet are effective February 1, 2015. This SPD replaces and supersedes prior SPDs.

The Plan provides coverage for Active and Retired Participants and their Dependents. There are different plans of benefits for Retirees and their Dependents before and after Medicare eligibility begins. The Plan has contracted with a third party to administer medical and prescription drug benefits for Actives and Non-Medicare Retirees, and a third party to provide a Medicare Advantage PPO Plan for Medicare Retirees. Please refer to the latter part of this booklet for details of the third party administrators for the Active and Non-Medicare Retiree medical program, and the Medicare program.

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
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- **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 Non-Medicare eligible Retirees 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 the information in this booklet in an easy-to-understand format and added 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 SPD 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, including contact information for precertification.

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

Sincerely,
Board of Trustees

Eligibility Requirements

Active Participants

Initial Eligibility

You become eligible for coverage under the Plan if you:

1. Perform work that is under the jurisdiction of an Iron Workers Local Union that participates in the Plan (i.e., Covered Employment); **and**
2. Complete at least 1,000 hours of work 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;
- Dental Benefits;
- Vision Benefits;
- Hearing Aid Benefits;
- Health Reimbursement Account (HRA);
- Weekly Income Benefits;
- Life Insurance Benefits; and
- Accidental Death and Dismemberment (AD&D) Insurance 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 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 not actively at work due to disability when coverage begins, eligibility for Weekly Income Benefits will not begin until you return to active employment.

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

Active Participant Example

Pat begins work on March 1, 2015 and completes 1,000 hours of work in Covered Employment prior to March 1, 2016. He will be eligible for benefit coverage beginning April 1, 2016.

Apprentice Example

Chris is an apprentice who begins work on March 1, 2015 and completes 500 hours of work in Covered Employment prior to August 1, 2015. He will be eligible for benefit coverage beginning September 1, 2015.

Continuing Eligibility

Once you become eligible, you must continue to work 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 become disabled and are collecting Weekly Income Benefits under the Plan or Workers' Compensation benefits for a work-related injury or illness that occurred while you were performing work in the Iron Workers' trade in this District Council, you will receive a 23-hour credit to maintain eligibility for each week of disability for up to a maximum of 26 weeks in a 12-consecutive-month period. To receive this credit, you must be disabled for at least four days.

If you have not worked the required number of hours for eligibility, you may be able to continue coverage by using hours in your hour bank, money bank, or HRA if you have a balance in any of these accounts, and/or making self-payments for self-payment continuation of coverage, or making self-payments for COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

Reserve Accumulation Account Hour Bank

If you work more than 1,800 hours in a calendar year, any hours you work over 1,800 will be credited to your reserve accumulation account hour bank, up to a maximum of 270 hours. Hours in your hour bank will be used to continue your eligibility if you have not met the hours' requirement to continue eligibility. If the hourly contribution rate that Employers are required to pay changes, hour bank balances may be adjusted accordingly, as determined by the Trustees.

Hours worked as a Non-Bargaining Participant are not credited to the Hour Bank.

Money Bank

Some Employers contribute more per hour than is required for eligibility for Plan benefits. This extra contribution, as set by the Collective Bargaining Agreement (CBA), goes into the money bank. The balance in the money bank is used to continue your eligibility if you do not have the 270 hours in a three-consecutive-month period. If you do not work the required hours, you must first exhaust your hour bank and then your money bank is

used to make up the hours you are missing. The money bank is also used to pay active self-payment and Retiree coverage premiums.

Annually, you elect whether to keep the money in your money bank or to transfer the balance into your Health Reimbursement Account (HRA). For more information on your HRA, please see the *Health Reimbursement Account (HRA)* section.

Contributions for hours worked as a Non-Bargaining Participant are not credited to the Money Bank.

Supplemental Hours

If you work fewer than 270 hours, but at least 215 hours over a three-consecutive-month period, you may make self-payments for the difference between 215 and 270 hours to maintain your eligibility. This coverage includes Medical, Hearing Aid, Life Insurance, and Accidental Death and Dismemberment Insurance Benefits. You will not be eligible for Dental, Vision, and Weekly Income Benefits. The Benefit Trust Office will send you notification if this additional self-payment is required.

Self-Payments

If your eligibility ends because you have not worked the required number of hours, you may also continue your eligibility for coverage by making monthly self-payments for yourself and your Dependents. You have two options to continue coverage, which include:

- Making self-payments for self-payment Continuation Coverage for up to nine (9) consecutive months; **or**
- Electing to make COBRA Continuation Coverage self-payments (please see the *COBRA Continuation Coverage* section*).*

Regular self-payments will continue all of your benefits, except Dental, Vision, and Weekly Income Benefits. You must elect to make regular self-payments **in writing within 25 days following the date you would otherwise lose your eligibility. The self-payment is due in the Benefit Trust Office before the first day of each month for which eligibility is continued.** If you fail to make a self-payment it cannot be made up. Coverage will terminate at the end of the previously paid month.

A self-payment also continues coverage for your eligible Dependents who were covered under the Plan on the day your eligibility ended.

Self-payment Continuation Coverage ends on the earlier of:

- The last day of the month for which you have made nine (9) months of self-payments;
- The date you again qualify for coverage under the Plan by working for a Contributing Employer;
- The last day of the month preceding the month you do not make a required self-payment; or
- The date the Plan is terminated.

Your Dependents' coverage will also end on the date your coverage ends.

Disability Pension Applicants

During Disability Pension Application Processing

If you submit an application to the Iron Workers District Council of Southern Ohio & Vicinity Pension Trust for a disability pension, for the period in which that application is pending, you may be eligible to make self-payments for self-payment Continuation Coverage pursuant to the terms set forth in the *Self-Payments* section, unless you are receiving auxiliary benefits.

After the Exhaustion of an Auxiliary Disability Benefit

When your auxiliary disability benefits end, you may be eligible to make self-payments for self-payment Continuation Coverage pursuant to the terms set forth in the *Self-Payments* section. However, if you are then awarded your disability pension on a retroactive basis, you will be required to repay the Benefit Trust the difference in cost between the self-payment Continuation Coverage rate and the rate for retiree premiums. In such cases, you will be required to repay the difference in rates back to the effective date of your retroactive disability pension.

When Eligibility Ends

When your coverage ends, you will be provided with certification of your length of coverage under the Plan. This may help reduce or eliminate any pre-existing condition limitation under a new group health plan.

When coverage ends, you or your eligible Dependents may be eligible to continue coverage by applying Health Reimbursement Account money (please see the *Health Reimbursement Account (HRA)* section for more information) and/or making monthly self-payments, or electing COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section). If you choose to make self-payments to continue coverage, you must waive your right to COBRA Continuation Coverage. If you elect COBRA Continuation Coverage, you must waive the self-payment option. Note: If you work fewer than 270 hours, but at least 215 hours over a three-consecutive-month period, you may pay a supplemental payment for the difference between 215 and 270 hours to maintain your eligibility. See the *Supplemental Hours* section above for more information.

Coverage ends on the earliest of the following:

- The date you die (your eligible Dependents are covered for one full year of coverage without the requirement to pay the premium for that year);
- The last day of the fourth month following the last three-consecutive-month period during which you met the eligibility requirements for continuing eligibility, either through hours of work completed or hours in your hour bank;
- If you are making self-payments for self-payment Continuation Coverage, the last day of the month for which you were entitled to and did make a correct and timely self-payment;
- If you are making COBRA self-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 any Collective Bargaining Agreement between the Employer and the withdrawing Local Union. If your eligibility ends, any credit due to disability while you were receiving Weekly Income Benefits or Workers' Compensation benefits will end and credits in your hour bank will be eliminated.

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.

Extended Benefits

If eligibility ends for you or your Dependents for any reason, you are eligible to continue certain benefits. The Plan will pay:

- Hospital benefits for an existing period of confinement;
- Weekly Income Benefits for an existing period of total disability; and
- AD&D Insurance Benefits for a loss that was suffered as the result of, and within 90 days fromthe date of, an accident that occurred before the date of termination.

If, on the date of the termination and the day before that date, you or your Dependents are totally disabled, benefits for Hospital services, Outpatient expenses, surgical procedures, Physician Hospital visits, and diagnostic procedures will apply. These benefits will apply to a confinement that began within three months after your termination date and other benefits described in this section will apply only to any charges for that disability that are incurred within three months after your termination date while the disability continues.

Benefits for Emergency medical care, organ transplants, Substance Abuse treatment, Hearing Aid, Dental, and Vision care are not included in this coverage.

If benefits end for you or your eligible Dependents and you or your eligible Dependents are totally disabled on that date and the day before that date, medical benefits will be paid for covered medical expenses related to the disability that are incurred during the calendar year in which benefits end. Medical benefits will also be paid for medical expenses incurred in the next calendar year for any injury, sickness, or pregnancy that has caused continuous total disability from your termination date to the date each medical expense is incurred, provided benefits are not payable for these expenses under any other group insurance policy or group plan.

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 (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. In addition, if your eligibility for coverage ends due to such employment, you will lose any accumulated hours/money remaining in your hour/money bank account. However, 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 and you will not be allowed to make self-payments to continue your eligibility, if you:

- Become employed by an employer in the building trades who is not required to make contributions to this Plan on your behalf; or
- Prior to retirement, are no longer available (other than due to a disability) for work at the trade in the jurisdiction of a participating Local Union for a Contributing Employer.

These special termination provisions will not apply if you are authorized by your Local Union to work in the jurisdiction of another building trade, which is not required to make contributions to this Plan. Written authorization from the Local Union for your work must be received at the Benefit Trust Office.

Reinstatement of Eligibility

If your eligibility ends under the active Plan and you return to work for a Contributing Employer:

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.

Active Non-Bargaining Participants

Initial Eligibility and Continuing Eligibility

Non-bargaining Participants are subject to all guidelines in the non-bargaining participation agreement.

The following describes the requirements for a non-bargaining Participant to be eligible to participate in the Plan.

- A non-bargaining unit Participant must have and maintain membership in one of the Iron Workers Local Unions in the Southern Ohio & Vicinity jurisdiction in order to be eligible, but is a person who, under federal law, is not entitled to invoke the protection of the negotiated Collective Bargaining Agreement.
- A non-bargaining unit Participant must work at least 1,000 hours in a 12-consecutive-month period to become eligible on the first day of the 14th month with at least one (1) hour worked in the first month.
- The non-bargaining-unit Participant must employ one or more bargaining unit employee(s) for a minimum of 40 hours per quarter each calendar year.
- If the non-bargaining Participant is the only one reported for the Employer in any week, the non-bargaining Participant must pay a minimum of 32 hours.
- When a non-bargaining Participant is notified of non-compliance with the minimum hour's rule, he or she will be required to bring hours into full compliance. A non-bargaining Participant's failure to comply will result in the termination of his or her right to continue participation retroactive to the first date of non-compliance, and the non-bargaining Participant will forfeit his or her right to self-pay benefits. The non-bargaining Participant whose participation is terminated may be eligible to elect COBRA Continuation Coverage if he or she would otherwise qualify.
- If a non-bargaining Participant works for another signatory Employer, he or she will be required to pay the difference up to 32 hours per week. Effective as of February 1, 2012, if a non-bargaining Participant works as an iron worker or in any other type of building trades for a company that is not a Contributing Employer, he or she will no longer be eligible to participate in the Plan and will not be eligible to make self-payments in order to continue coverage under the Plan and will only have the option of electing COBRA Continuation Coverage.
- Hours worked as a Non-Bargaining Participant are not credited to the Hour Bank.
- Contributions for hours worked as a Non-Bargaining Participant are not credited to the Money Bank.

Who is a Non-Bargaining Participant?

1. Non-bargaining-unit Participants who may elect to participate in the Benefit Trust include, but are not limited to, the following:

a) Corporate officer/owner
b) Corporate officer
c) Spouse of corporate owner or other common owner
d) Supervisor
e) Estimator

2. If one or more owners, each owner is considered non-bargained on a stand-alone basis.

3. A son or daughter working for a company owned by a parent may be considered to be a non-bargaining unit Participant under certain circumstances as more fully described in the Non-Bargaining Unit Member Participation and Eligibility Rules.

4. If a company is owned by a bargaining unit Participant's spouse and at least one other individual, the spouse may qualify as a non-bargaining unit Participant under these rules.

Continuing Eligibility and When Eligibility Ends

When a non-bargaining Participant is no longer eligible due to lack of hours reported to the Fund, the following guidelines apply:

- The non-bargaining Participant will be offered and allowed to pay the COBRA options.
- The non-bargaining Participant will be offered and allowed to pay the self-payment or COBRA options if he or she is in his first year of participation and the lack of hours reported to the Plan is due to a verifiable business downturn; provided, however, that effective as of February 1, 2012, the non-bargaining Participant will not be eligible for this self-payment option if he or she is working as an iron worker or in any other type of building trade for a company that is not a Contributing Employer. If the non-bargaining Participant is eligible for Continuation Coverage under either the self-payment or COBRA options, he or she must waive one form of Continuation Coverage to take the other form.
- The non-bargaining Participant must request and receive approval from the Board of Trustees in order to begin submitting hours to the Plan on himself or herself.
- If Board approval is obtained, the non-bargaining Participant is required to meet the 1,000 hours per 12-consecutive-month rule as explained under the initial eligibility rules.

In the case of a non-bargaining Participant who failed to pay all contributions due and owing on himself and/or his employees while participating as a non-bargaining Participant and thus left a delinquency at the time he loses eligibility, should he then become employed in Covered Employment as a regular Active Participant or return to employment as a non-bargaining Participant or elect to retire and apply for retiree health coverage, he shall not be eligible to participate in the Plan until such contribution delinquency is satisfied in full and such individual otherwise satisfies all eligibility requirements as established in the Plan.

In the case of a non-bargaining Participant who paid all contributions due and owing on himself and his employees while participating as a non-bargaining Participant and thus did not leave a delinquency at the time he loses eligibility, and who, upon losing such eligibility elected and paid for COBRA for the full eighteen (18) months, should he then return to employment as a non-bargaining Participant within twenty four (24) months following the last day he was previously eligible for coverage, he will become eligible again under the Plan if he has 270 hours within three consecutive months. At least one hour must be in the first month. He will become eligible the first day of the fifth month. Thereafter, he shall be subject to all eligibility requirements for non-bargaining Participants as established in the Plan.

For a copy of the complete owner/non-bargaining participation rules, please contact the Benefit Trust Office.

Retirees

Initial Eligibility

You become eligible for Retiree medical benefits under the Plan's self-payment program after you retire if you:

- Are receiving pension benefits from the Iron Workers District Council of Southern Ohio & Vicinity Pension Trust; **and**
- Have been eligible for coverage under the Plan for 36 of the 60 months before your retirement date.

Retired Participants (Retirees) may be eligible under the Retiree medical benefits program for:
- Medical Benefits; and
- Prescription Drug Benefits.

In the case of a non-bargaining Participant who failed to pay all contributions due and owing on himself and/or his employees while participating as a non-bargaining Participant and thus left a delinquency at the time he loses eligibility, he shall not be eligible to participate in the retiree coverage until such contribution delinquency is satisfied in full and such individual otherwise satisfies all eligibility requirements as established in the Plan.

Retiree coverage does not include Dental, Vision, Hearing Aid, Weekly Income, Life Insurance, or Accidental Death and Dismemberment Insurance Benefits. Self-payment Retiree coverage includes the run-out of any balance in your Health Reimbursement Account. You may also elect coverage for your spouse and Dependent children (please see the *Choice of Plans* section below).

If you are an Active Participant and lose eligibility for active coverage due to retirement but do not meet the eligibility requirements or choose not to elect Retiree coverage, you may be eligible for COBRA Continuation Coverage. COBRA Continuation Coverage provides the opportunity to elect the same benefits as active coverage except that there are no Weekly Income, Life Insurance, Accidental Death and Dismemberment Insurance Benefits, or Health Reimbursement Account benefits, and coverage will terminate after 18 months. Please see the *COBRA Continuation Coverage* section for additional information on COBRA.

Choice of Plans

No two individuals have the same needs – some may be more concerned with the level of coverage, while others may be more concerned with the cost of coverage. For that reason, the Fund offers different levels of Retiree coverage. Your level of coverage options will depend on whether or not you or your Dependents are eligible for Medicare; and if not, whether or not you elect Plan A or Plan B coverage:

- ***Medicare Eligible Retirees or their Medicare Eligible Dependents*** – If you or your Dependents are eligible for Retiree coverage and are eligible for Medicare, you will be covered under the Plan's insured MedicareAdvantage program. When you or any of your covered Dependents become eligible for Medicare, you MUST immediately notify the Benefit Trust Office and provide a copy of your Medicare card at that time. You must sign up for Medicare Part B in order to continue coverage under the Plan (there are exceptions to the requirement to sign up for Part B for those individuals covered under group active benefits – please contact the Benefit Trust Office for more information.). If you fail to follow these requirements you will be ineligible for this coverage. The Plan currently contracts with a third party to provide Medicare-eligible Retiree Participants with access to an insured MedicareAdvantage/Medicare Prescription Drug Plan (MAPD) program. Full details of the insured program are provided by the insurer. Summaries are available from the Benefit Trust Office when you are initially eligible and upon request. The insured program, which is subject to change, is not described in this booklet, but a separate Evidence of Coverage describing the benefits is issued by the Insurance Company, (please see *Contact Information* insert).

- ***Non-Medicare Eligible Retirees and/or their Non-Medicare Eligible Dependents*** – If you or your Dependents are eligible for Retiree coverage but are not eligible for Medicare, you will be eligible to elect coverage under Plan A or Plan B. **However, please note that all Non-Medicare eligible covered family members will be covered under the same Plan (Plan A or Plan B).**

When initially eligible for Retiree coverage, if you or your Dependents are eligible for Medicare, you will be eligible for coverage under the Plan's insured program. However, if you and/or your Dependents are not eligible for Medicare, you will be asked to choose Plan A or Plan B; whichever Plan is right for you and your family. If you select Plan A, you will be given an opportunity to switch to Plan B before the beginning of each calendar year. However, if you select Plan B, you will NOT be allowed to switch to Plan A in the future.

Plan A and Plan B are similar in that they cover the same benefits. However, what you will pay out of your pocket will vary. Plan A has lower Deductibles and Coinsurance amounts, but a higher monthly self-payment amount. In contrast, Plan B has a lower monthly self-payment amount, but your out-of-pocket costs at the time of service will be higher because there are higher Deductibles and Coinsurance amounts you must pay. Consider your choices carefully as you will remain covered under the Plan you elect as long as you and/or your Dependents are eligible for Plan coverage or, if earlier, until you or your Dependents are eligible for Medicare (at which time you or your Dependents will be covered under the Plan's insured program for Medicare-eligible Retirees).

Self-Payments for the Retiree Plans. Monthly self-payment amounts are set by the Trustees based on factors including but not limited to the cost of providing coverage, accumulation and maintenance of reserves, administrative and other expenses and costs, and the amount is subject to change at the sole and exclusive direction of the Trustees. You will be notified of the amounts when you are first eligible and subsequently thereafter.

Special Enrollment

If you are eligible for Retiree coverage and you or your eligible Dependents have other group health coverage, that person may decline Retiree coverage under this Plan when initially eligible. If you or your Dependents initially decline coverage under this Plan, you or your Dependents may be eligible for a special enrollment when the other coverage ends.
For special enrollments due to loss of other group health coverage:

- You must re-enroll for coverage;
- For Dependents to re-enroll, you must re-enroll or already be covered under the Plan at that time (unless you are deceased). (However, if your Dependents cancel coverage under this Plan after your death, your Dependents may not re-enroll at a later date);
- Your Dependents must otherwise be eligible for coverage;
- When coverage under this Plan was declined, the person declining coverage must have been covered under another group health coverage; and
- The re-enrolled person must submit proof to substantiate that he or she was covered under group health coverage and that six months of COBRA Continuation Coverage was paid upon termination from that coverage. (If no COBRA Continuation Coverage is offered due to the lack of the mandated 20 or more employees, the employer being the federal government, or being a church plan, you or your Dependents may re-enroll for Retiree coverage as of the date of the COBRA qualifying event.)

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, you must notify the Benefit Trust Office within 31 days of becoming eligible for re-enrollment, as described above.

If you stopped Retiree coverage on Dependents and your pension benefits end due to returning to work as an active Participant:

- You may pay the regular active self-payment amount beginning with the month you are no longer covered under the Retiree program due to your return to active work status (for a maximum of nine (9) months).
- Any Dependents normally covered under the active program will be covered once you meet the eligibility requirements; this includes Dependents previously cancelled from the Retiree program.
- When you retire again, any Dependents cancelled when previously on Retiree insurance cannot be covered under the Retiree program unless you have worked 1,000 hours within 12 consecutive months before the second date of retirement. However, this requirement is waived if the Dependents were covered under other group health insurance and six months of COBRA Continuation Coverage are paid upon termination from that coverage.

Continuing Eligibility

Your eligibility for Retiree coverage will continue as long as the required self-payment is received on your behalf. If you return to work as an Active Participant and you become eligible for active coverage, you will have the same benefits as an Active Participant. However, under certain circumstances, your Retiree coverage is not suspended (please see the *If You Return to Work* section on the next page). Once you are no longer eligible as an Active Participant, you will be subject to the Retiree eligibility requirements (please see the *Eligibility Requirements* section).

When Eligibility Ends

Your eligibility for Retiree coverage will end on the earliest of the following:

- The date you die;
- The day the Plan is terminated;
- The last day of the month preceding the month in which your self-payment is not received; or
- The date you no longer meet the eligibility requirements for Retiree coverage.

In the event of your death, your surviving Dependents may be eligible to make self-payments to continue coverage. The surviving Dependents must:

- Have never turned down or cancelled Retiree self-payment coverage unless covered under another group health insurance plan; and
- Have been Dependents of the Retiree who was eligible with the Plan during 36 of the 60 months before his or her retirement; or
- Have been Dependents of a Retiree who was eligible to maintain benefits under a retiree self-payment program on the date of his or her death.

The payment amount will be determined by the Trustees. If coverage is maintained after the surviving Dependents become eligible for Medicare, coverage may be continued under the Retiree program for Medicare-eligible Retirees. Self-payments must be received by the Benefit Trust Office before the first day of each month for which benefits are continued. After eligibility ends, it cannot be reinstated.

If You Return to Work

Normally, if you work for a Contributing Employer when you are retired, your benefits are suspended. However, in certain situations you are allowed to work without a suspension of benefits.

Work Not Covered by a CBA

If you return to work for a Contributing Employer within the jurisdiction of the Iron Workers District Council of Southern Ohio & Vicinity in work that is not covered under a Collective Bargaining Agreement (CBA), your benefits will not be suspended if you are age 55 or older, have at least 30 pension credits in the Iron Workers District Council of Southern Ohio & Vicinity Pension Trust, and have not applied for nor received a disability, deferred vested, or reduced vested pension.

Work Covered by a CBA

If you return to work for a Contributing Employer in work that is covered under a CBA, your benefits may not be suspended if all of the following conditions are met:

- You are at least age 55;
- You have at least 30 pension credits;
- You are not receiving a disability, deferred vested, or reduced vested pension;
- You work less than 600 hours a year.

You must annually elect whether you want to work in non-Covered Employment or in work as an Iron Worker under the Collective Bargaining Agreement.

Dependent Eligibility

Eligible Dependents include your:

- Legal spouse;
- Children up to 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.

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.

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. 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 Iron Workers 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.

If you die while eligible for active coverage (including running out your hour bank, receiving disability credit hours or other active credit hours), your covered Dependents may continue coverage for one year from the date of your death without having to pay the premiums that would otherwise be due for that period. After the year of coverage ends, your surviving Dependents may elect COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section). If you die while making self-payments (including payments through your money bank), your Dependents will not receive this year of coverage but will receive your life insurance benefit.

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 insured 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.
You may be required to provide a "Certificate of Group Health Plan Coverage" to the other plan when you enroll. If coverage ends under this Plan, we will automatically send you this certificate. We will also provide you, upon request, with a Certificate of Group Health Plan Coverage before you lose coverage or at any time within 24 months from the date you lose coverage under this Plan. If you have any difficulty obtaining a Certificate of Group Health Plan Coverage from your prior health plan, please contact the Benefit Trust Office for assistance.

COBRA Continuation Coverage

COBRA Continuation Coverage is a temporary extension of coverage under the Trust. The Plan offers other types of continuation coverage, including the active Iron Worker Supplement Payment, active Iron Worker Self-Payment, Retiree coverage/Medicare, and USERRA military service coverage. To elect

When your COBRA Continuation Coverage ends, you will be provided with certification of your length of coverage under the Plan.

any of these other forms of continuation coverage, you must waive your rights to COBRA Continuation Coverage.

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. You will be allowed to choose either Medical and Prescription Drug coverage only or, if your coverage terminates while you are an Active Participant, Medical, Prescription Drug, Dental, Vision, and Hearing Aid coverage. However, COBRA Continuation Coverage does not include Weekly Income, Life Insurance, or Accidental Death and Dismemberment Insurance Benefits.

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, your service is considered a qualifying event under COBRA because it is a reduction in hours or end of employment. You or your Dependents are entitled to elect to make self-payments for COBRA Continuation 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.

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 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
1470 Worldwide Place
Vandalia, OH 45377-1156

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 either the:

- Active Iron Worker Supplemental Payment Program;
- Active Iron Worker Self-Payment Program;
- COBRA Continuation Coverage;
- Retiree Comprehensive Coverage/Medicare Program; or
- USERRA Military Service 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.

If you elect coverage through regular self-payments, you must waive your COBRA Continuation Coverage rights. In addition, if you elect Retiree coverage under the Plan, you must waive any right to COBRA Continuation 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), 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 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 that 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

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, Prescription Drug, Dental, Vision, and Hearing Aid coverage if you are an Active Participant or Medical and Prescription Drug coverage if you are a Retiree. Once you provide the required information, coverage for your spouse begins on the later of the date of your marriage or four months prior to the date the information is posted. At this time, you also may want to update your Beneficiary information for your Life Insurance and AD&D Insurance Benefits.

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.

If you are a Retiree, you **must** notify the Benefit Trust Office **within 60 days of the date of your marriage to enroll your spouse into Retiree insurance coverage**. If you miss the 60-day deadline, your spouse will not be eligible for coverage.

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.

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 four months from the date the information is posted. 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. At this time, you may also want to review your Beneficiary designation for your Life Insurance and AD&D Insurance Benefits, if eligible. You will be held responsible for any overpayment of claims if you do not notify the Benefit Trust Office of your divorce.

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.

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.

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 active 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 using your hour bank, money bank, making monthly self-payments or applying money from your Health Reimbursement Account (HRA) for self-payment Continuation Coverage, or self-paying for 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.

When You Are Out of Work Due to Disability (For Active Participants)

If you are out of work due to a non-work related disability, you may receive Weekly Income Benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. In addition, you may receive up to 23 hours per week credit to continue your coverage under the Plan. A maximum of 26 weeks of credit is available within a 12-consecutive-month period.

The Fund requires proof that you are under the care of a Physician to be eligible for Weekly Income Benefits. You must be eligible at the time you become disabled. The Fund also has the right to require you to submit to a medical examination. Refer to the *Weekly Income Benefits (For Active Participants Only)* section for more information.

If you are out of work due to a non-work related disability:

Notify your Employer, Local Union, and the Benefit Trust Office.

Apply for Weekly Income Benefits by completing and submitting a weekly disability form to the Benefit Trust Office.

If you are out of work due to a work-related disability:

- Notify your Employer, Local Union, and the Benefit Trust Office.
- Contact your local Workers' Compensation office and apply for Workers' Compensation benefits.

If you become disabled due to an injury that is covered by AD&D Insurance Benefits, you may also be eligible for an AD&D Insurance Benefit.

If you are out of work due to a work-related disability, you may be eligible for Workers' Compensation benefits. Contact your local or state Workers' Compensation office. The Fund does not provide coverage for work-related disabilities. However, you may receive up to 23 hours per week credit to continue your coverage under the Plan. A maximum of 26 weeks of credit is available within a 12-consecutive-month period. You must submit proof of the dates you were paid benefits by the Workers' Compensation carrier to the Benefit Trust Office to receive these credits. **After your disability ends, you must notify the Benefit Trust Office and your Business Agent.**

In the Event of Your Death

If you are an Active Participant and eligible for coverage on the date of your death, your Beneficiary will receive a Life Insurance Benefit (and an AD&D Insurance Benefit, for Active Participants only if your death is caused by an accident). For more information about Life Insurance and AD&D Insurance Benefits, please see the *In the Event of Your Disability or Death* 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.
- Apply for your Life Insurance Benefit (and AD&D Insurance Benefit, if applicable).
- If your Dependents want to continue coverage under the Plan, they must enroll for self-payment Continuation Coverage or COBRA Continuation Coverage.

Active Participants

If you die while an Active Participant (including running out your hour bank, receiving disability credit hours or other active credit hours), coverage for your eligible Dependents will be continued until the last day of the month in which you die. Your Dependents may continue coverage for one year from the date of your death without having to pay the premiums that would otherwise be due for that period. After the year of coverage ends, 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 self-payments (please see the *COBRA Continuation Coverage* section) or may make self-payments for Retiree coverage, if eligible.

If you die while making self-payments, (including payments through your money bank) coverage for your eligible Dependents will be continued until the last day of the month in which you die. Your Dependents will not receive a year of coverage, but will receive your Life Insurance Benefit see the *Life Insurance Benefits (For Active Participants Only)* section.

Retirees

If you are a Retiree and you elected coverage for your Dependents, your Dependents' coverage will continue until the last day of the month in which you died. Your surviving Dependents can continue coverage through self-payments. If the self-payments are discontinued for any month, or if your Dependents do not elect to make self-payments when first eligible, your Dependents will not be eligible to continue coverage by making self-payments. Please see the *Eligibility Requirements* section for more information. Your Dependents may continue health care coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary self-payments.

When You Leave Covered Employment

You may continue eligibility in the Plan through a combination of the hour bank, money bank (if applicable), supplemental hours or self-payments (please see the *Eligibility Requirements* section). In addition, you may be able to 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 (For Active Participants)

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, Prescription Drug, Dental, Vision, and Hearing Aid 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 self-payments. To continue coverage, you or your Dependents must pay the required self-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 self-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 (For Active Participants)

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks 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. 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

When you retire:
- Notify the Benefit Trust Office in advance of your retirement.
- Apply for Retiree benefits if you are eligible.
- If you want to continue coverage under the Plan, enroll for COBRA Continuation Coverage, unless you qualify for Retiree coverage.

Coverage for you and your Dependents will end under the active Plan when you retire. When you retire, you may be eligible for coverage under the Retiree medical benefits program if you meet the eligibility requirements described in the *Eligibility Requirements* section. There are different programs of benefits for Retirees – for Retirees and Dependents not eligible for Medicare (if you or your Dependent spouse are not eligible for Medicare, you also have a choice of programs – Plan A or Plan B) and for Retirees and Dependents eligible for Medicare. In general, benefits under the Retiree program are the same as those for Active Participants, except that there are no Dental, Vision, Hearing Aid, Weekly Income, Life Insurance, or Accidental Death and Dismemberment Insurance Benefits. Please note that there are different Deductibles, Coinsurance, Copayments, and out-of-pocket maximums for Retirees.

If you are an Active Participant, and lose eligibility for active coverage due to retirement and do not meet the eligibility requirements for Retiree coverage, you may be eligible for COBRA Continuation Coverage (please see the *COBRA Continuation Coverage* section).

Returning to Work

Active Participants

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

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

Retirees

Your Retiree coverage under the Plan will end when you return to employment and you become eligible for active coverage for the Plan's reinstatement eligibility requirements. However, there are certain situations that do not terminate your Retiree coverage even if you work (please see the *Eligibility Requirements* section).

Medical Benefits

(For Active Participants, Non-Medicare Eligible Retirees, and Dependents)

The Plan offers comprehensive health care coverage to help you and your eligible Dependents stay healthy and helps provide financial protection against catastrophic health care expenses. This section describes how the Plan works for Active Participants, Non-Medicare eligible Retirees, and eligible Dependents. For information on coverage for Medicare-eligible Retirees and Dependents, please see the *Eligibility Requirements* section,

How the Plan Works

Preferred Provider Organization (PPO)

For Active Participants, Non-Medicare eligible Retirees, 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 based on whether you use a Network or Non-Network Provider, as listed on the applicable *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 subject to different benefit maximums. See the applicable *Schedule of Benefits* insert to this booklet for more information.

Here is an example of how using a Network Provider can save you money.

Let us look at what Pat, an Active Participant, would pay at a Network Hospital compared to a Non-Network Hospital. This assumes he has not satisfied his annual Deductible.

	*Network Hospital**	*Non-Network Hospital*
Covered Expenses	$1,700	$2,000
Deductible	- $300	- $500
Expenses For Reimbursement	$1,400	$1,500
Plan Pays	x 90% = $1,260	x 70% = $1,050
Pat Pays	$440 *(10% plus $300 Deductible)*	$950 *(30% plus $500 Deductible)*

In the above example, using a PPO Hospital saves Pat $510.

** This example assumes a PPO savings rate of approximately 15%. The actual savings may vary.*

Deductible

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

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 applicable *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 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.

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.

Precertification means that you obtain approval before receiving certain procedures or services. Services that require precertification include Hospital stays, 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. 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 applicable *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.

Coordination of Benefits

In 2018, if you or a family member receive a Coordination of Benefit Questionnaire from Anthem, please complete and return the form to Anthem to avoid disruption in claim payment. Failure to complete and return the questionnaire will result in the denial of claim(s).

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay out-of-pocket in a calendar year for Covered Expenses. 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 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 (even if for Mental Health Services);

Preventive Care Services;

Urgent Care Services;

Prescription Drug Benefits; and

Human Organ and Tissue Transplant Services.

Specific Benefit Maximums

You and each eligible Dependent can receive medical benefits up to the specific benefit maximums listed on the applicable *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.

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.

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 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, Non-Medicare Eligible Retirees, 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.

Medical and Prescription Drug Benefits

(For Medicare-Eligible Retirees and Dependents)

The Plan offers comprehensive health care coverage through an insured program to help you and your eligible Dependents stay healthy and protect you against catastrophic health care expenses. When you or your Dependents are eligible for Medicare, you are eligible for the Trust Fund's insured Retiree medical benefits. Currently, Medicare-eligible Retiree medical and prescription drug benefits are provided through a Medicare Advantage PPO Plan. This program is a Medicare Advantage and Medicare Prescription Drug Plan (MAPD).

If you or your Dependents are covered under the Medicare Advantage PPO Plan for Medicare-eligible Retirees and you enroll for another MedicareAdvantage or Medicare Prescription Drug Plan, you will automatically be disenrolled from the Medicare Advantage PPO Plan, which means that you will no longer have medical or prescription drug coverage through the Trust Fund.

If you are retired, but not eligible for Medicare, please see the *Eligibility Requirements* section for information about coverage for Non-Medicare eligible Retirees and Dependents.

The following information is a brief overview of the insured program. Actual program provisions are determined and will be provided by the insurer and are subject to change at any time.

How the Program Works

Under this program, while you are covered by Medicare, the Medicare Advantage PPO Plan replaces your Medicare Parts A, B, and D (prescription drug coverage); however, you must continue to pay your Medicare Parts A and B premiums. Since the program is insured by a third party, the third party pays benefits and determines the benefits offered, in accordance with Medicare regulations and guidelines.

You can receive care from any Physician, specialist, or Hospital in the U.S. who is eligible to be paid by Medicare and accepts Medicare Advantage PPO Plan terms and conditions of payment. The Medicare Advantage PPO Plan covers you for all Medicare A and B services and certain supplemental benefits.

When you go to a Physician or Hospital for non-Emergency Care, you must inform the Provider you are enrolled in the Medicare Advantage PPO Plan. If the Physician or Hospital treats you, you are only required to pay the cost-sharing amount allowed by the program. The Physician or Hospital will bill the Medicare Advantage PPO Plan for the remaining amount. If your Provider does not want to participate in the Medicare Advantage PPO Plan, then you must seek care from another Provider who is willing to furnish services for these services to be covered.

You should carry your Medicare Advantage PPO Plan membership card with you at all times to show to Providers when you get Covered Services. While covered under this program, **you *must* use your** Medicare Advantage PPO Plan **ID card instead of your red, white, and blue Medicare card.** However, keep your red, white, and blue Medicare card in a safe place. If you get Covered Services using your red, white, and blue Medicare card instead of your Medicare Advantage PPO Plan ID card while covered under this program, this program will not pay for these services and you may have to pay the full cost yourself.

If your Medicare Advantage PPO Plan ID card is ever damaged, lost, or stolen, you should get a replacement care as soon as possible.

Covered Expenses

The Medicare Advantage PPO Plan has its own, separate and unique, list of covered and non-Covered Expenses, including prescription medications. In general, to be considered a Covered Service, the medical care, service, supply, or equipment must be:

- Provided according to the Medicare coverage guidelines established by the Medicare program; and

- Medically Necessary (however, certain preventive care and screening tests are covered).

This program also provides prescription drug coverage that helps you pay for prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. Generally, all you have to do is pay your applicable Copayment or Coinsurance.

Covered medications include Medically Necessary medications listed in the program's formulary. There often are several types of medications that can be used to treat the same condition. To ensure high quality care and to help manage costs, this program has a formulary that 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. A copy of the formulary is available from the third party.

In addition, for prescription medications, you will need to get your prescriptions at a participating Pharmacy or through the mail order program. With few exceptions, you must use participating Pharmacies for your prescription drugs to be covered. A network Pharmacy is a Pharmacy that has contracted with the Medicare Advantage PPO Plan. In most cases, your prescriptions are covered only if they are filled at one of these participating Pharmacies. A list of network Pharmacies is available from the third party.

Covered medical services and prescription drugs under this program are listed in the materials provided by the third party. If you have questions as to whether a particular service or medication is covered or if a Physician or Hospital can treat you, contact the third party.

Expenses Not Covered

You should be aware that not every medical or prescription drug expense is covered by the program. For a list of expenses not covered by the Plan, refer to the materials provided by the third party.

Covered Medical Expenses

(For Active Participants, Non-Medicare Eligible Retirees, and Dependents)

This section includes Covered Expenses for Active Participants, Non-Medicare Retirees, and Dependents. *Medicare-eligible Retiree coverage is not described in this booklet.*

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 applicable *Schedule of Benefits* insert to this booklet.** The following charges are considered covered medical expenses under the Plan.

Preventive Care Services

Participants who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition but instead benefits will be considered under Diagnostic Services.

Preventive care benefits may vary based on your age, gender, and personal history and as determined appropriate by clinical coverage guidelines. Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Examples of preventive care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, licensing, sports programs, or other purposes are not Covered Services.) Examinations include, but are not limited to:
- Well-baby and well-child care, including child heath supervision services, based on American Academy of Pediatrics Guidelines. Child health supervision services include, but are not limited to, a review of a child's physical and emotional status performed by a Physician or health care professional under the supervision of a Physician in accordance with the recommendations of the American Academy of Pediatrics, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and Laboratory tests;
- Adult routine physical examinations;
- Pelvic examinations;
- Routine EKG, chest X-ray, and Laboratory tests, such as complete blood count;
- Comprehensive metabolic panel, urinalysis; and
- Annual dilated eye examination for diabetic retinopathy.

Immunizations (including those required for school) following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and American Academy of Family Physicians. These include, but are not limited to:

- Hepatitis A vaccine;
- Hepatitis B vaccine;
- Hemophilus influenza B vaccine (Hib);
- Influenza virus vaccine;
- Rabies vaccine;
- Diphtheria, Tetanus, Pertussis (DTP) vaccine;

- Mumps virus vaccine;
- Measles virus vaccine;
- Rubella virus vaccine; and
- Poliovirus vaccine.

Screening examinations, including, but not limited to:

- Routine screening mammograms;
- Routine cytologic and chlamydia screening (including pap test);
- Routine bone density testing for women;
- Routine prostate specific antigen testing; and
- Routine colorectal cancer examination and related Laboratory tests.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition, provided it is:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a health care professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a health care professional means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Physician Office Services

Physician office services include care in a Physician's office that is not related to maternity or Mental Health conditions, except as otherwise specified. Refer to the *Maternity Services* and *Mental Health and Substance Abuse Treatment* sections for services covered by the Plan. For Emergency accident or medical care, refer to the *Emergency Care and Urgent Care Emergency Care* section.

Office visits for medical care and consultations to examine, diagnosis, and treat an illness or injury performed in the Physician's office. Office visits also include injections, serum and allergy injections. When an allergy injection, testing, or allergy serum is the only charge from a Physician's office, a specific Copayment may apply as listed on the applicable *Schedule of Benefits* insert to this booklet.

Diagnostic Services when required to diagnose or monitor a symptom, disease, or condition.

Surgery and surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

When you need to see a Physician:
- Call to make an appointment.
- Write down any health-related questions you have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you are taking. Be sure to note how often you take the medication.
- Show your ID card when you go to your appointment to ensure your Physician knows where to file your claim.
- Consider asking your Physician for samples of any prescription medication you may need.

Therapy services for physical medicine therapies and other therapies when rendered in the office of a Physician or other professional Provider.

Inpatient Services

Inpatient services do not include care related to maternity or Mental Health conditions, except as otherwise specified. Refer to the *Maternity Services* and *Mental Health and Substance Abuse Treatment* sections for services covered by the Plan. Inpatient services include:

- Charges from a Hospital or other Provider for room, board, and general nursing services, including:
- A room with two or more beds;
- A private room. The private room allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available; and
- A room in a special care unit approved by the Plan's third party administrator or the Plan. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.
- Ancillary services, including:
- Operating, delivery, and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies, and services given by an employee of the Hospital or other facility Provider;
- Medical and surgical dressings, supplies, casts, and splints;
- Diagnostic Services; and
- Therapy services.

Professional services from a Physician while an Inpatient, including:

- Medical care visits limited to one visit per day by any one Physician;
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time;
- Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians;
- Consultation that is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded;
- Surgery and the administration of anesthesia; and
- Newborn examinations by a Physician other than the Physician who performed the obstetrical delivery.

If you or your Dependents are transferred from one Hospital or other facility Provider to another Hospital or other facility Provider on the same day, any Copayment stated in dollars per admission, as listed on the applicable *Schedule of Benefits* insert to this booklet, is waived for the second admission. Copayments or Coinsurance stated as a percentage are not waived.

Outpatient Services

Outpatient services include both facility and professional charges when rendered as an Outpatient at a Hospital, alternative care facility, or other Provider as determined by the Plan. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or other therapy services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) are the only Outpatient services charge, no Copayment is required if stated in dollars. Any Copayment or Coinsurance stated as a percentage will still apply to these services.

Emergency Care and Urgent Care Emergency Care (Including Emergency Room Services)

Medically Necessary services that the Plan's third party administrator determines to meet the definition of Emergency Care will be covered whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered and the patient is not required to pay more

than would have been required for services from a Network Provider. In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, seven days a week.

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and stabilization services without precertification for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs, Physician services, supplies, and prescriptions. Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the emergency room services Copayment for that emergency room visit will be waived.

For Inpatient admissions following Emergency Care, precertification is not required. However, you must notify the Plan's third party administrator, or verify that your Physician has notified the Plan's third party administrator of your admission within 24 hours or as soon as possible within a reasonable period. When the Plan's third party administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Plan's third party administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under the Plan. If your Provider does not have a participation agreement, you may be responsible for any care the Plan determines is not Medically Necessary.

Care and treatment provided once you are stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network benefit unless the Plan's third party administrator certifies the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the urgent care Copayment. Urgent care services can be obtained from any qualified Provider. If you experience an Accidental Injury or a medical problem, the Plan will determine whether your injury or condition is an urgent care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An urgent care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an urgent care medical problem is not an Emergency and does not require use of an emergency room at a Hospital. If you call your Physician before receiving care for an urgent medical problem and your Physician certifies you to go to an emergency room, your care will be paid at the level for emergency room services as listed on the applicable *Schedule of Benefits* insert to this booklet.

Ambulance Services

Transportation by a vehicle designed, equipped, and used only to transport the sick and injured:

- From home, scene of accident, or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; and
- From a Hospital or Skilled Nursing Facility to your home.

- Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire, or public safety official and you or your Dependents are not in a position to refuse; or
- When you or your Dependents are required by the Plan to move from a Non-Network Provider to a Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Mental Health and Substance Abuse Treatment

Covered Services include, but are not limited to:

- Inpatient services, which include individual or group psychotherapy, psychological testing, family counseling with family members to assist in diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when the Plan's third party administrator's subcontractor or the Plan's third party administrator certify an Inpatient stay.
- Partial hospitalization, which include a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least four to six hours of treatment per day. Patients are expected to participate up to five days per week.
- Intensive Outpatient treatment or day treatment, which include a structured program, offered at least three times per week for at least three hours per day. The program may be managed by a licensed Mental Health professional with a psychiatrist on staff. Therapy is provided by a licensed Mental Health professional.
- Outpatient treatment or individual or group treatment, which include office-based services, for example diagnostic evaluation, counseling, psychotherapy, family and marital therapy, and medication evaluation. The service may be provided by a licensed Mental Health professional and must be coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

You should have all Inpatient Mental Health and/or Substance Abuse services precertified. When you obtain precertification from the Plan's third party administrator and receive services from the Provider designated by that precertification, Covered Services will be considered a Network service. If you do not obtain precertification, Covered Services will be considered a Non-Network service.

Diagnostic Services

Diagnostic Services are tests or procedures generally performed when you have specific symptoms or to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of preventive care services, Physician office services, Inpatient services, Outpatient facility services, home care services, and Hospice services includes, but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;

- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMGs are not Covered Services;
- Echocardiograms;
- Bone density studies; and
- Positron emission tomography (PET scanning).

Central supply (IV tubing) or Pharmacy (dye) necessary to perform tests is covered as part of the test, whether performed in a Hospital or Physician's office.

When diagnostic radiology is performed in a Network Physician's office, no Copayment is required if stated in dollars. Any Copayment stated as a percentage or from a Non-Network Physician will still apply.

Surgical Services

Coverage for surgical services when provided as part of Physician office services, Inpatient services, or Outpatient services includes, but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- Correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Plan's third party administrator.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session.

Covered surgical services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, or laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, or tap or puncture of brain or spine; and
- Sterilization, regardless of Medical Necessity.

If you or your Dependents are receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, and elect breast reconstruction, the individual will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Therapy Services

Benefits for therapy services when provided as part of Physician office services, Inpatient services, Outpatient services, or home care services are limited to the following:

- Physical medicine therapies where the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period;
- Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices, provided such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part;
- Speech therapy for the correction of a speech impairment;
- Occupational therapy for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living, including tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (such as hobbies, arts and crafts);
- Spinal manipulation services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment, or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for spinal manipulation services as listed on the applicable *Schedule of Benefits* insert to this booklet;
- Cardiac rehabilitation to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning, and maintenance are not covered;
- Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents;
- Dialysis treatments of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine;
- Radiation therapy for the treatment of disease by X-ray, radium, or radioactive isotopes; and
- Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. See the applicable *Schedule of Benefits* insert to this booklet for benefit limitations.

Physical Medicine and Rehabilitation Services

Coverage for Inpatient services for a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible is covered. This includes skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy, and services of a Social Worker or Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting. Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major difference from an admission primarily for physical therapy.

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services may include, but are not limited to:

- Intermittent skilled nursing services (by an RN or LPN);
- Medical/social services;
- Diagnostic Services;
- Nutritional guidance;
- Home health aide services;
- Therapy services (Home care visit limits for home care services apply when therapy services are rendered in the home are listed on the applicable *Schedule of Benefits* insert to this booklet);
- Medical/surgical supplies;
- Durable medical equipment; and
- Prescription drugs (only if provided and billed by a Home Health Care Agency).

Home infusion therapy is covered and includes a combination of nursing, durable medical equipment, and pharmaceutical services that are delivered and/or administered intravenously in the home. Home infusion therapy includes services and supplies for Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.

Hospice Care Services

Hospice care may be provided in the home or Hospice facility for medical, social, and psychological services used as palliative treatment for patients with a terminal illness. Hospice services include routine home care, continuous home care, Inpatient Hospice, and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following:

- Skilled nursing services (by an RN or LPN);
- Diagnostic Services;
- Physical, speech, and inhalation therapies;
- Medical supplies, equipment, and appliances;
- Counseling services (except bereavement counseling);
- Inpatient confinement at a Hospice; and
- Prescription drugs obtained from the Hospice.

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient services, Outpatient services, or Physician office services depending on where the service is performed.

Covered Transplant Procedure and Services

Any Medically Necessary human organ and tissue transplant as determined by the Plan's third party administrator, including necessary acquisition costs and preparatory myeloblative therapy are considered covered transplant procedures.

All transplant procedures and all services directly related to the disease that has necessitated the covered transplant procedure or that arises because of the covered transplant procedure within a covered transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a patient's appropriateness for a covered transplant procedure are considered covered.

Notification

You should call the transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your ID card and ask for the transplant coordinator or for contact information. The Plan will then assist in maximizing benefits by providing coverage information including details regarding what is covered and whether any medical policies, Network requirements, or Plan exclusions are applicable. Failure to obtain this information before receiving services could result in increased financial responsibility.

Covered Transplant Benefit Period

The covered transplant Benefit Period starts one day before a covered transplant procedure and continues for 364 days. If, within this period, a second covered transplant procedure occurs, the covered transplant Benefit Period will begin one day before the second covered transplant procedure and continue for 364 days.

Transportation, Meals, and Lodging

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 to reach the facility where the covered transplant procedure will be performed. the Plan's third party administrator's assistance with travel expenses includes transportation to and from the facility, lodging, and meals for the patient and one companion. If the patient receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging, and meals may be allowed for two companions. The patient must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Plan's third party administrator when claims are filed. Contact the Plan's third party administrator for detailed information.

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment, and appliances described below are Covered Services. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility.

Covered Services include, but are not limited to:

- Medical and surgical supplies, including syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, petroleum jelly, and prescription drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera.

- Durable medical equipment, including the rental (or, at the Plan's third party administrator's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment that:
- Can withstand repeated use (i.e., could normally be rented, and used by successive patients);
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in a patient's home.

Examples include, but are not limited to, wheelchairs, crutches, Hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered.

Prosthetic appliances, including artificial substitutes for body parts, tissues, and materials inserted into tissues for functional or therapeutic purposes. Covered Services include purchases, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body part and its adjoining tissues or replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power source, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
- Left Ventricular Artificial Devices (LVAD) when used as a bridge to a heart transplant;
- Breast prosthesis whether internal or external following a mastectomy and two surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
- Minor devices for repairs such as screws, nails, sutures, and wire mesh;
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
- Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract-formulae and supplies are also covered);
- Cochlear implant;
- Electronic speech aids in post-laryngectomy or permanently inoperative situations;
- Space shoes when used as a substitute device when all or a substantial portion of the forefoot is absent; and
- Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).
- Orthotic devices, including the initial purchase, fitting, and repair of a custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities, to improve the function of movable parts of the body, or that limits or stops motion of a weak or diseased body part. The cost of casting, molding, fitting, and adjustments are included. Covered orthotic devices include, but are not limited to, the following:

  - See the applicable *Schedule of Benefits* insert to this booklet for benefit limitations.

- Cervical collars;
- Ankle foot orthosis;
- Corsets (back and special surgical);
- Splints (extremity);
- Trusses and supports;

- Slings;
- Wristlets;
- Built-up shoes; and
- Custom-made shoe inserts.

Orthotic appliances may be replaced once per year per person when Medically Necessary in the patient's situation. However, additional replacements will be allowed for patients under age 18 due to rapid growth or for any patient when an appliance is damaged and cannot be repaired.

Dental Services Related to Accidental Injury

Outpatient services, Physician office services, Emergency Care, and urgent care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth, or face that result from an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an Accidental Injury. Initial dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible, and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and Laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/maxillary reconstruction; and
- Anesthesia.

Other Dental Services

The only other dental expenses that are Covered Services are charges for Outpatient services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Maternity Services

Maternity services include Inpatient services, Outpatient services, and Physician office services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn. If a newborn is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment. If maternity services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and

Gynecologists in their Guidelines for Prenatal Care. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you and/or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
- The antepartum, intrapartum, and postpartum course of the mother and infant;
- The gestational stage, birth weight, and clinical condition of the infant;
- The demonstrated ability of the mother to care for the infant after discharge; and
- The availability of post discharge follow-up to verify the condition of the infant after discharge.

Covered Services include at-home post-delivery care visits at your residence by a Physician or nurse performed no later than 48 hours following your and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:

- Parent education;
- Physical assessments;
- Assessment of the home support system;
- Assistance and training in breast or bottle feeding; and
- Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening. In your discretion, this visit may occur at the Physician's office.

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 the see *General Plan Exclusions* section.

Prescription Drug Benefits

(For Active Participants, Non-Medicare Eligible Retirees, 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, Non-Medicare Retirees, and Dependents. *Medicare-eligible Retiree coverage is not described in this booklet.*

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 applicable *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.

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 applicable *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 applicable *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 applicable *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.

High Cost Generics

CVS Caremark will require prior authorization for Metformin ER, and Zegerid. These high cost generic drugs have lower cost generic alternatives available. Metformin ER's lower cost generic alternative is Metformin,

and the main alternatives for Zegerid are Omeprazole, Lansoprazole, Pantoprazole and Esomeprazole. To prevent any disruption in prescription refills, participants affected by this change will have 90 days after January 1st to transition to a different prescription drug.

Advanced Control Specialty Formulary

CVS Caremark will implement the Advanced Control Specialty Formulary for specialty prescriptions. Specialty prescriptions require special handling and are only filled using CVS Caremark's specialty pharmacy. Examples of specialty drug classes include Multiple Sclerosis Agents, Antivirals, and Growth Hormones. To prevent any disruption in prescription refills, participants affected by this change will have 90 days after January 1st to transition to a different prescription drug.

Step Therapy

CVS Caremark will require step therapy for the prescription Doxepin. This topical prescription is typically prescribed only for short-term use. Any participant affected by this step therapy program will be notified by CVS Caremark.

Opioid Management

CVS Caremark will implement new and updated quantity limitations for opioids. This will be in addition to existing prior authorizations on opioids. The limitations will take into account other opioid prescriptions filled by a patient and places a cap on the amount dispensed. These limits are being added to help ensure that your use of opioid medication for pain management is safe.

Prescription Drug Covered Expenses

Covered Services include only:

1. Prescription Legend Drugs;
2. Injectable insulin and syringes used for administration of insulin;
3. 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;
4. Oral contraceptive drugs are covered when obtained through an eligible Pharmacy;
5. Human growth hormones (whether natural or synthetic) when precertification is requested and provided;
6. Injectables; and
7. Medications for treatment of male or female sexual or erectile dysfunctions or inadequacies, regardless of the origin or cause.

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.
2. Off label use, except as otherwise prohibited by law or as approved by the Plan.
3. Drugs in quantities exceeding the quantity prescribed or for any refill dispensed later than one year after the date of the original prescription order.
4. Charges for the administration of any drug.
5. 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.
6. Any drug that is primarily for weight loss, except certain drugs for the treatment of morbid obesity may be covered based on Medical Necessity.
7. 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.
8. Drugs in quantities that exceed the limits established by the Plan or that exceed any age limits established by the Plan.
9. 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).
10. Contraceptive devices, oral immunizations, and biologicals, although they are federal legend drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over-the-counter drugs, devices, or products, they are not Covered Services.
11. 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 in its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
12. Fertility drugs.
13. CVS Caremark will exclude coverage for the following prescription drugs on January 1, 2018: Duexis and Vimovo. These drugs are used to treat arthritis and have many alternative prescription drugs available.

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.

Dental Benefits

(For Active Participants and Dependents)

Effective June 1, 2019, Delta Dental of Ohio ("Delta Dental") will process dental services under the Plan and the Delta Dental network will be the new dental network.

Preventive dental care can be important. To help meet the cost of routine and unexpected dental care, the Fund provides dental benefits for Active Participants and their eligible Dependents. Participants and eligible Dependents are covered under a dental Preferred Provider Organization shared network. Please refer to the *Schedule of Dental Services and Supplies* near the back of this booklet for more details about the benefits.

Dental Covered Expenses

When you or your family needs dental care, you can choose any Dentist. The Plan will pay Covered Expenses for the services of a Dentist licensed to practice dentistry within accepted standards of dental practice, up to the calendar year maximum as listed on the applicable *Schedule of Benefits* insert to this booklet and up to the maximum allowance for dental services as listed on the *Schedule of Dental Services and Supplies* insert to this booklet. The Schedule lists the dental services that are covered under the Plan and the maximum the Plan will pay for each service.

When you need dental care:
- Schedule an appointment with the Dentist of your choice.
- File a completed claim form with Delta Dental.

The amount the Plan pays depends on the type of dental service you receive and reasonable charges. Once the calendar year maximum is reached, the Plan will not pay dental expenses for the remainder of the calendar year.

Examples of covered dental expenses include:
1. Diagnostic;
2. Preventive;
3. Restorative;
4. Endodontics;
5. Periodontics;
6. Prosthodontics;
7. Oral surgery; and
8. Other general services.

Denture Coverage

Charges for full or partial dentures or bridgework will be covered if required due to loss of natural teeth. If the denture is at least one year old and cannot be made serviceable, replacement of an existing denture will be covered. Charges for repair of an existing denture or addition of teeth to an existing denture that is not being replaced will also be covered. However, charges for more than two repairs in 12 consecutive months or for more than one reline in any 24-consecutive month period will not be covered.

Dental Expenses Not Covered

You should be aware that any expenses not listed on the *Schedule of Dental Services and Supplies* are not covered by the Plan. The fact that a Dentist may prescribe, order, recommend, or approve a service does not, of itself, make it necessary or make the charge a Covered Expense, even though the service is not specifically listed as an exclusion. In addition to any general Plan exclusions or limitations (please see the *General Plan Exclusion*s section), benefits are not paid for:

1. Precision attachments, personalization, or characterization.
2. Cosmetic or orthodontic treatment, such as braces, except charges for related extractions or space maintainers.
3. Services provided by someone other than a Dentist or Physician, except for treatment performed by a duly qualified technician under the direction of a Dentist or Physician.
4. Oral examinations and prophylaxis not separated by four consecutive months.
5. Orthodontic services and/or supplies in connection with Temporomandibular Joint Disorder (TMJ).

The Plan is the final authority for determining whether services are covered. No additional dental benefits will be paid except as otherwise specified as covered by the Plan.

Vision Benefits

(For Active Participants and Dependents)

Vision coverage provides Active Participants and eligible Dependents with coverage for routine vision related expenses. You can obtain vision services from any licensed optical Provider legally qualified to perform the services.

Vision services must be provided by a licensed optical Provider to be covered.

Vision Covered Expenses

Benefits are paid based on reasonable charges for vision care for you and your family each calendar year, up to the amounts as listed on the applicable *Schedule of Benefits* insert to this booklet.

When you need vision care:

- Schedule an appointment with the optician, optometrist, or ophthalmologist of your choice.
- File a completed claim form with the Benefit Trust Office.

The Plan will provide vision benefits for:

1. Eye examinations with refraction; and
2. Prescription lenses (single, bi-focal, tri-focal) and frames; or
3. Contact lenses.

For vision claims incurred on or after January 1, 2018, the following prescription lens options have been added to the list of covered expenses and are included in the annual maximum payable per calendar year:

- Photochromatic lens tint
- Regular lens tint
- Anti-reflective lens coating
- Ultra-violet (UV) blocking lens coating
- Scratch-reistant lens coating
- Mirror lens coating
- Polarization of lens

Vision Care 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. Special procedures, such as orthoptics or vision training, and special supplies, such as plain sunglasses (plano) or subnormal vision aids.
2. Eye examinations required by an employer as a condition of employment, by an employer where the employer is required to provide by virtue of a labor agreement, or required by a government body.
3. Services or supplies that are covered in whole or in part under any other provision of the Plan or under medical benefits or vision benefits provided by an employer.

The Plan is the final authority for determining whether services are covered. No additional vision benefits will be paid except as otherwise specified as covered by the Plan.

Hearing Aid Benefits

(For Active Participants and Dependents)

The Plan provides hearing aid coverage for Active Participants and Dependents.

When you need hearing care:
- Schedule an appointment with a licensed hearing care Provider of your choice.
- File a completed claim form with the Benefit Trust Office.

Hearing Aid Covered Expenses

The Plan covers hearing aid devices once per person in any three-consecutive calendar year period and hearing examinations once per person in a consecutive 24-month period, up to the amounts as listed on the applicable *Schedule of Benefits* insert to this booklet. To determine whether an expense is included in a particular maximum benefit time period, expenses are considered to be incurred on the date the service is provided.

Benefits are payable for reasonable charges for hearing examinations to determine the need for a hearing aid and for hearing aids. The service must be performed by and a prescription provided by a licensed Physician operating within the scope of his or her license, including, but not limited to, an otologist or otolaryngologist.

Hearing Aid Expenses Not Covered

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

1. Medical examinations provided and hearing aids prescribed by persons other than a licensed Physician operating within the scope of his or her license, such as an otologist or otolaryngologist.
2. Hearing examinations required by an employer as a condition of employment or that the employer is required to provide by virtue of labor agreement.
3. Speech pathologist charges or any charges for speech therapy, speech reading, or lessons in lip reading.
4. Rental or purchase of amplifiers.
5. Repair of a hearing aid.
6. Batteries for or cleaning of a hearing aid.

The Plan is the final authority for determining whether services are covered. No additional hearing benefits will be paid except as otherwise specified as covered by the Plan.

Health Reimbursement Account (HRA)

The Plan includes a Health Reimbursement Account (HRA) benefit. Active Participants who receive Employer contributions on their behalf to the Plan will have an HRA established in their name. If you are eligible for the HRA, you and your eligible Dependents can use your HRA to get reimbursed for allowable health care expenses or to maintain eligibility under the Plan through self-payment or Retiree premiums. This benefit is not a vested benefit and the Trustees can modify or eliminate it at any time.

Eligibility

All bargaining Participants who are eligible for coverage as Active Participants and who receive Employer contributions on their behalf to the Plan are eligible for the HRA.

Self-employed individuals, including non-bargaining unit Participants who are owners of companies that elect to participate in the Plan, are not eligible for the HRA benefit.

Retirees who retired prior to January 1, 2008 are not eligible for the HRA. Retirees who retire after January 1, 2008 can continue to access their account until the balance reaches zero; however, no additional contributions will be made. Further details are provided in the next section.

Although expenses for your eligible Dependents can be reimbursed from your HRA, separate HRAs will not be established for them, except in the event of your death, as described below:

- If you die while you are an Active Participant, your eligible spouse or Dependents (if you are not married) are eligible to maintain Active coverage under the Plan. Your HRA will be transferred into your eligible Dependent's name after a six month claims run-out period to allow for payment of claims for the deceased Participant.
- If you die while you are a Retiree, your HRA will be transferred into the name of your eligible spouse or Dependents (if you are not married) after a six month claims run-out period to allow payment of claims for the deceased Retiree.

If you lose your eligibility for coverage under the Plan, you will be offered the opportunity to continue coverage by making self-payments or electing COBRA Continuation Coverage (please see the COBRA Continuation Coverage section). Similarly, when you retire, you may elect COBRA Continuation Coverage rather than Retiree coverage. If you elect to continue coverage under COBRA in either circumstance, your eligibility for the HRA will end and you will forfeit the balance remaining in your HRA at the time your coverage as an Active Participant ends.

Contributions to Your HRA

If you are an Active Participant, a portion of Employer contributions made on your behalf (as determined by the Trustees) is credited to your HRA each month. Your right to the contributions in your HRA is not vested and may be forfeited under certain circumstances.

Only Employer contributions are allowed in the HRA.

If you work for a Reciprocal Fund, allocations made to your HRA will be made based on the monthly health plan contributions divided by this Plan's contribution rate ($6.35 in 2015).

Reciprocal Example:

Sam works out of the area for a Reciprocal Fund. $952.50 in monthly health plan contributions is sent back to this Plan. Sam will receive $15.00 for that month into the HRA:

$952.50 divided by $6.35 = 150 hours

150 hours X $0.10 = $15.00

No credits will be made to your HRA if:

1. You are using your hour bank or your money bank to maintain your eligibility under the Plan;
2. You are granted extended eligibility due to periods of disability, qualified military service, or other non-work periods;
3. Your eligibility is extended due to your Employer's delinquency in making the required contributions.
4. You do not establish your eligibility for coverage under the Plan during a twelve-month period.

In the first two situations, your credits will resume when you return to Covered Employment and Employer contributions are made on your behalf. In the third situation, your credits will resume when your Employer resumes making contributions to the Plan. In the fourth situation, your credits will be reinstated when your eligibility under the Plan is established.

No credits will be made to a Retiree's HRA. Even if you return to Covered Employment under the 600 Rule and have contributions made on your behalf, no credits will be made to an HRA in your name unless you return to work for a Contributing Employer and your pension payments are suspended under the Pension Trust.

No credits will be made to an HRA established on behalf of a surviving spouse or surviving Dependents.

Using Your HRA

As an Active Participant, you may use the balance in your HRA to pay for eligible health care expenses, as described in the following section. You may also use the balance to continue Active coverage for yourself and your Dependents through self-payments.

If you retire after January 1, 2008 and have a balance in your HRA from contributions made while you were an Active Participant, you are entitled to use the balance in your HRA to pay your Retiree coverage premiums or receive reimbursement for eligible health care expenses, as described in the following section.

Once you lose your eligibility and are no longer covered under the Plan, you may continue to use the money in your HRA to pay for previously eligible expenses for up to 18 months or until the money runs out, whichever comes first. The previously eligible expenses must have be submitted within 12 months of the date of service. If you still have a balance in your HRA after 18 months, you will forfeit any remaining balance. The forfeited balance cannot be restored under any circumstances.

In the event of your death, your surviving eligible spouse or surviving eligible Dependents will be given the same opportunity to receive reimbursement for out of pocket medical expenses or pay Retiree premiums that you had as an Active Participant or Retiree. Once they and are no longer covered under the Plan, they may continue to use the money in the HRA to pay for eligible expenses for up to 18 months or until the money runs out, whichever

comes first as stated above. If there is still a balance in the HRA after 18 months, it will be forfeited. The forfeited balance cannot be restored under any circumstances.

You cannot use the balance in your HRA to pay your COBRA Continuation Coverage premiums. If you elect to continue coverage under COBRA, you will forfeit the balance remaining in your HRA at the time your coverage as an Active Participant ends. You will also forfeit your HRA balance if your eligibility under the Plan is terminated for failure to follow the Rules and Regulations, including working for a non-union employer in the geographic area covered by the Plan.

You will receive a quarterly statement that identifies the credits made to your HRA, as well as a summary of claims paid, and the net balance in your account that is available for future use. Any unused balanced in your HRA at the end of a calendar year will be carried over into the next year. The unused balance can be carried over year after year until it is used or forfeited.

Your HRA has no cash value and cannot be cashed out at any time.

Allowable Health Care Expenses

Generally, any Medical, Prescription Drug, Dental, Vision, and Hearing Aid expenses for which you are not reimbursed and which are allowable deductions on your income tax returns (*IRS Publication 502*) are allowable health care expenses for the HRA. Expenses must have been incurred during the period of time you and/or your eligible Dependents are eligible for the HRA under the Plan. Expenses that are eligible for reimbursement include:

Out-of-pocket expenses such as the Deductibles, Copayments and Coinsurances under the Plan;

Out-of-pocket expenses such as the Deductibles, Copayments and Coinsurances under your Dependent's medical, prescription, dental or vision plan (other than the Plan);

Expenses that are not Covered Benefits under the Plan or the eligible Dependent's plan;

Expenses that are over the maximum covered amount for that service under the Plan or the eligible Dependent's plan;

Active Iron Worker Supplemental and Self-Payment Program payments to continue eligibility in the Plan; and

Retiree self-payments to continue eligibility in the Plan.

Examples of Eligible Expenses

Following is a list of items that fall within the IRS definition of eligible health care expenses:

Acupuncture	Hospital Services
Alcoholism Treatment	In Vitro Fertilization / Fertility Services
Ambulance Service	Injections
Artificial Limbs	Lab Fees
Birth Control Pills	Learning Disability Tuition
Braille Books and Magazines	Nursing Home Services (if Medically Necessary and not custodial)
Car Controls for Handicapped	Optometrist Fees
Chiropractic Care	Organ Transplants
Contact Lenses	Orthodontic Treatment
Cosmetic Surgery (must be Medically Necessary)	Oxygen

Crutches	Smoking Cessation Programs
Dental Fees & Implants	Special Schools for the Handicapped
Diagnostic Tests	Surgery
Physician's Fees	Telephone for the Deaf
Duplicate Prosthetic Devices	Therapy for Mental or Nervous Disorders
Durable Medical Equipment and Supplies	Transportation for Medical Care
Eye Surgery (such as LASIK)	Vaccinations
Guide Dogs	Weight Loss Programs (if the Physician advises in writing that the program is for a specific diagnosed disease)
Hair Transplants	Wheelchairs
Hearing Aid & Exams	Wigs
Hearing Treatment	

The Board of Trustees or its delegate will determine whether a request for distribution from the HRA is for a covered health care expense, based on the relevant facts and circumstances.

Examples of Non-Eligible Expenses

There are also some expenses for which you cannot use your HRA. A few examples are listed below:

Controlled substances that are in violation of federal laws (even if prescribed by a Physician)	Long-term care services
Custodial Care	Massage Therapy
Dancing/swimming lessons (even if recommended for general improvement of the person's health)	Maternity clothes
Diaper service	Meals and lodging away from home for medical treatment not received at a medical facility
Electrolysis or Hair Removal	Non-prescription or over-the-counter medications
Expenses for trip or vacation taken for a non-medical reason (even if on Physician's advice)	Nursing services for a healthy baby
Expenses reimbursed through another source	Nutritional supplements
Funeral expenses	Psychoanalysis received as a part of training to be a psychoanalyst
Group medical insurance premiums from any Plan or insurance carrier other than the Benefit Trust and all COBRA premiums	School expenses for problem children
Health Club dues or membership fees	Teeth whitening
Hot tub or Jacuzzi	Weight loss programs (which are not prescribed by a Physician, or if merely recommended for general improvement of the person's health)
Household and domestic help (even though recommended by a qualified Physician due to the patient's inability to perform physical housework)	

Claims and Reimbursement Procedures

You can use your HRA to reimburse yourself for eligible health care expenses, and to make premium self-payments to maintain your eligibility as an Active Participant or to make Retiree premium payments.

Reimbursement of Eligible Health Care Expenses

As described in the section entitled *Using Your HRA*, you can use your HRA to reimburse yourself for eligible health care expenses as detailed in the preceding section.

Claim forms, along with detail filing instructions, are available from the Benefit Trust Office. The general rules for filing a claim for reimbursement of eligible health care expenses are as follows:

- Claims must be filed within twelve months of the date the eligible health care expense was incurred.
- The minimum required claim amount is $25.00. If the balance in your HRA is less than $25, your claim must be for the entire remaining balance.
- You must request the reimbursement of eligible medical expenses that were incurred only on your own behalf or on the behalf of one of your eligible Dependents. These expenses have to have been incurred during the time you were eligible for the HRA benefit.
- You must have already received the products or services.
- You must include a receipt for every eligible health care expense. A cancelled check is not an acceptable form of receipt.
- You cannot have received – nor will you receive – payment or reimbursement of the expense from any other plan or party.
- You must certify that the information on the claim form is complete and accurate.
- As the Active Participant or Retiree, you are the only person authorized to file a claim form, so ***you*** must sign the claim form. In the event of your death, the Dependents to whom your HRA was assigned can sign the form.

If the claim form is not properly completed or you do not provide the required documentation to substantiate the claim, for reimbursement, the Benefit Trust Office will issue a notice within 30 days requesting the additional information. If the additional information is not received within 45 days from the date the request was sent, the claim will be denied in full.

Once the properly completed claim form is received with all required documentation, the Benefit Trust Office will process the claim for reimbursement as follows:

- If the balance in your HRA is greater than the claim, you will be reimbursed in full.
- If the balance in your HRA is less than the total requested reimbursement, you will be reimbursed up to the amount remaining in your HRA (or not at all, if the balance is zero).

Any claim for reimbursement that is denied in whole or in part due to a lack of sufficient funds in the HRA must be refilled if you want to receive reimbursement in the future. Claims will ***not*** be automatically reprocessed.

Authorizing Payment of Premiums

As described in the preceding section entitled *Using Your HRA*, you can use your HRA to make premium self-payments if you do not elect COBRA Continuation Coverage when your eligibility as an Active Participant ends, and after the balances in your hours bank and/or money bank are exhausted. Similarly you can use your HRA to make Retiree premium payments if you do not elect COBRA Continuation Coverage when you retire.

You will receive an HRA claim form along with the self-payment or Retiree premium billing. The general rules for filing a claim authorizing payment of premiums are as follows:

- You must submit the authorization of payment to the Benefit Trust Office in advance of the premium due date to use your HRA balance to pay your premiums.
- You must include the billing statement from the Benefit Trust Office as the receipt for this claim.
- The minimum required claim amount is $25.00. If the balance in your HRA is less than $25, your request must be for the entire remaining balance, and you must pay the remainder directly to the Benefit Trust Office.
- You must certify that the information on the claim form is complete and accurate.
- As the Active Participant or Retiree, you are the only person authorized to file a claim form, so ***you*** must sign the claim form. In the event of your death, the Dependents to whom your HRA was assigned can sign the form.

Once the properly completed claim form is received with all required documentation, the Benefit Trust Office will process the claim as follows:

- If the balance in your HRA is greater than the claim, the premium payment will be made from your HRA to the Plan.
- If the balance in your HRA is less than the required premium, the premium payment will be made from your HRA to the Plan equal to the balance in the account. If you have not provided sufficient payment for the remaining premium, you will be billed for the difference. Payment must be made within ten days to maintain your eligibility for coverage.
- If the balance in your HRA is zero, the claim will be denied due to a lack of sufficient funds.

The Plan will not reimburse you directly for any premium or partial premiums you paid to maintain your eligibility.

In the Event of Your Disability or Death

Weekly Income, Life Insurance, and Accidental Death and Dismemberment (AD&D) Insurance Benefits help provide financial protection to you and/or your family in the event you become injured or die.

Weekly Income Benefits
(For Active Participants Only)

If you become totally disabled, you may be eligible for Weekly Income Benefits if you:

- Are eligible for coverage under the Plan when you become disabled;
- Become totally disabled as the result of an Accidental Injury, sickness, pregnancy, childbirth, or related medical condition;
- Are unable to work due to the disability;
- Are under the care of a duly-qualified Physician; and
- Receive certification of the disability from a doctor of medicine (M.D), osteopathy (D.O.), or podiatry (D.P.M.).

The amount of Weekly Income Benefits is listed on the applicable Schedule of Benefits insert to this booklet.

If you cannot work because of a non-work related injury or sickness:
- Call your Employer, Local Union, and the Benefit Trust Office.
- See a Physician as soon as possible.
- File a claim with the Benefit Trust Office.

Benefits for alcohol or drug-related disabilities are only payable while you are an Inpatient and under the precertified care of a Network Physician. You are liable for any repayment of Weekly Income Benefits if the precertified treatment program is not completed.

Benefits

The amount of Weekly Income Benefits is listed on the applicable *Schedule of Benefits* insert to this booklet. The Weekly Income Benefit for a period of total disability of less than seven days will be prorated.

When Benefits Begin

Your disability date will be determined from the date you were first treated by your Physician and the Physician certifies that you are totally disabled. In no event will your disability date be earlier than the date of the Physician visit.

Weekly Income Benefits will begin the:

First full day of disability due to an accident; or

Eighth day of disability due to sickness unless you are an Inpatient before the eighth day of disability in which case benefits will begin on the day of your Inpatient Hospital admission.

Successive periods of disability separated by less than one week of active full-time work are considered one period of disability unless the later disability is due to an injury or sickness entirely unrelated to the earlier disability and begins after you return to work full time.

Maximum Benefits

Benefits will be paid for up to:

- 26 weeks for each period of disability for accident or illness-related disabilities; or
- Three weeks for one period of disability per lifetime for drug or alcohol-related disabilities.

After your disability ends, you must notify the Benefit Trust Office that your disability has ended and that you are available for work.

Benefit Exclusions

Weekly Income Benefits are not paid for:

- Disabilities resulting from injuries or disease sustained while engaging in any occupation for wage or profit, or from disease/injury which are work-related in nature.

- A Participant receiving treatment for drug addiction or alcoholism unless the Participant is an Inpatient under the precertified care of a Network Physician.

- A Participant receiving Workers' Compensation, unemployment, or retirement benefits from the Iron Workers District Council of Southern Ohio & Vicinity Pension Trust or an industry-related pension plan.

If you begin receiving Workers' Compensation, unemployment, or retirement benefits while receiving Weekly Income Benefits, Weekly Income Benefits will end.

Life Insurance Benefits
(For Active Participants Only)

The Life Insurance Benefit is paid if you die while eligible for benefits as an Active Participant, even if the cause of death is work-related. Life Insurance Benefits are provided through an insurance company. If you would like a copy of the full terms of the policy, please contact the Benefit Trust Office for a free copy of the Certificate of Insurance.

Benefit Amount

The amount of the benefit is listed on the applicable *Schedule of Benefits* insert to this booklet. For your Life Insurance Benefit to be paid to your Beneficiary, written proof of your death (certified death certificate) must be provided to the insurance company. Benefits are paid in one lump sum. However, you or your Beneficiary may arrange to have all or part of your Life Insurance Benefit paid in equal monthly installments or a fixed amount, in accordance with the policy provisions.

To designate a Beneficiary, request an enrollment card from the Benefit Trust Office. Be sure to review your Beneficiary designation from time to time to ensure your Life Insurance Benefits are paid as you wish.

Life Insurance Benefit Conversion

If your Life Insurance Benefit ends, excluding if the group policy is terminated, you may convert your current coverage amount to an individual policy. The amount of the policy may be any amount up to the amount for which you were insured under the Plan, less any amount you become eligible for under any other group plan within 31 days. You will not have to provide evidence of insurability for this coverage. To convert your Life Insurance Benefit, you must submit to the insurance company the following within 31 days of the date your coverage ends:

- A completed coverage application; and
- Payment of your first premium.

If your Life Insurance Benefit ends because the Plan's group policy is amended or discontinued, and you have been insured under this policy for at least five years, you will have the same conversion privileges described above. The amount of the individual policy may not exceed $2,000, less the amount of any insurance you become eligible for under any other group plan within 31 days.

Your Life Insurance Benefit is payable if you die within the 31-day period allowed for conversion whether or not you have made an application for an individual policy.

Accidental Death and Dismemberment (AD&D) Insurance Benefit (For Active Participants Only)

The Accidental Death and Dismemberment (AD&D) Insurance Benefit is payable for the loss of life, loss of limb(s), or entire and irrecoverable loss of sight of one or both eyes. Benefits are payable only if the loss results from an accident while you are eligible. The loss must occur within one year of the accident.

The AD&D Insurance Benefit is provided through an insurance company. If you would like a copy of the full terms of the policy, please contact the Benefit Trust Office for a free copy of the Certificate of Insurance.

Benefits are paid directly to you for an injury or to your Beneficiary in the event of your death. The AD&D Insurance Benefit is in addition to the Life Insurance Benefit.

Benefit Amount

If you suffer any combination of losses as shown in the following table as the result of one accident, only one amount (the largest) is payable for all losses. The amount paid for all losses resulting from one accident will not exceed the full amount as listed on the applicable *Schedule of Benefits* insert to this booklet. Benefits are payable for the following losses:

Type of Loss	Benefit
Life	Full amount
Both hands, both feet, loss of sight in both eyes, one hand and one foot, one hand and loss of sight in one eye, one foot and loss of sight in one eye	Full amount
One hand, one foot, or loss of sight in one eye	One half of the full amount
Thumb and index finger of same hand	One-quarter of the full amount
Speech and hearing	Full amount
Speech or hearing in both ears	One-half of the full amount
Quadriplegia	Full amount
Paraplegia	One-half of the full amount
Hemiplegia	One-half of the full amount

Loss means:

- For hands and feet, dismemberment by severance through or above the wrist or ankle joints;
- For eyes, entire and irrevocable loss of sight,
- Loss of thumb and index finger means actual severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb,
- Loss of speech and hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury,
- Quadriplegia means total paralysis of both upper and lower limbs,
- Paraplegia means total paralysis of both lower limbs,
- Hemiplegia means total paralysis of upper and lower limbs on one side of the body, and

- Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete, and irreversible.

In addition, the Plan will pay an amount equal to 10% of the full amount shown for the loss of your life that results from injuries sustained while driving or riding in a private Passenger Car if your Seat Belt was properly fastened; but the amount payable will not (a) exceed $10,000; and (b) be less than $1,000.

Passenger Car means any validly registered four-wheel private Passenger Car. It does not include:

- Any commercial licensed car; or
- A private passenger car being used for commercial purposes.

Seat Belt means:

- Any child restraint device which meets the definition of the state law; or
- Any other restraint device which:
- Meets published federal safety standards;
- Has been installed by the car manufacturer; and
- Has not been altered after such installation.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

The Plan will not pay this benefit if you were driving while under the influence of alcohol or drugs.

Benefit Exclusions

The following losses are not covered under the AD&D Insurance Benefit, loss due to:

1. Physical or mental illness, diagnosis of or treatment for the illness;

2. An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident;

3. Suicide or attempted suicide;

4. Injuring oneself on purpose;

5. The use of any drug or medicine;

6. A war, or a warlike action in time of peace, including terrorist acts;

7. Committing or trying to commit a felony or other serious crime or an assault;

8. Any poison or gas, voluntarily taken, administered or absorbed;

9. Service in the armed forces of any country or international authority, except The United States National Guard; and

10. Operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the

Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation).

Naming a Beneficiary

You may designate anyone you wish as your Beneficiary for Life and AD&D Insurance Benefits. You can change your Beneficiary at any time, without the consent of your previous Beneficiary.

A Beneficiary is the person or persons shown in the Plan's records that you designate to receive your Life and AD&D Insurance Benefits.

To designate or change a Beneficiary, request an enrollment card from and file it with the Benefit Trust Office. Be sure to list your Beneficiary's full name, address, and his or her relationship to you. The change will take effect when the Benefit Trust Office receives the signed card. Your Beneficiary designation will be kept on file with the Benefit Trust Office. It is very important that you designate a Beneficiary. If there is no surviving Beneficiary at the time of your death, payment will be made to your estate.

If your Beneficiary is a minor or, in the opinion of the Trustees, is legally incapacitated, the Trustees reserve the right to make payment of any benefit pursuant to the requirements of state law governing payments to minors and/or incapacitated individuals.

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, 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.

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.

Dental, Vision, Hearing Aid, and Weekly Income Benefit Claims

Be sure to submit your claim forms within one year of the date of service. When completing your claim form be sure to:

- **Fill in the front of the claim form completely and sign it**. If the claim is connected to an accident, be sure to fill in all information related to the accident. If someone else is at fault for the accident, you may be required to sign a subrogation agreement (in the *Administrative Information* section) before the Plan will pay benefits for your claim.
- **Have your Physician fill in and sign the Physician's section.**
- **Keep a copy of all claim forms and bills for your records.**

You can obtain claim forms from your Local Union or the Benefit Trust Office. Send claims for Dental, Vision, Hearing Aid, and Weekly Income Benefits to:
Iron Workers District Council of Southern Ohio & Vicinity
Benefit Trust Office
1470 Worldwide Place
Vandalia, OH 45377-1156

In case of an Emergency, have the Hospital or a relative call the Benefit Trust Office at the number on your ID card as soon as possible. The person who calls should be able to provide your or your Dependent's:
- Name and address;
- Social Security number; and/or
- ID Number

Life and AD&D Insurance Benefit Claims

If you or your Beneficiary needs to file a Life Insurance and/or AD&D Insurance Benefit claim, you or your Beneficiary should contact the Benefit Trust Office for forms. Written proof of your dismemberment or death will need to be provided to the insurance company before benefits are paid. Dismemberment proof must be provided within 90 days of your loss.

HRA Reimbursement Claims

If you or your Dependents need to file an HRA claim and you do not have the necessary forms, you should contact the Benefit Trust Office. Please refer to the *Health Reimbursement Account (HRA*) section for details on claims filing procedures.

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, Retiree, eligible Dependents, or by someone authorized to act on behalf of the Participant, Retiree, 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, Prescription Drug, Dental, Vision, or Hearing Aid) 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 if medical, or the Benefit Trust Office if not medical.)

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, Prescription Drug, Dental, Vision, or Hearing Aid) treatment or supply for which payment is now being requested. Most claims are post-service claims.

Disability Claim – A disability claim is a claim for Weekly Income Benefits.

Life or AD&D Claim – A life or AD&D claim is a claim for Life Insurance and/or AD&D Insurance Benefits.

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.

Disability Claims – 45 days.

Life or AD&D Claims – 90 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.
- **Disability Claims –** 30 days (a second 30-day extension may be needed in special circumstances).
- **Life or AD&D Claims –** 90 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:

1. Reference to the Plan provisions on which the denial was based;
2. A description of the appeal procedures and the applicable time limits for following the procedures;
3. 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;
4. For urgent care claims, a description of the Plan's expedited review process will be provided; and
5. A statement concerning the claimant's right to bring a civil action under Section 502(a) of ERISA following an appeal.

Disability Claims. Claim denial notices will contain the following additional information:

1. An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

2. If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

5. If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

6. Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims. Other considerations:

1. A retroactive cancellation of disability coverage will be treated as a claim denial unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

2. Disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Claim Appeal Procedure

Appealing a Claim Denial

If a claim for Medical or Prescription Drug benefits is denied in whole or part, the claimant must follow the Complaint and Appeals Procedure provided through the Plan's third-party administrator. **This Claims and Appeals Procedure provides two mandatory levels of appeal.** After these appeals are exhausted, a claimant may file a voluntary appeal to the Board of Trustees under the appeal procedure outlined in this section.

With respect to any appeal concerning a claim under the Medicare Advantage PPO Plan, the claimant shall file such appeal with the third party in accordance with the procedures set forth in the Evidence of Coverage booklet provided to the claimant by the third party.

If a claim for eligibility, Dental, Vision, Hearing Aid, Weekly Disability or HRA benefits is denied in whole or part, the claimant may request a full and fair review (also called an appeal) by filing a written notice of appeal with the Board of Trustees. A claim for Medical, Prescription Drug, Life and Accidental Death and Dismemberment benefits must be appealed to the insurance carrier under its procedures first. The claimant should submit the request for review for the

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

When filing an appeal to the Plan:

- The appeal must be received by the Benefit Trust Office or the insurance carrier not more than 180 days (60 days for Life or AD&D claims) after the claimant receives the written notice of denial of the claim. The claimant must identify himself or herself as a Plan Participant.
- The claimant may orally request that the Plan review its denial of an urgent care claim by calling the Benefit Trust Office at (937) 454-1744 or (800) 331-4277 or the claimant may also submit the request in writing at the address listed above. The Benefit Trust Office may notify the claimant of its decision by telephone or facsimile.
- If the claimant disagrees with a claim denied by the Benefit Trust Office, the claimant may request a review by the Board of Trustees. The Trustees decision will be made within the time remaining for a decision on the appeal after the denial of the appeal.
- Another person may represent the claimant in connection with an appeal. If another person claims to be representing the claimant in the claimant's appeal, the Trustees have the right to require that the claimant give the Benefit Trust Office a signed statement, advising the Trustees that the claimant has authorized that person to act on the claimant's behalf regarding the claimant's appeal. Any representation by another person will be at the claimant's own expense.
- The claimant (and the claimant's authorized representative, if any) may request to appear in person before the Trustees. If the Trustees grant the claimant's request, the claimant's and his or her representative's appearance must be at the claimant's expense.
- The claimant or his or her authorized representative may review pertinent documents and may submit comments and relevant information in writing.
- Upon written request, the Benefit Trust Office will provide reasonable access to, and copies of, all documents, records or other information relevant to the claim.

- If an appeal involves a medical judgment, such as whether treatment is Medically Necessary, the Trustees will consult with a medical professional who is qualified to offer an opinion on the issue. If a medical professional was consulted in connection with the original claim denial, the Trustees will not consult with the same medical professional (or a subordinate of that person) for purposes of the appeal.
- If the opinion of a medical or vocational expert was obtained in connection with the claim, the claimant may request, in writing, the name of that expert.
- The Benefit Trust Office will not charge the claimant for copies of documents requested in connection with an appeal.
- In deciding the claimant's appeal, the Trustees will consider all comments and documents submitted, regardless of whether that information was available at the time of the original claim denial. The review will not defer to the initial denial, and will take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or relied upon in the initial determination.

The decision on the appeal of a claim made by the Trustees or by a committee delegated by the Trustees is final and binding.

Notification Following Review

If the appeal is for an urgent care claim, the claimant will be notified of the decision about the appeal as soon as possible, taking into account the circumstances, but no later than 72 hours after receipt of the request for review. Oral notification of a decision on an urgent care claim appeal will be followed up with a written or electronic notification within three days of the oral notification. In the case of pre-service claims, the claimant will be notified no later than 30 days after receipt of the request for review.

A review and determination for post-service claim to the Board of Trustees will be made no later than the date of the meeting of the Trustees that immediately follows the Plan's receipt of a request for review. However, if the request is filed within 30 days preceding the date of such meeting, a determination may be made by no later than the date of the second meeting.

If special circumstances (such as the need to hold a hearing) require a further extension of time, a determination will be made no later than the third meeting of the Trustees. Before the start of the extension, the claimant will be notified in writing of the extension, and that notice will include a description of the special circumstances and the date as of which the determination will be made.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, the claimant may go to court to enforce his or her rights. A claimant may not file suit against the Plan until the claimant has exhausted all of the procedures described in this section.

The claimant will be informed of the Trustees' decision, normally within five calendar days of the determination. The decision will be in writing unless the appeal was for an urgent care claim. When the claimant receives the written decision, it will contain:

- The reasons for the decision and specific references to the particular Plan provisions upon which the decision was based;
- A statement explaining that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim; and
- A statement of the claimant's right to bring an action under Section 502(a) of ERISA.

Disability Claims. Notices on appeal will contain the following additional information:

1. An explanation as to why the Plan disagreed with the views of (i) health care or vocational professionals who evaluated the Claimant or advised the Plan, or (ii) a disability determination of the Social Security Administration.

2. If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

5. If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

6. Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims on Appeal.

1. Before the Plan will deny an appeal, the Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.

2. Before the Plan will deny an appeal based on a new or additional rationale, the Plan will provide the Claimant, free of charge, with the rationale. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.

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.

Administrative Information

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, excluding Weekly Income, Life Insurance, and Accidental Death and Dismemberment (AD&D) Insurance Benefits**.**

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. Dependents must be enrolled in any and all other group insurance coverage available to them.

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 (e.g. a Retiree).

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.

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 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.

Coordination of Benefits with Medicare

When you or any of your covered Dependents become eligible for Medicare, you MUST immediately notify the Benefit Trust Office and provide a copy of your Medicare card at that time. You must sign up for Medicare Part B in order to continue coverage under the Plan (there are exceptions to the requirement to sign up for Part B for those individuals covered under group active benefits – please contact the Benefit Trust Office for more information.). If you fail to follow these requirements you will be ineligible for this coverage. Any benefits covered under both the Plan and Medicare will be paid according to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law. Except when federal law requires the Plan to be the primary payor, the benefits under the Plan for Participants age 65 and older, or Participants otherwise eligible for Medicare, do not duplicate any benefit for which members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all amounts payable by Medicare for services provided to Participants will be reimbursed by or on behalf of the Participant to the Plan, to the extent the Plan has made payment for such services.

Information about Medicare

Medicare is a multi-part program:

Enroll in Medicare Parts A and B as soon as you are eligible. The Plan requires this in order to continue your coverage.

- Hospital Insurance Benefits for the Aged and Disabled (commonly referred to as Part A of Medicare) covers Hospital benefits, although it also provides other benefits.
- Supplementary Medical Insurance Benefits for the Aged and Disabled (commonly referred to as Part B of Medicare) primarily covers Physician's services, although it too covers a number of other items and services.
- MedicareAdvantage (Part C of Medicare) covers Medicare managed care offerings.
- Medicare Prescription Drug Coverage (Part D of Medicare) covers prescription drug benefits.

If you are covered by a managed care plan, the Plan will presume that you have complied with the managed care program's rules necessary for your expenses to be covered by the managed care program. Part D is Medicare's prescription drug benefit program. If you are enrolled in either a Medicare managed plan or Medicare Part D, you cannot be covered under the Medicare Advantage PPO Plan or any other of the Plan's policies.

If you do not enroll for Part B coverage when you are first eligible, and you stop working or lose eligibility for Plan benefits, you should contact your local Social Security Office to enroll for coverage, so that you do not experience a gap in coverage or pay a penalty for Late Enrollment. Your monthly premium may be assessed a 1% per month increase for each full month of Late Enrollment.

It is your (and your Dependents') responsibility to apply for Medicare. If you or your Dependents are eligible for Medicare and want information about eligibility, enrollment, or coverage, contact your local Social Security Administration Office three months before your 65th birthday or when you are otherwise eligible for Medicare.

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after receiving Social Security Disability Income Benefit payments for two years.

If you or your Dependents are covered under the Medicare Advantage PPO Plan for Medicare-eligible Retirees and you enroll for Medicare Prescription Drug Coverage (Part D) or another MedicareAdvantage program, you will automatically be disenrolled from the Medicare Advantage PPO Plan, which means that you will no longer have Medical or Prescription Drug coverage through this Trust Fund.

Subrogation

Subrogation is substitution of the Fund to one'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, covered Retiree or your Dependents (hereinafter referred to a "Covered Person(s)") are paid any benefits, including short-term disability, 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, covered Retiree'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, Covered Retiree, 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, Covered Retiree, 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, Covered Retiree, 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 of the disability, 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.

Impact on eligibility for HRA and Retiree coverage. In addition to any other eligibility rule contained in the Plan relative to Participant coverage, Retiree coverage, and Dependent coverage, in the event the payment or overpayment is not immediately repaid to the Plan, or you fail to reach a repayment schedule agreeable to the Plan regarding such amount, you and your Dependents shall be **ineligible** for the Health Reimbursement Account, and you and your Dependents shall be **ineligible** for Retiree coverage. This applies to payments and overpayments existing prior to as well as those arising on and after September 9, 2014.

Rescission of Benefits

In accordance with the Patient Protection and Affordable Care Act (the "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: _____

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 September 23, 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 orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.
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.

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.

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.

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.

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.

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.

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 unemancipated 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 unemancipated 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 September 23, 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

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

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.

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.

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 Employer and Union representatives selected by the contractor associations and the local unions that have entered into Collective Bargaining Agreements relating to the Plan. 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 May 4, 2018 are:

Union	Employer
Ralph Copley Iron Workers Local Union No. 22 5600 Dividend Rd., Suite A Indianapolis, IN 46241-4302	Mike Kerr 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
Benton Amburgey, Jr. 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

Union	Employer
Russell Montgomery Iron Workers Local Union No. 769 2151 Greenup Avenue Ashland, KY 41101-7714	William E. Howes Triangle, Inc. P.O. Box 697 Hurricane, WV 25526
Bradley C. Winans Iron Workers Local Union No. 787 303 Erickson Boulevard Parkersburg, WV 26101-6687	Clinton Suggs Parkersburg-Marietta Cont. Association 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 501. 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 and Participant, Dependent, and Retiree self-payments are received and held in Trust by the Trustees pending payment of benefits and administrative expenses. Contributions are determined by the provisions of the Collective Bargaining Agreements in force with one or more of the Local Unions affiliated with the Iron Workers District Council of Southern Ohio & Vicinity. The Collective Bargaining Agreements require 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 names of Employers and the hours of work reported. Upon written request, you may receive information as to whether a particular employer or organization has entered into a Collective Bargaining Agreement with the Fund or obtain a copy of the Collective Bargaining Agreement. You are entitled to participate in this Plan if you work under one of the Collective Bargaining Agreements 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, Prescription Drug, Dental, Vision, Hearing Aid, Weekly Income, Life Insurance, and Accidental Death and Dismemberment Insurance Benefits. The Plan benefits are as listed on the applicable *Schedule of Benefits* insert to this booklet.

Insurance Companies/Vendors

Currently Life Insurance and Accidental Death and Dismemberment Insurance Benefits are provided under a group insurance policy issued by:

Metropolitan Life Insurance Company
200 Park Avenue, Floor 1200
New York, NY, 10166-0188

Medical benefits (Active and Non-Medicare) are processed by:

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

Prescription drug benefits (Active and Non-Medicare) are processed by:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Dental PPO Networks (Active Participants only) provided by:

Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com

Medicare-eligible benefits are provided by:

Medical Claim Address:
Humana
P.O. Box 14601
Lexington, KY 40512-4601

All other benefits are provided on a self-funded basis and processed directly from the Benefit Trust Plan.

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 active and Retiree 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.

Grandfathered Health Plan- Notice

Upon information and belief, the applicable plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable

Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to grandfathered health plans and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
    - You lose coverage under the plan;
    - You become entitled to elect COBRA Continuation Coverage; or
    - Your COBRA Continuation Coverage ends.

You must request the certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

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

Accidental Injury: Trauma to the body resulting from an accident, such as, but not limited to, a strain, sprain, abrasion, or contusion.

Active Participant: Participant who is not retired and who is either actively employed in Covered Employment or available for employment in the trade with a Contributing Employer.

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.

Beneficiary: Person(s) or parties properly designated by an Eligible Participant to receive the proceeds of the Plan's Life Insurance Benefit or any other Plan benefits provided otherwise payable (excluding those benefits previously assigned) after the death of the Eligible Participant.

Benefit Period: Period that benefits for Covered Services are payable under the Plan as listed on the applicable *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 applicable *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 to contribute to the Trust established in accordance with the Agreement and Declaration of Trust made August 1, 1952, as amended. Contributing Employer also includes participating Local Unions of the International Association of Bridge, Structural and Ornamental Iron Workers, AFL-CIO.

Covered Employment:

- Covered by a Collective Bargaining Agreement between a Contributing Employer and a participating Local Union of the International Association of Bridge, Structural and Ornamental Iron Workers; or
- For which contributions are made to the Plan pursuant to a participation agreement signed by a Contributing Employer.

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.

Creditable Coverage: Prior coverage from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, public health plan, individual insurance policy, or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break in coverage of 63 days or more before enrolling for Plan benefits.

Custodial Service or **Custodial 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 applicable *Schedule of Benefits* insert to this booklet, for which you are responsible to pay before benefits are paid under the Plan each Benefit Period.

Dentist: An individual who is licensed to practice dentistry by the applicable agency of the state in which the individual renders care or treatment, and who is acting within the usual scope of that license.

Dependent: includes your:

Eligible Dependents include your:

- Legal spouse;
- Children up to 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 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.

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 subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; 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.

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

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.

Non-Bargaining Participant:

1. Non-bargaining-unit Participants who may elect to participate in the Benefit Trust include, but are not limited to, the following:

    a) Corporate officer/owner
    b) Corporate officer
    c) Spouse of corporate owner or other common owner
    d) Supervisor
    e) Estimator

2. If one or more owners, each owner is considered non-bargained on a stand-alone basis.

3. A son or daughter working for a company owned by a parent may be considered to be a non-bargaining unit Participant under certain circumstances as more fully described in the Non-Bargaining Unit Member Participation and Eligibility Rules.

4. If a company is owned by a bargaining unit Participant's spouse and at least one other individual, the spouse may qualify as a non-bargaining unit Participant under these rules.

Non-Occupational Disease: A disease or sickness not arising out of nor in any way resulting from, any work for pay or profit. However, a disease is considered non-occupational, regardless of its cause, if proof is furnished to the Trustees that an individual is covered under a Workers' Compensation or similar law and such disease is not covered under the law.

Non-Occupational Injury: An Accidental Injury not arising out of or in the course of any work for pay or profit, nor in any way resulting from an injury that does.

Orthodontics: The specialty of dentistry that is concerned with the diagnosis and movement of teeth to correct or prevent malocclusion of the teeth.

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

Participant or **Participating Employee:** A person whose employment is covered by a Collective Bargaining Agreement between a Contributing Employer and a participating Local Union of the International Association of Bridge, Structural and Ornamental Iron Workers or a full-time Participant of a participating Local Union of the International Association of Bridge, Structural and Ornamental Iron Workers on whose behalf a participation agreement has been signed.

Plan: Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust 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. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. 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, 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).

Retired Participant or **Retiree:** A former Participant of a Contributing Employer who is:

- Receiving a pension under the Iron Workers District Council of Southern Ohio and Vicinity Pension Trust or another pension trust plan or Social Security; and
- Eligible for benefits under Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust during 36 of the 60 months prior to his or her date of retirement.

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 trust estate of the Iron Workers District Council of Southern Ohio & Vicinity Benefit Trust, as defined in the Agreement and Declaration of Trust.

Schedule of Benefits

Active Participants and Dependents Schedule of Benefits

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible (applies only to percentage Copayments or Coinsurance)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Calendar Year Out-Of-Pocket Maximum (including the Deductible)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Physician Office Services Including Office Surgeries, Allergy Serum, and Injections[1] Allergy Testing	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Preventive Care (medical history, mammography[1], pelvic exams, pap testing, PSA tests, immunizations[1], and annual diabetic eye exam)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Physical Medicine Therapies Combined Calendar Year Network and Non-Network Limits: Physical Therapy: 36 visits Occupational Therapy: 36 visits Spinal Manipulations: 12 visits Speech Therapy: 20 visits	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient Services Unlimited Days Except Combined Calendar Year Network and Non-Network Limits For: Physical Medicine and Rehabilitation: 60 days Skilled Nursing Facility : 180 Days	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Surgery Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Other Outpatient Services Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient and Outpatient Professional Charges	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Home Care Services (excludes IV therapy) Calendar Year Limit	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Hospice Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Emergency Room Emergency Care (covers all services; Copayment waived if admitted, then Inpatient Copayment or Coinsurance applies)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Urgent Care Facility; Copayment waived if admitted, then Inpatient Copayment or Coinsurance applies)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Medical Benefits	Network Coverage	Non-Network Coverage
Ambulance Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Maternity Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Medical Supplies, Equipment, and Appliances	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Behavioral Health Mental Health and Substance Abuse [2] ▪ Inpatient Facility Services ▪ Inpatient Professional Services ▪ Physician Office Services ▪ Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Human Organ and Tissue Transplants[3]	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy[4]**
Retail Pharmacy (includes diabetic test strip) Maximum Supply: 30 days Deductible (network and non-network Pharmacy combined) Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Rx Direct Mail Service (includes diabetic test strip) Maximum Supply: 90 days Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Dental Benefits	**Coverage**	
Calendar Year Maximum	See Summary of Benefits and Coverage	
Coinsurance	Benefits are paid for covered dental expenses up to the maximum allowance for dental services and as listed in the *Schedule of Dental Services and Supplies*	
Vision Benefits	**Coverage**	
Eye Examination with refraction Lenses Single Vision Bifocal/Trifocal Contact Frames	Plan pays up to a maximum of $200 per person per calendar year.	
Hearing Aid Benefits	**Coverage**	

Hearing Aid Examination	Plan pays up to $75 per person per 24-month period
Hearing Aid Instruments	Plan pays 80% up to $2,000 per person per 3-year period
Weekly Income Benefits (For Active Participants Only)	**Coverage**
Weekly Benefit	$375 per week effective for disability payments made on or after 6/12/2018
Accident and Illness Maximum Benefit Period	26 weeks per disability
Drug and Alcohol Maximum Benefit Period	3 weeks once per lifetime – Inpatient only
Life Insurance Benefits (For Active Participants Only)	**Coverage**
Benefit Amount	$7,000
AD&D Insurance Benefits (For Active Participants Only)	**Coverage**
Principal Benefit Amount	$7,000

Schedule of Dental Services and Supplies

SUMMARY OF DENTAL PLAN BENEFITS

This is an overview of benefits and not a guarantee of payment.

Send paper claims and pre-determinations to:
Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333-9085
800-524-0149
www.deltadentaloh.com

In-network: Covered dental procedures completed by a dentist in the dental PPO network will be covered at 100% of the PPO fee schedule, up to $2000 per person per year.

- **Diagnostic and Preventative Services:** Includes oral examinations, cleaning for adults and children, fluoride, sealants, bitewing and full mouth series x-rays, and space maintainers.
- **Basic Services**: Includes oral surgery, extractions, endodontics, periodontics, general anesthesia or intravenous sedation, and amalgam restorations.
- **Major Services**: Includes inlays and onlays, crowns, crown and bridge repair, prosthodontics (first installation of dentures and bridges), removable bridges, and full and partial dentures.

Out-of-network: Covered dental procedures completed by a non-network dentist will be paid based on the Iron Workers Benefit Trust Schedule of Dental Benefits up to the maximum $2000 per person per year. The patient is responsible for any difference between what is paid and what the dentist charges.

Coordination of benefits: Standard coordination. The Dental Plan will consider all charges still owed by the patient after the primary insurance processes the claim, up to the Iron Workers Benefit Trust schedule of benefits. An explanation of benefits (EOB) from the primary insurance is required to process the claim.

Maximum: $2000 per person per calendar year (January 1 to December 31)

Deductible: None

X-rays are not required when submitting claims. Pre-determinations are not required for any procedures. Crowns, bridges, and full and partial dentures are paid based on the prep date of the permanent appliance.

Exclusions and limitations:

- Oral exams (including evaluations by a specialist) are payable once every four consecutive months.
- Prophylaxes (cleanings) are payable once every four consecutive months.
- Fluoride treatments are payable once every 12 consecutive months with no age limit.
- Space maintainers are Covered Services with no limitations.
- Full mouth X-rays and panoramic X-rays are payable without limitation. Bitewing X-rays are payable once every twelve-month period.
- Periapical, extra-oral posterior, and 2D cephalometric X-rays are Covered Services.

- Sealants are payable for any tooth. The surface must be free from decay and restorations.
- Crowns, inlays, onlays, and substructures are Covered Services. Veneers on incisors, cuspids and bicuspids are Covered Services.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Inlays (any material) are Covered Services.
- Gold foils are Covered Services.
- Porcelain and resin facings on crowns are Covered Services on posterior teeth.
- Canal preparation and fitting of performed dowel or post are Covered Services.
- Gingivectomy or gingivoplasty to allow access for restorative procedures, provisional splinting, and localized delivery of chemotherapeutic agents are Covered Services.
- Certain oral surgery procedures including oroantral fistula closure, placement of temporary anchorage device, vestibuloplasty, incision and drainage of extraoral soft tissue; removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue; removal of reaction producing foreign bodies, partial ostectomy/sequestrectomy for removal of non-vital bone, maxillary sinusotomy for removal of tooth fragment or foreign body, frenulectomy and frenuloplasty are Covered Services.
- Full and partial dentures are payable once every twelve-month period. Reline and rebase of dentures and tissue conditioning are Covered Services.
- Bridges are payable once in any twelve-month period. Fixed Partial Denture single crowns/major restorative are Covered Services.
- Porcelain and resin facings on bridges are Covered Services on posterior teeth.
- Implants are payable once per tooth per lifetime. Implant related services are Covered Services.
- Services related to crowns over implants are Covered Services. Implant supported prosthetics are Covered Services once every twelve-month period.
- Office visits for observation, therapeutic parenteral drug administration, drugs or medicaments dispensed in the office for home use, application of desensitizing medicament and desensitizing resin, and occlusal guards are Covered Services.
- Removable harmful habit appliances are Covered Services.

Diagnostic		
D0120	Periodic oral evaluation	$66.50
D0140	Limited oral evaluation	$66.50
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver	$51.25
D0150	Comprehensive oral evaluation	$66.50
D0160	Detailed and extensive oral evaluation	$66.50
D0180	Comprehensive periodontal evaluation	$66.50
D0210	Intraoral – complete series of radiographic images	$91.50
D0220	Intraoral – periapical first radiographic image	$18.75
D0230	Intraoral – periapical each additional radiographic image	$16.00
D0240	Intraoral – occlusal radiographic image	$27.75
D0250	Extra-oral 2D projection radiographic image created using a stationary radiation source, and detector	$36.25
D0251	Extra-oral posterior dental radiographic image	$36.25
D0270	Bitewing – single radiographic image	$20.00
D0272	Bitewings – two radiographic images	$32.25
D0273	Bitewings – three radiographic images	$39.00
D0274	Bitewings – four radiographic images	$45.00
D0277	Vertical bitewings – 7 to 8 radiographic images	$68.00
D0330	Panoramic radiographic image	$76.50
D0340	2D cephalometric radiographic image	$94.75
D0460	Pulp vitality tests	$30.25
Preventive		
D1110	Prophylaxis – adult	$55.75
D1120	Prophylaxis – child	$43.50
D1206	Topical application of fluoride varnish	$38.75
D1208	Topical application of fluoride – excluding varnish	$24.75
D1351	Sealant – per tooth	$35.00
D1353	Sealant repair – per tooth	$35.00
D1510	Space maintainer – fixed, unilateral	$148.75
D1516	Space maintainer – fixed – bilateral, maxillary	$196.50
D1517	Space maintainer – fixed – bilateral, mandibular	$196.50
D1520	Space maintainer – removable – unilateral	$178.50
D1526	Space maintainer – removable – bilateral, maxillary	$252.50
D1527	Space maintainer – removable – bilateral, mandibular	$252.50
D1550	Re-cement or re-bond space maintainer	$32.25
D1555	Removal of fixed space maintainer	$29.75
Restorative		
D2140	Amalgam – one surface, primary or permanent	$70.50
D2150	Amalgam – two surfaces, primary or permanent	$86.75
D2160	Amalgam – three surfaces, primary or permanent	$106.50
D2161	Amalgam – four or more surfaces, primary or permanent	$129.50
D2330	Resin-based composite – one surface, anterior	$71.25
D2331	Resin-based composite – two surfaces, anterior	$86.75
D2332	Resin-based composite – three surfaces, anterior	$106.25
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$125.50
D2390	Resin-based composite crown, anterior	$139.25
D2391	Resin-based composite – one surface, posterior	$76.50
D2392	Resin-based composite – two surfaces, posterior	$100.50
D2393	Resin-based composite – three surfaces, posterior	$129.50
D2394	Resin-based composite – four surfaces, posterior	$158.50
D2410	Gold foil – one surface	$131.00
D2420	Gold foil – two surfaces	$218.25
D2430	Gold foil – three surfaces	$378.50
D2510	Inlay – metallic – one surface	$346.50
D2520	Inlay – metallic – two surfaces	$393.00
D2530	Inlay – metallic – three or more surfaces	$453.00
D2542	Onlay – metallic – one surface	$444.25
D2543	Onlay – metallic – two surfaces	$464.75
D2544	Onlay – metallic – three or more surfaces	$483.25

D2610	Inlay – porcelain/ceramic – one surface	$407.50
D2620	Inlay – porcelain/ceramic – two surfaces	$430.25
D2630	Inlay – porcelain/ceramic – three or more surfaces	$458.25
D2642	Onlay – porcelain/ceramic – two surfaces	$445.50
D2643	Onlay – porcelain/ceramic – three surfaces	$480.25
D2644	Onlay – porcelain/ceramic – four or more surfaces	$509.50
D2650	Inlay – resin-based composite – one surface	$267.75
D2651	Inlay – resin-based composite – two surfaces	$319.00
D2652	Inlay – resin-based composite – three or more surfaces	$335.50
D2662	Onlay – resin-based composite – two surfaces	$291.00
D2663	Onlay – resin-based composite – three surfaces	$342.50
D2664	Onlay – resin-based composite – four or more surfaces	$366.75
D2710	Crown – resin-based composite (indirect)	$206.75
D2720	Crown – ¾ resin-based composite (indirect)	$509.50
D2721	Crown – resin with predominantly base metal	$477.50
D2722	Crown – resin with noble metal	$488.00
D2740	Crown – porcelain/ceramic	$522.75
D2750	Crown – porcelain fused to high noble metal	$506.75
D2751	Crown – porcelain fused to predominantly base metal	$480.25
D2752	Crown – porcelain fused to noble metal	$492.00
D2780	Crown – ¾ cast high noble metal	$494.75
D2781	Crown – ¾ cast predominantly base metal	$465.75
D2782	Crown – ¾ cast noble metal	$481.00
D2783	Crown – ¾ porcelain/ceramic	$508.75
D2790	Crown – full cast high noble metal	$497.75
D2791	Crown – full cast predominantly base metal	$471.50
D2792	Crown – full cast noble metal	$480.25
D2799	Provisional crown – further treatment or completion of diagnosis necessary prior to final impression	$206.50

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$50.75
D2920	Re-cement or re-bond crown	$51.25
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$150.00
D2930	Prefabricated stainless steel crown – primary tooth	$140.00
D2931	Prefabricated stainless steel crown – permanent tooth	$158.25
D2932	Prefabricated resin crown	$168.75
D2933	Prefabricated stainless steel crown with resin window	$193.25
D2940	Protective restoration	$53.50
D2950	Core buildup, including any pins when required	$126.50
D2951	Pin retention – per tooth, in addition to restoration	$30.25
D2952	Post and core in addition to crown, indirectly fabricated	$211.00
D2953	Each additional indirectly fabricated post – same tooth	$105.50
D2954	Prefabricated post and core in addition to crown	$168.75
D2960	Labial veneer (resin laminate) – chairside	$407.75
D2961	Labial veneer (resin laminate) – laboratory	$462.50
D2962	Labial veneer (porcelain laminate) – laboratory	$502.75
D2980	Crown repair necessitated by restorative material failure	$94.00
D2981	Inlay repair necessitated by restorative material failure	$125.00
D2982	Onlay repair necessitated by restorative material failure	$139.00
D2983	Veneer repair necessitated by restorative material failure	$139.00
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$36.00
D3120	Pulp cap – indirect (excluding final restoration)	$29.75
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$85.00
D3221	Pulpal debridement, primary and permanent teeth	$93.25

D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$138.49
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$359.00
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$438.50
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$566.25
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$276.25
D3346	Retreatment of previous root canal therapy - anterior	$483.25
D3347	Retreatment of previous root canal therapy - premolar	$569.50
D3348	Retreatment of previous root canal therapy - molar	$682.50
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$283.25
D3410	Apicoectomy – anterior	$410.75
D3421	Apicoectomy – premolar (first root)	$448.75
D3425	Apicoectomy – molar (first root)	$507.50
D3426	Apicoectomy (each additional root)	$169.25
D3430	Retrograde filling – per root	$124.25
D3450	Root amputation – per root	$252.00
D3950	Canal preparation and fitting of preformed dowel or post	$174.66
Periodontics		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$431.50
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$181.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$181.00
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	$509.50
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	$265.25
D4249	Clinical crown lengthening – hard tissue	$578.50
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	$829.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$432.00
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$259.25
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$138.25
D4266	Guided tissue regeneration – resorbable barrier, per site	$302.50
D4267	Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)	$388.75
D4268	Surgical revision procedure, per tooth	$755.00
D4270	Pedicle soft tissue graft procedure	$604.75
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	$740.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	$209.00
D4275	Non-autogenous connective tissue graft procedure (including recipient and donor material) first tooth, implant or edentulous tooth position in graft	$388.75
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$630.75
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$315.50
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) each additional contiguous tooth,	$370.00

	implant or edentulous tooth position in same graft site	
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$157.75
D4320	Provisional splinting – intracoronal	$218.50
D4321	Provisional splinting – extracoronal	$191.00
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$120.75
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$65.50
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$65.00
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$79.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$73.75
D4910	Periodontal maintenance	$59.25
Prosthodontics		
D5110	Complete denture, maxillary	$798.00
D5120	Complete denture, mandibular	$798.00
D5130	Immediate denture, maxillary	$870.50
D5140	Immediate denture, mandibular	$870.50
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	$783.00
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$783.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any convention clasps, rests, and teeth)	$882.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$882.00
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests, and tooth)	$783.00
D5222	Immediate mandibular partial denture – resin base (including any	$783.00

	conventional clasps, rests, and teeth)	
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$882.00
D5224	Immediate mandibular partial denture – cast metal framework with resin dentures bases (including any conventional clasps, rests, and teeth)	$882.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests, and teeth)	$783.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)	$783.00
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	$514.00
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	$514.00
D5410	Adjust complete denture – maxillary	$43.75
D5411	Adjust complete denture – mandibular	$43.75
D5421	Adjust partial denture – maxillary	$43.75
D5422	Adjust partial denture – mandibular	$43.75
D5511	Repair broken complete denture base, mandibular	$87.45
D5512	Repair broker complete denture base, maxillary	$87.45
D5520	Replace missing or broken teeth – complete denture (each tooth)	$72.75
D5611	Repair resin partial denture base, mandibular	$94.75
D5612	Repair resin partial denture base, maxillary	$94.75
D5621	Repair cast partial framework, mandibular	$102.00
D5622	Repair cast partial framework, maxillary	$102.00
D5630	Repair or replace broken retentive/clasping materials – per tooth	$123.75
D5640	Replace broken teeth – per tooth	$80.25
D5650	Add tooth to existing partial denture	$109.25

D5660	Add clasp to existing partial denture – per tooth	$131.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$320.50
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$320.50
D5710	Rebase complete maxillary denture	$324.00
D5711	Rebase complete mandibular denture	$324.00
D5720	Rebase maxillary partial denture	$306.00
D5721	Rebase mandibular partial denture	$306.00
D5730	Reline complete maxillary denture (chairside)	$182.75
D5731	Reline complete mandibular denture (chairside)	$182.75
D5740	Reline maxillary partial denture (chairside)	$167.50
D5741	Reline mandibular partial denture (chairside)	$167.50
D5750	Reline complete maxillary denture (laboratory)	$244.00
D5751	Reline complete mandibular denture (laboratory)	$244.00
D5760	Reline maxillary partial denture (laboratory)	$240.25
D5761	Reline mandibular partial denture (laboratory)	$240.25
D5810	Interim complete denture (maxillary)	$415.25
D5811	Interim complete denture (mandibular)	$415.25
D5820	Interim partial denture (maxillary)	$316.75
D5821	Interim partial denture (mandibular)	$316.75
D5850	Tissue conditioning, maxillary	$76.50
D5851	Tissue conditioning, mandibular	$76.50
D5862	Precision attachment, by report	$250.75
D5863	Overdenture – complete maxillary	$752.50
D5864	Overdenture – partial maxillary	$776.25
D5865	Overdenture – complete mandibular	$752.50
D5866	Overdenture – partial mandibular	$776.25
D5982	Surgical stent	$397.00
Implants		
D6010	Surgical placement of implant body: endosteal implant	$1333.75
D6013	Surgical placement of mini implant	$531.75
D6056	Prefabricated abutment – includes modification and placement	$342.00
D6057	Custom fabricated abutment – includes placement	$418.50
D6058	Abutment supported porcelain/ceramic crown	$735.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$714.75
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$642.00
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$678.00
D6062	Abutment supported cast metal crown (high noble metal)	$694.50
D6063	Abutment supported cast metal crown (predominantly base metal)	$633.75
D6064	Abutment supported cast metal crown (noble metal)	$642.00
D6065	Implant supported porcelain/ceramic crown	$735.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$714.75
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$678.00
D6068	Abutment supported retainer for porcelain/ceramic FPD	$735.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$714.75
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$642.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$678.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$678.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$621.75
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$642.00
D6075	Implant supported retainer for ceramic FPD	$735.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$714.75

D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$678.00
D6080	Implant maintenance procedures when prostheses are removed or reinserted, including cleansing of prostheses and abutments	$43.50
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$89.25
D6090	Repair implant supported prosthesis, by report	$412.50
D6092	Re-cement or re-bond implant/abutment supported crown	$43.50
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$58.50
D6094	Abutment supported crown (titanium)	$618.75
D6095	Repair implant abutment, by report	$412.50
D6096	Remove broken implant retaining screw	$127.50
D6100	Implant removal, by report	$253.50
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	$327.00
D6102	Debridement of osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	$471.00
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	$236.25
D6104	Bone graft at time of implant placement	$472.50
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	$1723.90
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	$1723.90
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$1723.90
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$1723.90
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	$5500.00
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	$5500.00
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$5500.00
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$5500.00
D6194	Abutment supported retainer crown for FPD (titanium)	$714.75
D6199	Unspecified implant procedure, by report	$412.50
D6205	Pontic – indirect resin based composite	$644.13
D6210	Pontic – cast high noble metal	$509.25
D6211	Pontic – cast predominantly base metal	$477.25
D6212	Pontic – cast noble metal	$496.50
D6214	Pontic – titanium	$512.50
D6240	Pontic – porcelain fused to high noble metal	$503.00
D6241	Pontic – porcelain fused to predominantly base metal	$464.50
D6242	Pontic – porcelain fused to noble metal	$490.00
D6245	Pontic – porcelain/ceramic	$519.00
D6250	Pontic – resin with high noble metal	$496.50
D6251	Pontic – resin with predominantly base metal	$458.00
D6252	Pontic – resin with high noble	$472.75
D6253	Provisional pontic- further treatment or completion of diagnosis necessary prior to final impression	$214.00
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$211.50
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$232.50
D6549	Resin retainer – for resin bonded fixed prosthesis	$200.00
D6600	Retainer inlay – porcelain/ceramic, two services	$419.50
D6601	Retainer inlay – porcelain/ceramic, three or more surfaces	$440.00

D6602	Retainer inlay – cast high noble metal, two surfaces	$448.50
D6603	Retainer inlay – cast high noble metal, three or more surfaces	$493.25
D6604	Retainer inlay – cast predominantly base metal, two surfaces	$439.50
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	$465.75
D6606	Retainer inlay – cast noble metal, two surfaces	$432.50
D6607	Retainer inlay – cast noble metal, three or more surfaces	$479.75
D6608	Retainer onlay – porcelain/ceramic, two surfaces	$456.25
D6609	Retainer onlay – porcelain/ceramic, three or more surfaces	$476.00
D6610	Retainer onlay – cast high noble, two surfaces	$483.50
D6611	Retainer onlay – cast high noble, three or more surfaces	$529.25
D6612	Retainer onlay – cast predominantly base metal, two surfaces	$481.00
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces	$502.50
D6614	Retainer onlay – cast noble metal, two surfaces	$470.75
D6615	Retainer onlay – cast noble metal, three or more surfaces	$489.00
D6634	Retainer onlay – titanium	$471.00
D6710	Retainer crown – indirect resin based composite	$480.50
D6720	Retainer crown – resin with high noble metal	$560.50
D6721	Retainer crown – resin with predominantly base metal	$531.50
D6722	Retainer crown – resin with noble metal	$541.00
D6740	Retainer crown – porcelain/ceramic	$589.00
D6750	Retainer crown – porcelain fused to high noble metal	$574.00
D6751	Retainer crown – porcelain fused to predominantly base metal	$535.50
D6752	Retainer crown – porcelain fused to noble metal	$548.00
D6780	Retainer crown – ¾ cast high noble metal	$541.00
D6781	Retainer crown – ¾ cast predominantly base metal	$541.00
D6782	Retainer crown – ¾ cast noble metal	$502.50
D6783	Retainer crown – ¾ porcelain/ceramic	$557.25
D6790	Retainer crown – full cast high noble metal	$554.25
D6791	Retainer crown – full cast predominantly base metal	$525.25
D6792	Retainer crown – full cast noble metal	$544.50
D6793	Provisional retainer crown – further treatment of completion of diagnosis necessary prior to final impression	$227.25
D6794	Retainer crown – titanium	$544.50
D6930	Re-cement or re-bond fixed partial denture	$67.25
D6940	Stress breaker	$152.50
Oral Surgery		
D7111	Extraction, coronal remnants – primary tooth	$86.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$112.25
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$207.75
D7220	Removal of impacted tooth – soft tissue	$239.00
D7230	Removal of impacted tooth – partially bony	$318.00
D7240	Removal of impacted tooth – completely bony	$373.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$469.00
D7250	Removal of residual tooth roots (cutting procedure)	$201.50
D7251	Coronectomy – intentional partial tooth removal	$128.00
D7260	Oroantral fistula closure	$1678.50
D7280	Exposure of an unerupted tooth	$345.75
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$162.00
D7283	Placement of device to facilitate eruption of impacted tooth	$108.75
D7290	Surgical repositioning of teeth	$365.50
D7292	Placement of temporary anchorage device requiring flap; includes device removal	$543.00

D7293	Placement of temporary anchorage device requiring flap; include device removal	$345.75
D7294	Place of temporary anchorage device without flap; includes device removal	$250.00
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$222.25
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$360.46
D7320	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$321.00
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$1777.50
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$2000.00
D7473	Removal of torus mandibularis	$302.00
D7510	Incision and drainage of abscess – intraoral soft tissue	$212.25
D7520	Incision and drainage of abscess – extraoral soft tissue	$1011.25
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$364.50
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$403.25
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$251.75
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$1999.50
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$217.00
D7963	Frenuloplasty	$997.22
D7971	Excision of hyperplastic tissue – per arch	$153.00
Orthodontics		
D8210	Removal appliance therapy	$187.50
Adjunctive Services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$57.75
D9120	Fixed partial denture sectioning	$65.25

D9211	Regional block anesthesia	$26.25
D9212	Trigeminal division block anesthesia	$52.50
D9222	Deep sedation/general anesthesia – first 15 minutes	$107.00
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$107.00
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$84.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$84.00
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	$120.00
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$37.50
D9440	Office visit – after regularly scheduled hours	$75.00
D9610	Therapeutic parenteral drug, single administration	$24.50
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$49.00
D9630	Drugs or medicaments dispensed in the office for home use	$24.50
D9910	Application of desensitizing medicament	$26.25
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	$42.00
D9944	Occlusal guard – hard appliance, full arch	$187.50
D9946	Occlusal guard – hard appliance, partial arch	$140.50
D9951	Occlusal adjustment – limited	$73.50
D9952	Occlusal adjustment - complete	$412.50

Plan A Non-Medicare Eligible Retirees and Dependents
Schedule of Benefits

NOTE: Benefits for Medicare-eligible Retirees and Dependents are provided through an insured program and are not described in this booklet. Please contact the Benefit Trust Office for more information relating to these benefits.

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible (applies only to percentage Copayments or Coinsurance)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Calendar Year Out-of-Pocket Maximum (including the Deductible)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Physician Office Services (includes office surgeries, allergy serum, and injections) [1] Allergy Testing	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Preventive Care (includes medical history, mammography[1], pelvic exams, pap testing, PSA tests, immunizations[1], and annual diabetic eye exam)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Physical Medicine Therapies Combined Calendar Year Network and Non-Network Limits: Physical Therapy: 36 visits Occupational Therapy: 36 visits Spinal Manipulations: 12 visits Speech Therapy: 20 visits	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient Services Unlimited Days Except Calendar Year Combined Network and Non-Network Limits for: Physical Medicine and Rehabilitation: 60 days Skilled Nursing Facility : 180 Days	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Surgery Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Other Outpatient Services Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient and Outpatient Professional Charges	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Home Care Services (excludes IV therapy) Calendar Year Limit	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Hospice Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Emergency Room Emergency Care (includes all services; Copayment waived if admitted, then Inpatient Copayment or Coinsurance applies)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Urgent Care Facility; Copayment waived if admitted, then Inpatient Copayment or Coinsurance applies)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Ambulance Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Medical Benefits	Network Coverage	Non-Network Coverage
Maternity Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Medical Supplies, Equipment, and Appliances	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Human Organ and Tissue Transplants[3]	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Behavioral Health Mental Health and Substance Abuse [2] ▪ Inpatient Facility Services ▪ Inpatient Professional Services ▪ Physician Office Services ▪ Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Prescription Drug Benefits	**Network Pharmacy**	**Non-Network Pharmacy[4]**
Retail Pharmacy (includes diabetic test strip) Maximum Supply: 30 days Deductible (combined network and non-network Pharmacy) Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Rx Direct Mail Service (includes diabetic test strip) Maximum Supply: 90 days Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Plan B Non-Medicare Eligible Retirees and Dependents
Schedule of Benefits

NOTE: Benefits for Medicare-eligible Retirees and/or Dependents are provided through an insured program and are not described in this booklet. Please contact the Benefit Trust Office for more information relating to these benefits.

Medical Benefits	Network Coverage	Non-Network Coverage
Calendar Year Deductible (applies only to percentage Copayments or Coinsurance)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Calendar Year Out-of-Pocket Maximum (including the Deductible)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Physician Office Services (includes office surgeries, allergy serum, and injections)[1] Allergy Testing	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Preventive Care (includes medical history, mammography[1], pelvic exams, pap testing, PSA tests, immunizations[1], and annual diabetic eye exam)	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Physical Medicine Therapies Combined Calendar Year Network and Non-Network Limits: Physical Therapy: 36 visits Occupational Therapy: 36 visits Spinal Manipulations: 12 visits Speech Therapy: 20 visits	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient Services Unlimited Days Except Calendar Year Combined Network and Non-Network Limits for: Physical Medicine and Rehabilitation: 60 days Skilled Nursing Facility : 180 Days	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Outpatient Surgery Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Other Outpatient Services Hospital/Alternative Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Inpatient and Outpatient Professional Charges	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Home Care Services (excludes IV therapy) Calendar Year Limit	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Hospice Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Emergency Room Emergency Care	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Urgent Care Facility	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Ambulance Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Maternity Services	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Medical Benefits	Network Coverage	Non-Network Coverage
Medical Supplies, Equipment, and Appliances	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Human Organ and Tissue Transplants[3]	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Behavioral Health Mental Health and Substance Abuse [2] ▪ Inpatient Facility Services ▪ Inpatient Professional Services ▪ Physician Office Services ▪ Other Outpatient Services, Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Prescription Drug Benefits	Network Pharmacy	Non-Network Pharmacy[4]
Deductible (combined network Pharmacy, non-network Pharmacy, and network mail service)	See Summary of Benefits and Coverage	
Retail Pharmacy (includes diabetic test strip) Maximum Supply: 30 days Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage
Rx Direct Mail Service (includes diabetic test strip) Maximum Supply: 90 days Copayment: Generic Formulary Medication Brand Name Formulary Medication Non-Formulary Medication	See Summary of Benefits and Coverage	See Summary of Benefits and Coverage

Contact Information

If You Need Information About …	Contact …
▪ Locating a Network Provider (Active and Non-Medicare)	Anthem Blue Cross and Blue Shield (844) 610-1938 www.anthem.com
▪ Medical Claims (Active and Non-Medicare)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187 Member Services: (844) 610-1938 www.anthem.com
▪ Pre-Certification	Anthem Blue Cross and Blue Shield (866) 643-7087 www.anthem.com
▪ Prescription Drug Program	**Retail Pharmacy Claim Address:** CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 www.caremark.com **Member Services:** 888-202-1654 **Pharmacist Help Desk for Pharmacists:** 800-364-6331 **Mail-Order:** CVS Caremark
▪ Medicare Medical Claims*	**Medical Claim Address**: Humana P.O. Box 14601 Lexington, KY 40512-4601 **Member/Provider Service:** 800-733-9064 **Pharmacist/Physician Rx:** 800-865-8715
▪ Dental PPO Network	**Delta Dental of Ohio** P.O. Box 9085 Farmington Hills, MI 48333-9085 800-524-0149 www.deltadentaloh.com

▪ Insurance Eligibility ▪ Dependent Eligibility ▪ Dental Benefits ▪ Vision Benefits ▪ Hearing Aid Benefits ▪ Health Reimbursement Account (HRA) ▪ Weekly Income Benefits ▪ Life Insurance Benefits ▪ Accidental Death and Dismemberment (AD&D) Insurance Benefits	Benefit Trust Office 1470 Worldwide Place Vandalia, OH 45377-1156 (937) 454-1744 or (800) 331-4277 Fax: (937) 454-5457 www.ironworkersbenefits.com

* NOTE: Benefits for Medicare-eligible Retirees and/or their Dependents are provided through an insured program and are not described in this SPD booklet. Please contact the Benefit Trust Office for more information relating to these benefits.

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.