NORTHWEST IRONWORKERS
SHOP HEALTH AND SECURITY FUND
June 2009

SUMMARY PLAN DESCRIPTION
FOR
SHOP IRONWORKERS AND THEIR FAMILIES

NORTHWEST IRONWORKERS SHOP HEALTH AND SECURITY FUND

2815 SECOND AVENUE, SUITE 300
P.O. BOX 34203
SEATTLE, WA 98124

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McKenzie Rothwell Barlow & Korpi, P.S

CONSULTANT

The Segal Company

ADMINISTRATION OFFICE

Welfare & Pension Administration Service, Inc.

AUDITOR

Lockitch, Clements & Rice, P.S.

NORTHWEST IRONWORKERS SHOP HEALTH AND SECURITY FUND

TO ALL CONCERNED:

This Summary Plan Description/Plan (Booklet) has been prepared to describe the benefits available through the Northwest Ironworkers Shop Health and Security Fund. This Booklet sets forth the eligibility requirements that you must satisfy to qualify for benefits, the benefit programs provided by this Trust, and procedures for review and appeal of claims. This Booklet provides information about the administration of the program and your rights under the law, and includes all benefit changes made through February 1, 2008. It replaces all other plan Booklet/summary plan descriptions previously provided to you.

This Booklet contains descriptions of Medical, Prescription Drug, Weekly Income for Disability, Dental and Vision benefits provided directly by the Trust, and constitutes the Plan document for those benefits. This Booklet also contains a summary of Life Insurance and Accidental Death and Dismemberment benefits which are provided under an insurance policy between the Northwest Ironworkers Shop Health and Security Fund and The Union Labor Life Insurance Company. The benefits provided under the HMO option are described in separate brochures.

The Board of Trustees has the right to amend, change or discontinue the types and amounts of benefits under this Plan, and the rules determining who is eligible for benefits. The Board of Trustees and its Appeals Committee are granted the sole discretionary authority to make any and all determinations under the Plan, including who is eligible for benefits, the amount of benefits payable (if any), and the meaning and applicability of Plan provisions. Any such determinations shall be conclusive and binding on all parties having dealings with the Plan. No employer, employer association, or union, or any individual employed thereby, is authorized to interpret this Plan on behalf of the Board of Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the product is dispensed or the services giving rise to the claim are provided, or in the case of Life Insurance or Accidental Death and Dismemberment benefits, the event giving rise to the claim occurs. **These are not guaranteed lifetime benefits. Also, your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.**

IMPORTANT INFORMATION

Northwest Ironworkers Shop Health and Security Fund is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

We encourage you to read this Booklet carefully prior to obtaining health care. **Remember, not every expense you incur for health care is covered by the Plan**. If you have questions about Plan benefits, please contact the Administration Office.

Important Note: Please give special attention to the cost containment features designed by the Trustees to control costs without reducing the level of Medically Necessary care available to you. The Board of Trustees has entered into Preferred Provider arrangements with a network of health care providers that offer their services at negotiated rates to Plan participants. Contact the Administration Office for more information.

Sincerely,

Board of Trustees

WEB SITE

The Northwest Ironworkers Trust Funds have established a web site to prove you with immediate access to your plan information. The site located at www.ironworkerstrust.com includes the following Trust Fund related material: Forms, legal documents, Plan booklets, links to useful sites, Local Unions and District Council Contact Information.

This site will also provide a link to "My Personal Benefit" information, which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number. A PIN will be assigned and mailed to you upon your written request. To request a PIN, complete a "PIN REQUEST FORM" which can be printed from the website. For security purposes you *may not* choose you own PIN. "My Personal Benefits" information includes the following data:

- **Personal Information – name, address, gender, birth date, marital status, etc.**
- **Health Eligibility – eligibility in the current and past three months**
- **Retirement – annuity account balance**
- **Hours/Contributions – statement showing recent employers reporting hours**
- **Dependent Enrollment Information**

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QUICK REFERENCE CHART

FOR HELP OR INFORMATION

When you need information, please check this Booklet first. If you need further help, call the people listed in the following ***Quick Reference Chart***:

Information Needed	Whom To Contact
Claims Office • Claim Forms • Medical and Hospital Claims and Appeals • Plan Benefit Information • Weekly Income • Dental Claims and Appeals	**Welfare & Pension Administration Service, Inc. (WPAS)** 2815 2nd Ave., Suite 300 P.O. Box 34464 Seattle, WA 98124-1464 (206) 441-7226 or (866) 986-1515, Option "1"
Administration Office • Eligibility for Active Employees, Retirees, Surviving Spouses and COBRA Beneficiaries • Identification Card Orders • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • Information About COBRA Coverage • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	**Welfare & Pension Administration Service, Inc. (WPAS)** 2815 2nd Ave., Suite 300 P.O. Box 34203 Seattle, WA 98124-1203 (206) 441-7226 or (866) 986-1515 Option "4" www.ironworkerstrust.com
Preferred Provider Organization (PPO) • Medical Network Provider Directory • Additions/Deletions of Providers • Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price	**Premera Blue Cross (Washington and Alaska)** (800) 810-BLUE (2583) www.premera.com **Blue Cross/Blue Shield Blue Card (all other states)** (800) 810-BLUE (2583) www.premera.com

Information Needed	Whom To Contact
Hospital Utilization Management (UM) Program (includes both in and outpatient treatment for Chemical Dependency) • Preauthorization, Second and Third Opinions, Case Management, and Appeals of UM decisions	**First Choice Health Network** Seattle (206) 292-8255 Washington State (800) 231-6935 Outside Washington State (800) 345-5767
Prescription Drug Program • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Administers prescription drug benefits • Specialty Drug Program: Preauthorization and Ordering • Identification cards for Medicare retirees only	**Network Retail Pharmacy Service** WHI Walgreens Health Initiatives 9775 SW Gemini Drive Beaverton, OR 97005 (800) 207-2568 www.mywhi.com **Mail Order Drug Service** Walgreens P.O. Box 29061 Phoenix, AZ 85038-9061 (888) 265-1807
Medicare Benefits and Enrolling for Parts A, B and D coverage	Your local Social Security Office
Vision Plan • Vision Network and Provider Directory • Vision Claims and Appeals • Administers vision benefits	**Vision Service Plan (VSP)** 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com
Employee Assistance Program (EAP) (for active members and their dependents) • EAP counseling and referral services • Administers EAP Program	**Fully Effective Employees, Inc**. 3020 Issaquah Pine Lake Rd. Issaquah, WA 98029 (800) 648-5834

Information Needed	Whom To Contact
Fully insured Life Insurance, Dependent Life Insurance, and Accidental Death and Dismemberment benefits	**The Union Labor Life Insurance Company** 8403 Colesville Rd. Silver Spring, MD 20910 Phone number: (800) 431-5425
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Privacy Official** **WPAS, Inc.** P.O. Box 34203 Seattle, WA 98124 (206) 441-7574 (800) 331-6158 (206) 441-9110 (fax)

IMPORTANT NOTE:

You have a limited amount of time from the date Covered Expenses are incurred to submit claims to the Administration Office for payment.

Detailed information concerning these time limits as well as your rights to appeal denied claims can be found in the HOW TO FILE A CLAIM and CLAIMS REVIEW PROCEDURE sections of this Booklet.

CHOICE OF MEDICAL PLANS

MEDICAL PLANS

If you are a new Employee who meets the initial eligibility requirements, you and your eligible Dependents will be covered under the Comprehensive Medical Benefits Program offered by the Plan. During the next annual open enrollment period, you may elect to be covered under the Comprehensive Medical Benefits Program, or a health maintenance organization (HMO) offered through the Plan.

Your eligible Dependents will be covered under the same program you select for yourself. You may not split coverage, that is, you may not elect to be covered under the Comprehensive Medical Benefits Program and one or more of your eligible Dependents elect the health maintenance organization (HMO), or vice versa.

Comprehensive Medical Benefits Program

The benefits provided through the Comprehensive Medical Benefits Program are described in this Booklet. You may select a doctor and/or Hospital of your choice. However, use of Preferred Providers may result in lower out-of-pocket expenses to you, as Preferred Providers have agreed to provide services at special negotiated rates.

The Comprehensive Medical Benefits Program provides traditional medical benefits. You seek care and then file claim forms with the Administration Office for reimbursement of Covered Expenses.

Health Maintenance Organization (HMO)

A health maintenance organization (HMO) offers comprehensive medical care from a group of providers under contract to the HMO. It differs from the Comprehensive Medical Benefits Program in that you are limited in your choice of Physicians and Hospitals. In an HMO, you must select a Physician from among those employed by or under contract to the HMO and covered services and supplies are provided by the HMO facilities either at no cost to you or with minimal copayments. Further, there are no claim forms to file.

If you select the Trust Fund's HMO for medical coverage, prescription drug and vision coverages are also provided by the HMO.

Except for certain medical emergencies or authorized referrals, coverage is NOT provided if you go to Physicians, Hospitals, or pharmacies not affiliated with the HMO. If you do, neither the Trust nor the HMO will be responsible for the charges you incur.

Separate brochures describing the benefits offered through the HMO and the locations of providers are available during the open enrollment period from the HMO or the Administration Office. In order to elect the HMO you must live in the HMO's service area. The name, address and phone number of the HMO and the Administration Office are listed on the ***Quick Reference Chart*** in the front of this Booklet.

Transfers (Changing Medical Plan Options)

You must retain your coverage selection until the next annual open enrollment period (unless you move out of the HMO service area).

If you decide to change from one medical plan to another, the change becomes effective January 1, provided the Administration Office receives your election form before the end of each year's open enrollment period.

If you are enrolled in the HMO and subsequently move out of the service area, you may change medical plans, on the first of any month, by submitting a new election form.

ENROLLMENT FORMS

All Employees should complete enrollment forms and return them to the Administration Office. Enrollment forms can be obtained from the Administration Office, your Local Union office, or the Trust's website: www.ironworkerstrust.com.

The enrollment form is the means by which you designate Dependents, as well as the beneficiary of Life Insurance and Accidental Death and Dismemberment benefits.

It is important that you notify the Administration Office within 31 days if:

- You change your home address
- You wish to change your beneficiary
- There is any change in your family status, i.e., marriage, birth of a child, adoption, divorce, death, etc.

If the change in family status is due to marriage, you must provide a copy of the marriage certificate. If the change in family status is due to a divorce, you must provide a copy of the divorce decree. Failure to provide timely notice to the Plan of a change in family status may affect the ability to obtain benefits under the Plan and/or COBRA continuation coverage.

A beneficiary designation of a spouse is automatically revoked at the time a marriage is dissolved or invalidated. Therefore, you should complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to re-designate your former spouse.

IMPORTANT

Active and Retired Employees are held liable for benefit payments based on any incorrect information about family members, such as failing to notify the Administration Office in case of divorce, if a child is no longer a Dependent, or if an adoption is rescinded. In addition, the Active or Retired Employee is liable for other costs incurred by the Plan as a result of the incorrect information. These costs include (but are not limited to) attorney fees, administration costs, and reasonable interest.

Enrollment of Newly Acquired Dependents is Required. If you acquire a new Dependent through marriage, birth or adoption, you must contact the Administration Office ***within 31 days*** and request a new Enrollment Form. Any required documentation, such as marriage certificate or birth certificate must be provided as soon as it is available.

ELIGIBILITY FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

INITIAL ELIGIBILITY

You become an Active Employee and you and your eligible Dependents will be covered on the first day of the second month following the accumulation of:

- 250 or more paid work hours within a consecutive three-month period, or
- 500 or more paid work hours within a consecutive twelve-month period.

  For example: If you worked a total of 250 or more hours in January, February and March, you are eligible for benefits on May 1.

The term **"paid work hours"** means time for which an employer is required to make a contribution to the Trust on an Employee's behalf under a Collective Bargaining Agreement or Contribution Agreement while you are covered under that agreement. The Trustees may adopt a methodology for pro-rating paid work hours, if the contribution rate under a Collective Bargaining Agreement differs from the contribution rate under a Master Labor Agreement with the Ironworkers District Council of the Pacific Northwest.

CONTINUING ELIGIBILITY

Once you satisfy the initial eligibility requirements, you remain eligible as long as your "Hour Bank" does not fall below 105 hours. Your Hour Bank is an account containing all hours for which contributions are made by or required from contributing employers on your behalf. Your Hour Bank is credited with contributions made on your behalf one month following the month you actually worked. 105 hours is deducted from your Hour Bank to provide one month of eligibility. The maximum number of hours in your Hour Bank may not exceed 600 (after deduction of 105 hours for the current month's eligibility).

> **For Example:** If at the beginning of April, the number of hours in your Hour Bank totaled 500, 105 hours would be deducted for April's eligibility, and 395 hours would remain in your Hour Bank for future eligibility. Any additional hours reported during April would then be added to your Hour Bank, provided the total number of hours does not exceed 600.

To further check and verify your eligibility for a given month, call the Administration Office.

CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

Under the Uniform Services Employment and Reemployment Rights Act, you have certain rights to continue coverage if you enter military service. If you are an Active Employee and you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your Hour Bank. When your Hour Bank has less than one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.
- You may elect to freeze your Hour Bank until you return from military service. If you freeze your Hour Bank, you still have the option of electing to self-pay for USERRA continuation coverage for up to 24 months.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your Hour Bank, you must notify the Administration Office within 60 days of beginning military service. If you do not provide timely notice, your Hour Bank will continue to be used for updating eligibility each month until it is run out.

If you want to run-out your Hour Bank, and then elect USERRA continuation coverage, you must notify the Administration Office of your military service within 60 days of termination of your Hour Bank coverage. If you fail to notify the Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect USERRA continuation coverage. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election forms by the due date, you will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If you provide timely notice and properly elect to freeze your Hour Bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect to freeze your Hour Bank and elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your Hour Bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin immediately following the date Hour Bank coverage ended, provided you properly elect USERRA continuation coverage and the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the date in which your Hour Bank coverage ended or was frozen because of your entry into military service.
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA.
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents. You may elect the following coverage options:

1) Medical and Prescription Drug
2) Medical, Prescription Drug, Life and AD&D
3) Medical, Prescription Drug, Dental, Vision
4) Medical, Prescription Drug, Dental, Vision, Life and AD&D

USERRA continuation coverage is not available for weekly income benefits. Dependents may elect to continue options (1) or (3) only. Once you elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated Active Employees. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments

If your military leave is less than 31 days, coverage is continued at no cost. You will be credited with the hours necessary to keep coverage in effect as if you worked in covered employment with a contributing employer during the period of service.

If your USERRA military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify you of the self-payment amount when it sends you the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your Hour Bank coverage ended (or was frozen).

Reinstatement of Eligibility Following Military Service

If you properly elected to freeze your Hour Bank when you entered military service, the balance in your Hour Bank will be carried over until you have a USERRA qualifying discharge from military service. Your Hour Bank eligibility will be reinstated the first of the month of the discharge, provided you have sufficient hours for a month of coverage. Following reinstatement, Hour Bank eligibility will terminate the first day of any month your Hour Bank has less than a month of eligibility at the current Hour Bank deduction rate, unless you return to employment with a contributing employer within the time period required by USERRA, as explained below.

If you return to employment with a contributing employer immediately following a qualifying discharge from military service and within the time period required by USERRA, your Hour Bank will be credited with the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility), and eligibility will be reinstated the first of the month in which you return to employment. If you elected to freeze your Hour Bank, the frozen hours that remain on the date of reemployment, together with the credited hours, will not exceed the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility). Hour Bank eligibility will terminate the first day of any month your Hour Bank has less than a month of eligibility. However, you may be able to qualify for COBRA coverage.

If you are on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of reinstatement of eligibility.

You are responsible for immediately notifying the Administration Office of your discharge from military service so that frozen hours can be reinstated on a timely basis. You should also notify the Administration Office if you are reemployed within the time required by USERRA, so that your Hour Bank can be credited and eligibility reinstated without waiting periods.

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. See the COBRA Continuation Coverage section of this Booklet if you have questions regarding election or duration of COBRA.

COVERAGE DURING A FMLA LEAVE OF ABSENCE

If your employer approves your taking a leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you and your eligible Dependents continue to be covered under this Plan provided you were eligible when the leave began and your employer makes the required contributions during your leave. Coverage continues while on FMLA leave as if there is no interruption of active employment and as if you are continuing to work the number of hours required for coverage. Coverage will continue until the earlier of the expiration of FMLA leave or the date you give notice to your employer that you do not intend to return to work at the end of FMLA leave. If you do not return to work after the end of FMLA leave, your employer may require you to reimburse him for the contributions made to the Plan on your behalf during the leave.

TERMINATION OF YOUR ELIGIBILITY

Your coverage ends on the earliest of:

- the last day of the month preceding the month in which your Hour Bank has less than 105 hours, or
- on the date the Plan terminates.

CERTIFICATE OF CREDITABLE COVERAGE

If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan may be used to reduce the length of any pre-existing condition exclusion period contained in your new plan. A certificate of creditable coverage provides information regarding your period of coverage under this Plan, which your new plan may need to credit coverage. You should check with your new plan's administrator to verify whether your new plan has a limitation for pre-existing conditions and how creditable coverage is applied under that plan. Present your certificate to your new plan so that your new plan will know to apply your creditable coverage to the pre-existing condition exclusion period under your new plan.

"Creditable coverage" includes most types of health insurance such as COBRA or any group health plan or insurance policy (whether or not it is employer-sponsored), any individual health insurance policy or program, Medicare, Medicaid, military-sponsored health care, program of the Indian Health Service, state health benefits risk pool, State Children's Health Insurance Program (SCHIP), foreign plans and US government plan, the federal employees health benefit program, a public health plan, and/or any health benefit plan provided under the Peace Corps.

This Plan will automatically provide a certificate of creditable coverage when Plan coverage ends or when you become entitled to COBRA continuation coverage, as well as when your COBRA continuation coverage ceases. You may also request a certificate of creditable coverage before losing coverage, or within 24 months after losing coverage, by contacting the Administration Office. A written request for a certificate of creditable coverage must be mailed to the Administration Office and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address for the Administration Office is on the ***Quick Reference Chart*** in the front of this Booklet. A copy of the certificate will be mailed by the Plan to the address indicated.

IN CASE OF DISABILITY

If, while eligible under this Plan, you become unable to work as a result of a certified disability, the time lost because of a disability will be counted as time worked at the rate of 27 hours for each week of disability starting with the third full week of disability for up to a maximum of 26 weeks. No more than 105 hours will be credited to your Hour Bank in any calendar month, or a total of 630 hours for any one disability period. Proof of such disability shall be established by a receipt of Weekly Income for Disability Benefits as provided under this Plan, or by receipt of Workers' Compensation benefits.

If you suffer a second disability which occurs while receiving extended disability coverage, and the second disability is unrelated to the original disability, the Plan will only extend your coverage for the period you are considered disabled from the original Illness or Injury.

If you suffer a second disability which occurs after you return to work for a minimum of one hour, the disability will be considered a new disability if it is different and unrelated to the original Illness or Injury. You will be eligible to have hours credited for a new 26-week maximum period. If, however, the second disability is related to the original disability and occurs within 90 days from your return to work, the disability will be considered a successive period of disability and the maximum coverage extension for the second disability will be reduced by the length of extended coverage provided for the original disability. In no event will hours be credited for more than 26 weeks for the original and second disability combined.

REINSTATEMENT OF ELIGIBILITY

You must reinstate eligibility, as described below, within 8 months to avoid meeting the initial eligibility requirement again.

If coverage terminates because your Hour Bank has less than 105 hours, the balance of your hours (if any) will be carried for 6 months. If, during that 6-month period you work and add hours to your account, your eligibility will be reinstated on the first day of the second month following the month in which your Hour Bank account has accumulated a total of 105 hours.

> **For example**: If your last month of coverage was in August 2006 and your Hour Bank drops below 105 hours, the last month you could be reinstated through additional hours credited to your Hour Bank would be April 2007. In this example, the 6-month period to work and add hours to your Hour Bank account would include hours worked through February 2007. If you worked enough hours in February 2007 to bring your Hour Bank up to 105 hours, then March 2007 would be the lag month and coverage would be reinstated as of April 1, 2007.

If you do not reinstate your coverage during the eight-month period following termination, the balance of your hours (if any) will be forfeited and you must re-satisfy the provisions of Initial Eligibility in order to be covered by the Plan.

BENEFITS AFTER TERMINATION OF COVERAGE (EXTENDED COVERAGE)

A Totally Disabled individual will continue benefits after termination of eligibility if Covered Expenses are incurred during:

- a period of Hospital confinement existing on the date of termination or commencing within 90 days thereafter; or
- the calendar year of termination and the next following calendar year.

Notwithstanding the foregoing, benefits terminate if the Plan terminates.

For the individual to qualify, the total disability must be continuous from the date of termination to the date of treatment or service and the Covered Expenses must be incurred as a result of the disabling Injury or Illness existing on the date of termination.

"Totally Disabled," with respect to an Active Employee, means the individual is unable to perform any and every duty of his occupation, is not engaged in any activity for wages or profit, and is unable to engage in any employment which he may be able to perform based on his training, experience and abilities.

"Totally Disabled," with respect to a Dependent means that the individual is prevented from performing all regular and customary activities usual for a person of similar age and family status.

DEPENDENTS' ELIGIBILITY

Your eligible Dependents include:

- The lawful spouse of an Employee or Retired Employee (even if legally separated). The spouse must be legally married to the Employee or Retired Employee as determined under federal law, and must be treated as a spouse under the Internal Revenue Code.
- An unmarried child of an Employee or Retired Employee who satisfies the following requirements:

1) The child is a natural child, stepchild, adopted child, or child "placed for adoption." The term "placed for adoption" means the assumption and retention by the Employee or Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption.

   A child will also include an individual for whom the Employee or Retired Employee has been appointed legal guardian, provided the child resides with and is a member of the household of the Employee or Retired Employee on a full-time basis and the other requirements in this section are satisfied.

2) The child resides with the Employee or Retired Employee for more than one-half of the year. If the parents are divorced, legally separated or live apart and the Employee or Retired Employee is not the custodial parent, then this requirement is satisfied if the child receives over one-half of his support during the year from his parents, and the child is in the custody of one or both parents for more than one-half of the year.

3) The child is younger than 19 years of age; or is age 19 but less than 24 years of age and a full-time student at an accredited educational institution (must be a student in the spring quarter to have continued coverage in the summer). The child must remain dependent on the Employee or Retired Employee for support and maintenance; or older than the limiting age and unable to engage in any substantial gainful activity by reason of a mental or physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, provided the child was an eligible Dependent and so handicapped at the time of reaching the limiting age, and remains dependent upon the Employee or Retired Employee for support and maintenance. Evidence of the child's dependency and incapacity must be filed with the Board within 31 days after attaining the limiting age, and periodically thereafter. The Plan, at its own expense, has the right to designate a Physician to examine the Dependent when and so often as the Plan may reasonably require.

4) The child has not provided over one-half of his own support for the year.

- Eligibility will also be provided, as discussed below, to a child required to be recognized under a qualified medical child support order under ERISA Section 609(a)(2)(A).

Enrollment of Newly Acquired Dependents is Required. If you acquire a new Dependent through marriage, birth or adoption, you should contact the Administration Office within 31 days and request a new Enrollment Form. Any required documentation, such as marriage certificate or birth certificate must be provided as soon as it is available.

Your Dependents become eligible on the effective date of your eligibility, or if later, the date the Dependent is acquired. The effective date for newly acquired Dependents is as follows:

- Spouse - on the date of marriage to the Employee.
- Child - on the date of birth; or on the date an adopted child is placed in your custody; or the date you become stepparent of the child; or the date you are appointed the legal guardian.

If a **retiree** fails to notify the Administration Office within 31 days of the marriage, the spouse will not be allowed to enroll in this Plan unless he/she qualifies under the Special Enrollment Rules described under the rules for retiree coverage. You must also pay the additional required premium.

TERMINATION OF DEPENDENTS' ELIGIBILITY

Your Dependents' eligibility terminates on the earliest of the following occurrences:

- On the date your coverage ends; or
- On the last day of the month he or she no longer qualifies as a Dependent, as defined above; or
- On the date the Dependent fails to submit to any required medical examination or provide proof of incapacity requested by the Plan;
- In the case of your death, at the end of the month preceding the month in which your Hour Bank totals less than 105 hours; or
- On the date the Plan terminates.

If you have any questions concerning your eligibility for coverage, you should contact the Administration Office.

CONTINUATION OF ELIGIBILITY FOR DEPENDENTS IN THE EVENT OF THE DEATH OF AN ACTIVE EMPLOYEE

The surviving Dependents of a deceased Employee may continue Medical, Vision, Hearing Aid and Dental benefits for the duration of the Employee's Hour Bank eligibility.

Coverage for your Dependents will terminate sooner in the event of one of the following occurrences:

- remarriage of the surviving spouse; or
- your Dependent ceases to be a Dependent as defined under this Plan.

When the Employee's Hour Bank eligibility has been exhausted, the surviving Dependents may choose to continue certain health benefits under COBRA Continuation Coverage. Please refer to the **COBRA CONTINUATION COVERAGE** section of this Booklet for more information.

If an Employee dies prior to retirement and he or she was eligible for retirement and Retired Employee coverage at the time of death, the surviving spouse and Dependents may apply to self-pay for Retiree coverage. Coverage includes Medical, Vision and Hearing Aid benefits. Premiums must be received by the Administration Office on the 15th of the month prior to the month of coverage. Contact the Administration Office for information regarding self-payments.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls Dependent children as directed by the Order. A Qualified Medical Child Support Order is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an Administration agency under applicable state law which:

- provides child support or health benefit coverage to a Dependent child, or
- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the Employee does not enroll the Dependent child, then the non-Employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Employee and the name and mailing address of each Dependent child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such Dependent child,
- the period of coverage to which the Order applies, and
- the name of each plan to which the Order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No eligible Dependent child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

When a Qualified Medical Child Support Order is Received: If a proposed or final order is received, the Administration Office will notify the Employee and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order."

Within a reasonable time, the Employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party(ies) filing the order will be given an opportunity to correct the order or appeal the decision through the Claim and Appeal Procedures explained in this Booklet. If the order is qualified, the notice will give instructions for enrolling each child named in the order.

A copy of the entire Qualified Medical Child Support Order and any required self-payments must be received prior to enrollment. Any child(ren) enrolled pursuant to an order will be subject to all provisions applicable to Dependent coverage under the Plan.

ELIGIBILITY FOR RETIRED EMPLOYEES AND THEIR DEPENDENTS

ELIGIBILITY

A former Employee must satisfy either condition 1) or 2) and either 3) or 4) to be eligible for coverage from the Plan as a Retired Employee:

1) You had eligibility under this Trust for 30 of the last 60 months immediately prior to your retirement date; or
2) You had eligibility under this Trust for 60 of the last 120 months immediately prior to your retirement date. Up to 18 months of Northwest Ironworkers Retirement Trust pension credit, or pension credit from a reciprocal retirement trust may be used to satisfy this test, which is calculated on the basis of one month's credit for every 100 hours of credited pension service earned, with no more than 1,200 hours counted in any single Plan Year; and
3) You are receiving a Service, Normal, Early or Disability Retirement benefit from the Northwest Ironworkers Retirement Trust or the Alaska Ironworkers Retirement Trust (including a reciprocal pension); or
4) You have attained age 55 and have had Active eligibility under this Trust for a total of at least 120 months immediately prior to your retirement.

Your self-pay retiree coverage will begin on the later of:

- the first of the month following your retirement date, or
- the first of the month following termination of eligibility as an Active Employee under this Plan.

If you elect Retiree coverage, you and your eligible Dependents will be covered for Medical and Vision benefits. Life Insurance, AD&D, Weekly Income and Dental benefits described in this Summary Plan Description cease when your coverage under the Active Plan terminates.

As an alternative, Retirees have the option to continue Active eligibility for a limited time period of 18 months for themselves and their Dependents on a self-pay basis under COBRA Continuation Coverage. Upon exhaustion of COBRA, the Retiree and any eligible Dependents may enroll in Retiree coverage. Refer to the **COBRA Continuation Coverage** section of this Booklet.

ENROLLMENT AND SELF-PAYMENTS FOR COVERAGE

You must apply for Retiree coverage by the first day of the month after eligibility as an Active Employee terminates, or 31 days following written approval of pension benefits by the applicable Retirement Trust. Premiums must be received by the Administration Office on the 15th of the month prior to the month of coverage. You may arrange with the Administration Office to have the self-payments automatically deducted from your monthly pension payments. Please note: **self-payment rates are subject to change as required by the Plan.**

SUSPENSION OF ELIGIBILITY

Eligibility may be suspended and the monthly payment shall not be required during any month of eligibility as an Active Employee under the Plan or as an Active Employee under the Intermountain or California Ironworkers Health Trusts, provided that the monthly payment for Retired Employee eligibility is timely and paid for the month immediately preceding the month eligibility as an Active Employee commences, and is timely resumed for the month in which coverage as an Active Employee ceases.

LATE ENROLLMENT

This Plan does not offer a late enrollment provision. See the Special Enrollment Rules in the following provision.

SPECIAL ENROLLMENT RULES

If a Retired Employee chooses not to enroll on the date first eligible because the Employee or a Dependent had other health coverage under another health insurance policy or program (including any COBRA Continuation Coverage, individual insurance or a public program such as Medicaid), and the Retired Employee or a Dependent cease to be covered by that other coverage, the Retired Employee and any eligible Dependents must request enrollment in this Plan within 31 days after termination of the other coverage if the other coverage terminated due to any of the following reasons:

- The loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation;
- The termination of employer contributions toward the other coverage;
- If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is "exhausted" if it ceases for any reason other than failure to pay premiums on a timely basis;
- HMO coverage terminated because you moved out of the service area and, for group coverage, no other option is available under the other plan;
- The other plan ceased to offer coverage to a group of similarly situated individuals;
- The loss of dependent status under the other plan's terms;
- The termination of a benefit package option under the other plan, unless substitute coverage was offered; or
- The loss of eligibility due to reaching the lifetime benefit maximum on all benefits under the other plan. For Special Enrollment that arises from reaching a lifetime benefit maximum on all benefits, an individual will be allowed to request Special Enrollment in this Plan within 31 days after a claim is denied due to the operation of a lifetime limit on all benefits.

If a Retired Employee is enrolled for coverage and acquires a new Dependent (Spouse or child), the Retired Employee must enroll the newly acquired Dependent within 31 days after the date the new Dependent is acquired, unless the newly acquired Spouse has other coverage. If that other coverage is later lost the spouse may enroll in this Plan under the Special Enrollment rules described above.

If a Retired Employee, after declining coverage, acquires a new Dependent (spouse or child), the Retired Employee may enroll himself and the newly acquired Dependent(s) within 31 days after the date the new Dependent(s) is acquired.

Provided special enrollment is received by the Plan within 31 days after termination of the other coverage or the date a Retired Employee acquires a new Dependent. The effective date is as follows:

- For a Retired Employee, coverage is effective the first of the month after special enrollment is received by the Plan.
- For a new Dependent acquired by marriage, coverage is effective on the date of marriage to the Retired Employee.
- For a newborn Dependent, coverage is effective retroactively to the date of birth. For an adoption or placement for adoption, the effective date is the date of adoption or placement.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, as are available to similarly-situated employees.

TERMINATION OF YOUR ELIGIBILITY

Coverage for you and your Dependents ends on the earliest of:

- The last day of the month for which no self-payment is received on your behalf;
- On the date the Plan no longer provides benefits for Retired Employees; or
- The Plan terminates.

CONTINUATION OF ELIGIBILITY FOR DEPENDENTS IN THE EVENT OF DEATH OF A RETIRED EMPLOYEE

In the event of your death, your eligible Dependents remain covered until the earliest of:

- Remarriage of the surviving spouse; or
- Your Dependent ceases to be a Dependent as defined under this Plan; or
- The required monthly self-payment is not made by the 15th of the month before the month of coverage.

Once coverage terminates, it cannot be reinstated.

BENEFITS AFTER TERMINATION OF COVERAGE (EXTENDED COVERAGE)

A Totally Disabled individual will continue benefits after termination of eligibility if Covered Expenses are incurred during:

- A period of Hospital confinement existing on the date of termination or commencing within 90 days thereafter; or
- The calendar year of termination and the next following calendar year.

Notwithstanding the foregoing, benefits terminate if the Plan terminates.

For the individual to qualify, the total disability must be continuous from the date of termination to the date of treatment or service and the Covered Expenses must be incurred as a result of the disabling Injury or Illness existing on the date of termination.

"Totally Disabled," with respect to a Retired Employee or a Dependent, means that the individual is prevented from performing all regular and customary activities usual for a person of similar age and family status.

COBRA CONTINUATION COVERAGE

CONTINUATION COVERAGE (COBRA)

Pursuant to a federal law known as COBRA, and under the circumstances described below, you and your Dependents each have an independent right to elect to continue your health coverage beyond the time coverage would ordinarily have ended. You or your spouse may elect COBRA on behalf of other eligible family members. A parent or legal guardian may elect COBRA on behalf of a minor child.

NOTICES TO TRUST CONCERNING COBRA

The Administration Office is responsible for administering COBRA continuation rights for the Plan. All communications must be made in writing, and identify the Employee or Retiree and the individual requesting COBRA, the Plan's name, and the qualifying event. Communications must be sent to the Administration Office at the address listed in the ***Quick Reference Chart***.

QUALIFYING EVENTS

COBRA coverage is available if you or your Dependents lose coverage because of specific qualifying events. You have the right to elect continuation coverage if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your Dependent spouse has the right to choose continuation coverage if he or she would otherwise lose eligibility for any of the following reasons:

- Your termination of employment or reduction in hours of employment;
- Your death; or
- Your divorce from your spouse.

A Dependent child has the right to elect continuation coverage if eligibility would otherwise be lost for any of the following reasons:

- Your termination of employment or reduction in hours of employment;
- Your death;
- Your divorce from your lawful spouse; or
- The child no longer qualifying as an eligible Dependent under the Plan.

NOTICE OF QUALIFYING EVENT

The Plan offers continuation coverage only after it has been notified of a qualifying event. You or your eligible Dependents have the responsibility to inform the Administration Office of a loss of coverage resulting from a divorce or legal separation or a child losing Dependent status. You or your eligible Dependents must provide this notice to the Administration Office in writing within 60 days of the later of: the date of the qualifying event; the date coverage would be terminated as the result of the qualifying event; or the date you are first provided this notice, or another notice describing the procedure for electing continuation coverage. Notice of the qualifying event must identify the individual who has experienced the qualifying event; the Employee or Retired Employee's name, if different; the qualifying event that occurred; and the Plan. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan, and you and your Dependents will lose the right to elect continuation coverage.

Your employer is responsible for informing the Plan of any other qualifying event. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

ELECTION OF COBRA

Once the Administration Office has received proper notice that a qualifying event has occurred, it will notify you and your eligible Dependents of the right to elect continuation coverage. A written election must be sent to the Administration Office at the address listed on the ***Quick Reference Chart***, and be postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished.

Failure to elect continuation coverage within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan, and you and your Dependents will lose the right to elect continuation coverage.

AVAILABLE COVERAGE

The continuation coverage offered is the same as provided to current participants of your employer.

You and/or your eligible Dependents may elect the following coverage options:

1) Medical and Prescription Drug
2) Medical, Prescription Drug, Life, and AD&D
3) Medical, Prescription Drug, Dental, Vision
4) Medical, Prescription Drug, Vision
5) Medical, Prescription Drug, Dental, Vision, Life and AD&D

Dependents of Active Employees may elect to continue options (1) or (3) only. Dependents of Retirees may elect to continue option (1) or (4) only. Once the coverage option is selected, it cannot be changed.

Continuation coverage is not available for weekly income benefits.

ADDING NEW DEPENDENTS

COBRA is only available to individuals who were eligible under the Plan at the time of the qualifying event. However, if you elect COBRA and acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may add the new Dependent to your COBRA coverage by providing written notice to the Administration Office at the address listed in the ***Quick Reference Chart***, within 31 days of acquiring the new Dependent. The written notice must identify the Employee or Retired Employee, the new Dependent, and the date the new Dependent was acquired. A copy of the marriage certificate, birth certificate or adoption papers must be included with the written notice. If timely written notice is not provided to the Administration Office, you will not be entitled to add a new Dependent.

Children acquired through birth, adoption or placement for adoption who are timely enrolled in continuation coverage are entitled to extend their continuation coverage if a second qualifying event occurs, as discussed below.

CONTINUOUS COVERAGE REQUIRED

Your coverage under COBRA must be continuous from the date your Plan coverage would have ended if monthly self-payments were not made.

COST

There is a cost for continuation coverage. The cost for the coverage available through the Plan is set annually. Information regarding the cost will be sent with the election forms. If you or your Dependents are eligible for a disability extension of continuation coverage, discussed below, the cost of the coverage may be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your or your Dependent's disability.

MONTHLY SELF-PAYMENTS REQUIRED

You or your eligible Dependents are responsible for the full cost of continuation coverage. All payments must be sent to the Administration Office at the address listed in the ***Quick Reference Chart***.

The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Eligibility for continuation coverage will not commence, nor will claims be processed until the initial payment has been made. You or your Dependents will lose the right to continuation coverage if the initial payment is not postmarked or received by the Administration Office by the due date.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. Continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

LENGTH OF CONTINUATION COVERAGE

Continuation coverage may last for up to 18 months following loss of coverage that results from a termination of employment or reduction in hours. If regular plan coverage was extended due to the Employee's disability, the maximum continuation period will be 18 months less the number of months of the extended disability coverage. The 18-month period may be extended as provided below for "Disabled Individuals," "Second Qualifying Event," and "Medicare Entitlement."

For all other qualifying events, (death of the Employee or divorce from the Employee or Retiree, or a child no longer qualifying as a Dependent under the Plan) continuation coverage may last for up to 36 months.

Continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not postmarked or received by the Administration Office on a timely basis for the next monthly coverage period;
- You or your eligible Dependent become covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage). You are required to notify the Administration Office when you become eligible under another group health plan;
- You or your eligible Dependent provide written notice that you wish to terminate your coverage;
- You or your eligible Dependent become entitled to Medicare after the date of the election of COBRA; or
- The Plan terminates, or the Employee's employer no longer participates in the Plan, unless the employer or its successor does not offer another health plan for any classification of its employees who formerly participated in the Plan.

LENGTH OF CONTINUATION COVERAGE – DISABLED INDIVIDUALS

If you or your eligible Dependent is determined by the Social Security Administration to be disabled either before an 18-month qualifying event, or within the first 60 days of continuation coverage, you and your eligible Dependents can extend COBRA for up to an additional 11 months beyond the original 18 months, up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Administration Office in writing within 60 days of the later of your qualifying event; or the receipt of your Social Security Disability Determination, but prior to the end of your initial 18-month period of continuation coverage. A copy of the Social Security Disability Determination must be included with the

written notice. If the disabled individual is subsequently found not to be disabled, you must notify the Administration Office within 30 days of this determination.

Continuation coverage will end on the earlier of 29 months from the loss of coverage, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

LENGTH OF CONTINUATION COVERAGE – SECOND QUALIFYING EVENT

Eligible Dependents who are entitled to continuation coverage as the result of an Employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs which is the Employee's death or a divorce from the Employee or Retiree, or a child losing Dependent status.

If an eligible Dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. Failure to give such timely written notice of a second qualifying event will cause the individual to lose the right to extend COBRA. In no event will continuation coverage extend beyond a total of 36 months.

LENGTH OF CONTINUATION COVERAGE - MEDICARE ENTITLEMENT

If you have an 18-month qualifying event after becoming entitled to Medicare, your Dependents may continue COBRA coverage until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction of hours; or
- 36 months from the date you become entitled to Medicare.

RELATIONSHIP BETWEEN COBRA AND MEDICARE OR OTHER HEALTH COVERAGE

Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If your Medicare or other group health coverage already existed when you elected COBRA, however, you can be eligible for both.

If you have Plan coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Plan will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for less than six months. If you have Medicare coverage based on end stage renal disease and have Plan coverage (based on COBRA or otherwise), the Plan will pay primary during the 30-month coordination period provided for by statute.

Retirees and their spouses are expected to enroll in Medicare Part A and Part B when first eligible. Even if you retire and elect COBRA continuation coverage in lieu of Retiree benefits you must enroll in Medicare Part A and Part B. If you are eligible to enroll in Medicare Part A and Part B benefits are provided by the Plan as if you are enrolled regardless of whether you actually did enroll.

If you have other group health coverage, it will pay primary and the Plan's continuation coverage will be secondary.

EFFECT OF NOT ELECTING CONTINUATION COVERAGE

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law: (1) pre-existing condition exclusions

under a future group health plan may apply if you have more than a 62-day gap in health coverage, and electing continuation coverage may help you avoid such a gap; (2) you can lose the right to purchase guaranteed individual health coverage that does not impose a pre-existing condition exclusion if you do not obtain continuation coverage for the maximum time available to you; and (3) you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 31 days after your group health coverage from the Plan ends because of your qualifying event. You will also have the same special 31-day enrollment right at the end of the maximum continuation coverage period available to you.

ALTERNATIVE COVERAGE

There is no conversion option available for medical, prescription drug, dental, vision or AD&D benefits provided by the Plan. However, the Plan offers certain other alternatives which may be elected in lieu of COBRA continuation coverage.

There is a conversion option for Life Insurance benefits, provided you complete the application form and send it to the Plan's Life Insurance provider with the first premium payment within 31 days of the termination of the Plan's Life Insurance benefits. See the Life Insurance section for details.

If the Employee becomes unable to work as a result of a certified disability, coverage may be extended for up to 26 weeks for the Employee and Dependents. Consult the section, "In Case of Disability" for details about this coverage. Following termination of extended disability coverage, you may elect COBRA, however, the maximum COBRA continuation coverage period will be reduced by the number of months of extended disability coverage.

If you leave employment with a contributing employer for military service, you may elect to continue coverage for up to 24 months in accordance with the Uniform Services Employment and Reemployment Rights Act ("USERRA"). Consult the section on "Continued Coverage While in Uniformed Service" for details.

If you qualify for both COBRA continuation coverage and Retiree benefits, you and your eligible Dependents may elect COBRA in lieu of Retiree benefits. Following termination of COBRA, you and your Dependents may apply for Retiree benefits. However, if COBRA continuation coverage is declined in favor or Retiree benefits, COBRA may not thereafter be elected, unless there is a new qualifying event.

ADDITIONAL INFORMATION

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration or visit its website at www.dol.gov/esba.

To help ensure you receive necessary notices, you should notify the Administration Office if your address or that of any family member changes.

The Trade Act

The **Trade Adjustment Assistance Reform Act of 2002** (also called the Trade Act) creates a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called eligible individuals).

- Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA.
- If you have questions about these new tax provisions call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282 (TTD/TTY: 1-866-626-4282). See also the information about the Trade Act at: www.doleta.gov/tradeact/2002act_index.cfm

RECIPROCITY

Eligibility may be provided under this Plan for Employees who would otherwise lose eligibility because their employment is divided between local union jurisdictions. For purposes of reciprocity, the following definitions apply:

"Employee" means any employee on whose behalf payments are required to be made to a Cooperating Fund by an Employer pursuant to a collective bargaining agreement or other written agreement with a Local Union or District Council of the International Association of Bridge, Structural and Ornamental Ironworkers.

"Employer" means any employer signatory to a collective bargaining agreement or other written agreement providing for contributions to a Cooperating Fund.

"Cooperating Fund" means any health, welfare or insurance fund which by resolution of the Board of Trustees, has approved participation in and executed the Ironworkers International Health and Welfare Reciprocal Agreement or has a signed reciprocity agreement with another health trust.

"Home Fund" has the same meaning as in the Ironworkers International Reciprocal Health and Welfare Agreement. The following rules are used in determining an Employee's Home Fund.

- If the Employee is a member of a local union and he has established eligibility in a Cooperating Fund in which his local union participates, that Cooperating Fund shall be his Home Fund.
- If the Employee is not a member of a local union or if he has not established eligibility in a Cooperating Fund, his Home Fund shall be the Cooperating Fund which has received the largest amount of contributions on his behalf in the preceding twelve (12) month period.

POINT-OF-CLAIM RECIPROCITY

Transfer of Contributions for Employment Outside Home Fund Jurisdiction. If an Employee is working in the jurisdiction of a Cooperating Fund other than his Home Fund, and he is not eligible for benefits from the Cooperating Fund, he will continue to file all claims incurred with his Home Fund for so long as he remains eligible in his Home Fund. If he is not eligible in his Home Fund, but is eligible in another Cooperating Fund, such claim should be filed with that Cooperating Fund. If the Employee is not eligible in any Cooperating Fund, then the claim should be filed with his Home Fund which shall contact the other Cooperating Funds in whose jurisdiction the Employee worked to determine if a transfer of contributions will reinstate the Employee's eligibility in his Home Fund at the time the claim was incurred. If a transfer will make the Employee eligible in his Home Fund the contributions shall be transferred as explained below.

Transfer of Contributions to Home Fund. Upon request by a Home Fund to another Cooperating Fund in whose jurisdiction an Employee has worked, the Cooperating Fund will transfer all Employer contributions made on the Employee's behalf back to his Home Fund. The amount of contributions transferred will be based on all of the Employee's hours of work up to and including the month in which the claim was incurred during the eligibility period set forth in the Home Fund's plan. Such hours shall be multiplied by the contribution rate of the transferring Cooperating Fund. Upon transfer of hours and contributions, such hours transferred will not be used for determining future eligibility for the Employee under the Cooperating Fund's rules.

Hours and contributions shall first be transferred from the Cooperating Fund in whose jurisdiction the Employee was working when the claim was incurred. If those hours and contributions do not result in establishing the Employee's eligibility on the basis of hours, then contributions shall be transferred from

all other Cooperating Funds in reverse order of employment until eligibility is established within the Home Fund's eligibility period.

Upon transfer of contributions by a Cooperating Fund in connection with an Employee's claim, the hours represented by contributions transferred will not be included in a determination of eligibility for benefits for that Employee under the Cooperating Fund's rules. However, subsequent hours worked, but not transferred, in the jurisdiction of the Cooperating Fund will be used in the determination of an Employee's eligibility for benefits.

Designation of New Home Fund. If an Employee changes his membership from one local union to another local union, his Home Fund will be the Cooperating Fund in the jurisdiction of his new local union. Claims incurred by the Employee will be filed with his new Home Fund if he is eligible under the new Home Fund. If he is not eligible in his new Home Fund, but is eligible in his prior Home Fund, claims will be filed with his prior Home Fund. If he is not eligible in either his new Home Fund or the prior Home Fund, but would be eligible in the new Home Fund if contributions were transferred from his prior Home Fund, the contributions will be transferred to the new Home Fund as explained below.

Transfer of Contributions to New Home Fund. Upon a request from a new Home Fund to a prior Home Fund, the prior Home Fund will transfer Employer contributions made on the Employee's behalf to the new Home Fund. The amount of contributions transferred will be based on the Employee's actual hours of work during the period that will establish his eligibility in the new Home Fund for the claim he has incurred. However, such hours will be limited to those worked after the date on which the Employee lost eligibility in his prior Home Fund. In any event, such hours will not include an Employee's hours in an "hour bank" arrangement. Such hours will be multiplied by the contribution rate to be transferred.

Information To Be Transferred. The transfer of hours and contributions must be made within thirty (30) days of the date requested by the Home Fund or the new Home Fund.

MONEY-FOLLOWS-THE-MAN-RECIPROCITY

"Money-follows-the-man reciprocity" will only apply if both the Employee's Home Fund and Cooperating Fund have adopted the Point-of-Claim and Transfer of Contributions Exhibits of the Ironworkers International Reciprocal Health and Welfare Agreement.

Employee Authorization. If contributions are or will be made on an Employee's behalf to a Cooperating Fund, the Employee may request that the Cooperating Fund transfer the contributions to the Home Fund. The request must be made in writing on a form approved by the Cooperating Fund and Home Fund, and must be signed and dated by the Employee. The request shall release the Boards of Trustees of the Cooperating Fund and the Home Fund from any liability or claim by an Employee, or anyone claiming through him, that the transfer of contributions may not work to his best interest. The completed request form will be filed by the Employee with the Cooperating Fund within sixty (60) days following the beginning of his employment within the Cooperating Fund's jurisdiction, unless the Cooperating Fund, in its discretion, grants an extension of that sixty (60) day period for special circumstances.

If the Employee does not file a timely request form with the Cooperating Fund, he will be treated as electing not to authorize a transfer of contributions and the point-of-claim provisions of the Cooperating Fund's plan shall apply to the Employee. By filing a request for transfer of contributions, the Employee agrees that his eligibility for benefits and all other participant rights are governed by the terms of the Home Fund's plan and not by the terms of the Cooperating Fund's plan.

Transfer of Contributions. Upon receipt of a timely and properly completed request for a transfer of contributions to the Employee's Home Fund, the Cooperating Fund will collect and transfer to the Employee's Home Fund the contributions required to be made to the Cooperating Fund on the Employee's behalf. The contributions will be forwarded to the Employee's Home Fund within sixty (60) calendar days following the calendar month in which the contributions were received. Any delay in transferring contributions is considered a violation of the Ironworkers International Health and Welfare Reciprocal Agreement and subject to its provision for arbitration. The contributions transferred will be accompanied by such records or reports which are necessary or appropriate. The Cooperating Fund shall transfer the actual dollar amount of contributions received regardless of any difference in the contributions rates between the funds.

Eligibility. The Board of Trustees of each Home Fund will be responsible for determining whether an Employee is eligible to receive benefits under the Home Fund's plan based on the Home Fund's eligibility rules and a uniform application of how such transferred contributions should be credited. When contributions are transferred to this Plan, hours will be prorated based upon the contribution rate of this Plan and the contribution rate of the Cooperating Fund.

Acceptance of Contributions After Retirement. The Plan will not accept contributions from any Cooperating Fund for hours worked by an Employee after he becomes eligible for benefits from this Plan as a Retired Employee.

COMPREHENSIVE MEDICAL BENEFITS FOR ACTIVE AND RETIRED EMPLOYEES AND THEIR DEPENDENTS

PREFERRED PROVIDER PROGRAM

The Plan has contracted with a national preferred provider organization (PPO) that has developed and maintained a network of Preferred Providers (Physicians and Hospitals) that have agreed to provide you and your Dependents with Medically Necessary professional services at special negotiated discounted rates. These rates reduce the cost to you and the Trust. Your out-of-pocket expense is less when you use Preferred Providers.

The name and telephone number for the PPO network can be located on the ***Quick Reference Chart***. A Preferred Provider Directory is available, without charge, as a separate document. You may call the Preferred Provider Organization to obtain a Directory or go to the Premera Blue Cross website: www.premera.com.

Not applicable to Medicare eligible Retirees: If a Retired Employee and/or his dependent spouse are eligible for Medicare, the Plan does not require them to use PPO doctors and hospitals. The Plan will pay remaining Covered Charges after it receives a ***Medicare Explanation of Benefits***.

Your Comprehensive Medical Benefit provides coverage of Covered Expenses incurred for a non-occupational Illness or Injury, and is subject to a deductible and coinsurance provision that applies to each participant each calendar year. The Comprehensive Medical Benefit has been structured to provide an incentive to use a Preferred Provider.

You should also know the exclusions and limitations of the Comprehensive Medical Benefit. Some of these exclusions and limitations are described with the Plan benefits; others are described in the **General Exclusions and Limitations** section of this Booklet.

EXCEPTIONS TO PPO HANDLING

Exception for Out-of-Area Use of Non-Preferred Hospitals and Other Medical Providers: If you reside outside of an area covered by a Preferred Hospital or other medical provider and are admitted to the closest Non-Preferred Hospital or receive services from the closest non-Preferred medical provider for a covered Illness or Injury, benefits will be payable at the Preferred level. The Plan will consider that you reside out-of-area if there is no Preferred Hospital or Preferred Medical Provider within a 20-mile radius of your home.

Exception for Use of Non-Preferred Hospitals and Non-Preferred Medical Providers for Specialized Services: If you reside within an area covered by a Preferred Hospital but require specialized services only available at a Non-Preferred Hospital or from another non-PPO medical provider, benefits will be payable at the Preferred Provider level if you are admitted to a Non-Preferred Hospital or receive services from a non-PPO medical provider, provided you or your Physician obtains preauthorization from the Trust's Hospital Utilization Management Organization.

Exception for treatment and services provided by a Non-PPO Physician in the emergency room of a PPO Hospital: If you are treated by a Non-PPO Physician while you are in the emergency room of a PPO hospital, benefits will be payable at the PPO benefit level.

Exception for Non-PPO Anesthesiologist or Assistant Surgeon: Covered Expenses for treatment and services provided by a Non-PPO anesthesiologist or assistant surgeon at a PPO Hospital or a PPO free-standing surgical facility will be payable at the PPO level, provided that the surgeon is a PPO provider.

Exception for Ambulance: Covered Expense for Ambulance services to transport a patient who requires paramedic support to a hospital due to sudden onset of Illness or following an Accidental Injury will be payable at the PPO level.

OVERVIEW OF THE MEDICAL (PPO) PLAN DESIGN

Deductibles	Coinsurance Maximum	Lifetime Maximum
The deductible is the amount you must pay each calendar year before the Plan pays benefits. **The following services do not apply toward the deductible:** • Routine physical exam (applies to active employee and retired employee only) • Office visit (including a visit to a specialist) with a network provider. • Hearing aids • Prescription drugs obtained through the outpatient prescription drug plan. • Chemical dependency treatment • Supplemental accident benefit • The additional $250 penalty applied as a result of not obtaining preauthorization review prior to a Hospital admission. • Colonoscopy and sigmoidoscopy screenings. See also the Common Accident Benefit row of the Schedule of Medical Benefits. The deductible does not apply to certain benefits as outlined on the Schedule of Medical Benefits	The coinsurance maximum refers to how you and the Plan will split the cost of certain covered medical expenses, after the deductible is met. **The following services do not apply toward the coinsurance maximum:** • Skilled Nursing Facility • Supplemental Accident benefits • Common Accident Benefit • Hearing Aids • Routine Physical exams (for active employee and retired employees only) • Retail and Mail Order Prescription Drugs • Chemical Dependency treatment • Non-covered services and charges exceeding UCR • The additional $250 penalty applied as a result of not obtaining a preauthorization review prior to a Hospital admission.	The lifetime maximum Plan benefit is the most this Plan will pay for all Covered Expenses for any person. Note that Outpatient Prescription Drug Plan benefits do not accumulate to meet the lifetime maximum plan benefit. **Lifetime Maximum Reinstatement Provision**: An amount equal to the benefits paid up to $1,000 per person will be reinstated on January 1 of each year.
$350/person $1,050/family Note that services from PPO and non-PPO providers are combined to meet your annual deductible amount. Note that chemical dependency inpatient services have a separate $500 deductible/ person. Note: $20 copayment credited towards the deductible and co-insurance maximum	After deductibles are met, you are responsible to pay for **25% (PPO)** or **50% (Non-PPO)** of the first $50,000 of eligible expenses each calendar year, per person, including copayments. Once your coinsurance maximum is met the Plan pays 100% of most covered Eligible Expenses and copayments are no longer assessed. **In-Network**: Plan pays 75% You pay 25% **Out-of-Network:** Plan pays 50% You pay 50%	**Lifetime Maximum Plan Benefits:** $1 million per person per lifetime **Benefit Maximums (including annual and limited benefits):** See the Schedule of Medical Benefits for details.

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.

All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Hospital Services (Inpatient) • Room and board facility fees in a semiprivate room with general nursing services. • Specialty care units (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Hospital Charges for well baby nursery care are covered on the same basis as other Hospital care. Coverage is provided for nursery services and miscellaneous Hospital services for a well baby from birth until release from the Hospital. Any charges incurred after a reasonable period of Hospital confinement, which are solely for the convenience of the parent, will not be covered by the Plan.	• **All Hospitalization is subject to preauthorization except for emergency and maternity stays less than 48 hours (or 96 hours as applicable).** See the section titled "Hospital Preadmission Authorization Program" for details. – Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. – Under certain circumstances the medical benefits will be provided for the facility fees and anesthesia associated with Medically Necessary dental services covered under Dental benefits if the patient is a child (age 6 and under) if it is determined that the care is needed to safeguard the health of the patient during performance of dental services.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Physician and Other Health Care Practitioner Services • Benefits are payable for professional fees when provided by a Physician or other covered health care practitioner in an office, hospital, emergency room (ER), urgent care facility or other covered health care facility location. • Payable Physicians and health care practitioner professional fees include: – Surgeon; – Assistant surgeon (if Medically Necessary); – Anesthesia provided by Physicians and certified registered nurse anesthetists; – Pathologist; radiologist; – Nurse practitioner; nurse midwife (licensed or certified midwife who is also a licensed registered nurse and who has privileges at an accredited Hospital or birth center), Registered graduate nurse. • Charges of a registered physical therapist required for the treatment of an acute medical condition when prescribed and supervised by a Physician. • Charges of a licensed social worker, licensed mental health counselor or licensed marriage and family therapist for mental health treatment.	• See also the definition of Physician and Optometrist in the Definitions section. • **Assistant surgeon** fees are payable if the use of an assistant was Medically Necessary and the surgical assistance was done by a physician or a physician assistant (PA), the benefit payable will be based on 20% of the PPO Allowed Amount or the Usual, Customary and Reasonable Amount for the corresponding surgeon fees. • An office visit associated with either a routine mammography screening or Pap smear test is covered. • Charges by a Physician, surgeon, assistant surgeon, and anesthesiologist for the performance of a covered operation or the repair of a dislocation or fracture. • For **multiple surgeries performed during the same operative session** which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, as determined by the Administration Office, benefits will be determined as: – 100% of the PPO Allowed Amount or Usual, Customary and Reasonable (UCR) for the primary procedure; – 50% of the PPO Allowed Amount or Usual, Customary and Reasonable (UCR) for the secondary or any additional procedures.	**Office Visit**: 100% after a $20 copay per visit **Lab and x-rays done in conjunction with and billed with an office visit:** 100% **All Other Covered Professional Fees:** 75%	50%

SCHEDULE OF MEDICAL BENEFITS

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician.	75%	50%
Ambulance Services If treatment requires special transportation, benefits will be payable for Medically Necessary transportation by a legally licensed vehicle, helicopter or airplane certified for emergency patient transportation as follows: • **Local ground vehicle transportation** to and from the Hospital or other facility in connection with any one disability. Transportation must be to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness. • **Air transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. Air transportation must be to the closest facility that can treat the patient's condition.	• Expenses for ambulance services are covered only when those services are for an Emergency.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Blood Transfusions • Blood or blood plasma and its administration.	• Covered only when ordered by a Physician. • Expenses related to drawing of blood from the patient for use in his or her own surgery, and blood storage fees are covered.	75%	50%
Chemical Dependency Benefit	• See the specific exclusions related to chemical dependency treatment, in the General Exclusions and Limitations section. • Services for chemical dependency treatment **do not apply toward the medical deductible. Note that chemical dependency inpatient services have a separate $500 deductible for each inpatient admission.** • Chemical dependency treatment is not applied toward the Plan's coinsurance maximum. • All chemical dependency treatment requires authorization for treatment by the Utilization Management coordinator. Failure to preauthorize treatment will result in a benefit **penalty of $250**. • Coverage under this Plan for substance abuse treatment is limited to **$5,000 per course of treatment** (except for **adolescents where maximum benefit per course of treatment benefit is $10,000**). • Benefits are limited to the lesser of **two inpatient courses of treatment but not to exceed a maximum lifetime benefit of $12,000** per Eligible Individual.	**Inpatient 1st course of treatment:** After separate deductible of $500, 90% **2nd course of treatment:** After separate deductible of $500, 65% **Outpatient:** 1st course of treatment 90%. Subsequent courses of treatment 65%	**Inpatient 1st course of treatment:** After separate deductible of $500, 55% **2nd course of treatment:** After separate deductible of $500, 45% **Outpatient:** 1st course of treatment 55% 2nd course of treatment 45%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the chemotherapy is delivered or received by the patient. For example, if chemotherapy is delivered in a Hospital, the Hospital services coverage applies; if it is delivered at home or in a Physician's office, see Physician's and other health care practitioners (above) in this Schedule of Medical Benefits.	75%	50%
Chiropractic Services	• See the row titled **"Complementary and Alternative Medicine"** of this Schedule of Medical Benefits.		
Colonoscopy and Sigmoidoscopy Screenings • Benefits are available to Employees and eligible Dependents **age 50 and over**.	Screening for the detection of colorectal cancer is covered as follows: • **Sigmoidoscopy** – allowed once every 5-years, plus a fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year; **or** • **Colonoscopy** – allowed every 10 years. • **Procedures for treatment of a diagnosed medical condition, see section titled "Physician and Other Health Care Practitioner Services"**	75%, no deductible	50%
Common Accident Benefit	• If two or more eligible family members are **injured in the same accident**, only one deductible will be charged against the combined total Covered Expense resulting from the accident, regardless of the number of family members injured. This combined deductible will also apply to future reapplication of the deductible for such accident • Benefits are not subject to the annual deductible or coinsurance maximum**.** • Benefits may vary depending on the location and type of services received.	See Other Sections	See Other Sections

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Complementary and Alternative Medicine Benefits Covered benefits include services provided by: • a chiropractor for manipulation of the spine and its supporting structures. • a naturopathic acting within the scope of his/her license. • an acupuncturist acting within the scope of his/her license, provided such acupuncture treatment has been recommended by a Physician for pain management based upon the Physician's diagnosis.	• **Not all Alternative Health Care Services are covered.** See the exclusions section for details. • Services are covered only if the Plan Administrator or its designee determines that the practitioner is licensed or duly authorized to practice in the jurisdiction in which the services are provided. • **The annual maximum benefits for all Complementary and Alternative Medicine combined is $1,250 per calendar year (subject to deductible).** • Covered Expenses do not apply toward the coinsurance maximum.	Office Visit: 100% after a $20 copay per visit (subject to deductible) Lab and X-rays done in conjunction with and/or billed with an office visit: 100% All other covered professional fees: 75%	50% of Usual, Customary and Reasonable

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Corrective Appliances, Prosthetic Devices and Durable Medical Equipment • Subject to the limitations and maximum Plan benefits shown in the Explanations and Limitations column. Coverage is provided for Medically Necessary: – rental (but only up to the allowed purchase price of the device). – initial purchase of standard model. – repair, adjustment or servicing of the device or replacement of the device if the existing device cannot be repaired, or replacement is prescribed by a Physician because of a change in physical condition. • Oxygen and the rental of equipment for its administration are covered. – Prosthetic devices and braces (including surgically implanted devices and corrective appliances), excluding replacements or repairs. Benefits will be provided when prosthetic devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. This benefit also covers the first intraocular lens prescribed to replace the lens of an eye.	• Any accrual of charges for the rental of equipment that is in excess of the normal purchase price for that medical equipment is not a Covered Expense. • A **device** used specifically as a safety item or to affect performance primarily in sports-related activity is not a Covered Expense. • Non-durable medical supplies including (but not limited to) ace bandages, gauze and like products, air purifiers, heating pads, bed boards, orthopedic shoes, exercise equipment, special equipment for homes or cars are not Covered Expenses. • **Foot orthotics or other supportive devices of the feet such as braces, splints, insoles and supports** are covered if prescribed by a Physician for the treatment of an Illness or Injury to the foot. Impression casts required for the fitting of these devices are also covered. <u>This benefit is provided to **Active Employees only** and is limited to a maximum lifetime payment by the Plan of $200.</u> • Casts, splints, braces, and crutches are covered.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Corrective Appliances, Prosthetic Devices and Durable Medical Equipment *(continued)*			
• Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired, or replacement is prescribed by a Physician because of a change in physical condition. • Foot orthotics.	• Covered Expenses include durable medical equipment and those supplies which are: – ordered by a Physician; – usable only by the Patient; – of no further use when medical need ends; – not primarily for the comfort or hygiene of the Participant; – not for environmental control; – not for exercise; – manufactured specifically for medical use; – approved as Medically Necessary treatment, as determined by the Trust, and – not for prevention purposes. • Benefits are not provided for electronic prostheses, penile prostheses, or devices directly related to an organ transplant. • Examples of items not covered include, but are not limited to: heating lamps, gym memberships and custom features.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Dental Services payable under the Medical portion of the Plan • See also the row titled "Temporomandibular Joint Dysfunction (TMJ Services)" • Under certain circumstances medical benefits are provided for the facility fees and anesthesia associated with Medically Necessary dental services covered under Dental Benefits if the patient is a child (age 6 and under) and if it is determined that the care is Medically Necessary to safeguard the health of the patient during performance of dental services. Please note the services must be performed in an outpatient facility and not in a dental office.	• Dental services rendered by a Physician or dentist for the treatment of an injury to the jaw or to teeth, including the initial replacement of those teeth and any necessary dental x-rays resulting from an accident, provided the treatment is rendered within six months of the accident. • Charges by a dentist, in excess of any benefits payable under the Dental Benefits section, for Medically Necessary treatment to the teeth, jaw or gums as a direct result of radiographic treatment for cancer, provided the treatment starts within 18 months of the cessation of radiographic or chemotherapeutic treatment and treatment is completed within a one-year period. Treatment which starts after the required 18-month period will be payable if the Plan receives certification from the attending Physician that treatment could not have been started earlier due to the patient's medical condition. Treatment after the 18-month period must start as soon as medically feasible. • Expenses incurred for dental implantology are **not covered**, except when the individual is totally edentulous (without teeth) and the ridge is severely resorbed and cannot support regular dentures or when necessary due to an accidental Injury to teeth provided treatment is done within one year of the injury. • Services provided in a dental office that are covered under the dental provision of the Plan are **not covered** under this provision.	75%	50%
Diabetes Educational Program • Services include teaching the care and management of diabetes for an Eligible Individual or parent of an Eligible Dependent child.	• Must be prescribed by a Physician (for a patient or a parent of a Dependent child patient). • Diabetes educational expenses are payable to a maximum of $500 per lifetime.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Diagnostic X-ray and Lab • Charges for diagnostic X-ray examinations or microscopic or other laboratory tests or analysis made or recommended by a licensed Physician in or out of the Hospital.		100% after a $20 copay per visit	50%
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• **It is important that Eligible Individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age.** See also the Coordination of Benefits section that discusses what this Plan pays when you are also Medicare eligible.	75%	50%
Emergency Room Facility, Urgent Care Facility • Hospital emergency room (ER) facility for a medical Emergency. • Urgent Care facility. • Ancillary charges (such as lab or x-ray) performed **during** the Emergency Room or Urgent care visit. • (See also the Ambulance section of this schedule.)	• **Expenses for Emergency room services are covered.** • **Charges for a Non-PPO Physician who sees an Eligible Individual in the emergency room of a PPO Hospital will be paid at the PPO benefit rate after the deductible.**	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Family Planning, Reproductive, Contraceptive (Fertility) and Erectile Dysfunction Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure) are covered for the Employee or the Dependent Spouse. • Prescription contraceptives such as oral birth control pills/patch, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service are covered for the Employee and/or the Dependent Spouse. • Prescription medication for treatment of erectile dysfunction (impotency) including prescription drugs such as Viagra limited to 8 pills when purchased at a retail pharmacy (30-day supply) and 24 pills when purchased through the Mail Order Drug Service (90-day supply).	• Any treatment or service related to the restoration of fertility or the promotion of conception, including (but not limited to) the reversal of a tubal ligation or vasectomy; tuboplasty; fertility drugs; artificial insemination; in-vitro fertilization; and embryo transplantation **are not covered.** • Certain contraceptives are payable under the prescription drug program. • Prescription contraceptives for Dependent children are not covered. • Penile implants **are not covered**.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Hearing Evaluation and Hearing Aid Benefit • Includes benefits for a hearing evaluation and a hearing aid device.	• Not subject to the annual coinsurance maximum limit or deductible. • **The maximum benefit for hearing evaluation and hearing aid is $800 in a period of three consecutive years.** • In order to receive a hearing aid benefit, you must be examined by a Physician and **provide written certification** from the examining Physician that you are suffering from a hearing loss that may be lessened by the use of a hearing aid. Benefits will **not** be provided without this certification. • Covered Expenses for hearing aid benefits include: – One otologic examination by a Physician or surgeon. – One audiologic examination and hearing evaluation by a certified or licensed audiologist including a follow-up consultation; and – The hearing aid (monaural or binaural) prescribed as a result of such examination, which shall include: (a) ear mold(s); (b) the hearing aid instrument; (c) the initial batteries, cords and other necessary ancillary equipment; (d) a warranty; and (e) follow-up consultation within 30 days following delivery of the hearing aid. • Covered Expenses for hearing aid benefits **will not include**: – The replacement of a hearing aid for any reason more than once in a three-year period. – Batteries or related equipment other than that obtained upon purchase of the hearing aid. – Repairs, servicing or alteration of hearing aid equipment. – A hearing aid which exceeds the specifications prescribed for correction of hearing loss. – Expenses incurred after termination of coverage under this Plan except expenses for a hearing aid which was ordered prior to termination and was delivered within 45 days after the date of termination.	75%, no deductible, up to the benefit maximum	75%, no deductible, up to the benefit maximum

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Home Health Care • Part-time, intermittent **skilled nursing care** services and Medically Necessary supplies to provide Home Health Care. • The services and supplies must be provided under a Home Health Care Plan.	• Home health care services are covered only when ordered by a Physician or health care practitioner and provided by a licensed home health care agency. • Home hospice coverage is payable under hospice benefits. • Services and supplies provided under a Home Health Care Plan are covered up to a **maximum of 130 home health care visits** in a calendar year. • Covered home health care services include: – part-time (less than an 8-hour shift) or intermittent home nursing care by or under the supervision of a registered nurse; – part-time or intermittent home health care by a Home Health Aide; – physical, occupational or speech therapy; – the services of a licensed practical nurse, respiratory therapist or a medical social worker with a Masters degree in social work; – ambulance service that is certified by a Physician as Medically Necessary in the Home Health Care Plan or for unexpected emergency situations; – drugs, medicines and other supplies prescribed by the attending Physician, if the cost of these items would have been Covered Expenses had you or your Dependent been Hospital confined; – laboratory services by or for a Hospital, if the cost of these services would have been Covered Expenses had you or your Dependent been Hospital confined; – rental of durable medical equipment needed for treatment (such as wheelchairs, hospital beds (if confined to bed) or crutches). – Safety items such as commode or shower bench and rails **are not covered.**	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Hospice • Hospice services include inpatient hospice care and outpatient home hospice for Physician prescribed services and supplies furnished directly by a hospice, hospice care team, Home Health Care Agency or Skilled Nursing Facility when the patient is diagnosed as being terminally ill.	**Hospice:** The Plan benefit for combined inpatient and outpatient Hospice care is **$10,000 per lifetime** and includes coverage for the following Covered Expenses: • inpatient and outpatient care, home care, nursing care, counseling and other supportive services and supplies provided to meet the physical, psychological, spiritual and social needs of the terminal individual; • respite care that is continuous care in the most appropriate setting for a maximum of five days per three-month period of hospice care; • ambulance service that is certified by a Physician as Medically Necessary in the hospice care plan or for the unexpected emergency situations; • Drugs, medicines and other supplies prescribed for the terminal individual by any Physician who is part of the hospice care team; • instructions for care of the patient, counseling and other supportive services for the family of the terminal individual. Covered Expenses will **not include** hospice care charges that: • exceed the maximum benefit for hospice care services as described above; or • are for hospice care services not approved by the attending Physicians; or • are for transportation services, except for licensed ambulance services; or • are for custodial care (services or supplies provided to assist a person in daily living - e.g. meals and personal grooming) other than care which is incidental to general nursing care.	75%	50%

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Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Laboratory Services (Outpatient). Also, see the row titled "Diagnostic X-ray and Lab" • Technical and professional fees.	• Covered only when ordered by a Physician or health care practitioner. • Inpatient laboratory services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Some laboratory services are payable under the Wellness benefits in this Schedule.	75% 100% if billed in conjunction with a physician's office visit	50%
Maternity Services • Hospital and birth (birthing) center charges and Physician (and midwife) fees for Medically Necessary maternity services including charges for obstetrical services, miscarriage and prenatal care are covered on the same basis as any other medical condition for a female Employee or Employee's Dependent spouse.	• A Dependent daughter's pregnancy, maternity care, miscarriage or abortion, are not covered except when treatment or services are for Complications of Pregnancy. • **Hospital Length of Stay for Childbirth**: This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).	75%	50%

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This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Mental Health • **EAP Program**: The Plan provides an Employee Assistance Program ("EAP") for Active Employees and their Dependents. The purpose of the Employee Assistance Program ("EAP") is to provide confidential referral services to assist Active Employees and their Dependents who are experiencing personal problems including behavioral disorders, substance abuse, and/or psychological injury. EAP services are provided through an organization that has a contract with the Trust. EAP services are voluntary. The EAP, and its trained counselors, may be accessed by calling the number listed in the ***Quick Reference Chart*** in the front of this Booklet • **Inpatient Admission and Outpatient visits** are payable. • Psychological (Psychiatric) Testing	• **Inpatient Benefits**. If you or your Dependents are confined in a Hospital for the treatment of a mental health disorder, the Plan will pay in the same manner as for any other Illness. **All inpatient Hospitalization is subject to preauthorization.** • See the specific exclusions related to mental health benefits, including mental retardation and learning disability, in the General Exclusions and Limitations section. • Services by a Physician, clinical psychologist, licensed mental health counselor or licensed marriage and family therapist for mental health treatment are covered. • Outpatient prescription drugs for mental health are payable under Drugs in the Schedule of Prescription Drug Benefits. • **Outpatient Visits**: Maximum of 25 visits per calendar year (for both PPO and Non-PPO providers).	**Inpatient** 75% **Outpatient** 75%	**Inpatient** 50% **Outpatient** 50%
Neurodevelopmental Therapy Services for children age 6 and younger • Neurological and psychological testing, evaluations and assessments. • Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment. • Outpatient physical, occupational and speech therapy.	• Services must be provided by a licensed physical, speech, or occupational therapist with a formal written plan. • After the deductible, maximum lifetime benefit per person is **$3,000**.	75%	50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Naturopathic Treatment	• See Complementary Benefits section		
Outpatient (Ambulatory) Surgery Facility • Ambulatory (Outpatient) Surgical Facility (e.g. surgi-center, same day surgery). • Physician fees payable under the Physician services section of this Schedule of Medical Benefits.	• Medical benefits will be provided for the facility fees and anesthesia associated with Medically Necessary dental services covered under the Dental Benefits section of this Booklet, provided the patient is a child (age 6 and under) and it is determined that the care is Medically Necessary to safeguard the health of the patient during performance of dental services. No medical benefits are provided toward the dentist or any assistant dental provider fees.	75%	50%
Physical Exam Benefit • **For Active and Retired Employees only**	• Includes one exam and related tests and x-rays every 2-year period to a maximum benefit of $380. • No benefits are payable for: – Services or treatments that are the result of Injury or Illness. – Services received while confined in a Hospital, extended care facility, nursing home, night care center or similar institution. – Optometry or dental examinations. – Physical examinations required for employment, or for a physical examination which an employer is obligated to pay. – Pre-marital examinations. – Routine vaccinations and/or immunizations	100%; no deductible	100%; no deductible

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.
***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) Also, see the row titled "Diagnostic X-ray and Lab" • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy. • Includes radium, radioactive isotopes and x-ray therapy.	• Covered only when ordered by a Physician or health care practitioner. • Some radiology procedures are covered under the Physical Exam Benefit described in this Schedule.	75%	50%
Reconstructive Services and Breast Reconstruction After Mastectomy • Reconstructive Surgery only if such procedures or treatments are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital or developmental anomaly that causes a functional defect. • This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any Eligible Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage is provided for: – reconstruction of the breast on which the mastectomy was performed; – surgery and reconstruction of the other breast to produce a symmetrical appearance; – prostheses and physical complications of mastectomy, including lymphedemas.	• See the exclusions related to cosmetic services (including reconstructive surgery) in the General Exclusions and Limitations section. Most cosmetic and dental services are excluded from coverage.	75%	50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Rehabilitation Services (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.) with or without percutaneous transluminal coronary angioplasty (PTCA).	• Cardiac Rehabilitation programs must be Medically Necessary and ordered by a Physician. • **Pulmonary Rehabilitation** is not covered.	75%	50%
Rehabilitation Services **(Physical, Occupational & Speech Therapy)** • Short-term **active, progressive** rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient rehabilitation services in an acute Hospital rehabilitation unit or facility or Skilled Nursing Facility for short term, **active**, **progressive** rehabilitation services **that cannot be provided in an outpatient or home setting.**	• Charges of a registered physical therapist required for the treatment of an acute medical condition when prescribed and supervised by a Physician. The Physician must include the frequency and duration of the treatment needed. • Charges for speech therapy and job retraining therapy to include only rehabilitation treatment to restore function lost following an Illness or Injury. This includes **Speech Therapy** if the services are provided by a licensed or duly qualified speech therapist to **restore** normal speech or to correct dysphagic or swallowing defects and disorders due to Illness, Injury or surgical procedure. Speech therapy for functional purposes, (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin) or childhood developmental speech delays and disorders are excluded from coverage, except as described under the Neurodevelopmental benefit. • Maintenance rehabilitation and coma stimulation services are **not covered**. • Myofunctional therapy, or pulmonary rehabilitation are **not covered**.	75%	50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Skilled Nursing Facility (SNF) or Sub-acute Facility	• If you or your Dependent are admitted to a Skilled Nursing Facility after confinement in a Hospital and the admission is for the same or a related Illness or Injury as the Hospital confinement, the Plan will pay Covered Expenses for **up to 120 days**, provided the patient is under the continuous care of a Physician who has certified the Medical Necessity of the confinement. Only days for which the patient is being actively treated for his/her Illness or Injury are covered. • Covered Expenses at a Skilled Nursing Facility include room and board and other Medically Necessary services required for treatment. • Covered Expenses will **not** include any charges after the date the attending Physician stops treatment or withdraws certification of Medical Necessity. • **Skilled Nursing Facility** does not include rest homes, homes for the aged or places for treatment of mental disease, drug addiction or alcoholism.	75%	50%
Spinal Manipulation Services	• See row titled "Complementary and Alternative Medicine Benefits."		

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.

***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Supplemental Accident Benefit	• If an Eligible Individual incurs Covered Expenses as a result of an Injury within 90 days from the date of the injury-causing accident, the Trust will pay the Usual, Customary and Reasonable charges (or the PPO allowable charges) incurred while eligible, up to $230 for the following: – Surgery performed or medical attention provided by a legally qualified doctor of medicine; – Hospital care; – Nursing care provided by a registered graduate nurse; and – X-ray or laboratory examinations. • Covered Expenses for Supplemental Accident Benefits **will not include**: – Braces, crutches, artificial limbs or eyes; – Rental of a wheelchair, hospital bed or respirator; – Dental fees or charges for eye examination or fitting of eyeglasses.	100%; no deductible	100%; no deductible
Temporomandibular Joint Dysfunction (TMJ Services) • Also, see row titled "Dental Services payable under the Medical Portion of the Plan" • Temporomandibular Joint (TMJ) dysfunction or syndrome.	• See the exclusions related to dental services in the General Exclusions and Limitations section. • **Lifetime Plan benefit** for non-surgical treatment of TMJ dysfunction or syndrome, including appliances, is **$1,000** per person (after satisfaction of the deductible).	75%	50%

SCHEDULE OF MEDICAL BENEFITS

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted.
***IMPORTANT**: **Non-PPO providers are paid according to Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Transplants (Organ and Tissue): • Coverage is provided only for eligible services directly related to **non-experimental transplants** of human organs or tissue along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.	• **Transplant services including pre-transplant workup tests are subject to preauthorization. See the Hospital Preadmission Authorization Section for details.** • Benefits are payable only if services are provided in a Hospital or health care facility approved by the Plan. • See the specific exclusions related to **Experimental and Investigational** services in the **General Exclusions and Limitations** section. Donor expenses are not covered unless the person who receives the donated organ/tissue is a person covered by this Plan.	75%	50%
Wellness (Preventive) Program Well Child Examinations and Immunizations • Outpatient newborn and well child care to age 2.	• Services of a Physician for routine well-baby care from birth to age 2. • Covered Expenses include office visits, preventive immunizations, and related laboratory tests. • Immunizations required for eligible Dependents to begin preschool and/or elementary school are covered. Covered expenses will also include the office visit associated with the administration of the preventive immunizations. (Note: Proof of the required immunization must be provided to the Administration Office). • Subject to deductible and applicable coinsurance.	75%	50%
Wellness (Preventive) Program: Well Woman Care • Gynecology exam and pap test • Screening mammogram	• Subject to deductible; • Covered the same as any other Illness or Injury.	75%	50%

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Benefit Description	Explanations and Limitations	PPO Providers	Non-PPO Providers
Drugs (Outpatient Prescription Medicines) • Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other health care practitioner authorized by law to prescribe them. • Coverage is also provided for prenatal vitamins; prescription contraceptives such as birth control pills, insulin and diabetic supplies, self-administered injectables such as Epipen and Glucagon. • **Specialty Pharmacy drugs** are injectable and other drugs which involve complex administration, are expensive and difficult to find, require strict compliance, special storage, handling and delivery and/or education, monitoring and ongoing patient support. They are limited to a 30-day supply or less. The first fill of a specialty pharmacy drug may be obtained from a participating retail pharmacy. Subsequent fills must be obtained from a retail pharmacy of the pharmacy benefit manager or from the mail order pharmacy. • Drugs not yet approved by the FDA are not covered. **New FDA-approved drugs** will be covered by the Plan unless an amendment states otherwise or the class of drug is excluded. • The following drugs are covered only when accompanied by a written statement from the Physician confirming medical necessity: Oral/topical acne drugs (e.g. Retin A), Growth Hormones, Prenatal Vitamins, Impotence medication such as Viagra/Levitra, Prescription contraceptives for Dependent children, Ritalin, ADHD/Narcolepsy drugs.	**The Prescription Drug Program**: Benefits for prescription drugs are provided through the Plan's Prescription Drug Services listed on the ***Quick Reference Chart*** in the front of this Booklet. The Plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether you or your doctor request it, you will pay the brand copay plus the difference in cost between the generic and brand name drug. • **Retail Drugs**: To obtain up to a 30-day supply of medicine for the copay noted to the right present your ID card to any PPO retail pharmacy. Contact the Network Retail Pharmacy Service (listed on the ***Quick Reference Chart***) for the location of preferred retail pharmacies. • **Mail Order (Home Delivery) Drug Service**: The Mail Order Service is the easiest and least expensive way to obtain many medications plus the medications are mailed directly to your home. You may use the Mail Order Service (see the ***Quick Reference Chart***) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note that not all medicines are available via mail order. ***(continued on next page)***	**PPO Retail Pharmacy** (**up to a 30-day supply**): *20% copay with a $5 minimum $50 maximum* **Mail Order Service** (**up to a 90-day supply**): *Generic: $5* *Brand: $20* **Specialty Drugs** (**up to a 30-day supply**): *20% copay with a $5 minimum $50 maximum* If a generic drug is available but a brand-name drug is purchased, the difference between the cost of the brand name drug and the generic drug is added to the copay and due at the time the prescription is filled unless the prescribing Physician indicates that a brand-name drug should be dispensed as written, or no generic drug is available	**Use of a Non-PPO Retail Pharmacy:** If you fill a prescription at a Non-PPO retail pharmacy location, you will need to pay for the drug at the time of purchase and send your drug receipt to the Administration Office. Charges will be reimbursed as though a PPO pharmacy was used (deductible and coinsurance is waived).

SCHEDULE OF PRESCRIPTION DRUG BENEFITS (Continued)			
Benefit Description	**Explanations and Limitations – Mail Order *(continued)***	**PPO Providers**	**Non-PPO Providers**
	• Check with the Mail Order Drug Service for further information. To use mail order: – Have the doctor write the prescription for a 90-day supply, with the appropriate refills. – Mail your prescription, copay and the mail order form to the Mail Order Drug Services listed on the ***Quick Reference Chart***. Mail order forms may be obtained from the Mail Order Drug Service. Allow up to 14 days to receive your order. • A 90-day supply of maintenance prescription drugs may also be obtained at the participating provider copayment rates from those participating retail pharmacies selected by the Trust's Network Retail Pharmacy Service. • See also the definition of "Experimental and/or Investigational" in the Definitions section. • Coverage is not provided for non-prescription contraceptives, home fluoride kits, over the counter (OTC) medications, fertility/infertility drugs, weight control drugs, anabolic steroids. • **Tobacco/smoking cessation benefit:** Coverage is provided for 50% of the cost for a prescription smoking cessation product up to **$500 for one course of treatment per person per lifetime.** No benefit is provided for any product that is available without a prescription. • Prescription drugs for impotence (e.g. Viagra, Levitra) are limited to 8 pills when purchased at a retail pharmacy (30-day supply) and 24 pills when purchased through the Mail Order Drug Service (90-day supply). • Copayments for drugs are not applied to meet the Plan's deductibles, lifetime maximum benefits or annual coinsurance maximum. • Prescription contraceptives for Dependent children are **not** covered unless determined to be for treatment of a medical condition**.**		

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

LIFE INSURANCE FOR ACTIVE EMPLOYEES, DEPENDENTS OF ACTIVE EMPLOYEES

This is only a brief summary of the Life Insurance benefits available for Active Employees and Dependents of Active Employees. You must be eligible at the time of the loss. The amount of insurance on any person is determined in accordance with the following Schedule of Benefits. **Please contact the Administration Office for a copy of the entire Certificate of Coverage.**

LIFE INSURANCE FOR ACTIVE EMPLOYEES AND DEPENDENT LIFE INSURANCE FOR DEPENDENTS OF ACTIVE EMPLOYEES	
Employee Life Insurance	$ 6,000
Dependent Life Insurance	
Spouse	$ 2,000
Unmarried child, age:	
14 days to 6 months	$ 200
6 months to 2 years	$ 400
2 years to 3 years	$ 800
3 years to 4 years	$ 1,200
4 years to 5 years	$ 1,600
5 years to 19 years	$ 2,000
Full time students, 19 years to 24 years	$ 2,000

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR ACTIVE EMPLOYEES

This is only a brief summary of the Accidental Death and Dismemberment Benefits that may be available to you if you, while eligible, sustain any of the losses mentioned below as a result of purely accidental means. The loss must take place within 365 days from the date of the accident for the benefits to be payable. This benefit is in addition to your other benefits under this Plan. **Please contact the Administration Office for a copy of the entire Certificate of Coverage.**

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS FOR ACTIVE EMPLOYEES

Loss of Life	$12,000 (Paid to your beneficiary, in addition to your Life Insurance)
Loss of: Both hands, Both feet, Sight of both eyes, One hand and one foot, One hand and sight of one eye, or One foot and sight of one eye	$12,000 (Paid to you)
Loss of: One hand, One foot, or Sight of one eye	$6,000 (Paid to you)
Loss of: One thumb and index finger	$3,000 (Paid to you)

Losses that are not Covered.

The Accidental Death and Dismemberment Benefit does not cover any loss resulting from:

- bodily or mental illness or disease of any kind;
- ptomaines or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
- suicide or attempted suicide, while sane or insane;
- intentional self-inflected injury;
- participation in, or the result of participating in, the commission of a felony, or a riot, or insurrection;
- war or act of war; declared or undeclared; or service in the military, naval or air forces;
- medical or surgical treatment of an Illness or Injury;
- service in the civilian forces auxiliary to the military, naval or air forces or from any cause while a member of such military, naval or air forces, of any country at war, declared or undeclared;
- parachuting, skydiving, bungee cord jumping, flying, ballooning, parasailing or any other aeronautic activities except as a fare-paying passenger on a commercial aircraft;
- drug addiction including the intake of any drug, medication or sedative unless prescribed by a Physician, or intake of any alcohol in combination with any drug, medication or sedative; or
- alcoholism including the use of alcohol, non-prescriptive drugs such as PCP (also known as "angel dust"), LSD or any other hallucinogens, cocaine, heroin or any other narcotics, amphetamines or other stimulants, barbiturates or other sedatives or tranquilizers, or any other combination of one or more of these substances.

DESIGNATION OF BENEFICIARY

Payment will be made to the beneficiary or beneficiaries named in writing by you. You may change your beneficiary at any time by contacting the Administration Office for the appropriate form and returning it upon completion. The change of beneficiary will take effect as of the date that you signed the form, even if you have since died. **A designation of a spouse will be automatically revoked upon dissolution or invalidation of the marriage, and it is your responsibility to complete a new beneficiary designation form even if you re-designate your former spouse**.

Unless you designate otherwise, payment shall be made as follows:

1) If more than one beneficiary is named, each will be paid an equal share.
2) If any named beneficiary dies before you, you should complete the proper forms with the Administration Office to designate a replacement beneficiary(s).
3) If no beneficiary is named, or if no named beneficiary survives you, the benefit will be paid to your surviving relatives in the following order:
    - all to your surviving spouse; or
    - if your spouse does not survive you, in equal shares to your surviving children; or
    - if no child survives you, in equal shares to your surviving parents; or
    - if no parents survive you, in equal parts to your brothers and sisters; or
    - to the executors or administrators of your estate.

However, the Plan may, at its option, pay up to $500 of your benefit to any party it deems to be entitled to such payment because of your burial expense.

CONTINUATION OF LIFE INSURANCE

Continuation During Disability

If you become totally and permanently disabled before age 65, your Employee Life Insurance Benefit only may be continued in force as long as you remain so disabled, provided proof of disability is furnished to the Administration Office within 12 months after eligibility terminates. This continuation of your Life Insurance Benefit will cease upon your retirement.

Conversion Rights After Fund Eligibility Terminates

If your eligibility or that of your dependent is terminated, your life insurance and the life insurance of your dependents will be continued for 31 days. During this period of time you will be entitled to convert your life insurance and the life insurance of your spouse to an individual policy on any one of the forms customarily issued by the insurance company (except term insurance). These individual policies will be issued without medical examination at the insurance company's regular premium rates. An application for conversion of life insurance should be requested from the Administration Office.

Note: Life insurance is not offered under the COBRA option. You must apply for conversion of your policy within 31 days of the date your active eligibility terminates.

WEEKLY INCOME FOR DISABILITY

WEEKLY INCOME FOR DISABILITY FOR ACTIVE EMPLOYEES	
Per week (Non-occupational) **(Maximum Benefit 13 weeks)**	$100

When you are Totally Disabled, the Plan will pay a net benefit of $200 per week payable every 2 weeks while you are unable to work due to a non-occupational accident or sickness for up to 13 weeks. Benefits begin on the first day of disability due to an accidental bodily Injury, and on the eighth day of disability due to Illness. However, if you are confined as an inpatient in a Hospital, or for outpatient surgery, benefits begin on the first day of hospitalization or surgery for the disabling condition due to either an Injury or Illness.

Totally Disabled means you are unable to perform any and every duty of your occupation, are not engaged in any activity for wages or profit, and are unable to engage in any employment which you may be able to perform based on your training, experience and abilities.

Two or more periods of disability are considered one period of disability, unless between periods of disability you have returned to full-time work for at least two weeks, or unless the disabilities are due to causes entirely unrelated and begin after you have returned to full-time work.

Disability will be considered a result of Illness unless disability is the direct result of and commences within thirty days after an accidental bodily Injury. Benefits will not be paid for any disability during which you are not under the professional care and regular attendance of a legally qualified Physician. Periodic proof of continued disability from your Physician is required.

Weekly Income benefits are not payable for Illness or Injury covered by Workers' Compensation or for Illness or Injury arising out of any employment for wage or profit. In addition, benefits will not be payable for any period of Illness or Injury caused by the act or omission of another person (known as the "third party"), including a period of Injury or Illness covered by any liability policy of the third party, and any period of Injury or Illness for which first-party coverage is available under an automobile insurance policy, homeowners policy, or commercial premises policy.

TAXES

Your Weekly Income for Disability Benefit payment is subject to taxes, both FICA (Social Security) and FIT (Federal Income Tax). The Trust has arranged to pay your FICA taxes, so you can receive the full scheduled benefit. You will receive a W-2 at year-end so you will be able to file your Federal Income Taxes. The FICA tax paid by the Trust on your behalf will be included in the gross taxable income on your W-2.

EXCLUSIONS

No Weekly Income is available for:

- any period which the employee is not under the care of a Physician.
- any period of Disability covered by Workers' Compensation or for Illness or Injury arising out of employment for wages or profit, whether self-employed, no such claim was filed, or such coverage was waived or not elected.
- any period of Injury or Illness caused by the act or omission of another person (known as the "third party"), including a period of Injury or Illness covered by any liability policy of the third party, and any period of Injury or Illness for which first-party coverage is available under an automobile insurance policy, homeowners policy, or commercial premises policy.
- Any period for which you are eligible to receive unemployment benefits.

UTILIZATION MANAGEMENT (UM) PROGRAMS

The Plan includes a Utilization Management Program to help reduce the cost of medical care for you and the Trust. Please read this section carefully, as failure to use Utilization Management properly may result in additional out-of-pocket expense to you.

HOSPITAL PREAUTHORIZATION PROGRAM

When your Physician recommends admission to the Hospital or if you receive treatment for chemical dependency, you, your Dependent, or your Physician must contact the Plan's Utilization Management (UM) Coordinator to request preauthorization. For all Hospital admissions, except for medical emergencies or for maternity care of 48 hours or less (96 hours in the case of a cesarean), you must obtain preauthorization from the UM Coordinator prior to admission. Emergency Hospital admissions must be preauthorized by the Plan's UM Coordinator within 48 hours of the time you are admitted to the Hospital.

BENEFITS ARE REDUCED BY $250 FOR ANY HOSPITAL CONFINEMENT THAT IS NOT APPROVED BY THE UM COORDINATOR. IN ADDITION, SERVICES THAT ARE NO MEDICALLY NECESSARY WILL NOT BE COVERED BY THE PLAN.

All hospitalizations (except emergency admissions and maternity admissions less than 48 hours or 96 hours in the case of a cesarean (as outlined on the following page) require a Hospital preauthorization by the UM Coordinator. **PAYMENT FOR A HOSPITAL CONFINEMENT WHICH IS NOT APPROVED WILL BE SUBJECT TO A BENEFIT PENALTY OF $250.** Emergency inpatient admissions and maternity admissions less than 48 (or 96 hours in the case of a cesarean) do not require a preauthorization review; however, you must notify the UM Coordinator within 48 hours after an emergency admission.

The UM Coordinator is your "healthcare advocate." This preauthorization review by trained medical personnel is intended to monitor the medical care you receive while reducing the cost to you and to the Plan. The UM Coordinator may be contacted at the phone number shown in the ***Quick Reference Chart***. That number is also shown on the back of your identification card.

The UM Coordinator will need the following information:

- Name of patient.
- Hospital name and telephone number.
- Name and phone number of admitting Physician.
- Admission date.

The UM Coordinator, together with your Physician, will review the reason for admission and the procedures to be performed, and discuss options such as pre-admission testing and the possibility of treatment as an outpatient. In many cases, the Hospital stay can be shortened or in some cases, the Hospital admission may not be necessary. If hospitalization is necessary, they will determine the number of days needed in the Hospital.

During the Hospital stay, the UM Coordinator is in contact with the Hospital and Physician to make sure that the admission takes place upon the determined date and that the patient is actually receiving the prescribed care, and that the patient is released from the Hospital when Hospital care is no longer needed.

The UM Coordinator also will monitor potentially costly hospitalizations, and look for more appropriate, less costly ways to assure care. This process is called large case management. Under large case management, the UM Coordinator identifies alternative settings of care, coordinates the care among

various healthcare providers, and works with the Administration Office to assure that claims are handled correctly.

If all or a portion of a Hospital stay is denied by the UM Coordinator, the type of care you receive is still up to you and your doctor. **However, the Plan will pay only for those Hospital Charges that are determined by the UM Coordinator to be Medically Necessary**.

A retrospective review may take place after the patient has been discharged and the bill for Hospital services has been received to make sure that it conforms to the diagnosis and treatment. If discrepancies exist, the Hospital billing department may be contacted.

Please note: The UM Coordinator **cannot** answer questions regarding your Plan, your eligibility, or what benefits you have available – the Administration Office is available to provide this information. The Administration Office cannot pre-authorize Hospital admissions – this can only be done by the UM coordinator.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT (NEWBORNS' ACT)

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 a length of stay not in excess of 48 hours (or 96 hours). However, stays exceeding these time frames must be authorized.

RESTRICTIONS AND LIMITATIONS OF UTILIZATION MANAGEMENT PROGRAMS

- The fact that your Physician recommends surgery, hospitalization, or confinement in a specialized facility, or that your Physician or another provider proposes or provides other services/supplies does not mean that the recommended services/supplies will be determined Medically Necessary or covered under any provisions of the Plan.
- Utilization management is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Certification of Medical Necessity does not necessarily mean that you or your Dependents are eligible for Plan benefits or that Plan benefits will be payable. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.
- All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician believe to be the most appropriate. Benefits payable by the Plan may, however, be affected by Utilization management.
- The Plan and the UM Coordinator are not responsible for either the quality of health care services actually provided, or for the results if you or your Dependent choose not to receive health care services that have not been certified as Medically Necessary.

APPEAL OF A DENIAL OF PREAUTHORIZATION

Regular Appeal

If the UM Coordinator determines that the proposed service is not Medically Necessary, you and/or your Physician may submit a written appeal accompanied by any additional information to support the need for the proposed service. The appeal should be sent to the UM Coordinator. You can expect that the UM Coordinator will respond in writing within 30 days after receiving the request and any required medical records and/or information.

Expedited Appeal

If the UM Coordinator determines that the proposed service is not Medically Necessary, the treating Physician may telephone the UM Coordinator to request an expedited appeal with the medical director or a Physician designated by the UM Coordinator to provide the necessary review. The UM Coordinator will usually respond to the Physician by telephone within 24 working hours, and confirm the determination in writing to you, your Physician, and the Administration Office.

In lieu of appealing a denial of preauthorization to the UM Coordinator, you may submit the appeal to the Board of Trustees pursuant to the Claims and Appeals Procedures in this booklet. You may also submit the matter for review by the Board of Trustees following a determination on appeal by the UM Coordinator.

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations are applicable to the Medical Plan and Prescription Drug Benefits. Payments as described in this Booklet are made only for those Covered Expenses incurred while eligible, except for benefits continued after termination of coverage as specifically indicated. In addition, benefits are not payable for:

- Occupational injuries or illnesses while working for wage or profit (or self-employed), whether or not occupational insurance is purchased or such claim is made.
- Confinement, surgical, medical or other treatment received in or from a local, state, or U.S. government hospital, except where required by law.
- Conditions caused by or arising out of an act of war, armed invasion or aggression.
- Any claim under this Plan if you were injured as the result of the commission of an assault, battery, or felony, or if you were an aggressor against another person, or if you were engaged in any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances.
- A Dependent daughter's pregnancy, maternity care, miscarriage or abortion, except when treatment or services are for Complications of Pregnancy.
- Amounts in excess of Usual, Customary, and Reasonable charges.
- Expenses for services not required for treatment of Injury or Illness unless specifically listed in this Booklet as a Covered Expense.
- The following Prescription Drugs and Devices:
    - Non-legend Drugs, and any Drugs available without a prescription.
    - Medications prescribed for cosmetic purposes only (e.g. Botox, Retin-A for other than acne, or Rogaine/minoxidil for hair loss).
    - Nicorette, vitamins, cosmetics, health and beauty aids.
    - Anorexiants.
    - Therapeutic devices or appliances, support garments and other non-medical substances.
    - Medical appliances, devices, and other supplies/equipment except covered diabetic supplies.
    - Medications with no approved FDA indications; Investigational or Experimental Drugs; including compounded medications for non-FDA approved use.
    - Drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county or municipal government program.
    - Prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation.
    - Replacement prescription drugs resulting from loss, theft or breakage.
    - Biological sera, blood or blood products.
    - Prescription drugs dispensed by a Hospital during a hospital confinement that are covered under the Comprehensive Medical Benefits Program.

- Any services that are not Medically Necessary or are not specifically listed in this Plan as Covered Expenses.
- Charges for which the Eligible Individual is not legally obligated to pay.
- Services for which no charge is made to the Eligible Individual.
- Services for which no charge is made to the Eligible Individual in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
    - It must be internationally known as being devoted mainly to medical research, and
    - At least ten percent of its yearly budget must be spent on research not directly related to patient care, and
    - At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and
    - It must accept patients who are unable to pay, and
    - Two-thirds of its patients must have conditions directly related to the Hospital's research.

  Notwithstanding the foregoing, benefits shall be provided without taking into account an Eligible Individual's entitlement to Medicaid benefits.
- Any treatment or service not recommended by a Physician.
- Services furnished by a provider not meeting the definition of Physician, except as specifically provided by the Plan.
- Professional services or supplies received from a provider who lives in the patient's home or who is related to the patient by blood or marriage.
- Custodial care or rest cures.
- Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- Hyperkinetic syndrome, learning disabilities, behavioral problems, developmental delay, attention deficit disorder, mental retardation or autistic disease of childhood, except as specifically provided by the Plan.
- Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums other than for tumors except as specifically provided under Comprehensive Medical Benefits. (Refer to the Dental Benefits section of this Booklet for a description of covered dental services.)
- Any treatment or service directly related to the restoration of fertility or the promotion of conception, including (but not limited to) the reversal of a tubal ligation or vasectomy; tuboplasty; fertility drugs; artificial insemination; in-vitro fertilization; and embryo transplantation.
- Any expense for alcoholism and/or drug treatment in excess of per treatment limitations or the lifetime maximum benefit.
- Chelation therapy, except for treatment of lead or other trace metals in the blood stream.
- Cosmetic surgery or other services for beautification, except to correct a functional disorder.

- Any treatment or service with respect to trimming nails, paring, excision, cauterization or radiation of corns, or calluses, weak or fallen arches, flat or pronated feet, metatarsalgia, massage, casting, taping, manipulative procedures of the foot, or prescriptions for, or purchase of orthotics or similar appliances or shoes, except as specifically listed in this Booklet as a Covered Expense.
- Acupuncture treatment (except as provided for under Complementary/Alternative Medicine benefit).
- Hospital care or medical services or supplies for which benefits are available to an Eligible Individual under Federal Medicare (whether or not the Eligible Individual has qualified for such benefits by enrollment or other procedures available to him), except for an Active Employee or his Dependent spouse who has attained age 65.
- Educational services, nutritional counseling or food supplements or substitutes, unless such food supplements or substitutes are the only means of nutrition as documented by a Physician, except for diabetic educational benefits.
- Hypnotism, stress or anger management, and any goal oriented behavior modification (biofeedback) therapy, such as to quit smoking, lose weight, or control pain.
- Charges for services, supplies and associated expenses for procedures intended primarily for treatment of obesity, including gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, wiring of the jaw, and health services of a similar nature. Obesity includes, but is not limited to morbid or gross obesity.
- Services furnished by a midwife for home births, except as specifically provided in the Plan.
- Speech therapy (except as outlined in the Neurodevelopmental Therapy Services in the Schedule of Benefits) or job retraining therapy (except rehabilitation treatment to restore function lost following an Illness or Injury), myofunctional therapy, or pulmonary rehabilitation.
- Any services and supplies which are Experimental and/or Investigational.
- Services for an Injury or Illness caused by the act or omission of another person (known as the "third party"), including an Injury or Illness covered by any liability policy of the third party, and services for an Injury or Illness for which first-party coverage is available under an automobile insurance policy, homeowners policy, or commercial premises policy.
- Expenses incurred for dental implantology, except when the individual is totally endentulous (without teeth) and the ridge is severely resorbed and cannot support regular dentures or when necessary due to an accidental Injury to teeth provided treatment is done within one year of the Injury.
- Charges which result from or caused by the voluntary taking of, or being under the influence of, or overdose of a lega1 prescription, over-the-counter drug, illegal drug or other chemical substance, including alcohol, not administered on the advice of a physician, unless the charges are for an Illness or Injury that is the result of a medical condition. Being under the influence of a chemical substance will not be considered to affect the person's ability to form intent.

- Intentionally self-inflicted injuries, and injuries or illnesses sustained in the following circumstances, unless the injury or illness results from a documented medical condition:
    - Suicide or attempted suicide; or
    - While engaged in a felony, regardless of whether prosecuted; or
    - While performing any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances.
- Routine vaccinations and immunizations, except as provided under Well Child Program.
- Eye exam refraction fees.
- Massage therapy.
- Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and testing is needed to identify the disease in order for the physician to prescribe covered appropriate treatment, provided such testing is not Experimental or Investigational.
- Counseling, educational, or training services. This includes vocational assistance and outreach; smoking cessation programs; and family, marital, social, sexual, nutritional, fitness counseling, or relaxation therapy, except for diabetic education benefit.
- Charges for missed appointments, telephone or other consultations where a patient is not physically seen by a physician or other covered provider.
- Medical record fees for records not requested by the Claims Administration Office.
- Shipping and handling fees.
- Electronic prostheses, penile prostheses (including penile implants), or devices directly related to an organ transplant.

DENTAL BENEFITS FOR ACTIVE EMPLOYEES AND THEIR QUALIFIED DEPENDENTS ONLY

These benefits are not provided for Retired Employees or their Dependents. The Dental Plan is funded directly by the Trust Fund.

SUMMARY OF DENTAL BENEFITS	
DENTAL PLAN MAXIMUM	$2,000 per person, **per calendar year**
DENTAL PLAN DEDUCTIBLE	$50 per person **per calendar year**
CLASS I CHARGES *(Diagnostic and Preventive)*	100% of Covered Expenses after the deductible
CLASS II CHARGES *(Restorative service, Oral Surgery, Periodontics, Endodontics)*	• 90% of Covered Expenses after the deductible for certain **basic restorative** services such as restoration of carious teeth to a state of functional acceptability utilizing filling materials such as amalgam, silicate or plastic, provided that restorations on the same surface of the same tooth are covered once in a two-year period. • 85% for **all other restorative** services after the deductible, including crowns, inlays or onlays (whether gold, porcelain, plastic, gold substitute castings or combinations thereof), except that crowns, inlays and onlays on the same tooth are covered only once in a five-year period. If a tooth can be restored with a filling material such as amalgam, silicate or plastic, an allowance will be made for such material toward the costs of any other type of restoration that may be provided.
CLASS III CHARGES *(Prosthodontic services, bridges, dentures, partials)*	70% of Covered Expenses after the deductible
ORTHODONTIC Lifetime maximum benefit for treatment program including banding	50% of Covered Expenses up to $2,000 The Plan pays 50% of the lesser of the Usual, Customary and Reasonable fees or the fees actually charged for orthodontic treatment up to $500 at completion of the banding phase.
Method of Plan Payments	After deduction of the charges for banding, the Plan pays 50% of remaining Covered Expenses for the orthodontic treatment program on either a monthly or a quarterly basis, up to the overall $2,000 lifetime maximum. The amount to be paid is prorated over the duration of the treatment program.

ESTIMATE OF BENEFITS/OPTIONAL TREATMENTS

If your dental care will be extensive, ask your dentist to complete and submit a pre-treatment estimate to the Administration Office. This will allow you to know in advance exactly what procedures are covered and the amount the Plan may pay toward the treatment.

CLAIMS FILING PROCEDURE

It is your responsibility to have the dentist complete a claim form. You are also responsible for submitting the claim to the Administration Office. Payment of benefits is made to you or to your dentist (if you have assigned benefits).

ELECTIVE CARE

If there are optional methods of treatment carrying different fees, the Plan pays the appropriate percentage of the lesser fee and the patient must pay the remainder. This provision commonly applies to gold restorations, crowns and bridgework, so it is important that you have your dentist submit an estimate before the work begins to avoid any misunderstanding.

DIAGNOSTIC AND PREVENTIVE SERVICES (Class I)

If you or your Dependent receives diagnostic or preventive services from a licensed dentist, the Plan pays 100% of covered dental expenses after the deductible.

Covered Diagnostic Expenses

- Routine examination once in a six-month period.
- Emergency examinations and initial examinations by a specialist in an American Dental Association specialty.
- Supplementary bitewing x-rays once in a six-month period.
- Complete full-mouth series or panoramic x-rays once in a three-year period.

The Plan will not cover:

- Diagnostic Services and x-rays related to TMJ (see TMJ benefit in Medical section), consultations, study models or carries susceptibility tests.
- Services and supplies excluded under general exclusions.

Covered Preventive Expenses

- Prophylaxis once in a six-month period.
- Topical application of fluoride for persons under the age of 19, once in a six-month period, when performed in conjunction with a prophylaxis.
- Space maintainers when used to maintain space for eruption of permanent teeth.
- Pit and fissure sealants for Dependent children up to age 18. Payment for sealants will be made only if applied to permanent posterior teeth which do not contain any filling material. Coverage of sealants is provided once every three-year period per tooth or quadrant.

The Plan will not cover:

- Plaque control programs.
- Oral hygiene or dietary instruction and home fluoride kits.
- Cleaning of prosthetic appliances.
- Replacement of a space maintainer previously provided by the Plan.
- Services and supplies excluded under general exclusions.

RESTORATIVE SERVICES (Class II) including ORAL SURGERY, PERIODONTIC AND ENDODONTIC SERVICES

If you or your Dependent receives covered restorative dental services from a licensed dentist, the Plan pays the appropriate percentage (85% or 90%) of covered dental expenses after the deductible in accordance with the schedule above.

Covered Restorative Expenses

- Restoration of carious teeth to a state of functional acceptability utilizing filling materials such as amalgam, silicate or plastic, except that restorations on the same surface of the same tooth are only covered once in a two-year period.
- Crowns, inlays or onlays (whether gold, porcelain, plastic, gold substitute castings or combinations thereof), except that crowns, inlays and onlays on the same tooth are covered only once in a five-year period. If a tooth can be restored with a filling material such as amalgam, silicate or plastic, an allowance will be made for such material toward the costs of any other type of restoration that may be provided.
- A temporary appliance or crown is considered to be permanent unless replaced within 12 months of initial placement and is subject to the Plan's regular replacement limitations for such appliance or crown. The amount paid toward a temporary appliance will be deducted from the permanent appliance when replaced within 12 months.

The Plan will not cover:

- Restorations done solely to correct vertical dimension or to restore occlusion;
- Overhang removal, re-contouring or polishing of restoration;
- Services and supplies excluded under general exclusions.

Covered Oral Surgery Expenses

- Removal of teeth and surgical extractions.
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures.
- Treatment of pathological conditions and traumatic facial injuries.
- General anesthesia when administered by a dentist who meets the educational guidelines established by the appropriate state Dental Disciplinary Board in conjunction with a covered oral surgery procedure.

The Plan will not cover:

- Extraoral grafts (grafting of tissues from outside the mouth or use of artificial materials).
- Ridge extension for insertion of dentures (vestibuloplasty).
- Tooth transplants.
- Services and supplies excluded under general exclusions.

Covered Periodontic Expenses

The following surgical and non-surgical procedures for treatment of the tissues supporting the teeth:

- Root planing.
- Subgingival curettage.
- Gingivectomy.
- Limited adjustments to occlusion. Occlusal adjustment (limited) is defined as the relief of traumatic occlusion (8 teeth or less) such as smoothing of teeth or reducing of cusps. If occlusal adjustment is submitted with occlusal restorations, it is considered part of the restorative procedure. Adjustment of teeth opposing a prosthetic appliance is also considered part of this procedure.

The Plan will not cover:

- Nightguards and occlusal splints.
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting.
- Periodontal appliances.
- Services and supplies excluded under general exclusions.

Covered Endodontic Expenses

The following procedures for pulpal and root canal therapy, except that root canal treatment on the same tooth is limited to once in a two-year period:

- Pulp exposure treatment.
- Pulpotomy.
- Apicoectomy.

The Plan will not cover:

- Bleaching of teeth.
- Root canal therapy performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III percentage.
- Services and supplies excluded under general exclusions.

PROSTHODONTIC SERVICES (Class III)

The Plan will pay 70% of Covered Dental Expenses after the deductible when services are provided by a licensed dentist or by a licensed denturist acting within the scope of his license. **Replacement of an existing prosthetic device is covered only once every five years and only then if the device is unserviceable and cannot be made serviceable.**

The following procedures are Covered Dental Expenses:

- **Full, immediate and overdentures.** The appropriate amount for a full, immediate or overdenture will be allowed toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.
- **Partial dentures.** The appropriate amount for a cast chrome and acrylic partial denture will be allowed, if a more elaborate or precision devise is used to restore the case.
- **Denture adjustments and relines** are covered provided they are done more than six months after the initial placement. Subsequent relines and jump rebases, but not both, will be covered once in a twelve-month period.

- **Temporary Dentures**. The benefit for a temporary denture will be deducted from the benefit payable for a permanent denture. Temporary dentures will be considered permanent if not replaced within one year.
- **Implants.** The appropriate amount for a crown or a full or partial denture will be covered toward the cost of the prosthetic to be placed on the implants and appliances constructed thereon. If an allowance is made toward the cost of the prosthetic placed on the implants, any replacement placed within five years will not be covered.

The Plan will not cover:

- Duplicate dentures.
- Cleaning of prosthetic appliances.
- Surgical placement or removal of implants or attachments to implants.
- Crowns and copings in conjunction with overdentures.
- Services and supplies excluded under the general exclusions.

ORTHODONTIC TREATMENT BENEFIT

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

After satisfaction of the deductible, the Plan will pay 50% of the lesser of UCR charges or the fees actually charged. Orthodontic treatment must be preauthorized as appropriate and necessary prior to commencement of treatment. The lifetime maximum amount payable by the Plan for orthodontic benefits is $2,000. Not more than $500 of the orthodontic lifetime maximum shall be payable for treatment during the "construction phase" or "banding phase."

After the construction or banding phase, the Plan pays 50% of UCR charges for the treatment program up to the maximum orthodontic benefit available. The Plan will pay equal quarterly or monthly installments prorated over the estimated duration of the treatment program. Monthly or quarterly installments are made depending on the payment frequency requirements of your dentist. Payment of monthly or quarterly charges is limited to completion of the treatment program, or through age 23 for a qualified Dependent, whichever comes first.

The Orthodontic Treatment Benefit will not cover:

- Replacement or repair of an appliance.
- Services which in the determination of the Trustees are considered to be inappropriate and unnecessary.
- Services and supplies excluded under general exclusions.
- Payment for any month in which you are not eligible for Dental Benefits under the Plan.

GENERAL DENTAL EXCLUSIONS

The following services are excluded under the Dental portion of the Plan.

- Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws regardless of whether a claim has been filed, services which are provided to the eligible person by a federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision.
- Dentistry for cosmetic reasons. Cosmetic treatment includes, but is not limited to, laminates or bleaching of teeth.
- Restorations or appliances solely for the purpose of correcting vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
- Application of desensitizing medicaments.
- Experimental services or supplies whose use is not generally recognized by the ADA as tested and accepted dental practice.
- Services with respect to treatment of temporomandibular joints.
- Analgesics (such as nitrous oxide or I.V. sedation) or any other euphoric Drugs, injections or Prescription Drugs.
- Hospitalization charges and any additional fees charged by the dentist for Hospital treatment.
- Dental services started prior to the date the person became eligible for services under this Plan.
- Broken appointments.
- Patient management problems.
- Completion of claim forms.
- Laboratory examination of tissue specimen.
- Habit breaking appliances.
- All other services not specifically included in this program as covered dental benefits.
- Services for an Injury or Illness caused by the act or omission of another person (known as the "third party"), including an Injury or Illness covered by any liability policy of the third party, and services for an Injury or Illness for which first-party coverage is available under an automobile insurance policy, homeowners policy, or commercial premises policy.
- No coverage is extended for expenses incurred after termination of eligibility except for procedures that were started while still eligible and finished/delivered no more than 21 days after termination of coverage.
- Implants except as specifically provided by the Plan.

VISION BENEFITS FOR ACTIVE AND RETIRED EMPLOYEES AND THEIR DEPENDENTS

OVERVIEW OF THE VISION PLAN

All Eligible Individuals who are covered under the Comprehensive Medical Benefit Program are eligible for vision benefits. These vision benefits are not available to individuals who elect the HMO plan option.

Vision benefits are effective on the date your medical benefits are effective. Vision benefits are designed to provide for regular vision examinations and benefits toward eyeglasses or contact lenses.

The Plan contracts with a national network of vision providers who extend a discount to you for covered vision services. Covered Expenses are noted in the Schedule of Vision Benefits in this section and refer to the Usual, Customary and Reasonable charge for Covered Expenses up to the maximum allowed as payable under vision benefits.

VISION NETWORK

- **PPO Providers:** PPO providers (licensed ophthalmologist, optometrist or dispensing optician) have a contract to provide discounted fees to you for Covered Expenses. By using the services of a PPO provider, both you and the Plan pay less (see the PPO column of the Schedule of Vision Benefits). A current list of PPO vision providers is available free of charge when you call the Vision Service Plan whose name, address and telephone number are listed on the ***Quick Reference Chart*** in the front of this Booklet. To receive services, simply call a PPO vision provider and identify yourself as a member of this Vision Service Plan.
- **Non-PPO Providers**: Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, this Plan will pay at the Non-PPO level as noted in the Schedule of Vision Benefits. The itemized bill reflecting the Non-PPO provider's fees must be submitted to the Vision Service Plan Claims Administrator for reimbursement. You will be reimbursed according to the Usual, Customary and Reasonable fee or the schedule below, whichever is less. Non-PPO provider services may cost you more than if those same services were obtained from a PPO provider. Non-PPO providers may bill you for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. You can avoid balance billing by using PPO providers.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- **A vision exam** includes a professional eye examination and an eye refraction.
- **Dispensing Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry.
- **Ophthalmologist** is a physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.

SCHEDULE OF VISION BENEFITS			
This chart shows what the Plan pays.		**Plan Pays**	
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section*	**PPO Provider**	**Non-PPO Provider**
Vision Examination	• One vision exam is payable once every 18 months.	100% per exam after $15 copay	100%, not to exceed $45 per exam.
Frames for Eyeglasses	• One frame is payable once every 18 months if replacement is necessary	100% for basic frames after $15 copay.	100%, to $47
Lenses for Eyeglasses	• Lenses are covered once every 18 months. • No coverage for special coatings or tints on lenses. • A single vision, bifocal, trifocal or progressive lens is payable once each calendar year.	100% after $15.00 copay	*Single Vision*: 100%, up to $45. *Bifocals:* 100%, up to $65. *Trifocals:* 100%, up to $85. *Lenticular*: 100% up to $125.
Contact Lenses: Medically Necessary contact lenses are considered for the following reasons: —following cataract surgery; —to correct extreme visual acuity problems that cannot be corrected with regular lenses; —certain conditions of anisometropia; and —keratoconus. Contact lenses that do not meet the above criteria are considered "not Medically Necessary" or elective.	• The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan. • One set of Medically Necessary contact lenses are payable each 18 months. • One set of not Medically Necessary contact lenses are payable each 18 months in lieu of eyeglasses. • You may use your annual contact lens allowance toward permanent and/or disposable lenses	*Cosmetic Lenses (not Medically Necessary):* 100%, up to $105 per pair *Contact Lenses (Medically Necessary):* 100% after $15 copay	*Cosmetic Lenses* (*not Medically Necessary):* 100%, up to $105 per pair. *Contact Lenses (Medically Necessary):* 100%, up to $210 per pair.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section*	PPO Provider	Non-PPO Provider
Safety Eyecare • Limited level supplemental vision exam; • Lenses meeting the following standards: —be no less than 3mm at the thinnest point. —be impact tested with a one-inch steel ball dropped from a height of 50 inches. —be engraved by the manufacturer that it is a safety lens. • Frames meeting the following standards: —have a "Z-87" stamp on the front and temples. —be fabricated of a slow burning material. —have the manufacturer's logo imprint. —be constructed so that, if impacted from the front, the lens will not come out through the back of the frame	• Available for Active employees who require safety eyewear due to the nature of their work only. • Payable once every 18 months.	**Exam** 100% after a **$15** copay **Lenses** 100% after **$15** copay **Frames** payable up to plan allowance less **$15** copay	Not Covered
Low Vision Benefit • Includes supplemental testing and low vision therapy	• All Low Vision Benefits are payable up to **$1,000** PPO or Non-PPO. This benefit maximum excludes the copay for materials	**Supplementary testing** covered in full. **Supplemental Care aids- 75%**	**Supplementary testing** covered up to $125 **Supplemental Care aids - 75%** Benefit will not exceed what would have been payable to a PPO provider.

EXCLUSIONS AND LIMITATIONS

EXTRA COST - The plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following and your doctor does not receive prior authorization, there will be an extra charge.

- Contact lenses (except as noted elsewhere).
- Oversize lenses - 61mm or larger.
- Optional cosmetic processes.
- Mirror coating.
- Scratch coating.
- Anti-reflective coating.
- Cosmetic lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- Laminated lenses.
- Color coated lenses.
- A frame that costs more than the Plan allowance.

In addition to the above limitations, the following will also apply to the Safety Eyecare benefit:

- Blended Lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.

NOT COVERED - There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses.
- Two pair of glasses in lieu of bifocals.
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an experimental nature.
- Costs for services and/or materials above Plan's allowances.
- Services and/or materials not indicated on the Schedule of Vision Benefits.

In addition to the above exclusions, the following will also apply to the **Safety Eyecare benefit**:

- Subnormal vision aids.
- Contact lenses.
- Rimless frames.
- Exams above a limited level unless the covered person:
  - is not eligible for an eye exam under the Plan;
  - received an eye exam from another member doctor during the same eligibility period;
  - received an eye exam during the preceding 6 months from a practitioner in the same member doctor's office that is providing the Safety EyeCare exam.

COORDINATION OF BENEFITS

Benefits (including medical, vision, dental and hearing aid benefits) contain non-duplication provisions which are included to coordinate benefits of this Plan with benefits of other plans which provide for payment of medical, dental, vision and hearing aid expenses. The intent is to provide that benefits from all plans will not exceed 100% of total allowable expenses.

An "Allowable Expense" is any covered charge of which at least a portion is covered under one of the plans covering an individual for whom a claim is made. However, the difference between the cost of a private room and the cost of a semiprivate room will be an Allowable Expense only when confinement in a private room is Medically Necessary. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

A "Plan" for the purposes of Coordination of Benefits will mean a plan that provides medical, vision, dental and/or hearing aid expenses. The plan must be provided by Medicare, Group Insurance, or a Group Hospital or Health Care Service Contractor, or a Health Maintenance Organization Group Contract, or any other coverage arranged through any employer, trustee, union, employee benefit association, or any coverage sponsored by, or provided through, an educational institution.

The word "Plan" shall not include benefits provided under a student accident policy, the first $200 per day of group hospital indemnity benefits, or benefits provided under a state medical assistance program where eligibility is based on financial need. In addition, a plan will not include individual insurance policies.

A "Plan" does not include insurance coverage mandated by state law.

The word "Plan" shall be construed separately with respect to each policy, agreement, or other arrangement that provides for the benefits or services.

When a claim is made, the Primary Plan pays its benefits without regard to any other plans. The Secondary Plan adjusts their benefits so that the total benefits available will not exceed the Allowable Expenses. No Plan pays more than it would without the coordination provision.

When this plan is the Secondary Plan and its payment is reduced to consider the Primary Plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year - to the extent there are Allowable Expenses that would not otherwise be fully paid by this Plan and the other.

ORDER OF BENEFITS DETERMINATION

A Plan without a Coordination of Benefits provision is always the Primary Plan.

If all or both plans have a Coordination of Benefits provision, the claim is determined as follows:

- The Plan covering the patient directly as an Employee (not as an Employee's Dependent) is the Primary Plan and the other is the Secondary Plan;
- Except as described below, if the patient is a Dependent child whose parents are not separated or divorced (whether or not the parents have ever been married), the Plan of the parent whose birthday occurs earlier in a calendar year ("Birthday Rule") shall be the Primary Plan. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. (If another Plan has instead a rule based on the gender of the parent, then that rule shall be used to determine the Primary Plan.)

If two or more Plans cover a Dependent child of divorced or separated parents (whether or not the parents have ever been married), benefits for the child are determined in this order:

- first, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child; and
- finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the court decree establishes provisions for joint custody but does not establish financial responsibility for the child's health, the Birthday Rule will apply. This paragraph does not apply with respect to any claim determination period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

The Plan which covers an individual who is neither laid off nor retired or that individual's Dependent will be the Primary Plan, and the Plan which covers an individual who is laid off or retired or that individual's Dependent will be the Secondary Plan. If the other Plan does not have this rule, and if as a result, the Plans do not agree on who is Primary, this rule will not apply.

If the rules outlined above do not establish an order of benefit determination, the benefits of the Plan which has covered the individual for the longer period is the Primary Plan.

For coverage maintained under this Plan through COBRA, any other group health plan will be determined to be the Primary Plan.

EFFECT OF 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 (generally after a waiting period).

If the total amount of benefits provided by the Plan together with the amount of "like benefits" you or your Dependent receives or is entitled to receive from Medicare exceeds the actual expenses incurred for such benefits, the benefits provided by the Plan will be reduced so that the combined benefits do not exceed the actual expenses for such benefits.

"Like benefits" refers to reimbursement for the cost of services and supplies for which benefits would otherwise be payable under the Plan.

Active Employees and their spouses will normally have benefits paid first by this Plan, then by Medicare. The law allows you to choose Medicare as your primary coverage. However, if you choose Medicare as primary, you cannot receive benefits from this Plan.

Retirees and their spouses are expected to enroll in both Part A and Part B of Medicare. If you are retired, you are expected to enroll in Medicare even if you elect COBRA in lieu of retiree medical benefits. This Plan will not pay benefits for services which would have been reimbursed by Medicare, even if you fail to enroll in Medicare.

Retirees and their spouses who are eligible to enroll in Medicare and enter into a private contracting arrangement with a provider, will have benefits for Covered Expenses paid as if they are enrolled in Medicare. This will result in substantial out-of-pocket expenses.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an Eligible Individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan generally pays first and Medicare pays second for 30 months starting the earlier of the

month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS FOR RETIREES WITH MEDICARE

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage outlined in this Booklet is "creditable." This means that the Plan's prescription drug coverage provided to Medicare-eligibles is of equal or greater financial value as the Medicare Part D benefits.

Because this Plan's prescription drug coverage is "creditable coverage," you **do NOT need to enroll** in a Medicare Prescription Drug Plan in order to avoid a late penalty under Medicare.

If you go 63 days or longer without prescription drug coverage that is "creditable coverage," your monthly Medicare premium will go up at least 1% per month for every month that you did not have that coverage. For example, if nineteen months pass without your having creditable prescription drug coverage, your monthly premium for Medicare drug coverage will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll.

You may enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving employer/union coverage may also be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

If you enroll in Medicare Part D, you will lose your current prescription drug coverage under the Northwest Ironworkers Shop Health and Security Plan and you will not be reimbursed for your Part D premiums.

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare and You" handbook. All persons enrolled in Medicare (a "beneficiary") should receive a copy of the handbook in the mail each year from Medicare. Medicare beneficiaries may also be contacted directly by Medicare approved prescription drug plans. For more information about Medicare prescription drug plans visit: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Please contact the Administration Office **before** you enroll in any Part D Plan.

ENTITLEMENT TO MEDICAID

Benefits will be provided under this Plan without taking into account your entitlement to Medicaid benefits. Benefits will be made in accordance with any assignment of rights by or on your behalf as required by a State Medicaid Plan. If benefits have been provided under a State Medicaid Plan, and the Plan has liability to make payment, benefits will be paid by the Plan in accordance with any applicable State law which provides that the State acquired the rights with respect to such payment to you.

COORDINATION WITH TRICARE/CHAMPUS OR VETERANS AFFAIRS FACILITY SERVICES

Under federal law, Tricare/CHAMPUS is always the secondary plan. If you are covered by both this Plan and Tricare/CHAMPUS, this Plan pays first and Tricare/CHAMPUS pays second.

If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related Illness or Injury, benefits are not payable by this Plan.

If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related Illness or Injury, benefits are payable by this Plan to the extent those services are Covered Expenses. If you are also eligible for Medicare, your benefits under this Plan are paid secondary to Medicare.

DISPUTED WORKERS COMPENSATION CLAIMS

The Plan does not provide benefits for any condition for which benefits of any nature are recovered, or are found to be recoverable through adjudication or settlement, under workers' compensation laws, occupational disease laws, or similar laws, even though the Eligible Individual fails to claim such right to benefits. If a dispute arises concerning whether an Injury or Illness is work-related, and the Eligible Individual appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the Eligible Individual submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the Eligible Individual is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the Eligible Individual. The Eligible Individual shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers' compensation claim, no further benefits will be provided related to the Injury or Illness.

RIGHT TO REIMBURSEMENT

The Plan excludes medical, prescription drug, dental, and time loss benefits for any Injury or Illness caused by the act or omission of another person (known as the "third party"), including an Injury or Illness covered by any liability policy of the third party; or an Injury or Illness for which first party coverage is available under an automobile insurance policy, homeowners policy or commercial premises policy. If an Eligible Individual has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the Eligible Individual, may advance benefits pending the resolution of the claim. However, the Plan's payment of benefits in excess of $5,000 is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery.

If the Plan provides benefits in excess of $5,000, the Plan is entitled to reimbursement of all benefits paid in excess of $5,000, regardless of whether the Eligible Individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the Eligible Individual complies with the terms of the Plan and any agreement to reimburse, the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, as described below.

The Plan can require that an Eligible Individual execute an agreement acknowledging this Plan's reimbursement right, the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved and a factual description of the accident and/or Injury or Illness.

When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into a trust account or escrow and held there until the Plan's claims are resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the Eligible Individual, or the individual named to hold the funds in trust shall be liable for any loss the Plan suffers as a result.

If reasonable attorney fees are incurred by the Eligible Individual in recovering from the third party or insurer, the Plan pays a percentage of attorney fees on the amount reimbursed to the Plan, not to exceed the percentage actually charged by the attorney to the Eligible Individual. If reasonable costs are incurred by the Eligible Individual in recovering from the third party or insurer, the Plan pays a pro rata share of the costs, based upon the Plan's share of the gross recovery to the total gross recovery. Costs incurred solely for the benefit of the Eligible Individual shall be the responsibility of the Eligible Individual. The Plan's payment of attorney fees and costs is contingent on compliance with the Plan's reimbursement provisions and/or the agreement to reimburse.

The Plan may cease advancing benefits, if there is a reasonable basis to determine that the Eligible Individual will not honor the terms of the Plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.

After recovery by the Eligible Individual, and pending reimbursement to the Plan, the Plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the Eligible Individual's family members, by denying such payments until the amount of benefits provided has been recovered. The Plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.

If the Plan is not reimbursed, it may bring an action against the Eligible Individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the Plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

After recovery from a third party or insurer, the Plan is relieved from any obligation to pay further benefits for the Injury or Illness up to the amount of the balance of the recovery.

DEFINITIONS

There are certain terms that are used in describing the Plan. The following definitions will be helpful to you in understanding the Plan.

Active Employee means an Employee eligible for benefits on the basis of hours in the Hour Bank account, or self-payment, as described in the Eligibility section of this Booklet.

Approved Chemical Dependency Treatment Facility means an institution licensed by and approved under the laws of the state, as a Chemical Dependency Treatment Facility.

Coding Systems. Below is a list of common coding systems used to bill payors of health services:

- *Code on Dental Procedures and Nomenclature*. A listing of descriptive codes identifying dental procedures, distributed by the American Dental Association.
- *Current Procedural Terminology (CPT*). Published annually by the American Medical Association, the CPT is a listing of descriptive terms and identifying codes for accurately describing medical, surgical and diagnostic services performed by Physicians.
- *HCFA Common Procedural Coding System (HCPCS).* A list of services, procedures, and supplies developed by the Health Care Financing Administration. These 5-digit codes include CPT codes and national alpha-numeric codes developed by Medicare carriers.
- *International Classification of Diseases, 9th Edition, Clinical Modification (ICDA-9-CM).* Diagnoses and identifying codes used by Physicians to report a patient's diagnosis.
- *National Drug Codes (NDC).* Codes identifying drugs and biologicals.

Coinsurance means the arrangement where you pay a percentage of the Covered Expense and the Plan pays the remaining portion of the Covered Expense.

Collective Bargaining Agreement means the Labor Agreement between the Northwest Ironworkers Employers Association, Inc. and the Ironworkers District Council of the Pacific Northwest and any other labor agreement between the Union and any other Employer association, and/or any special or compliance agreement between an Individual Employer and the Ironworkers International, the Ironworkers District Council of the Pacific Northwest or any Ironworkers Local in which the employer agrees to be bound by the Master Labor Agreement, including any and all extensions, modifications, or renewals thereof which provide for the making of contributions to the Trust.

Complete Visual Analysis means refraction and eye examination including case history, examination for disease or pathological abnormalities of eye and lids, range of clear single vision and balance and coordination of muscles for farseeing, nearseeing and special working distances analysis and professional consultation.

Complications of Pregnancy means all physical effects suffered which have been directly caused by the pregnancy, but which would not be considered from a medical viewpoint the effects of a normal pregnancy, and will include, but not be limited to, conditions such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy which terminated, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.

Copayment or Copay means a set dollar amount you are responsible for paying for certain services (such as prescription drugs or office visits).

Cosmetic Treatment means surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to, treatment to alter:

- the texture or configuration of the skin, or
- the configuration or relationship with contiguous structures of any feature of the human body which is provided primarily for psychological or aesthetic purposes or which does not correct or improve a bodily function.

Covered Expense means the expenses incurred by an Eligible Individual while coverage is in force which are:

- made for care and treatment of an Illness or Injury as defined in the Plan; and
- Medically Necessary; and
- Usual, Customary and Reasonable; and
- covered under provisions of the Plan, or which are not expressly excluded.

Covered Month means that period of time beginning on the first day of any calendar month and ending on the last of the same calendar month in which an individual is eligible.

Drugs means any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician licensed by law to administer it.

Eligible Individual means and Active Employee, Retired Employee or eligible Dependent who has satisfied the Plan's requirements for eligibility.

Emergency means medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- The patient's life or health being placed in serious jeopardy.
- A serious dysfunction or impairment of a bodily organ or part.
- In the event of a behavioral health disorder, the patient harming himself or herself and/or other persons.

The Plan has the discretion and authority to determine if a service or supply is or should be classified as an "Emergency."

Employee means an individual on whose behalf contributions are required by the contributing Employer as provided for under a collective bargaining or other written agreement with the Union and/or Trust.

ERISA means the Employee Retirement Income Security Act of 1974, as amended. ERISA is a federal law that governs the establishment, operation and administration of employee benefit plans, including the Northwest Ironworkers Shop Health and Security Plan. ERISA protects participants and beneficiaries by requiring disclosure of certain information, establishing standards of fiduciary conduct, and providing for appropriate remedies. The Trustees are responsible for complying with ERISA.

Experimental and/or Investigational. The Plan or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan or its designee, (based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for preauthorization under the Plan's

Utilization Management programs), any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in written documents by the health care provider that performs the service or prescribes the supply;
- The prescribed service or supply may be given only with approval of an institutional review board as defined by federal law;
- There is an absence of authoritative medical or scientific literature on the subject, or that literature indicates that the service or supply is Experimental and/or Investigational or that more research is needed;
- Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration;
- The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

Fee for Service is a traditional reimbursement system used under conventional indemnity plans in which the Physician (or other provider) is paid according to the service rendered.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 is legislation designed to improve the portability of health coverage and to make other changes in the health delivery system, group plan design and administration, and nondiscrimination.

Health Maintenance Organization (HMO) is a form of health insurance in which a premium for health services is prepaid. There is generally no paperwork to file and only a small copayment to pay for certain services such as office visits or prescription drugs.

Home Health Aide means a qualified person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a home health care agency.

Home Health Care Agency means a hospital or agency possessing: a) a valid operating certificate which certifies the agency to provide home care services, or b) a non-profit or public health service agency possessing a valid certificate of approval issued in accordance with state or local law.

Home Health Care Plan means a program of home care that is required as a result of an Illness or Injury; is established in writing and periodically reviewed by the attending Physician; and is certified by the Physician as a replacement for hospital confinement that would otherwise be necessary.

Hospice Care Program means a program that is managed by a hospice and established jointly by a hospice, a hospice care team and an attending Physician to meet the special physical, psychological and spiritual needs of dying individuals and their families.

Hospital(s) means a legally operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of doctors, and with 24-hour-a-day nursing service, or one accredited as a hospital by the Joint Commission on Accreditation of Hospitals. The term also includes a state recognized mental health institute provided treatment is given in accordance with a prescribed treatment program which is medically related to Injury or Illness and the treatment is in lieu of similar treatment by a Physician. The term does not include a nursing home nor an institution, or part of one, used mainly as a facility for convalescence, nursing, rest, the aged or care of drug addicts or alcoholics.

Hospital Charges means the actual cost charged to an Eligible Individual by a hospital for room and board (maximum Covered Expenses are specified on the Schedule page) and for other customary hospital services and supplies required for purposes of treatment if the Eligible Individual is confined in the hospital for any period of time while undergoing a surgical operation or while receiving emergency care as a result of and within twenty-four hours after an accident or is confined for any other cause.

Hour Bank means the account established for an Employee to which are credited all hours for which contributions are made or are required to be made to the Trust with respect to the Employee's work by the Employer. One hundred five hours are deducted from the Employee's Hour Bank for each month of eligibility. The maximum hours in an Employee's Hour Bank may not exceed 600 hours after the deduction of 105 hours for the current month's eligibility.

Illness means a bodily disorder, infection, or disease (including pregnancy) and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

Injury means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Services and supplies are **Medically Necessary** or provided due to **Medical Necessity** if such service or supply is determined by the Plan to be:

- Appropriate and necessary for the symptoms, diagnosis or treatment of an Illness, Injury or condition; and
- Not Experimental and/or Investigational; and
- Not primarily for the convenience of the Eligible Individual, their Physician or another provider; and
- Not primarily for research or data accumulation; and
- Within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in which services are provided; and
- The most appropriate supply or level of service which can safely be provided. When applied to hospitalization, Medically Necessary means that the symptoms or condition cannot safely and adequately be treated on an outpatient basis.

The Board of Trustees or its designee reserves the right to make a determination as to whether services, treatment, supplies, confinement or portion of a confinement, is or is not Medically Necessary. The fact that a Physician or other health care provider may prescribe, order, recommend or approve a service or supply does not mean that such a service or supply will be considered to be Medically Necessary for the coverage provided by this Plan.

Non-Preferred Provider Organization or **Non-PPO** means a health care provider that is NOT under contract with the Plan to provide services and supplies at agreed-upon discounted rates as payment in full. These providers may balance bill a patient for billed charges remaining (in excess of the required copayment) after the Plan has made payment.

Optometrist means an individual who is legally licensed to practice optometry by a governmental authority having jurisdiction over the licensure and practice of optometry.

Preauthorization Approval means the requirement to notify the Utilization Management Organization prior to receiving certain services. (See Utilization Management section.)

Physician(s) means a physician licensed to practice medicine and perform surgery. The term also includes an allied practitioner acting within the scope of his or her license including:

- a licensed dentist, denturist, podiatrist, chiropodist or chiropractor duly licensed by the state law and acting within the scope of his practice.
- a nurse practitioner, physician's assistant, licensed practical nurse, and anesthetist practicing within the scope of their profession and authority.
- services of a licensed physical therapist required for the treatment of an acute medical condition when prescribed and supervised by a Physician.
- a licensed, registered nurse certified as a nurse midwife (CNM) and who has privileges at an accredited HMD, hospital or birth center.
- a clinical psychologist.
- a mental health counselor or marriage and family therapist duly licensed by state law and acting within the scope if his practice.
- services of a naturopathic physician which are within the scope of the naturopath's license (subject to the limitations outlined in the Schedule of Benefits).

Physician Visit means a personal interview between and Eligible Individual and a Physician and does not include telephone calls or interviews in which the Physician does not physically see the individual.

Plan means the Northwest Ironworkers Shop Health and Security Fund. This Booklet constitutes the Plan document for self-funded medical, prescription drug, dental and weekly income for disability benefits.

Preferred Provider Organization or **PPO** means a network of health care providers that is under contract with the Plan to provide services and supplies at agreed-upon discounted rates as payment in full, except with respect to a defined copayment for which the Eligible Individual is responsible.

Retiree or **Retired Employee** means a former Employee who is eligible for Retiree coverage under the Plan.

Skilled Nursing Facility means an institution that is licensed to provide skilled nursing care for persons recovering from Illness or Injury and which:

- is supervised on a full-time basis by a Physician or a registered nurse; and
- has transfer arrangements with one or more hospitals, a Utilization Management plan, and operating policies developed and monitored by a professional group that includes at least one Physician; and
- has a contract for the services of a Physician, maintains daily records on each patient and is equipped to dispense and administer Drugs; and
- provides 24-hour nursing care and other medical treatment.

Skilled Nursing Facility does **not** include rest homes, homes for the aged or places for treatment of mental disease, drug addiction or alcoholism.

The term **Trust Agreement** or **Trust** means the Trust Agreement establishing the Northwest Ironworkers Shop Health and Security Fund, and any modification, amendment, extension or renewal. Trustees shall mean any person(s) designated as Trustees under the terms of the Trust Agreement, and the successor of such persons from time to time in office.

The term **Board of Trustees** and **Board** means the Board of Trustees established by the Trust Agreement.

Union means Ironworkers District Council of the Pacific Northwest and Locals 14, 29, 86, and 751 of the International Association of Bridge, Structural & Ornamental Ironworkers affiliated with said District Council, and any other Local Unions of such International Association that hereafter execute an agreement to be bound by the terms of the Northwest Ironworkers Shop Health and Security Fund.

Usual, Customary and Reasonable or **UCR** means the lesser of:

- The usual fee which the provider of service most frequently charges to the majority of his or her patients for a similar service or medical procedure.
- The fees which fall within the customary range of fees charged in a locality by most providers of service of similar training and experience for the performance of a similar service or medical procedure.
- The fees resulting from unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular service or medical procedure.

The provision recognizes that there will be differences in Physician's charges because of such factors as geographical location, skill of the provider of service, and the complexity of the service performed. The Trust shall make the final determination as to whether or not the fee is "Usual, Customary and Reasonable."

Utilization Management is a managed care review procedure to determine the Medical Necessity, appropriateness, location and cost-effectiveness of health care services. This review procedure can occur before, during or after services are rendered, and may include (but is not limited to):

- Preauthorization/Preauthorization Review for hospitalizations, discharge planning and retrospective review, audits of provider billings, and provider fee negotiation.
- Medical Case Management.

An independent Utilization Management organization, staffed with licensed health care professionals, operates under an agreement with the Plan to administer the Utilization Management services.

HOW TO FILE A CLAIM

FOR LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND WEEKLY INCOME BENEFITS

- Obtain a claim form from your Local Union or the Administration Office.
- Complete the form according to the instructions.
- Return the form (in case of death with a certified copy of the death certificate) to the Administration Office whose address is listed on the ***Quick Reference Chart***.

FOR MEDICAL BENEFITS

Preferred Provider

If you receive services from a Preferred Provider, your provider will bill the Plan directly, you don't need to file a claim. Benefit payments are issued directly to Preferred Providers. The Explanation of Benefits form (EOB) you receive from the Administration Office will indicate the remaining balance you owe the Preferred Provider.

However, you must file a claim if you have other insurance not declared when you enrolled (for example, through your spouse's employer) or if a third party may be liable for incurred expenses.

Non-Preferred Provider

If you receive services from a Non-Preferred Provider, you will need to file a claim. Benefit payments are issued directly to you unless you assign benefits to the Non-Preferred Provider.

Filing your Claim

- Obtain a claim form from your Local Union, the Administration Office, or the Trust website.
- Complete the form according to the instructions. Note that there is a section for your doctor to complete.
- Failure to submit itemized doctor and hospital bills, as well as to include your correct identification number (as printed on your ID card) and your signature will delay payment of your claim.
- Mail your completed claim form, with all itemized bills attached to the Administration Office whose address is listed on the ***Quick Reference Chart***.

Please note that many providers, and all Preferred Providers, will submit claims to the Administration Office on your behalf. However, you should confirm that all claims have been submitted.

No claim will be accepted unless it is filed within 12 months from the date the service is incurred.

FOR DENTAL BENEFITS

- Obtain a dental claim form from your Local Union, the Administration Office or the Trust website. Your dentist may use his or her standard dental form.
- Mail your completed form to the Administration Office whose address is listed in the ***Quick Reference Chart***.

No claim will be accepted unless it is filed within **90 days** from the date the dental treatment was performed.

You must submit all orthodontic claims before the work is started. You should also request your dentist to submit a pre-treatment estimate before any extensive dental work is done. The Administration Office will review the claim and estimate in advance how much will be paid. This will help you plan your payment of any balance remaining on treatment fees, and avoid any misunderstanding about the conditions of your coverage.

FOR VISION BENEFITS

Refer to the Vision Benefits section of this Booklet for instructions on how to obtain vision care services.

FOR PRESCRIPTION DRUG BENEFITS

Refer to the **Prescription Drug Benefit** section in the Schedule of Prescription Drug Benefits for instructions on how to use the retail and mail order Prescription Drug Programs.

CLAIM AND APPEAL PROCEDURES

CLAIM

A claim for benefits is a request for benefits from the Plan made in accordance with the Plan's claim procedures.

What is NOT a "claim"

- A request for a determination regarding the Plan's coverage of a medical treatment or service that your Physician has recommended is not a "claim" under these procedures if the treatment or service has not yet been provided and the treatment or service is for non-urgent care for which the Plan does not require prior authorization. In this circumstance, you may request a determination from the Administration Office regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment, because such a request is not a "claim" as described in this section and therefore will not be subject to the requirements and timelines described in this section.
- When you present a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

CLAIM DETERMINATION

Post-Service Medical, Dental, Vision and Prescription Drug Claims

A post-service claim is any properly filed claim for medical, dental, vision, or prescription drug benefits that is not a pre-service claim and does not involve urgent care. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies you within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to your failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and you will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Pre-Service Claims

A pre-service claim is a properly filed claim which must be preauthorized to receive full benefits from the Plan. Under this Plan, preauthorization is required for: (1) Hospital admission, except emergencies; (2) and inpatient and outpatient chemical dependency treatment. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies you within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to your failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and you will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

Urgent Care Claims

Urgent care claims are pre-service claims where the normal time frames for review could seriously jeopardize your life or health, or expose you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by you or by the health care provider with knowledge of your medical condition.

A decision on a properly filed claim for urgent care will generally be made within 72 hours after receipt of a claim that is complete when submitted. You will be notified within 24 hours if additional information is required to process the claim, and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period you have been afforded to provide the additional information.

A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

Weekly Income for Disability Claims

A claim for Weekly Income for Disability Benefits will generally be processed within 45 days of receipt. This period may be extended for up to 30 days, if the Plan determines that an extension is necessary due to matters beyond the control of the Plan, and notifies you within the initial 45-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension is necessary due to matters beyond the control of the Plan, and notifies you prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days.

If an extension is necessary due to your failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and you will be provided at least 45 days to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Life Insurance/Accidental Death and Dismemberment

A claim for life insurance or accidental death and dismemberment benefits will generally be processed within 90 days after receipt. This period may be extended by up to 90 days, if special circumstances require an extension. If the Plan needs additional information from you to make its decision, you will be notified as to what information must be submitted.

DENIAL

If a claim is denied, the written notice of denial will give:

- Specific reasons for denial;
- A reference to pertinent Plan provisions;
- A description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon, either a copy of the rule, guideline, protocol or criterion, or a statement that it is available upon written request without charge;

- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon written request;
- An explanation of the Board of Trustees' Claim Appeal Procedures, including a statement of your right to bring a civil action under ERISA § 502(a);
- In the case of an adverse determination of a claim for urgent care, a description of the expedited review process.

BOARD OF TRUSTEES' CLAIM APPEAL PROCEDURES

Notification of Appeal

Any employee or beneficiary (hereafter "claimant") who applies for benefits and is ruled ineligible by the Trustees (or by the administrator acting for the Trustees), or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees, will have the right to appeal to and request review of the matter by the Board of Trustees, provided that he makes such a request, in writing, within 180 days after the Board's action or within 180 days after receipt of the notification or decision. The appeal of a claim for urgent care may be made orally or in writing.

The written request for appeal should include the reasons for disputing the claim and any additional pertinent material that was not previously submitted.

The appeal will be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees, which has been allocated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal

Except for claims involving pre-service and urgent care, the Trustees will review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within 30 days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustees' receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination will be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustees' receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan will notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

The Trustees will review a properly filed appeal of a pre-service claim within 30 days after receipt of the appeal. The Trustees will review a properly filed appeal of an urgent care claim within 72 hours after receipt of the appeal. All necessary information on a claim for urgent care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method.

Appeal Procedures

The claimant is generally entitled to present his position and any evidence in support of his position, at an appeal hearing. However, in order to expedite review, the appeal of a pre-service or urgent care claim may be held telephonically by the Trustees, and unless the participation of the claimant or his representative is necessary to develop an adequate record, may be based upon the written record. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

The claimant may be represented by an attorney or by any other representative of his choosing at his own expense. In the case of an appeal involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing

The Trustees will issue a written decision on review of a claim (other than a pre-service or urgent care claim) as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim will be made within 30 days after receipt of the appeal, and a decision on review of an urgent care claim will be made within 72 hours after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- 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 claimant's claim for benefits.
- A statement of the claimant's right to bring a civil action under ERISA § 502(a).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon written request.

REVIEW OF TRUSTEES' DETERMINATION

A claimant must exhaust the Trustees' Claim and Appeal Procedures prior to filing a civil action. Following exhaustion of the Claim and Appeal Procedures, a claimant may bring a civil action under ERISA § 502(a).

The question for review of the Trustees' decision will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

NOTE: **Before requesting a hearing as set forth above, it is suggested that you contact the Administration Office. They may be able to help solve any problems and thereby save you considerable time and trouble.**

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have completed the Plan's claim and appeal procedures (described in this Booklet). No lawsuit may be started more than three years after the Trustees' issuance of a written decision on an appeal.

IMPORTANT PROVISIONS AND INFORMATION

FACILITY OF PAYMENT

Protection of Trust Fund, Contributions, and Benefits. No part of the Trust Fund (including the contributions) or the benefits payable under the Plan shall be subject in any manner by an Employee, Retiree or Dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from an Employee, Retiree or Dependent or other beneficiary to a doctor, hospital, or other person or institution that has treated or cared for, or provided services or goods to the Employee, Dependent or other beneficiary, and provided further that the Trustees shall recognize the assignment of benefits under a State Medicaid Plan, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order. No part of the Trust Fund (including contributions, or the benefits payable under the Plan) shall be liable for the debts of an Employee, Dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against an Employee, Dependent or other beneficiary and any attempt shall be null and void.

In the event the Trust determines that an individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event an individual has not provided the Trust with an address at which he can be located for payment, the Trust may during the lifetime of the individual, pay any amount otherwise payable to the individual to the husband or wife or relative by blood or to any other person or institution determined by the Trust to be equitably entitled thereto; or in the case of the death of the individual before all amounts payable under the Plan have been paid, the Trust may pay any such amount to any person or institution determined by the Trust to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the individual: lawful spouse, child or children, mother, father, brothers or sisters, or to the estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Trust hereunder.

AVAILABILITY OF FUND RESOURCES

Benefits provided by the Plan can be paid only to the extent that the Trust has available adequate resources for such payments. No contributing employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments, nothing in the Plan shall be construed as obligating any contributing employer to make payments in order to provide Plan benefits.

A portion of the benefits available to you are paid directly from the assets of the Trust. There is no liability on the Trustees, individually or collectively, or upon any employer, the Union, signatory association or other person or entity to provide benefits if the Trust does not have sufficient assets to pay premiums due or to make benefit payments.

AUTHORITY TO MAKE CHANGES

In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for Employees, the Board expressly reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend either the amount or conditions with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
- To alter or postpone the method or payment of any benefit; and
- To amend or rescind any other provisions of the Plan.

The benefits of this Plan are provided on a month-to-month basis to the extent that employer contributions and self-payments continue to be sufficient for such purpose. There is no long-range funding or reserve program. The Trustees reserve the right to change the eligibility rules, reduce the benefits, increase the required self-payments or eliminate the Plan entirely, as may be required by future circumstances.

RIGHT TO RECOVER EXCESS PAYMENTS

In the event that through mistake or inadvertence or any other circumstance, an Employee, Dependent or other beneficiary has been paid or credited with more than he is entitled to under the Plan or under the law or has become obligated to the Trust in any other way, the Trust may set off, recoup and recover the amount of overpayment or excess credit accrued or thereafter accruing to such Employee, Dependent or beneficiary, to such extent as the Board shall determine.

ADMINISTRATION AND OPERATION OF PLAN

The Board of Trustees shall administer the Plan and serve as named fiduciaries pursuant to the Employee Retirement Income Security Act of 1974, as amended. The Trustees may establish rules for the transaction of their business and the administration of the Plan. The Trustees have the exclusive right to determine eligibility under the Plan, to construe the provisions of the Plan, and to determine any and all questions arising under the Plan or in connection with its administration, including the right to remedy possible ambiguities, inconsistencies, or omissions and any construction or determination by the Trustees made in good faith shall be binding upon the Union, Employees, Retired Employees, employers, and any association signatory to the Trust Agreement.

The Trust recognizes that new technologies may develop which are not specifically addressed in the Plan. The Trust reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Covered Expense. If an Employee, Retiree, or Dependent selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration under the Plan.

The Board of Trustees may engage employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or persons to render advice and/or perform services with regard to any of its responsibilities under the Plan, as determined to be necessary and appropriate.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

Protected Health Information. For purposes of this Article, the term "Protected Health Information" ("PHI") shall have the same meaning as in 45 CFR § 164.501. This Article shall be administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

Request, Use and Disclosure of PHI by Trustees. The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following Administration functions:

- To make or obtain payment for care received by Eligible Individuals.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Eligible Individuals.
- In connection with judicial or Administration proceedings in response to an order of a court or Administration tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan Administration functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.
- For authorized activities by health oversight agencies, including audits, civil, Administration or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to an Eligible Individual's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers' compensation or similar programs.

Trustee Certification

The Plan will only disclose PHI to a Trustee upon receipt of a certification that these procedures have been adopted and the Trustees, as Plan sponsor, agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.

- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify that he has no employees, or other persons under his control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

HIPAA Security

Effective April 21, 2005 in compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
- Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

NORTHWEST IRONWORKERS SHOP HEALTH AND SECURITY FUND
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

PROTECTED HEALTH INFORMATION

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating physician to another treating physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Trust will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Your Personal Representative. The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Trust may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the Plan.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Trust's Privacy Contact Person, listed below. The Trust will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person, listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003** when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its web site, www.wpas-inc.com.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official, listed below.

Privacy Contact Person

Assistant Manager – Employee Benefits – Claims
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574 or Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official

Manager – Employee Benefits – Claims
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574 or Toll Free: 800-331-6158
Fax No: 206-441-9110

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Name of Plan

This Plan is known as the Northwest Ironworkers Shop Health and Security Fund.

Board of Trustees-Plan Administrator

This Plan is maintained and administered by a joint labor management Board of Trustees, the address and telephone number of which are:

c/o Welfare & Pension Administration Service, Inc.
2815 2nd Avenue, Suite 300
P.O. Box 34203
Seattle, WA 98124
Administration and Claims Office: (206) 441-7226 or (866) 986-1515

A list of participating employers and labor organizations can be examined at this office.

Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is:

EIN 91-6068079. The Plan Number is: **PN 501**.

Type of Plan

This Plan can be described as an employee welfare benefit plan which provides Medical, Prescription Drug, Life, Accidental Death and Dismemberment, Weekly Income, Dental, Hearing and Vision Benefits.

Type of Administration

This Plan is administered by the Board of Trustees, with the assistance of Welfare and Pension Administration Service, Inc., a contract administration organization.

Description of Collective Bargaining Agreements

This Plan is maintained by a number of collective bargaining agreements requiring contributions by the employers into the Trust Fund for the purpose of providing and maintaining benefits.

Funding Medium

The Trust is funded through employer contributions, the amount of which is determined through collective bargaining agreements and contribution agreements. Self-payments are also permitted as outlined in this Summary Plan Description. The Comprehensive Medical, Prescription Drug, Dental, Weekly Income and Vision Benefits are provided directly from Trust assets. HMO benefits are fully insured and are provided under contracts with carriers whose names, addresses and telephone numbers are outlined on the ***Quick Reference Chart***. Life Insurance and Accidental Death and Dismemberment coverage is fully insured and is provided under contract with the carrier whose name, address and telephone number is outlined on the ***Quick Reference Chart***.

Fiscal Year/Plan Year

The end of the Plan's fiscal year and official plan year is June 30.

Members of the Board of Trustees

The names, addresses and titles of the individual Trustees as of the date of this Booklet are as follows:

EMPLOYER TRUSTEES	UNION TRUSTEES
E. Scott Dahlgren, Chairman Dahlgren Industrial, Inc. P. O. Box 3515 Seattle, WA 98134 (206) 236-2300	**Ron Piksa, Secretary** Ironworkers Dist. Council of the Pacific Northwest 10828 Gravelly Lake Boulevard SW, Suite 212 Lakewood, WA 98499 (253) 984-0514
Dennis Carey 26126 SE 452nd Ave Sandy, OR 97055 (503) 668-3985	**Jeff Glockner** Ironworkers Local No. 86 4550 S. 134th Place, Suite 102 Tukwila, WA 98168 (206) 248-4246
Dave Harrison Skanska USA Building 221 Yale Avenue North, Suite 400 Seattle, WA 98109 (206) 494-5404	**Kevin Jensen** Ironworkers Local No. 29 11620 NE Ainsworth Circle, Suite 200 Portland, OR 97220 (503) 774-0777
John Hightower Structural Systems, Inc. 734 S 1st W Missoula, MT 59801 (406) 728-5597	**Greg Kucera** Ironworkers Union Local No. 751 8141 Schoon Street Anchorage, AK 99518 (907) 563-4766
Jeff Illenstine Tri States Rebar, Inc. 7208 E. Indiana Avenue Spokane, WA 99212 (509) 922-5901	**Rick Morton** East 411 Sierra Court Spokane, WA 99208 (509) 927-8288
Steven LaRue Garco Inc. E. 4114 Broadway Ave. Spokane, WA 99202 (509) 535-4688	**Donnie Patterson** Ironworkers Local No. 14 16610 E. Euclid Spokane, WA 99216 (509) 927-8288
Brian O'Neill StressCon USA 19142 Molalla Ave., Suite B Oregon City, OR 97045 (503) 518-7700	**James Pauley** Ironworkers Local No. 29 11620 NE Ainsworth Circle, #200 Portland, OR 97220 (503) 774-0777
Rex D. Smith REFA Erection, Inc. 14255 SW 72nd Ave Tigard, OR 97224 (503) 639-3141	**Steve Pendergrass** Ironworkers Local No. 86 4550 S. 134th PL, #102 Tukwila, WA 98168 (206) 248-4246

Each member of the Board of Trustees is an agent for the purpose of accepting service of legal process on behalf of this Plan.

Availability of Information

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request, so you can find out the cost before ordering.

Future of the Plan and Trust

The Board of Trustees is providing this program of benefits, including the Retiree benefits, to the extent that monies are currently available to pay the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditures of such monies for the program. The program is not guaranteed to continue indefinitely. The program may be terminated or modified at any time by the Board of Trustees.

The Trust Fund will terminate upon the expiration of all collective bargaining agreements requiring the payment of contribution to the Trust Fund. In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Northwest Ironworkers Shop Health and Security Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request of the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself and Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this Booklet.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and the interest of other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you have the right to a hearing before the Trustees at which you may present your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of your choosing. If you are dissatisfied with the Trustees' determination, you may also file suit in 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 frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Seattle regional office of the Pension and Welfare Benefits Administration is located at: MIDCOM Tower, 1111 Third Avenue, Suite 860, Seattle, Washington 98101-3212, telephone number (206) 553-4244.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.