Northwest Ironworkers Trust Funds

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124 Phone (206) 441-7226 or (866) 986-1515 • Fax (206) 505-9727 • Website www.ironworkerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

October 6, 2020

TO: All Plan Participants of the
Northwest Ironworkers Shop Health and Security Fund

RE: New Summary Plan Description

Summary Plan Description

The Board of Trustees is pleased to present you with this new and up-to-date 2020 Edition of the Summary Plan Description (Plan booklet) for the Northwest Ironworkers Health and Security Fund for Shop Employees. This Plan booklet supersedes all previous versions of the Plan booklet.

This revised Plan booklet describes the benefits available to eligible shop participants and their dependents. From time to time the Board of Trustees has issued Summaries of Material Modifications (SMM) to provide notice of material benefit changes to the Plan. This Plan booklet has incorporated all the SMMs issued through January 1, 2020.

Below are some of the most recent benefits incorporated to this Plan booklet:

- Bariatric (Weight Loss) Surgery
- Dialysis treatment for End Stage Renal Disease (ESRD)
- Coverage of Preventive Care Services
- Exclusion of Charges Related to Home Births
- Removal of Hospice lifetime maximum

This Plan booklet is also available on the Trust's website at www.ironworkerstrust.com. We encourage you to visit the website any time you need forms or have questions about your benefits or eligibility.

Please refer to this Plan booklet when health plan questions arise and keep it with your records for future reference.

Board of Trustees
Northwest Ironworkers Shop Health and Security Fund

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at (866) 986-1515, option 1. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NORTHWEST IRONWORKERS SHOP

HEALTH AND SECURITY FUND

SUMMARY PLAN DESCRIPTION
January 2020

TO ALL ELIGIBLE INDIVIDUALS:

This Summary Plan Description/Plan (Booklet) has been prepared to describe the benefits available through the Northwest Ironworkers Health and Security Fund (Trust) for Shop Ironworkers. This Booklet sets forth the eligibility requirements that you and your Dependents 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 certain rights you and your Dependents have under the law. It includes all benefit changes made through January 1, 2020, and replaces all other Plan Booklet/Summary Plan Descriptions previously provided.

This Booklet contains descriptions of Medical, Prescription Drug, Weekly Disability Income, 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 Health and Security Fund and The Union Labor Life Insurance Company.

We encourage you and your Dependents to become familiar with the benefits provided and the valuable protection they offer. This Booklet also explains the services that are covered and special steps that may be needed to receive the highest level of coverage.

The following steps can help keep health care costs reasonable:

- **Use Preferred Providers.** Using PPO Providers (hospitals, doctors, lab, etc.) can benefit both you and the Plan by reducing costs. These providers have agreed to provide Eligible Individuals with efficient, cost effective services and supplies at discounted rates (see page 43).
- **Use Network Pharmacies**. You and your Dependents can also save money on prescription drugs by using a pharmacy in the EnvisionRx network; and it avoids the need to fill out a claim form (see page 79).
- **Use Teladoc.** Contact Teledoc for treatment of many medical issues by phone or video. The Trust covers these visits in full, with no cost to you and your Dependents (see page 49).

Also, don't forget to notify the Administration Office whenever your address (or the address of Dependent child) changes.

If you or your Dependents have any questions about eligibility or benefits, please call the Administration Office at (866) 986-1515 or (206) 441-7226.

Sincerely,

Board of Trustees

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
Discrimination is Against the Law

Northwest Ironworkers Health and Security Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Northwest Ironworkers Health and Security Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ❖ Qualified sign language interpreters
  - ❖ Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - ❖ Qualified interpreters
  - ❖ Information written in other languages

If you or your Dependents need these services, contact the Manager of Employee Benefits, PO Box 34203, Seattle, WA 98124-1203, (866) 986-1515, extension 3500, Fax (206) 441-9110.

You or your Dependents may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html.***

Spanish - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-986-1515.

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-986-1515。

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-986-1515.

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-986-1515 번으로 전화해 주십시오.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-986-1515.

Tagalog - PAUNAWA**:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-986-1515.

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-986-1515.

Mon-Khmer, Cambodian - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-986-1515.

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-986-1515 まで、お電話にてご連絡ください。

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-986-1515.

Cushite - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-866-986-1515.

Arabic - ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-986-1515.

Panjabi - ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-986-1515 'ਤੇ ਕਾਲ ਕਰੋ।

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-986-1515.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-986-1515.

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-986-1515.

Samoan - MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-866-986-1515.

Ilocano - PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-866-986-1515

Thai - เรียน**:** ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเ หลือทางภาษาได้ฟ รี โทร 1-866-986-1515

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-986-1515.

Romanian – ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-866-986-1515.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شمافراهم می باشد. با 1-866-986-1515 تماس بگیرید. **Persian** –

French – ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-986-1515.

Serbo-Croation – OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-986-1515.

Sudan – ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-866-986-1515

Norwegian – MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-866-986-1515.

Pennsylvanian Dutch – Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-986-1515.

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-986-1515.

IMPORTANT INFORMATION

Northwest Ironworkers 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 Board of Trustees 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.

The Board of Trustees has delegated to its third-party administrator and other designated entities the authority to provide certain administrative services to the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions. The Plan's third-party administrator or other entity used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. The Plan's third-party administrator does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Plan's third-party administrator is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

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. Only 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.

NORTHWEST IRONWORKERS SHOP HEALTH AND SECURITY FUND

7525 SE 24th Street, Suite 200
Mercer Island, WA 98040-2341

or

P.O. Box 34203
Seattle, WA 98124-1203

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CONSULTANT
Rael & Letson

ADMINISTRATION OFFICE
Welfare & Pension Administration Service, Inc.

AUDITOR
Anastasi, Moore & Martin, PLLC

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QUICK REFERENCE CHART

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

Information Needed	Whom To Contact
Claims Office • Plan Benefit Information • Claim Forms • Medical Claims and Appeals • Dental Claims and Appeals • Weekly Disability Claims and Appeals • Prescription Drug Claims (non-network only)	**WPAS, Inc.** Mailing Address: PO Box 34464 Seattle, WA 98124-1464 Street Address: 7525 SE 24th Street, Suite 200 Mercer Island, WA 98040-2341 (206) 441-7226 or (866) 986-1515, Option 1
Administration Office • Eligibility for Active Employees, Retirees, Surviving Spouses and COBRA Beneficiaries • Identification Card Orders • Information about COBRA Continuation Coverage • Medicare Part D Notice of Creditable Coverage	**WPAS, Inc.** Mailing Address: PO Box 34203 Seattle, WA 98124-1203 Street Address: 7525 SE 24th Street, Suite 200 Mercer Island, WA 98040-2341 (206) 441-7226 or (866) 986-1515 Option 4 ***www.ironworkerstrust.com***
Preferred Provider Organization (PPO) • Medical Network Provider Listing	**Premera Blue Cross** (800) 810-BLUE (2583) ***www.premera.com***

Information Needed	Whom To Contact
• Always check with the Network before visiting a provider to confirm that they are still a PPO Provider	
Telemedicine • Telephone or video access to a doctor through Teladoc	**Teladoc** (855) 332-4059 www.Teladoc.com/Premera
Medical Management Programs/Utilization Management (UM) Coordinator • Inpatient Preauthorization • Outpatient Services Preauthorization • Healthy Mother Baby Program • Care Counseling • Second and Third Opinions • Case Management	**Innovative Care Management (ICM)** (800) 862-3338 ***www.innovativecare.com*** For more information about the Healthy Mother Baby Program, contact Innovative Care Management directly
Prescription Drug Program • Administers Prescription Drug Benefits • Prescription Drug Information • Retail Network Pharmacy Listing • Mail Order Pharmacy • Specialty Drug	**EnvisionRx** (800) 361-4542, Option 2 ***www.envisionrx.com***

Information Needed	Whom To Contact
Program: Preauthorization and Ordering • Identification cards for Medicare retirees only	
Medicare Benefits and Enrolling for Medicare Parts A, B and D Coverage	The local Social Security Office
Vision Plan • Administers Vision Benefits • Vision Network Provider Listing • Vision Claims and Appeals	**Vision Service Plan (VSP)** (800) 877-7195 ***www.vsp.com***
Employee Assistance Program (EAP) (for Active Employees and their Dependents) • EAP counseling and referral services • Administers EAP Program	**Fully Effective Employees, Inc.** (800) 648-5834 ***www.fee-eap.com***
Life Insurance, Dependent Life Insurance, and Accidental Death and Dismemberment Benefits	**WPAS, Inc.** PO Box 34203 Seattle, WA 98124-1203
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Privacy Official** **WPAS, Inc.** PO Box 34203 Seattle, WA 98124-1203 (206) 441-7574 (800) 331-6158 Fax Number: (206) 441-9110

IMPORTANT

You and your Dependents 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 the right to appeal denied claims can be found in the HOW TO FILE A CLAIM and CLAIM AND APPEAL PROCEDURES sections of this Booklet.

WEBSITE AVAILABLE

The Northwest Ironworkers Trust Funds have established a website to provide you and your Dependents with immediate access to Plan information. The site, located at ***www.ironworkerstrust.com***, includes the following Trust Fund-related material:

- Plan Booklets
  - ❖ Health and Welfare
  - ❖ Retirement
  - ❖ Annuity
  - ❖ Updates to Plan Documents
- Website links
  - ❖ Premera
  - ❖ Innovative Care Management
  - ❖ EnvisionRx
  - ❖ Vision Service Plan (VSP)
- Forms
  - ❖ Health and Welfare Enrollment/Beneficiary Designation Form
  - ❖ Medical, dental and vision claim forms
  - ❖ Retirement
- HIPAA Privacy Notice and Information
- Links to Useful Sites
  - ❖ Local Unions
  - ❖ District Council

This site also provides access to your personal information, which may be viewed through a secure location requiring the entry of a Personal Identification Number (PIN) and your WPAS ID or 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 your own PIN. Your personal 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
- Beneficiaries
- Hours/Contributions – statement showing recently reported hours
- Dependent Enrollment
- Medical/Dental Claim Summary

Employees will only have access to their own paid claims history and that of dependents under the age of 13. Spouses and dependent children age 13 and over must request their own PIN. To request a dependent PIN, go to the Trust website (***www.ironworkerstrust.com***) and download a Dependent Only PIN form.

If you have any questions about the contents of the website or access to your personal information, please contact the Administration Office at (866) 986-1515.

ENROLLMENT

All Employees must complete and return enrollment forms and any supporting documentation (i.e. a copy of your marriage certificate for your spouse and/or copies of birth certificates for your eligible Dependents) 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 used to enroll your Dependents and designate beneficiaries for your Life Insurance and Accidental Death and Dismemberment benefits.

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

- You or your Dependents have a change of 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.

Enrollment of Newly Acquired Dependents Is Required. If you acquire a new Dependent through marriage, birth or adoption, you must contact the Administration Office ***as soon as possible*** and request a new enrollment form. Any required documentation, such as the marriage certificate for your spouse or a birth certificate for your child must be provided as soon as it is available. No claims will be paid until all required enrollment documentation is on file.

Provided that all the requested enrollment documentation is received, coverage for your eligible dependents begins on the later of: 1) the date your coverage begins; or 2) the date your dependents first meet the definition of an eligible dependent as described in this section (for example: date of marriage, date of birth, date of adoption, etc.). Dependents will not be eligible for coverage until all requested enrollment documentation is provided. Please note: If requested enrollment documentation is not provided, the Plan will not pay claims until the documentation is received. Delayed enrollment documentation may result in the denial of claims. In no event will the Plan pay claims submitted or completed more than 12 months after the incurred date.

If a change in family status is due to divorce, you must immediately notify the Administration Office and 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 for Life Insurance or Accidental Death and Dismemberment benefits 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.

ACTIVE EMPLOYEE ELIGIBILITY

ELIGIBILITY FOR SHOP EMPLOYEES COVERED BY A COLLECTIVE BARGAINING AGREEMENT

This Plan provides health and welfare coverage for Shop Ironworkers and their Dependents. Eligibility is determined on the basis of an Hour Bank system. Your Hour Bank is an account containing hours for which employer contributions are made on your behalf. Hours are credited one month following the month you actually worked. Hour Bank eligibility differs depending upon whether you work as a bargaining unit employee under a Collective Bargaining Agreement or as a non-bargaining employee covered by an Associate Agreement.

INITIAL ELIGIBILITY UNDER A COLLECTIVE BARGAINING AGREEMENT

If you work under a Collective Bargaining Agreement, your Hour Bank is credited with hours for which your employer makes a contribution to the Trust on your behalf pursuant to the terms of the Collective Bargaining Agreement while you are covered under that agreement. The Trustees may adopt a methodology for pro-rating hours, if the contribution rate under a Collective Agreement differs from the contribution rate under a Master Labor Agreement with the Ironworkers District Council of the Pacific Northwest.

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 work hours in your Hour Bank within a consecutive three-month period, or
- 500 work hours in your Hour Bank within a consecutive twelve-month period.

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

CONTINUING ELIGIBILITY UNDER A COLLECTIVE BARGAINING AGREEMENT

Once you satisfy the initial eligibility requirements, 105 hours are deducted from your Hour Bank to provide one month of eligibility. You remain eligible as long as your Hour Bank does not fall below 105 hours.

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.

CREDITING HOUR BANK FOR HOURS WORKED UNDER A COLLECTIVE BARGAINING AGREEMENT BUT UNPAID

Your Hour Bank can also be credited with hours for which contributions are required under a Collective Bargaining Agreement but which are not paid by your employer. The maximum number of hours that will be credited to your Hour Bank for contributions required but not paid by your employer is 315 hours in every rolling twelve-consecutive month period. It is your responsibility to contact the Administration Office if you believe hours that you worked were not credited to your Hour Bank. You will also be required to provide documentation (such as paycheck stubs) of the hours worked to the Administration Office. To further check and verify your eligibility for a given month, call the Administration Office or visit the Trust website.

ELIGIBILITY FOR EMPLOYEES COVERED BY AN ASSOCIATE EMPLOYEE AGREEMENT

INITIAL ELIGIBILITY UNDER AN ASSOCIATE EMPLOYEE AGREEMENT

If you are not covered by a Collective Bargaining Agreement, you may only participate in the Plan if your employer signs a written Associate Employee Agreement with the Trustees. Generally, owners, spouses of owners, and certain supervisory or management employees may only participate under an Associate Employee Agreement. Participation under an Associate Employee Agreement is subject to the terms in that agreement and the Trustees' Policy Regarding Associate Employees.

If you work under an Associate Employee Agreement, your Hour Bank is credited with hours for which your employer makes a contribution to the Trust on your behalf pursuant to the terms of the Associate Agreement., You generally 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:

- 375 or more hours in your Hour Bank within a consecutive three-month period, or
- 750 or more hours in your Hour Bank within a consecutive twelve-month period.

For example**:** If you worked a total of 375 or more hours in January, February, and March, you are eligible for benefits on May 1.

The Trustees may adopt a methodology for pro-rating or allocating hours if you periodically work under both a Collective Bargaining Agreement and an Associate Employee Agreement, or if you are a temporary or part-time employee covered under an Associate Employee Agreement.

CONTINUING ELIGIBILITY UNDER AN ASSOCIATE EMPLOYEE AGREEMENT

Once you satisfy the initial eligibility requirements, 150 hours are deducted for your Hour Bank to provide one month of eligibility. You remain eligible as long as your Hour Bank does not fall below 150 hours. The maximum number of hours in your Hour Bank may not exceed 900 (after deduction of 150 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, 150 hours would be deducted for April's eligibility, and 350 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 900.

CONTRIBUTIONS MUST BE PAID FOR ASSOCIATE EMPLOYEES TO RECEIVE HOUR BANK CREDIT

Your Hour Bank will not be credited with hours unless the contributions required by the Associate Employee Agreement for those hours are actually paid by your employer.

TERMINATION OF YOUR HOUR BANK 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 the minimum hours required for a month of eligibility; or
- On the date the Plan terminates.

Following termination of Hour Bank eligibility, there may be options for continuing coverage, as explained in the COBRA Continuation Coverage section (page 28) and the Alternative Continuation of Coverage Options section (page 35).

REINSTATEMENT OF HOUR BANK ELIGIBILITY

If coverage terminates because your Hour Bank has less than the minimum required for a month of eligibility, the balance of your hours (if any) will be carried for 6 months from the last day of Hour Bank eligibility. If, during that 6-month period you work and accumulate sufficient hours for a month of eligibility, your eligibility will be reinstated on the first day of the second month following the month in which your Hour Bank has sufficient hours for a month of eligibility.

For example**:** If you work under a Collective Bargaining Agreement and your last month of eligibility was August 2018 because your Hour Bank dropped below 105 hours, you must work sufficient hours before the end of February 2019, so that eligibility is reinstated no later than April 2019.

If you do not accumulate sufficient hours during the six-month period following termination (and as a result eligibility is not reinstated 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.

RECIPROCITY

Eligibility may be provided under this Plan for Employees who work in other local union jurisdictions provided that the other jurisdiction's trust fund or health plan has executed a reciprocal agreement with the Northwest Ironworkers Health and Security Fund. Additionally, you may request that this Plan transfer contributions made on your behalf to another trust fund or health plan if it has executed a reciprocal agreement with the Northwest Ironworkers Health and Security Fund. Generally in order for you to become eligible under a reciprocal agreement you must request in writing the transfer of contributions made on your behalf from one plan to another and the contributions must actually be transferred on your behalf. For additional information regarding your eligibility for reciprocal transfers, including whether a specific plan has a reciprocal agreement with the Northwest Ironworkers Health and Security Fund, please contact the Administration Office. 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.

DEPENDENT ELIGIBILITY

Your Dependents are eligible for coverage from the Plan. Your Dependents become eligible on the effective date of your eligibility, or if later, the date the Dependent is acquired.

DEFINITION OF DEPENDENT

A Dependent means any one of the following persons:

- 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, including a legally recognized same-sex spouse.
- A child of an Employee or Retired Employee. Children of an Employee or Retired Employee include the following:

    1) A natural child, stepchild, adopted child, child placed for adoption or foster child under the age of 26. 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. The term foster child means a foster child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

    2) An unmarried child, other than those mentioned above, for whom the Employee or Retired Employee has legal custody or is the legal guardian pursuant to a judgment, decree, or other order of any court of competent jurisdiction, provided the child is under age 19, or under age 24 and a full time student at an accredited educational institution (must be a student in the spring quarter/semester to have continued coverage in the summer). In addition, the child must reside with and be a member of the household of the Employee or Retired Employee on a full-time basis and is dependent on the Employee or Retired Employee for support and maintenance.

    3) An unmarried child who has reached the limiting age and is 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 disabled 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 Administration Office 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 as often as the Plan may reasonably require.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls an Employee's natural Dependent children, adopted Dependent children, and Dependent children placed with the Employee in anticipation for adoption as directed by the Order. A QMCSO 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 QMCSO 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.

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 QMCSO.

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 QMCSO and any required self-payments must be received prior to enrollment. Any child(ren) enrolled pursuant to a QMCSO will be subject to all provisions applicable to Dependent coverage under the Plan.

NEWLY ACQUIRED DEPENDENTS

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. Claims will not be processed until all required enrollment documentation is on file.

The effective date of coverage for newly acquired Dependents is as follows:

- Spouse - on the date of marriage.

- 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 Retired Employee fails to enroll a new Dependent within 31 days of the date the Dependent is acquired, the Dependent 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

Unless they are eligible to continue coverage under a continuation right set forth in this Plan booklet, your Dependents' eligibility will terminate on the earliest of the following occurrences:

- On the date your eligibility terminates for any reason, including death; 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; or
- On the date the Plan terminates.

See the COBRA Continuation Coverage section (page 28) and the Alternative Continuation Coverage Options section (page 35) for information on how to continue coverage in the event coverage under the Plan is terminated. If you have any questions concerning your eligibility for coverage, you should contact the Administration Office or visit the Trust website.

ADULT DEPENDENT OPT-OUT COVERAGE

If you are an Active Employee, your Dependent spouse or adult Dependent children (over age 18) may elect to opt-out of Plan coverage by submitting a signed written request to the Administration Office at the address listed in the ***Quick Reference Chart***.

The opt-out will be effective for all claims incurred on and after the first of the month following the month in which the opt-out request is received by the Plan. The opt-out will apply to all Plan coverage, including Medical, Prescription Drug, Dental, Vision and Life Insurance.

An opt-out of Plan coverage is not a COBRA qualifying event and a Dependent who opts out will not be eligible for COBRA Continuation Coverage. A Dependent who opted out of coverage and is not enrolled in the Plan at the time of a COBRA qualifying event will not be eligible to re-enroll or to elect COBRA Continuation Coverage.

A Dependent who opted out of coverage may re-enroll, provided you are an Active Employee on the date enrollment would become effective and your Dependent still satisfies the requirements for Dependent eligibility. Re-enrollment will be effective the first of the month following the month in which all necessary and completed re-enrollment information is received. A written request for re-enrollment must be submitted to the Administration Office at the address listed in the ***Quick Reference Chart***.

You may not unilaterally remove an adult Dependent from coverage without the adult Dependent's written consent. A minor child cannot opt-out of Plan coverage and cannot be removed from the Plan by you or your spouse.

COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your Dependents each have an independent right to elect to continue Trust health coverage beyond the time coverage would ordinarily end. 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 for the Trust. All communications must be made in writing, and identify the Employee or Retiree and the individual requesting COBRA, the Trust's name (Northwest Ironworkers Health and Security Fund), and the qualifying event. Communications must be sent to the Administration Office at the following address:

Northwest Ironworkers Health & Security Fund
PO Box 34203
Seattle, WA 98124-1203

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

- The Employee's termination of employment or reduction in hours of employment;
- Death of the Employee; or
- Divorce from the Employee or Retiree.

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

- The Employee's termination of employment or reduction in hours of employment;

- Death of the Employee;
- Divorce of a lawful spouse from the Employee or Retiree; or
- The child losing Dependent status.

COBRA NOTIFICATION RESPONSIBILITIES

The Trust offers COBRA only after it has been notified of a qualifying event. You or your Dependents are required to inform the Administration Office of a loss of coverage resulting from a divorce or a child losing Dependent status. You or your Dependents must provide this notice in writing to the Administration Office 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 COBRA. Notice of the qualifying event must identify the individual who has experienced the qualifying event; the Employee's name, if different; the qualifying event that occurred; and the Trust. Even after you have made a written election with the Administration Office you may later revoke, change or modify your election by forwarding a new notice with a follow-up written election notice to the Administration Office before the 60 days has expired. Elections, changes or revocations must be sent to the Administration Office in writing within the 60-day period to the address listed above under Notices to Trust Concerning COBRA.

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 COBRA.

Your employer is responsible for informing the Trust of a qualifying event which is a termination of employment, reduction in hours or your death. 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 Dependents of the right to elect COBRA and provide an election form. A written election must be sent to the Administration Office at the address listed above under Notices to Trust Concerning COBRA, 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.

Failure to elect COBRA 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 COBRA.

AVAILABLE COVERAGE

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 and Vision
4. 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), (with or without vision coverage) only. Once the coverage option is selected, it cannot be changed.

COBRA coverage is not available for Weekly Disability Income benefits.

ADDING NEW DEPENDENTS

COBRA is available to individuals who were covered 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 indicated above under Notices to Trust Concerning COBRA, within 31 days of acquiring the new Dependent. The written notice must identify the Employee or Retiree, 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 COBRA coverage if a second qualifying event occurs, as discussed below.

CONTINUOUS COVERAGE REQUIRED

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

COST

There is a cost for COBRA. The cost for the coverage available through the Trust is set annually. If you or your Dependents are eligible for a disability extension discussed below, the cost of coverage may be 150% of the COBRA self-payment rate for the additional 19th through 29th month of COBRA. Information regarding the cost will be sent with the election forms.

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. Thereafter, payments must be made monthly. All payments must be sent to the Administration Office.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date of the qualifying event until the appropriate COBRA payments have been made. COBRA terminates if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment, or any subsequent payment is not made in a timely fashion, COBRA terminates.

MONTHLY SELF-PAYMENTS REQUIRED

You or your Dependents are responsible for the full cost of COBRA. All payments must be sent to the Administration Office at the address printed on the payment coupons. 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 COBRA will not commence, nor will claims be processed until the initial payment has been made. You or your Dependents will lose the right to COBRA 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 Hour Bank coverage was provided under the provisions for Hour Bank Credit in Case of Disability (see page 35), the maximum continuation period will be 18 months less the number of months of the hour bank 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, divorce from the Employee or Retiree, or a child no longer qualifying as a Dependent under the Plan) COBRA coverage may last for up to 36 months.

Continuation coverage will end on the last day of the monthly 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 Dependent becomes 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 pre-existing condition of the individual seeking COBRA). You are required to notify the Administration Office when you become eligible under another group health plan;
- You or your Dependent provide written notice that you wish to terminate your coverage;
- You or your Dependent become entitled to Medicare after the date of the election of COBRA;
- 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 that formerly participated in the Trust.

LENGTH OF CONTINUATION COVERAGE – DISABLED INDIVIDUALS

If you or your 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 COBRA coverage, you and your 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 prior to the end of your initial 18-month period of COBRA coverage. A copy of the Social Security Disability Determination must be included with the written notice. Failure to give notice and provide the Social Security Disability Determination prior to the end of the initial 18-month period will cause you and your Dependents to lose the right to extend COBRA. 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

Dependents who are entitled to COBRA 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, a divorce from the Employee, or a child losing Dependent status.

If a 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 COBRA 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 Trust 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 Trust 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 Trust coverage (based on COBRA or otherwise), the Trust 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 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 Trust's COBRA coverage will be secondary.

ALTERNATIVE CONTINUATION OF COVERAGE OPTIONS

There is no individual or group conversion option available for Medical, Prescription Drug, Dental, Vision or Accidental Death & Dismemberment benefits provided directly by the Trust

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

Please read this section carefully, because the other coverage options in this section may be in addition to COBRA coverage or may be an alternative to COBRA coverage. Some of these options are more affordable than enrolling in COBRA.

HOUR BANK CREDIT IN CASE OF DISABILITY

This provision only applies to Active Employees covered by a Collective Bargaining Agreement; Employees covered by an Associate Employee Agreement are not eligible for this disability credit.

If, while eligible under this Plan as an Active Employee, you become Totally Disabled, 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 Disability Income benefits as provided under this Plan, or by receipt of Workers' Compensation benefits.

If you suffer a second disability which occurs while receiving this 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 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.

Following termination of this disability coverage, you may elect COBRA; however, the maximum COBRA coverage period will be reduced by the number of months of this disability coverage.

EXTENSION OF HOUR BANK COVERAGE DURING A FMLA LEAVE OF ABSENCE

If your employer approves your leave under 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. To qualify, you must be employed by an employer who employees 50 or more employees within 75 miles from your worksite, and you must have been employed by that employer for at least one year and at least 1,250 hours over the previous twelve months. 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.

CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

Under the Uniform Services Employment and Reemployment Rights Act (USERRA), 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 hours in your Hour Bank are less than the number required for 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 Disability 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 for 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 the number of hours required for one 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 (page 28), if you have questions regarding election or duration of COBRA.

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, Prescription Drug, 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 (page 28).

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, Prescription Drug, and Vision 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.

RETIREE COVERAGE

Shop Retired Employees may be eligible for retiree coverage under the Northwest Ironworkers retiree plan. The retiree plan's eligibility and benefits are described in the Northwest Ironworkers Health and Security Fund's plan for field ironworkers. Generally to be eligible for retiree coverage you must satisfy either condition 1) or 2) and either 3) or 4) you are eligible for coverage from the Plan as a Retired Employee:

1) You had eligibility as an Active Employee under the Trust for 30 of the last 60 months immediately prior to your retirement date; or

2) You had eligibility as an Active Employee under the 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, if you were not otherwise covered by the Health and Security Fund. This 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 you had eligibility as an Active Employee under this Trust for a total of at least 120 months immediately prior to your retirement.

For more information regarding Retiree medical coverage, please contact the Trust Administration Office.

Shop Ironworkers who qualify for both COBRA and Retiree medical, may elect COBRA for themselves and their Dependents. If COBRA is elected, the Employee and Dependents may apply for Retiree medical following termination of COBRA. However, if COBRA is declined in favor of Retiree medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

HEALTH INSURANCE MARKETPLACE

Instead of enrolling in COBRA, more affordable coverage may be available through the Health Insurance Marketplace. Employees or Dependents who enroll in coverage through the Marketplace may qualify for lower monthly premiums and lower out-of-pocket costs than under COBRA.

Employees or Dependents who elect COBRA can switch to a Marketplace plan during the Marketplace open enrollment. Employees and Dependents may also be able to end COBRA early and switch to a Marketplace plan if there is an event that gives rise to a special enrollment period, such as marriage or birth of a child. However, if COBRA is terminated early without an event that gives rise to a special enrollment, then Marketplace coverage is not available until the next Marketplace open enrollment period.

Once COBRA is exhausted and expires, special enrollment is also available through the Marketplace, even if the open enrollment ended.

If a Marketplace plan is selected instead of COBRA, then COBRA may not thereafter be elected unless there is a new COBRA qualifying event.

For information about health insurance options available through the Health Insurance Marketplace, and to find assistance in a particular geographic area who can provide information about the different options, visit ***www.HealthCare.gov.***

COMPREHENSIVE MEDICAL BENEFITS

The benefits described in this section apply to all Eligible Individuals who have enrolled in the Comprehensive Medical Benefits Program.

PREFERRED PROVIDER PROGRAM

The Plan has contracted with a national preferred provider organization (PPO) that has developed and maintained a network of Preferred (PPO) Providers (Physicians, Hospitals and other providers) 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 PPO Providers.

The name and telephone number for the PPO network can be located on the ***Quick Reference Chart***. A PPO Provider Directory is available on the Premera Blue Cross website: ***www.premera.com/sharedadmin***. You may also obtain information as to whether a particular provider is in the network by calling (800) 810-BLUE (2583).

The Preferred Provider Program Does Not Apply to Medicare-eligible Retirees: The Plan does not require a Medicare eligible Retired Employee or a Medicare eligible spouse of a Retired Employee to use PPO doctors and Hospitals. The Plan will pay remaining Covered Expenses after it receives a ***Medicare Explanation of Benefits***.

The Comprehensive Medical Benefit provides benefits for Covered Expenses incurred for a non-occupational Illness or Injury. Covered Expenses are subject to a deductible and coinsurance/copay that applies to each Eligible Individual each calendar year. The Comprehensive Medical Benefit has been structured to provide an incentive to use a PPO Provider.

MEDICAL MANAGEMENT PROGRAMS

The Plan includes Medical Management Programs to help you and your Dependents make informed decisions about health care and to help reduce the cost of medical care for you and the Plan. Please read this section carefully, as failure to use Medical Management properly may result in additional out-of-pocket expenses.

Note: The Medical Management Programs do not apply when Medicare is your primary coverage.

The Plan has contracted with a specialty health company, Innovative Care Management (ICM), to provide you with a confidential unbiased resource to help you navigate the health system and your care. The Medical Management Programs consists of the following unique programs:

CARE COUNSELING PROGRAM

The Plan encourages you and your Dependents to call a Care Counselor before needing treatment outside of the primary doctor's office. ICM Care Counselors can provide information about the different network providers who offer the needed services as well as the cost of the services. You and your Dependents may continue to select any provider, but calling a Care Counselor helps to make informed choices about spending your health care dollars.

ICM Care Counseling may be reached at (800) 862-3338. Representatives are available Monday through Friday from 7:00 A.M. to 5:00 P.M. (Pacific Time). The Care Counseling number is included on your ID card.

INPATIENT PREAUTHORIZATION PROGRAM

When a Physician recommends an inpatient admission to a Hospital or Treatment Facility, you, your Dependent, or your Physician must contact the Plan's Utilization Management (UM) Coordinator to request preauthorization of Medical Necessity. You and your Dependents are required to obtain preauthorization from the UM Coordinator for all inpatient admissions, except for a medical Emergency or maternity care of 48 hours or less (96 hours in the case of a cesarean). Preauthorization or non-Emergency inpatient admissions must be obtained from the UM Coordinator prior to admission. Emergency inpatient admissions must be preauthorized by the Plan's UM Coordinator within 48 hours of admission.

BENEFITS ARE REDUCED BY $250 FOR ANY INPATIENT ADMISSION THAT IS NOT PREAUTHORIZED BY THE UM COORDINATOR. SERVICES THAT ARE NOT MEDICALLY NECESSARY WILL NOT BE COVERED BY THE PLAN.

Important: It is the responsibility of you and your Dependents to ensure that the Physician, or facility complies with the preauthorization

requirements of the Plan. Even if your doctor initiates the process, we encourage you and your Dependents to also contact the UM Coordinator to confirm compliance with the Plan's requirements. Failure to obtain preauthorization may result in significant financial consequences.

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 the Plan 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 the treating 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 inpatient stay can be shortened or in some cases, the inpatient admission may not be necessary. If inpatient admission is necessary, the UM Coordinator will determine the number of days needed inpatient.

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

If all or a portion of an inpatient stay is denied by the UM Coordinator, the type of care received is still up to the patient and the patient's doctor. **However, the Plan will pay only for those Hospital or Treatment Facility 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 inpatient services has been received to make sure that it conforms to the diagnosis and treatment. If discrepancies exist, the Hospital or Treatment Facility billing department may be contacted.

Please note: The UM Coordinator cannot answer questions regarding your Plan, your eligibility, or benefits you have available – the Administration Office is available to provide this information. The Administration Office cannot preauthorize inpatient admissions for Medical Necessity – this can only be done by the UM Coordinator.

OUTPATIENT PREAUTHORIZATION PROGRAM

You and your Dependents are required to obtain preauthorization for most non-emergency outpatient services performed outside of your primary doctor's office. Outpatient services are medical procedures or tests that can be done in a medical center without an overnight stay. The following outpatient services require preauthorization:

- All outpatient surgeries and procedures;
- Ancillary testing (e.g., MRI, PET, and CT scans);
- Durable medical equipment (when costs exceed $500);
- Chemotherapy or radiation;
- Clinical Trials;
- Transplants (organ and tissue);
- Physical, speech or occupational therapy after 8 visits.

Taking this simple step can help you and your Dependents make an informed decision about the level of care needed and how to spend health care dollars.

Here is what you need to do:

- The treating doctor should initiate the outpatient review process; however, if the doctor does not obtain preauthorization, it is the patient's responsibility. Even if the doctor initiates the process, we encourage you and your Dependents to contact the UM Coordinator as well.
- The UM Coordinator will confirm the Medical Necessity for these services.
- If authorization is not received in advance, the procedure may be deemed not Medically Necessary and you and your Dependents will be responsible for the full cost of treatment.

If care is needed outside of your regular doctor's office, contact Innovative Care Management (ICM) at the phone number shown in the ***Quick Reference Chart*** before seeking your treatment.

CASE MANAGEMENT

Case Management is a program designed to help you and your family cope with serious medical conditions. An Innovative Care Management (ICM) nurse works closely with you, your family, and your physicians to ensure that you have the information and support that you need. Whether you need specialized equipment, referrals, or simply a sympathetic ear, the ICM nurse assigned to you can help you get what you need when you need it. This support can help you feel more in control and confident when dealing with the increasingly complicated healthcare system.

You may be contacted by an ICM case manager regarding your condition and treatment.

HEALTHY MOTHER BABY PROGRAM

This Plan offers a Healthy Mother Baby Program for Active and Retired Employees and their Dependent spouses only. The Healthy Mother Baby Program offers the following at no cost to you:

- Access to a nurse specializing in maternity and newborns;
- Educational information packets including a prenatal care book;
- Brochures and coupons;
- A resource library with additional materials, information, and support for high-risk pregnancies.

Contact Innovative Care Management at (800) 862-3338 for more information about this program.

RESTRICTIONS AND LIMITATIONS OF MEDICAL MANAGEMENT PROGRAMS

- The fact that a Physician recommends surgery, hospitalization, or confinement in a specialized facility, or that a Physician or another Covered 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.
- Medical 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 the patient and the Physician. Eligible Individuals should follow whatever course of treatment the Eligible Individual and the treating Physician believe to be the most appropriate. Benefits payable by the Plan may, however, be affected by Medical Management provisions.
- 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, the Eligible Individual and/or the treating 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. The UM Coordinator should 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 the Eligible Individual, Physician, and the Administration Office.

In lieu of appealing a denial of preauthorization to the UM Coordinator, the Eligible Individual may submit the appeal to the Board of Trustees pursuant to the Claims and Appeals Procedures in this Booklet. In the alternative, an Eligible Individual may submit the matter for review by the Board of Trustees following a determination on appeal by the UM Coordinator.

TELADOC

Teladoc is an affordable alternative treatment option to costly urgent care or emergency room visits. Teladoc provides access to U.S. board-certified doctors who can treat many medical issues by phone or video 24/7, 365 days a year. The Plan covers Teladoc visits in full; visits are not subject to the medical annual deductible or copay/coinsurance provisions.

Teladoc doctors, who are practicing primary care physicians, pediatricians and family medicine physicians, can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more

To set up a phone or video call with a Teladoc doctor:

- Visit ***www.Teladoc.com/Premera*** to set up an account
- Enter your information and complete the "My Medical History"
- To request a phone or video consult, log in at ***www.Teladoc.com/Premera*** or call (855) 332-4059

Note: Teladoc is an independent company that arranges virtual medical care services on behalf of Premera Blue Cross. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, nontherapeutic drugs and certain other drugs which may be harmful because of the potential for abuse.

DEDUCTIBLE

The deductible is the amount of Covered Expenses that each Eligible Individual must pay each calendar year before most Covered Expenses are paid by the Plan. Services for PPO and Non-PPO Providers are combined to meet the annual deductible. The annual deductible is:

Per Eligible Individual:	$350
Per Family:	$1,050

This means you pay the first $350 of Covered Expenses during the calendar year. The deductible is limited to $1,050 for a family each calendar year. Once the family deductible is satisfied, no further deductible amounts will be required for any family member for the rest of that calendar year.

If two or more eligible family members are injured in the same accident, only one individual deductible will be charged against the combined total Covered Expense resulting from the accident, regardless of the number of family members injured. The combined deductible also applies to the future reapplication of the deductible for the accident.

The $20 copay required for a Physician, Acupuncture, Naturopathic Services and Spinal Manipulation Services office visit with a PPO Provider applies toward meeting the annual deductible.

The following are not subject to the medical deductible:

- Physician office visits with a PPO Provider, when a copay applies, including lab and x-rays in conjunction with the office visit.
- Hearing aids.
- Hearing evaluations.
- Preventive Care

Any penalty applied for not preauthorizing services, balance billed charges and charges in excess of the Usual, Customary and Reasonable amount do not apply to the annual deductible.

COPAY

Most Covered Expenses are subject to the annual deductible (described above) and the coinsurance percentage (described below).

However, for a Physician, Acupuncture, Naturopathic Services and Spinal Manipulation Services office visit with a PPO Provider, the annual deductible and coinsurance do not apply. Instead, an Eligible Individual is responsible for a $20 copay per visit and the Plan pays the rest.

Medical copays made in a year are credited towards meeting the annual deductible. Medical copays for a Physician and Naturopathic Services office visit with a PPO Provider also apply toward your Medical Out-of-Pocket Maximum.

This copay provision does not apply to Retirees and their Dependents who are eligible for Medicare.

COINSURANCE

Coinsurance is the Eligible Individual's share of Covered Expenses after the deductible is satisfied. Unless otherwise stated under Covered Medical Expenses, the coinsurance rates for all Covered Medical Expenses are as follows:

	Plan pays:	**You pay:**
PPO Provider:	75% of the PPO Amount	25% of the PPO Amount
Non-PPO Provider:	50% of the UCR Amount	50% of the UCR Amount (plus any amount in excess of the UCR Amount)

When services or supplies are provided by a PPO Provider, the Plan generally pays a higher percentage of Covered Expenses than it does when services are provided by a Non-PPO Provider. The Medical Out-of-Pocket Maximum is also higher when services are provided by a Non-PPO Provider. In addition, a Non-PPO Provider, may balance bill the Eligible Individual for the difference between the billed charges and the UCR Amount. Therefore, in most cases, an Eligible Individual's out-of-pocket costs are higher when services are provided by a Non-PPO Provider than when services are provided by a PPO Provider.

Coinsurance amounts for Covered Expenses are based on:

- The PPO Amount which is the fee negotiated by the PPO with the PPO Provider as described in the Definitions.
- The UCR Amount which is the Usual, Customary and Reasonable amount as described in the Definitions.

Covered Expenses for a Medicare eligible Retired Employee or a Medicare eligible spouse of a Retired Employee are processed at the PPO coinsurance rate.

EXCEPTIONS TO PPO HANDLING

Exception for Out-of-Area Use of Non-PPO Hospitals, Treatment Facility and Other Medical Providers: If an Eligible Individual is Out-of-Area and is admitted to a Non-PPO Hospital or Treatment Facility or receives services for Covered Expenses from a Non-PPO medical provider, benefits will be payable at the PPO coinsurance rate applied to the UCR Amount. An Eligible Individual is Out-of-Area if there is no PPO Provider that can provide the services within a 20 mile radius of an Eligible Individual's home, or within a 20 mile radius of where the services are performed.

Exception for Use of Non-PPO Hospitals and Non-PPO Medical Providers for Specialized Services: If an Eligible Individual is within a PPO Service Area and receives specialized services only available at a Non-PPO Hospital or from a Non-PPO medical provider, benefits will be payable for the specialized services at the PPO coinsurance rate applied to the UCR Amount provided preauthorization was received from the UM Coordinator. A PPO Service Area is any area where a PPO Hospital, Treatment Facility or medical provider is within a 20 mile radius of where the services are performed.

Exception for Treatment and Services Provided by a Non-PPO Physician in the Emergency Room of a PPO Hospital: Covered Expenses for treatment by a Non-PPO Physician while in the emergency room of a PPO Hospital will be payable at the PPO coinsurance rate applied to the UCR Amount.

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 coinsurance rate

applied to the UCR Amount, provided that the surgeon is a PPO Provider.

Exception for Ambulance: Covered Expenses for Ambulance services to transport a patient who requires paramedic support to a Hospital due to an Emergency Medical Condition will be payable at the PPO coinsurance rate applied to the UCR Amount.

ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM

The annual Medical Out-of-Pocket Maximum is the most an Eligible Individual pays during the calendar year before the Plan begins to pay 100% of the PPO Amount or the UCR Amount for Covered Expenses. For claims incurred between January 1st and December 31st, the following Out-of-Pocket Maximums apply:

	PPO Provider	**Non-PPO Provider**
Per Eligible Individual:	$12,500 after deductible	$25,000 after deductible
Per Family:	No limit	No limit

The Out-of-Pocket Maximum for medical expenses does not include contributions an Eligible Individual pays for COBRA or Retiree Medical, balance-billed charges, expenses that are not Covered Expenses under the Plan, services and supplies covered under the hearing aid benefit, and penalties for failure to preauthorize services or the deductible.

The $20 copay required for a Physician and Naturopathic Services office visit with a PPO Provider applies toward meeting the annual Out-of-Pocket Maximum.

The Out-of-Pocket Maximums are subject to adjustment each calendar year as allowed by law.

COVERED MEDICAL EXPENSES

Most Medically Necessary services and supplies required for the treatment of a non-occupational Illness or Injury are considered Covered Expenses under the Plan. All Covered Expenses are subject to the limitations and exclusions as shown in this section as well as the General Exclusions and Limitations as shown on page 108.

ACUPUNCTURE

Professional fees for acupuncture are covered as follows for Covered Providers acting within the scope of their license and if acupuncture treatment has been recommended by a Physician for pain management based upon the Physician's diagnosis:

- For PPO Providers in an office setting, there is a $20 copay per visit which applies toward meeting the annual deductible. Covered Expenses are not subject to the annual deductible. Lab and x-rays in conjunction with an office visit are covered at 100%, not subject to the annual deductible.
- For PPO Providers outside an office setting, benefits are subject to the annual deductible and coinsurance of 25% of the PPO Amount.
- For Non-PPO Providers, benefits are subject to the annual deductible and coinsurance of 50% of the UCR Amount, 25% of the UCR Amount Out-of-Area.
- For Retirees and their Dependents who are eligible for Medicare, benefits are subject to the annual deductible and coinsurance of 25% of the Medicare allowance.

Benefits for acupuncture and spinal manipulation services are limited to a combined maximum benefit of $1,250 per person per calendar year, regardless of the type of provider (e.g. MD, DC, DO) providing the services except for situations when the medically necessity treatment is recommended in writing by a medical doctor.

ALLERGY SERVICES

The following allergy services are covered only when ordered by a Physician:

- 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.

AMBULANCE SERVICES

Ambulance services for Medically Necessary transportation are covered as follows:

- **Local ground vehicle transportation** is covered to and from the Hospital or other facility in connection with any one disability. Transportation must be by a legally licensed vehicle to the nearest appropriate facility that can provide Medically Necessary treatment of a medical Emergency or acute illness.
- **Air transportation** is covered for an Emergency if 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. The aircraft must be legally licensed and certified for Emergency patient transportation.

BARIATRIC (WEIGHT LOSS) SURGERY

Preauthorization is required for all bariatric surgery. See the section titled Medical Management Programs beginning on page 43 for details.

Bariatric surgery is covered for the treatment of morbid obesity in adults when the following criteria are satisfied:

- Medical Necessity.
- A body mass index (BMI) greater than 40 kg/m, or a BMI greater than 35 kg/m with certain comorbidities.
- Evidence of active participation in a Physician supervised weight reduction program of at least 6 consecutive months duration within the two-year period prior to surgery and documented in the medical records.
- A psychological evaluation by a licensed mental health Covered Provider to establish emotional stability and the ability to comply with post-surgical limitations.

BLOOD PRODUCTS AND SERVICES

The following are covered only when ordered by a Physician:

- Blood or blood plasma and its administration.
- Expenses related to drawing of blood from the patient for use in the patient's own surgery, and blood storage fees.

CHEMOTHERAPY

Preauthorization is required for all chemotherapy. See the section titled Medical Management Programs beginning on page 43 for details.

Chemotherapy drugs and supplies are covered when 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.

COLONOSCOPY AND SIGMOIDOSCOPY BENEFIT

See the Preventive Care Services benefit on page 67.

DENTAL SERVICES

The following dental services are covered under the Comprehensive Medical Benefits:

- 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.
- 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 that 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. Only those charges in excess of any benefits payable under the Plan's Dental Benefits are covered under the Comprehensive Medical Benefits.
- Dental implantology provided 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.
- Facility fees and anesthesia associated with Medically Necessary dental services covered under the Plan's Dental Benefits if the patient is a child (age 6 and under) or it is determined that the care is Medically Necessary to safeguard the health of the patient during performance of dental services. Services must be performed in an outpatient facility and not in a dental office.
- See also the Temporomandibular Joint Dysfunction (TMJ Services) benefit on page 72.

- Services provided in a dental office that are covered under the Dental Benefits are not covered under Comprehensive Medical Benefits provisions.

DIABETES EDUCATIONAL PROGRAM

Diabetes Educational Programs are covered when prescribed by a Physician (for a patient or a parent of a Dependent child patient). Services include teaching the care and management of diabetes for an Eligible Individual or parent of an eligible Dependent child.

DIALYSIS TREATMENT FOR END STAGE RENAL DISEASE (ESRD)

Eligible Individuals diagnosed with end stage renal disease (ESRD) may be eligible for Medicare by nature of the diagnosis. Although, enrolling in Medicare Part A and/or Part B is not mandatory, Plan benefits will be based on the assumption that a person enrolls in Medicare when eligible to do so. Enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Outpatient kidney dialysis for treatment of ESRD is covered as follows:

- If an Eligible Individual is not yet eligible to enroll in Medicare (months 1-3 post diagnosis), benefits are provided subject to the annual deductible and coinsurance of 25% of the PPO Amount for PPO Providers or 50% of the UCR Amount for Non-PPO Providers.
- If an Eligible Individual is enrolled in, or eligible to enroll in Medicare (months 4-34 post diagnosis), and Medicare becomes or is eligible to become the secondary payer, benefits are provided at 150% of the current Medicare allowed amount, not subject to the annual deductible or coinsurance.
- If Medicare becomes the primary payer, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, an Eligible Individual is required to provide the Administration Office with a copy of their Medicare card showing the effective date of Medicare Part A and Part B coverage.

If you or your Dependent is diagnosed with ESRD contact the Administration Office for assistance.

Dialysis treatment for other than ESRD is covered as any other condition.

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Preauthorization is required for durable medical equipment for costs in excess of $500. See the section titled Medical Management Programs beginning on page 43 for details.

- Coverage is provided for rental or initial purchase of durable medical equipment and supplies which are:
  - ordered by a Physician;
  - useable only by the patient;
  - of no further use when medical need ends;
  - not primarily for the comfort or hygiene of the patient;
  - not for environmental control;
  - not for exercise;
  - manufactured specifically for medical use;
  - in use for all activities of daily living;
  - approved as Medically Necessary treatment, as determined by the Plan, and
  - not for prevention purposes.

  Covered Expenses also include repair, adjustment, or servicing of the device, and replacement of the device if the existing device cannot be repaired or if replacement is prescribed by a Physician because of a change in the patient's physical condition.
- Oxygen and the rental of equipment for its administration are covered.
- Casts, splints, braces, and crutches are covered.

The following are not covered:

- Deluxe items.
- Any accrual of charges for the rental of equipment that is in excess of the normal purchase price for that medical equipment.
- Devices directly related to an organ transplant.
- A device used specifically as a safety item or to affect performance primarily in sports-related activity.
- Non-durable medical supplies including (but not limited to) ace bandages, gauze and like products, air purifiers, heating pads, heating lamps, bed boards, orthopedic shoes, exercise equipment, special equipment for homes or cars, gym memberships and custom features.

EMERGENCY ROOM SERVICES

The following emergency room services are covered:

- Hospital emergency room (ER) facility.
- Ancillary charges (such as lab or x-ray) performed during the emergency room visit.
- Emergency room Physician charges performed during the emergency room visit.

Covered Expenses incurred from a Non-PPO Provider are paid at the PPO Provider coinsurance rate when emergency room services are for treatment of an Emergency Medical Condition.

FAMILY PLANNING, REPRODUCTIVE, CONTRACEPTIVE (FERTILITY) AND ERECTILE DYSFUNCTION SERVICES – For Employees, Retirees And Dependent Spouses Only

Sterilization services (e.g., vasectomy, tubal ligation, implants) are covered for the Employee, Retiree or the Dependent spouse.

The following are not covered:

- 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.
- Penile implants.

Contraceptives and erectile dysfunction medications are covered under the Prescription Drug Benefits (see page 79).

FOOT ORTHOTICS – For Active Employees Only

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.

This benefit is provided to Active Employees only and is limited to a maximum benefit of $200 every 5 years.

HABILITATIVE THERAPY SERVICES FOR MEDICALLY NECESSARY TREATMENT OF A MENTAL HEALTH DISORDER

The following habilitative therapy services are covered for Medically Necessary treatment of a mental health disorder:

- Neurological and psychological testing, evaluations and assessments.
- Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment.
- Speech, occupational, physical, and other Medically Necessary therapies when provided under a formal written treatment plan.
- Neurodevelopmental therapy services for coverage of Medically Necessary speech, occupational, physical and other Medically Necessary therapies to treat developmental conditions identified as mental health disorders in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). (See the Neurodevelopmental Therapy Services section on page 65 for benefits for treatment of a condition not identified as a mental health disorder).

HEARING AIDS

Hearing aids are covered when there is an examination by a Physician who **provides written certification** of a hearing loss that may be lessened by the use of a hearing aid. Benefits will **not** be provided without this certification.

Benefits are limited to $800 in a three consecutive year period, which includes: the purchase of a hearing aid instrument (monaural or binaural) prescribed as a result of the examination; ear mold(s); the initial batteries,

cords and other necessary ancillary equipment; a warranty; and follow-up consultation within 30 days following delivery of the hearing aid.

The following are not covered:

- 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.

Charges are not subject to the Medical deductible or Out-of-Pocket Maximum.

HEARING EVALUATION

The following expenses for a hearing evaluation are covered once each calendar year:

- One otologic examination by a Physician.
- One audiologic examination and hearing evaluation by a certified or licensed audiologist including a follow-up consultation

Charges are not subject to the Medical deductible.

HOME HEALTH CARE

The following services and supplies provided by a licensed Home Health Care Agency, under a Home Health Care Plan, are covered up to a maximum of 130 home health care visits per year, when ordered by a Physician:

- 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 the Eligible Individual 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).

The following are not covered:

- Safety items such as a commode or shower bench and rails**.**
- Services or supplies not provided under a Home Health Care Plan.
- Visits that exceed the 130 visits calendar year maximum.
- Home hospice coverage is payable under Hospice benefits.

HOSPICE

The following services and supplies are covered when the patient is diagnosed as terminally ill:

- Inpatient and outpatient care, home care, nursing care, counseling and other supportive services and supplies provided by a Hospice Care Agency, hospice care team, Home Health Care Agency, or Skilled Nursing Facility 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 5 days per three-month period of hospice care;
- Ambulance service that is certified by a Physician as Medically Necessary 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.

The following are not covered:

- Hospice care services not approved by the attending Physicians.
- Transportation services, except for licensed ambulance services (see page 54).
- 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.

HOSPITAL SERVICES

All inpatient Hospitalization is subject to preauthorization except for emergency stays and maternity stays (less than 48 hours for a natural delivery or 96 hours for a cesarean). If preauthorization is not obtained, a $250 penalty applies which does not count toward meeting the annual medical deductible or Out-of-Pocket Maximum. See the section titled Inpatient Preauthorization Program on page 44 for details.

The following Hospital services are covered:

- Room and board facility fees in a semiprivate room with general nursing services. Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.
- Specialty care units (e.g., intensive care unit, cardiac care unit).
- Lab/x-ray/diagnostic services.
- Operating room, surgical supplies, hospital anesthesia services and supplies.
- Related Medically Necessary ancillary services (e.g., prescriptions, supplies).
- 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.

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 an Employee, Retiree or their Dependent spouse.

The Healthy Mother Baby Program through Innovative Care Management (see page 47), is also provided at no cost to you. It features access to a nurse specializing in maternity and newborns, educational information packets including a prenatal care book, brochures and coupons, a resource library with additional materials and information and support for high-risk pregnancies.

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 for a cesarean).

The following is not covered:

- A Dependent daughter's pregnancy, maternity care, miscarriage or abortion, except when treatment or services are for Complications of Pregnancy, or are otherwise required by law.

MENTAL HEALTH

Coverage is provided for Medically Necessary treatment of a mental health disorder as follows:

- Inpatient Hospital or Treatment Facility expenses are covered in the same manner as for any other Illness. ***All inpatient admissions are subject to preauthorization (see page 44).***
- Outpatient expenses are paid in the same manner as for any other Illness.
- Services by a Physician, clinical psychologist, licensed mental health counselor or licensed marriage and family therapist for mental health treatment, or other Covered Provider acting within the scope of their license are covered.
- Outpatient prescription drugs for mental health disorders are payable as outlined under the Prescription Drug benefit (see page 79).

- Psychological (Psychiatric) Testing is covered.
- The Employee Assistance Program (EAP) is also available to assist you and your Dependents (see page 124 for details).

NATUROPATHIC SERVICES

Professional fees for naturopathic services are covered for the examination, diagnosis and treatment of an Illness or Injury as follows:

- For PPO Providers in an office setting, there is a $20 copay per visit which applies toward meeting the annual deductible. Covered Expenses are not subject to the annual deductible. Lab and x-rays in conjunction with an office visit are covered at 100%, not subject to the annual deductible.
- For PPO Providers outside an office setting, benefits are subject to the annual deductible and coinsurance of 25% of the PPO Amount.
- For Non-PPO Providers, benefits are subject to the annual deductible and coinsurance of 50% of the UCR Amount, 25% of the UCR Amount Out-of-Area.
- For Retirees and their Dependents who are eligible for Medicare, benefits are subject to the annual deductible and coinsurance of 25% of the Medicare allowance.

Only the office visit and Medically Necessary lab work and x-rays are covered; charges for prescribed vitamins and supplements are not covered.

NEURODEVELOPMENTAL THERAPY SERVICES - For Children Age 6 and Younger

The following neurodevelopmental therapy services are covered:

- Neurological and psychological testing, evaluations and assessments.
- Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment.
- Occupational, speech, physical and other Medically Necessary therapies under a formal written treatment plan by a Covered Provider authorized and licensed to deliver the services.

After the deductible, the maximum lifetime benefit per person is $3,000 unless Medically Necessary for the treatment of a mental health disorder**.**

(See the Habilitative Therapy section on page 60 for Habilitative Therapy benefits for treatment of a mental health disorder).

OUTPATIENT (AMBULATORY) SURGERY FACILITY

All outpatient surgeries are subject to preauthorization (see page 46). Outpatient surgery facility fees are covered, subject to the annual deductible and applicable coinsurance percentage.

Physician fees associated with the surgery are payable under the Physician Services Outside An Office Setting section (see page 66).

PHYSICAL EXAM BENEFIT

See Preventive Care Services benefit on page 67**.**

PHYSICIAN OFFICE VISITS

Professional fees of a Physician office visit are covered for the examination, diagnosis and treatment of an Illness or Injury as follows:

- For PPO Providers there is a $20 copay per visit which applies toward meeting the annual deductible. Covered Expenses are not subject to the annual deductible. Lab and x-rays in conjunction with an office visit are covered at 100%, not subject to the annual deductible.
- For Non-PPO Providers, benefits are subject to the annual deductible and coinsurance of 50% of the UCR Amount, 25% of the UCR Amount Out-of-Area.
- For Retirees and their Dependents who are eligible for Medicare, benefits are subject to the annual deductible and coinsurance of 25% of the Medicare allowance.

An office visit associated with either a routine mammography screening or pap smear test is also covered.

Note: As an alternative, you can use the services of a Teladoc physician at no cost to you. See page 49 for information about contacting a physician by phone or video.

PHYSICIAN SERVICES OUTSIDE AN OFFICE SETTING

Professional fees of a Physician for services received in a Hospital, emergency room (ER), urgent care facility or other covered health care facility location are covered. Benefits are subject to the annual deductible and applicable coinsurance percentage.

Note: As an alternative, you can use the services of a Teladoc physician at no cost to you. See page 49 for information about contacting a physician by phone or video.

PREVENTIVE CARE SERVICES

Preventive Care Services are covered with no deductible, copay or coinsurance when provided by a PPO Provider. Preventive Care Services provided by a Non-PPO provider are covered subject to the annual deductible and coinsurance.

Preventive Care Services are limited to medically appropriate services. Guidance on coverage or frequency will be followed when included in the recommendations for covered Preventive Care Services listed below. If no guidance on coverage or frequency is given, the Plan may adopt or utilize reasonable medical management techniques to determine the coverage and frequency limit. The following services are covered:

- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. These recommendations include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas. A complete list of these services and screenings can be found at ***www.uspreventiveservicestaskforce.org***.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. Current ACIP recommendations and immunization schedules can be found at ***www.cdc.gov/vaccines***.
- For infants, children, and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). These guidelines describe recommended coverage of items such as mammograms and cervical cancer screenings. A complete list of these services can be reviewed at ***www.hrsa.gov/womens-guidelines***.

- Physician's office services for smoking cessation. Drugs to ease nicotine withdrawal that require a written prescription are covered under the Prescription Drug Benefit (see page 79).

Unless otherwise agreed to by the Board of Trustees, any additions to the above list of preventive services will be effective on the first day of the plan year beginning 12 months after the new preventive service is listed.

PROSTHETIC DEVICES

- Coverage is provided for the initial purchase of prosthetic devices and braces (including surgically implanted devices and corrective appliances) which 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;
- 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 patient;
- not for environmental control;
- not for exercise;
- manufactured specifically for medical use;
- approved as Medically Necessary treatment, as described by the Plan, and
- not for prevention purposes.

Coverage is limited to 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.

Coverage is also provided for the first intraocular lens prescribed to replace the lens of an eye.

The following are not covered:

- Electronic prostheses, penile prostheses, or devices directly related to an organ transplant.
- Custom features.

RECONSTRUCTIVE SERVICES AND BREAST RECONSTRUCTION AFTER MASTECTOMY

All inpatient admissions are subject to preauthorization (see page 44).

Reconstructive surgery is covered if it is 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.

Covered Expenses include reconstructive breast surgery of the involved breast following or coinciding with a mastectomy necessitated by Illness or Injury. In accordance with the Women's Health and Cancer Rights Act of 1998, such Covered Expenses include reconstruction of the breast on which the mastectomy was performed, one surgery on the other breast to produce symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Most Cosmetic and dental services are excluded from coverage.

REHABILITATION SERVICES (CARDIAC)

Cardiac rehabilitation is covered provided the patient 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.

REHABILITATION SERVICES (PHYSICAL, OCCUPATIONAL & SPEECH THERAPY)

Preauthorization is required after 8 visits (see page 46).
Coverage is provided for the following rehabilitation services:

- 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 by a Covered Provider required for the treatment of a 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.

The following are not covered:

- Maintenance rehabilitation.
- Coma stimulation.
- Myofunctional therapy.
- Pulmonary rehabilitation.

SKILLED NURSING FACILITY (SNF) CARE

All inpatient admissions are subject to preauthorization (see page 44).

Skilled Nursing Facility services and supplies are covered after confinement in a Hospital and provided the admission is for the same or a related Illness or Injury as the Hospital confinement, and the patient is under the continuous care of a Physician who has certified the Medical Necessity of the confinement. The Plan covers up to 120 days per confinement.

The following are not covered:

- Days for which the patient is not being actively treated for Illness or Injury.
- Any charges after the date the attending Physician stops treatment or withdraws certification of Medical Necessity.

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

SPINAL MANIPULATION SERVICES

Professional fees for spinal manipulation are covered for treatment of an Illness or Injury as follows:

- For PPO Providers in an office setting, there is a $20 copay per visit which applies toward meeting the annual deductible. Covered Expenses are not subject to the annual deductible. Lab and x-rays in conjunction with an office visit are covered at 100%, not subject to the annual deductible.
- For PPO Providers outside an office setting, benefits are subject to the annual deductible and coinsurance percentage of 25% of the PPO Amount.
- For Non-PPO Providers, benefits are subject to the annual deductible and coinsurance of 50% of the UCR Amount, 25% of the UCR Amount Out-of-Area.
- For Retirees and their Dependents who are eligible for Medicare, benefits are subject to the annual deductible and coinsurance of 25% of the Medicare allowance.

Benefits for spinal manipulations and acupuncture are limited to a combined maximum benefit of 24 visits per person per calendar year.

SUBSTANCE ABUSE TREATMENT

Preauthorization is required for inpatient substance abuse treatment. See the section titled Inpatient Preauthorization Program on page 44 for details.

Inpatient treatment and outpatient visits for treatment of substance abuse are covered as any other Illness.

The Employee Assistance Program (EAP) is also available to assist you and your Dependents (see page 124 for details).

SUPPLEMENTAL ACCIDENT BENEFIT

Up to $300 will be covered without deductible or coinsurance for the following Covered Expenses incurred as a result of an Injury within 90 days from the date of the accident causing the Injury:

- Surgery or medical attention provided by a Physician or other Covered Providers acting within the scope of their license;
- Hospital care;

- Nursing care; 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.
- Expenses incurred after termination of eligibility.

SURGERY

All inpatient admissions are subject to preauthorization (see page 44); all outpatient surgeries are subject to preauthorization (see page 46).

Expenses incurred for services of the surgeon and anesthesiologist are covered for surgical procedures. The Plan covers expenses incurred for an assistant surgeon at 20% of the PPO Amount or UCR Amount of the corresponding surgeon's fees, provided the use of an assistant was Medically Necessary and the assistant surgeon was a provider acting within the scope of their license.

If secondary procedures are performed during the same operative session which are not incidental to, nor part of, another procedure, and which add significant time or complexity to the complete procedure, as determined by the Administration Office, benefits will be determined as follows:

- The Plan covers 100% of the PPO Amount or UCR Amount for the primary procedure;
- The Plan covers 50% of the PPO Amount or UCR Amount for the secondary or any additional procedures.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ SERVICES)

Non-surgical treatment of TMJ dysfunction or syndrome, including appliances, is covered up to a lifetime maximum benefit of $1,000 per person, subject to the annual deductible and applicable coinsurance percentage.

TRANSGENDER HEALTH CARE SERVICES

Preauthorization is required for inpatient Hospitalization. A coverage determination should also be requested prior to beginning any

transgender services. See the sections titled Inpatient Preauthorization Program on page 44 and Outpatient Preauthorization Program on page 46 for details.

The following transgender health care services are covered for Medically Necessary treatment of Gender Dysphoria (also called Gender Identity Disorder):

- Counseling.
- Hormone therapy.
- Gender reassignment surgery.
- Services typically associated with one sex, which may continue to be required after transition.
- Prescription drugs (as covered under the Prescription Drug Program of this Plan).

To be eligible for transgender health care services, you must:

- Be 18 years of age or older;
- Have a well-documented diagnosis of Gender Dysphoria or Gender Identify Disorder meeting the diagnostic criteria of the current edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM); and
- In the event of gender reassignment surgery, have no medical contraindications and complete specific evaluation and recommendation requirements.

The Plan utilizes the Premera Medical Policy for Gender Reassignment Surgery in determining whether gender reassignment surgery is Medically Necessary and a Covered Expense. A copy of the Premera Medical Policy is available by contacting the Administration Office.

The Plan does not cover services that are considered cosmetic, not Medically Necessary and/or are otherwise excluded under the Plan. This includes, but is not limited to:

- Rhinoplasty or nose implants.
- Face-lifts.
- Lip enhancement or reduction.

- Facial bone reduction or enhancement.
- Blepharoplasty (eyelid surgery).
- Breast augmentation.
- Liposuction.
- Reduction thyroid chondroplasty (Adam's Apple reduction).
- Hair removal except medically necessary procedures (including electrolysis) to treat tissue donor sites prior to phalloplasty or vaginoplasty.
- Voice modification surgery or training.
- Skin resurfacing.
- Travel expenses.

TRANSPLANTS (ORGAN AND TISSUE)

Preauthorization is required for all transplant services, including pre-transplant workup tests. See the section titled Medical Management Programs beginning on page 43 for details.

- Coverage is provided only for services directly related to **non-experimental transplants** (see page 128) of human organs or tissue along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.
- Benefits are payable only if services are provided in a Hospital or health care facility approved by the Plan.
- Donor expenses are not covered unless the person who receives the donated organ/tissue is a person covered by this Plan.

URGENT CARE FACILITY

Charges incurred at an urgent care facility, including ancillary charges such as lab and x-rays, will be covered.

X-RAY AND LAB SERVICES

Preauthorization is required for some ancillary tests (see page 46).

The following services are covered when ordered by a Physician or other Covered Provider:

- Diagnostic x-ray exams or other laboratory tests or analysis to assist in finding or completing a diagnosis.
- Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.
- Radium, radioactive isotopes and x-ray therapy.
- Inpatient laboratory and x-ray services are covered under the Hospital Services benefit (see page 63).
- Some routine x-ray and laboratory services are payable under the Preventive Care Services benefits (see page 67).

Note: X-ray and laboratory services in conjunction with an office visit to a PPO Provider are covered at 100% and are not subject to the annual deductible (see page 66).

MEDICAL EXCLUSIONS AND LIMITATIONS

The Plan does not cover:

- A Dependent daughter's pregnancy, maternity care, miscarriage or abortion, except when treatment or services are for Complications of Pregnancy, or as required by law.
- Pregnancy related charges incurred by an Eligible Individual who is acting as a surrogate for another party, or by a person acting as a surrogate for an Eligible Individual. This exclusion includes services or supplies related to the surrogate mother becoming pregnant, pregnancy, delivery charges and Complications of Pregnancy. Additionally, a child of a surrogate mother will not be considered a eligible Dependent if the child is not the biological child, adopted child or child placed for adoption with an Active Employee or Retiree, or if the surrogate mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth unless the child is an eligible Dependent of an Active Employee or Retiree. Surrogate mother is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.
- Amounts in excess of Usual, Customary, and Reasonable Amount.
- Expenses for services and supplies not required for treatment of Injury or Illness unless specifically listed in this Plan as a Covered Expense.

- Any services or supplies that are not Medically Necessary or are not specifically listed in this Plan as Covered Expenses.
- Any services or supplies that are not provided in accord with generally accepted professional medical standards.
- Any services or supplies that are Experimental and/or Investigational.
- Any treatment, service or supply not recommended by a Physician or other Covered Provider.
- Services furnished by a provider not meeting the definition of Physician or other Covered Provider acting within the scope of his or her license, except as specifically provided by the Plan.
- 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 otherwise 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.
- 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 Plan as a Covered Expense.

- Acupuncture treatment (except as specifically listed in this Plan as a Covered Expense).
- 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 the Active Employee's Dependent spouse who has attained age 65, unless otherwise required by law.
- 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 or as otherwise required by law.
- Hypnotism, stress or anger management, and any goal-oriented behavior modification (biofeedback) therapy, such as to 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, except as otherwise covered by the Plan or required by law. Obesity includes, but is not limited to morbid or gross obesity.
- Speech therapy (except as outlined for Rehabilitation Services, Habilitative Therapy or Neurodevelopmental Therapy Services in Covered Expenses) or job retraining therapy (except rehabilitation treatment to restore function lost following an Illness or Injury), myofunctional therapy, or pulmonary rehabilitation.
- Expenses incurred for dental implantology, 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.
- Any claim under this Plan if you are injured as the result of your 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.

- Intentionally self-inflicted Injuries including suicide and attempted suicide, unless the Injury or Illness results from a medical condition or is the result of being a victim of domestic violence.
- Routine vaccinations and immunizations, except as provided under the Preventive Care Services benefit.
- Eye exam refraction fees (see Vision benefits on page 96 for routine services).
- 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, or as required by law.
- Educational, unless otherwise covered by the Plan, or training services. This includes vocational assistance and outreach; and family, marital, social, sexual, nutritional, fitness counseling, or relaxation therapy, except for diabetic education benefit, or as required by law.
- Charges for missed appointments.
- Medical record fees for records not requested by the Administration Office.
- Shipping and handling fees.
- Electronic prostheses, penile prostheses (including penile implants), or devices directly related to an organ transplant.
- Fees for automated lab tests.
- Physical examinations required for employment, or for a physical exam which an employer is obligated to pay.
- Charges for home births, including physician and nursing services and supplies provided during non-emergency births performed at home or outside of an accredited Hospital or licensed birth center.
- Charges, services and supplies excluded or limited under General Exclusions and Limitations.

PRESCRIPTION DRUG BENEFITS

The benefits described in this section apply to all Eligible Individuals who have enrolled in the Comprehensive Medical Benefits Program. Prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy program or the Mail Order Pharmacy program. Both programs are administered by EnvisionRx.

FORMULARY

The Plan uses a prescription drug formulary plan design. A formulary is a list of drugs that have been determined by EnvisionRx to be the most clinically and/or cost effective for each disease or condition. The formulary contains both generic and brand name drugs. A prescription drug not included on the formulary list will be denied and is not covered by the Plan. If a drug is not on the formulary, you will need to change the prescription drug to one that is on the formulary or pay for the full cost of the drug out of pocket. The list is maintained by EnvisionRx and is updated periodically. You may contact EnvisionRx to determine whether your prescription is on the formulary before purchasing your drug. However, please note, inclusion on the formulary is not a guarantee that the drug will be covered by the Plan. Coverage will ultimately be determined when you request your prescription be filled. If your physician believes that a non-formulary drug is medically necessary for your specific situation, a formulary exceptions appeal process is available through EnvisionRx. To initiate the process, you or your physician will need to call EnvisionRx.

RETAIL PHARMACY

The retail pharmacy program is designed for short term or single use medications.

The Plan has contracted with EnvisionRx which maintains a network of pharmacies. The network includes both national and independent local pharmacies that have agreed to fill prescriptions at negotiated price levels. You and your eligible Dependents are not required to use a network pharmacy, but doing so should save both you and the Trust money. In addition, a network pharmacy can file prescription drug claims on your behalf if a Plan ID card is presented at the time the prescription is filled.

The EnvisionRx retail pharmacy network works as follows:

1. Take the prescription to a network pharmacy and present it to the pharmacist with the Plan ID card.

2. The pharmacy will have access to the Trust's on-line eligibility and your Plan's provisions and will confirm eligibility for benefits. Once eligibility is confirmed, the following copay or coinsurance amount must be paid to the pharmacy for each prescription:

   Active Employees and their Dependents, Non-Medicare Retirees, Non-Medicare Dependents of Retirees

   - **Formulary Generic Drugs** – $4 copay, for up to a 30 day supply
   - **Formulary Brand-Name Drugs** – $4 copay, for up to a 30 day supply
   - **Non-Formulary Generic or Brand-Name Drugs –** 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity

   Medicare Eligible Retirees, Medicare Eligible Dependents of Retirees

   - **Formulary Generic Drugs** – 20% of the cost, with a minimum of $5 and a maximum of $50, for up to a 30 day supply
   - **Formulary Brand-Name Drugs** – 20% of the cost, with a minimum of $5 and a maximum of $50, for up to a 30 day supply
   - **Non-Formulary Generic or Brand-Name Drugs –** 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity

3. The pharmacist will then fill the prescription and bill the Plan directly for the remaining costs. Eligible Individuals do not have to submit any claim forms.

A list of EnvisionRx participating pharmacies can be obtained by accessing the EnvisionRx website at ***www.envisionrx.com***, or by calling EnvisionRx's Help Desk at (800) 361-4546.

If a prescription is filled at a pharmacy that is not in the EnvisionRx network, or the Eligible Individual does not present the health plan ID card to the pharmacist, then you or your Dependent will need to pay the pharmacy for the full cost of the prescription. The Eligible Individual can then submit a claim for reimbursement to the Administration Office, subject to the copays/coinsurance listed above, to the address listed on the ***Quick Reference Chart***.

MAIL ORDER PHARMACY

The mail order program is designed for long term maintenance medications needed for ongoing or chronic conditions. EnvisionRx mail order services are provided through its affiliate, EnvisionMail.

Using the mail order pharmacy will lower an Eligible Individual's out-of-pocket costs, and medications will be delivered directly to a home address, or other address selected. Contact the mail order pharmacy at least two weeks before requiring the next fill to allow for processing and mailing of the prescription.

For prescriptions ordered through the mail order pharmacy, the following copays apply for each prescription:

Active Employees and their Dependents, Non-Medicare Retirees, Non-Medicare Dependents of Retirees

- **Formulary Generic Drugs** – $8 copay, for up to a 90 day supply
- **Formulary Brand-Name Drugs** – $8 copay, for up to a 90 day supply
- **Non-Formulary Generic or Brand-Name Drugs –** 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity

Medicare Eligible Retirees, Medicare Eligible Dependents of Retirees

- **Formulary Generic Drugs** – $5 copay, for up to a 90 day supply
- **Formulary Brand-Name Drugs** – $20 copay, for up to a 90 day supply

- **Non-Formulary Generic or Brand-Name Drugs –** 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity

Before mailing in a prescription, you and your Dependents must REGISTER with EnvisionMail by using any of the following 3 easy registration options:

1. **Online:** (Recommended method) Visit ***www.envisionpharmacies.com*** and select ***Not registered? Click here to register.*** The account will activate within 24 hours. By registering online, Eligible Individuals can also track the progress of their orders**.**

2. **Phone:** Call EnvisionMail Customer Service at (866) 909-5170 to speak with a representative.

3. **Mail:** Complete the Registration and Prescription Order Form available from the Administration Office.

Once registered, Physicians can fax prescription(s) to EnvisionMail at (866) 909-5171. Only faxes sent from a Physician's office will be considered valid and fillable.

For a new prescription, fill out an EnvisionMail Prescription Request form, available from the Administration Office, and send it and the original prescription(s) written for a 90 day supply of your medication (plus refills, if applicable), to the address on the form.

MAINTENANCE PRESCRIPTION DRUGS

Maintenance drugs are certain medications used to treat chronic or long term conditions such as diabetes, arthritis, heart conditions, cholesterol, digestive conditions, asthma and blood pressure.

Maintenance prescription drugs written for a 30-day supply can be filled at a retail pharmacy. However, any maintenance prescriptions written in excess of a 30-day supply can also be purchased from:

- EnvisionRx mail order, as described above.

- Any EnvisionRx network retail pharmacy, at an $8 copay, for up to a 90 day supply. (Applies to Active Employees and their Dependents,

non-Medicare Retirees and non-Medicare Dependents of Retirees only.)

- Any EnvisionRx network retail pharmacy, at 20% of the cost (minimum of $5 and maximum of $50), for up to a 90 day supply. (Applies to Medicare eligible Retirees and Medicare eligible Dependents of Retirees).

STEP THERAPY

The step therapy program helps identify lower cost drugs for treating common health conditions. The step therapy program applies to many, but not all, medical conditions.

Under the step therapy program, lower cost drugs are called primary products. These drugs are determined to be cost effective for treating a specific condition. The primary drug is similar in clinical effectiveness to the secondary drug in achieving the intended health goal.

If a secondary drug is prescribed, a first fill may be obtained at the pharmacy but the copay or coinsurance amount for the primary drug will be charged. The copay or coinsurance for subsequent refills may be more unless you switch to a primary drug. A notice will be provided of the alternative primary drugs that are available, and the estimated costs, to assist the Eligible Individual in obtaining new prescription for a primary drug. The Eligible Individual should discuss this program with their Physician and ask if a less costly primary may be prescribed.

An exception to step therapy may be provided if the Eligible Individual's Physician completes a short form and submits evidence to EnvisionRx of a recognized medical reason for an exception. To request an exception, call the EnvisionRx Help Desk at (800) 361-4542. If approved, the copay or coinsurance for the primary drug will apply.

PREVENTIVE CARE PRESCRIPTION DRUGS

In accordance with the federal law, the Plan covers preventive care drugs at 100% with no copay. Preventive care drugs include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender, age and/or other limits may apply. Please note that over-the-counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

A complete and up-to-date list of preventive care drugs can be found at ***www.hhs.gov/healthcare*.** This list may be subject to change.

ROUTINE IMMUNIZATIONS

Routine immunizations are available at many retail pharmacies.

The Plan provides benefits for routine immunizations at a $0 copay when received at an EnvisionRx network pharmacy. Included immunizations are those recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at ***www.cdc.gov/vaccines.*** Not all ACIP recommended immunizations are available at EnvisionRx network pharmacies.

SPECIALTY DRUGS

The Plan employs various management programs for specialty drugs to ensure the safe and cost-effective use of these medications. This may include, but not be limited to, prior authorization, days supply limits and formulary management. Specialty drugs share some of the following characteristics:

- High cost.
- Unique storage or shipping requirements.
- May require patient compliance and safety monitoring.
- Potential for significant waste due to the high costs.
- Prescribed for complex conditions like multiple sclerosis, rheumatoid arthritis, cancer as well as others.

EnvisionSpecialty is the exclusive provider for specialty medications as part of your prescription drug benefit. Managing chronic and complex conditions requires knowledgeable, caring professionals and personalized care. EnvisionSpecialty pharmacists, pharmacy technicians and care representatives are trained to provide the best information and therapy available.

EnvisionSpecialty offers the following patient support services at no charge:

- Personalized support to help achieve the best results from the prescribed therapy.

- Convenient delivery to home or prescriber's office.
- Easy access to a care team who can answer medication questions, provide educational materials about the condition, help manage any potential medication side effects, and provide confidential support – all with one toll-free phone fall.
- Assistance with specialty medication refills.

For questions, or to take advantage of these complimentary patient support services, please call EnvisionSpecialty at (877) 437-9012.

For your convenience, you can fill your first specialty prescription through any EnvisionRx network retail pharmacy. After the first fill, you will be required to use EnvisionSpecialty for all your specialty needs.

An up to date list of specialty drugs may be obtained at the EnvisionRx website: ***www.envisionrx.com.***

MEDICARE PART D

Eligible Individuals who are enrolled in Medicare Part D are not eligible for Prescription Drug Benefits from the Plan. See the section titled Information About Medicare Part D Prescription Drug Plans for Retirees with Medicare on page 118.

PRESCRIPTION DRUG EXCLUSIONS

The following are some of the common categories of drugs that are excluded from this prescription drug benefit:

1. Any drugs for illness, disease or injury provided in whole or in part by state or federal Workers' Compensation laws or other legislation.
2. Cosmetic drugs or health and beauty aids.
3. Nontherapeutic vitamins, dietary supplements, nutrients, medical foods or herbal remedies regardless of whether prescribed by a Physician, unless specifically stated as covered for preventive care on page 83.
4. Over-the-counter drugs, unless prescribed and specifically provided for preventive care as stated in the section above.

5. Drugs administered or taken while confined in the Hospital, Skilled Nursing Facility, rest home, nursing home or similar institution, or a health care provider's office.
6. Drugs prescribed for the treatment of conditions which are not within the medical uses approved by the FDA or the manufacturer (i.e. off label uses).
7. Drugs which are considered Experimental or Investigational as defined on page 128.
8. Drugs for which no prescription is obtained, except insulin.
9. Drugs lost, stolen, or damaged.
10. Drugs in excess of the allowable quantity limits established by the Plan.
11. Drugs not yet approved by the FDA.
12. Fertility/infertility medications.
13. Weight loss drugs.
14. Anabolic steroids.
15. New to market medications until a clinical review and formulary placement decision have been made by the EnvisionRx Pharmacy and Therapeutics Committee.
16. Drugs prescribed for impotence that exceed the Plan's supply limit for erectile dysfunction drugs.
17. Fluoride, unless prescribed and specifically provided for preventive care as stated in the section above.
18. Therapeutic devices or appliances, support garments and other non-medical substances
19. Medical appliances, devices and other supplies/equipment except covered diabetic supplies.
20. Biological sera, blood or blood products.
21. Non-formulary drugs.

DENTAL BENEFITS

These benefits are only available to Active Employees and their Dependents; these benefits are not provided for Retired Employees or their Dependents. The Dental Plan is funded directly by the Trust Fund.

Active Employees and their Dependents may opt-out of Dental Benefits. An opt-out is offered in order that the Plan can comply with Federal Law. Opting out of Dental Benefits does not affect eligibility for other benefits provided by the Plan (Medical, Prescription Drug, Vision, Weekly Disability Income, Life Insurance and Accidental Death and Dismemberment), and will not affect the hours that are required for coverage in the Hour Bank. To opt-out of the Dental Benefits coverage, please contact the Administration Office at the number indicated on the ***Quick Reference Chart.***

SUMMARY OF DENTAL BENEFITS	
ANNUAL DEDUCTIBLE	$50 per person, per calendar year
ANNUAL MAXIMUM	• $2,500 per Eligible Individual age 18 or older, per calendar year (Class I, II, III Charges) • $2,500 per child under age 18, per calendar year (Class III Charges only)
CLASS I CHARGES *(Diagnostic and Preventive)*	100% of the UCR Amount for Covered Expenses, after the deductible, up to the annual maximum.
CLASS II CHARGES *(Restorative, Oral Surgery, Periodontics, Endodontics)*	• 90% of the UCR Amount for 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, up to the annual maximum. • 85% of the UCR Amount for Covered

SUMMARY OF DENTAL BENEFITS	
	Expenses, after the deductible, for **all other restorative** services, including endodontics, periodontics, oral surgery, crowns, inlays or onlays (whether gold, porcelain, plastic, gold substitute castings or combinations thereof), up to the annual maximum.
CLASS III CHARGES *(Prosthodontic services, bridges, dentures, partials)*	70% of the UCR Amount for Covered Expenses, after the deductible, up to the annual maximum.
ORTHODONTIC CHARGES	50% of Covered Expenses after the deductible, up to a lifetime maximum of $2,000 per person. The Plan pays 50% of the lesser of the Usual, Customary and Reasonable (UCR) Amount or the fees actually charged for orthodontic treatment up to $500 at completion of the banding phase. 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

Prior to commencing any extensive dental care, an Eligible Individual should ask the treating dentist to complete and submit a pre-treatment estimate to the Administration Office at the address shown in the ***Quick Reference Chart***. The Administration Office can then provide information in advance of treatment on the services that will be covered and the benefits that will be available.

CLAIMS FILING PROCEDURE

It is Eligible Individual's responsibility to have the dentist complete a claim form. The Eligible Individual is also responsible for submitting the claim to the Administration Office.

ELECTIVE CARE

If there are optional treatment methods carrying different fees, the Plan pays the appropriate percentage of the lesser fee and the patient must pay the remainder of the provider's charges. This provision commonly applies to gold restorations, crowns and bridgework, so it is important to have this dentist submit a pre-treatment estimate to the Administration Office before the work begins to avoid any misunderstanding.

CLASS I - DIAGNOSTIC AND PREVENTIVE SERVICES

After the deductible, the Plan pays 100% of the UCR Amount for the following Covered Expenses for diagnostic and preventive services provided by a licensed dentist, up to the annual maximum.

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.
- Carries susceptibility tests.

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.

CLASS II - RESTORATIVE SERVICES

including ORAL SURGERY, PERIODONTIC AND ENDODONTIC SERVICES

After the deductible, the Plan pays the appropriate percentage of the UCR Amount (85% or 90% as indicated in the above schedule) of Covered Expenses up to the annual maximum.

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.

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.

Covered Periodontic Expenses

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

- Root planing allowed once in a 3-month period
- Periodontal maintenance allowed once in a 3-month period with a history of active periodontal disease.
- 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.

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.

CLASS III - PROSTHODONTIC SERVICES

After the deductible, the Plan pays 70% of the UCR Amount for the following Covered Expenses for prosthodontic services, up to the annual maximum. **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.**

Covered Prosthodontic 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.

ORTHODONTIC SERVICES

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 the deductible, the Plan pays 50% of the lesser of the UCR Amount or the fees actually charged, up to the maximum orthodontic benefit available. 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 is payable for treatment during the construction phase or banding phase.

After the construction or banding phase, the Plan pays 50% of the lesser of the UCR Amount or the fees actually charged 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 the dentist. Payment of monthly or quarterly charges is limited to completion of the treatment program, or through age 26 for Dependent child, whichever comes first.

The Plan will not cover:

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

DENTAL EXCLUSIONS

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

- Dentistry for Cosmetic reasons. Cosmetic treatment for purposes of dental benefits 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 (see page 72 for Medical benefits available).
- 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.
- 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.
- Any exclusion or limitation listed under General Exclusions and Limitations.

VISION BENEFITS

OVERVIEW OF THE VISION PLAN

All Eligible Individuals who are covered under the Comprehensive Medical Benefit described in this Booklet are eligible for these vision benefits. Vision benefits are effective on the date medical benefits are effective. Vision benefits are designed to provide for regular vision examinations and benefits toward eyeglasses or contact lenses.

The Trust has an agreement with VSP Vision Care to provide vision benefits to Eligible Individuals. Eligible Individuals may use any provider, but more benefits may be available if a VSP provider is used. A VSP provider will also automatically file claims on behalf of the Eligible Individual.

COVERED VISION EXPENSES

The following table summarizes vision care benefits:

Covered Expense	**If you see a VSP provider**	**If you see a non-VSP provider**
Copay	$15 for glasses	None
Exams (once/18 months)	100%	up to $200 for exam and eyeglasses or contact lenses
Lenses (once/18 months)*		
• Single vision	100% after copay	
• Bifocal	100% after copay	
• Trifocal	100% after copay	
• Lenticular	100% after copay	
• Tints	100% after copay	
• Progressive/blended	100% after copay	
• Polycarbonate for children	100% after copay	
• High index/photochromic	100% after copay	
Frames (once/18 months)	up to $130	

Covered Expense	If you see a VSP provider	If you see a non-VSP provider
Contacts (once/18 months in place of eyeglass lenses and frames) • Elective • Necessary**	100% up to $105 for contacts and exam 100% after copay	
* You are responsible for additional non-covered lens options, such as coatings. ** Covered (with prior VSP approval) following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia and for keratoconus.		

In addition, the following benefits are available when services are received from a VSP provider:

- *Glasses and Sunglasses*
  - ❖ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of the last well vision exam.
  - ❖ Extra $20 to spend on featured frame brands. Go to ***vsp.com/specialoffers*** for details.
- *Contacts*
  15% off cost of contact lens exam (fitting and evaluation).
- *Retinal Screening*
  Guaranteed pricing on retinal screening as an enhancement to your well vision exam.
- *Laser Vision Correction*
  Average 15% off the regular price, or 5% off the promotion price; discounts only available from contracted facilities.

SAFETY GLASSES – EMPLOYEE ONLY – VSP PROVIDERS ONLY

A pair of prescription safety glasses is available through VSP as a second pair of glasses, in addition to the standard prescription glasses. Materials and services are subject to the same 18 month frequency as listed above. You pay a $15 copay for the eyewear, and the frames are covered up to $65.

The lenses and frame provided are certified safe for the work environment by meeting the necessary requirements set forth by ANSI (American National Standards Institute).

Prescription safety glasses obtained from a non-VSP provider are not covered.

DIABETIC EYECARE PROGRAM

Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD) are covered with a $20 copay per visit. Retinal screening for Eligible Individuals with diabetes is also covered. Limitations and coordination with medical coverage may apply. Ask the treating doctor for details.

LOW VISION COVERAGE

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses. Please discuss treatment options with the provider. Coverage includes:

- Supplemental care aids – 75% (25% copay)
- Supplemental testing – 100% at a VSP provider, up to $125 at a non-VSP provider
- Benefit maximum – $1,000 per two years for services related to low vision

The above benefits are also available when low vision care is received from a non-VSP provider, but the Eligible Individual must pay the non-VSP provider's full fee, and then submit a request for reimbursement as outlined on page 138.

OBTAINING VISION CARE

To receive eye care services or eyewear from a VSP provider:

- Contact VSP by calling (800) 877-7195 or visiting ***www.vsp.com*** to determine if the provider is in the VSP network or to locate a VSP provider.
- When making an appointment, advise the provider that benefits are through VSP and provide the employee's or Retiree's Social Security number (last 4 digits) and first and last name. The VSP provider will verify eligibility and available benefits before the scheduled appointment.
- The patient is responsible for the $15 copay, and the cost of any cosmetic options, as well as any frame or contact lens overage.
- There's no need to file a claim – the VSP provider does it for you.

To receive service from a non-VSP provider.

- Make an appointment with any provider.
- Pay the bill in full.
- File a claim for reimbursement as outlined on page 138; the Plan reimburses you up to the covered amount.

All claims must be filed within one year of the date vision services are completed. Reimbursement is made directly to you and can be assignable to the provider if they are willing.

VISION LIMITATIONS AND EXCLUSIONS

Because the vision benefits provided by this Plan are designed to cover visual needs rather than cosmetic eyewear, there is an extra charge for:

- Coated or laminated lenses.
- Contact lenses (except as noted above).
- Cosmetic lenses and optional processes.
- Frames that cost more than the Plan allowance.
- Oversize lenses (61 mm or larger).
- UV (ultraviolet) protected lenses.

This vision benefit does not cover:

1. Claims received after the 12-month filing limit.
2. Experimental procedures or lenses.

3. Medical or surgical treatment of the eyes.
4. Orthoptics or vision training or any associated supplemental testing.
5. Plano lenses.
6. Replacement of lost or broken lenses or frames furnished under these vision benefits (except at the normal intervals).
7. Two pair of glasses in place of bifocals.

WEEKLY DISABILITY INCOME

This benefit is only available to Active Employees

BENEFIT

When you are Totally Disabled, the Plan will pay a net benefit of $100 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 have 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 a non-occupational 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.

EXCLUSIONS

No Weekly Disability Income is available for:

- Any period which the employee is not under the care of a Physician.
- Illness or Injury covered by Workers' Compensation or for Illness or Injury arising out of any employment for wage or profit, regardless of whether you are self-employed, filed a claim, or waived the right to file a claim.
- 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, homeowner's policy, or commercial premises policy.

- Any period for which you are eligible to receive unemployment benefits.

TAXES

Your Weekly Disability Income 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.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

LIFE INSURANCE FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

This is only a brief summary of the Life Insurance benefits available for Active Employees and Dependents of Active Employees. Life Insurance benefits are not available to Retirees and their Dependents. Life Insurance is provided under a group insurance policy issued by an insurance company.

An Active Employee or Dependent 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.

SCHEDULE OF BENEFITS	
Employee Life Insurance	$ 6,000
Dependent Life Insurance	
Spouse	$ 2,000
Dependent child, age:	
Birth to less than 6 months	$ 200
6 months to age 2	$ 400
2 years but less than 3 years	$ 800
3 years but less than 4 years	$ 1,200
4 years but less than 5 years	$ 1,600
5 years to the last day of the calendar month in which child attains age 26	$ 2,000

A Dependent who is eligible for benefits as an Employee will not also be eligible for Dependent Life Insurance.

If Life Insurance Benefits are payable as a result of your death, payment will be made to your beneficiary. If Life Insurance Benefits are payable as a result of your Dependent's death, the payment will be made to you. If you die prior to your Dependent, benefits will be paid in the order of preference as listed in the Designation of Beneficiary For Life and Accidental Death and Dismemberment section (see page 106).

WAIVER OF PREMIUM FOR TOTAL DISABILITY

If you are an Active Employee under age 65 and become disabled while covered under the Plan with a Total Disability that has lasted at least 9 months, you may apply to the life insurance company to continue your life insurance under a waiver of premium provision. The initial continuation of insurance under the waiver of premium provisions is 12 months, but in no event longer than 24 months from the date Total Disability began. The waiver of premium ends on the earlier of the date your Total Disability ends, or the end of the 12 month period.

For purposes of the waiver of premium, a Total Disability means your complete inability, due to injury or illness (including pregnancy, childbirth and related conditions), to engage in any business, occupation or employment for which you are qualified, or become qualified (by reason of education, training, or experience), for pay, profit or compensation.

Please contact the Administration Office for further information on applying for the waiver of premium.

CONVERSION RIGHTS AFTER TRUST ELIGIBILITY TERMINATES

If your eligibility or that of your Dependent is terminated, you or your Dependent may convert the insurance to an individual policy issued by the insurance company (other than term insurance or insurance that provides disability or other supplemental benefits). An application for conversion of life insurance may be requested from the Administration Office. To qualify for the conversion policy, you or your Dependent must submit a written application to the insurance company and pay the first premium within 31 days from the date the Life Insurance benefits terminated.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS FOR ACTIVE EMPLOYEES

This benefit is only available to 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.

SCHEDULE OF BENEFITS	
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: Thumb and index finger	$3,000 (Paid to you)

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

PROOF OF LOSS

Written proof of loss must be given to the Administration Office no later than 90 days after the date of loss, unless it is shown that it was not reasonably possible to furnish proof and the proof is submitted as soon as reasonably possible. No claim will be paid if proof is received more than one year after the date of loss. The proof must include information necessary to determine the nature of the loss and date of the loss. No legal action may be commenced with respect to a claim for Accidental Death and Dismemberment Benefits until 60 days after proof of the claim has been given or more than three years after the time the proof of claim is required.

PAYMENT OF CLAIM

Except in the case of loss of life, benefits are paid directly to you. In the case of loss of life, benefits are paid to your beneficiary.

AD&D 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;
- aviation including but not limited to travel or flight as a pilot or crew member in any kind of aircraft; travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the Health Trust, a contributing employer or the armed forces; or being operated for any training or instructional purpose;
- 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 FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

If Life Insurance or Accidental Death and Dismemberment Benefits are payable as a result of your death, the payment will be made to the

surviving 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 upon receipt of the signed form by the Administration Office. 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. If any named beneficiary dies before you, you should complete the proper forms with the Administration Office to designate a replacement beneficiary(s).

If more than one beneficiary is named, each surviving beneficiary will be paid an equal share.
If you do not designate a beneficiary, or your designated beneficiary predeceases you, payment will be made in the following order of preference:

1) all to your surviving spouse; or
2) if your spouse does not survive you, in equal shares to your surviving children; or
3) if no child survives you, in equal shares to your surviving parents; or
4) if no parents survive you, in equal parts to your brothers and sisters; or
5) 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.

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations are applicable to the Medical, Prescription Drug, Dental and Vision 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.
- Injuries that are the result of the Eligible Individual's commission of an assault, battery, or felony, or if the Eligible Individual was an aggressor against another person, or if the Eligible Individual was engaged in any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances.
- 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.

- 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.
- 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, homeowner's policy, or commercial premises policy. The Plan may agree to advance benefits if the participant agrees to reimburse the Plan as set forth in the Plan's Third-party reimbursement provision.
- Charges for services or supplies received when not eligible under the Plan, except as specifically provided.
- Charges for services or supplies (including supporting documentation that has been requested) that are not submitted within one-year from the date(s) of service.
- Services, supplies and prescription drugs that are contrary to internal guidelines or medical protocols (including guidelines and protocols used for diagnosis, treatment, prescription or billing practices) that are utilized by the Utilization Management Coordinator, prescription drug program, or Board of Trustees in determining coverage for specific services, supplies and prescription drugs.
- Charges for services or supplies that are limited or excluded under the specific benefit.
- Charges for claims that are submitted or completed more than one year from the date of service.
- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.
- Charges for services or supplies billed or charged in breach of or contrary to the providers PPO network agreement or in breach of or

contrary to provider guidance or policies established by the PPO network.

COORDINATION OF BENEFITS

Benefits (including Medical, Vision, and Dental 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 its 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

This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as a retired employee; then the order of benefits is reversed so that the plan covering the person as a dependent pays first; and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More than One Plan

A. The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if;

    1. The parents are married;

    2. The parents are not separated (whether or not they ever have been married); or

3. A court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is not court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is;

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third, and
4. The plan of the spouse of the non-custodial parent pays last; and
5. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the

calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

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

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

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

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of new plan does not include a change;

1. In the amount or scope of a plan's benefits;
2. In the entity that pays, provides or administers the plan; or
3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan has no COB rules

If the other coverage has no COB rules, this Plan will always pay secondary.

MEDICARE

WHAT IS MEDICARE

Medicare includes:

- Part A (hospital insurance) which helps cover inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Generally, there is no cost for Medicare Part A. Retirees and Dependents should enroll in Medicare Part A when eligible, because the benefits of this Plan are provided as if actually enrolled in Medicare Part A.
- Part B (medical insurance) which helps cover Physician's services and outpatient hospital care. It may also cover some services that Medicare Part A does not cover. A monthly premium is generally required for Medicare Part B. A deductible is also required before Medicare starts to pay. Retirees and Dependents should enroll in Medicare Part B when eligible, because the benefits of this Plan are provided as if actually enrolled in Medicare Part B.
- Part C which is a Medicare Advantage Plan (like an HMO or PPO). Part C includes BOTH Part A (hospital insurance) and Part B (medical insurance) and in some instances, a Medicare Advantage Plan may also include Part D (prescription drug coverage). A Retiree or Dependent who is enrolled in a Medicare Advantage Plan that includes prescription drug coverage is not eligible for the Plan's prescription drug benefits.

- Part D (prescription drug coverage) which helps cover prescription drugs. A monthly premium is generally required for Medicare Part D. A Retiree or Dependent who enrolls in Medicare Part D, or a Medicare Advantage Plan that includes coverage for prescription drugs, is not eligible for the Plan's prescription drug benefits.

MEDICARE ENROLLMENT

Individuals receiving benefits from Social Security or the Railroad Retirement Board, should be automatically enrolled in Medicare the first day of the month they turn age 65. Individuals under age 65 and disabled, should be automatically enrolled after receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). Individuals who do not want Medicare Part B must follow the instructions that come with the Medicare card**. However, if a Retiree or Dependent of a Retiree is eligible for Medicare Part B, benefits under this Plan are provided as if the Retiree or Dependent is enrolled in Medicare Part B, regardless of whether they actually enroll.**

Individuals turning age 65 who are not receiving Social Security or Railroad Retirement benefits must apply for Medicare. Even if the Social Security age is older than age 65, eligibility for Medicare enrollment is still age 65.

There is an initial enrollment period for Medicare Part B, which begins three months before the month an individual turns age 65, and ends three months after the month an individual turns age 65. However, the starting date for Medicare Part B will be delayed for individuals who do not sign up before the month they turn age 65.

Individuals who do not sign up for Medicare Part B during the initial enrollment period may sign up during the general enrollment period which runs from January 1, through March 31 of each year. Medicare Part B will start on July 1 of the year of sign up. The cost of Medicare Part B generally increases for each 12-month period that an individual could have taken Medicare Part B, but did not.

There is a special enrollment period for those who waited to enroll in Medicare Part B because they or a spouse was working and had other group health plan coverage based upon that employment. The special

enrollment period is anytime the individual is still covered in the group health plan, or during the eight months following the earlier of the month that group health plan ends or employment ends.

Individuals with end-stage renal disease should also enroll in Medicare. Different enrollment rules may apply and you should contact Social Security for information.

In order to receive full Plan benefits, a Retiree and Dependent of a Retiree MUST enroll in Medicare Parts A and B (or C) when eligible for that coverage. Even if COBRA is elected in lieu of Retiree coverage, a Retiree and Dependent are expected to enroll in Medicare when eligible. This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A, Part B, or Part C if a Retiree or Dependent fails to enroll.

Eligible Individuals with End-Stage Renal Disease should also enroll in Medicare when eligible.

COORDINATION OF BENEFITS WITH MEDICARE

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 Dependent spouses will normally have benefits paid first by this Plan, then by Medicare. The law allows Active Employees and their Dependent spouses to choose Medicare as the primary coverage. However, if Medicare is elected as the primary coverage, benefits cannot be received from this Plan.

Retirees and their Dependent spouses who are eligible for Medicare have benefits paid first by Medicare, then by the Plan. **The Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A or Part B even if a Retiree or Dependent fails to enroll.**

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

Individuals who are entitled to Medicare Part A or enrolled in Medicare Part B, are also eligible to enroll in 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 on average for all Plan participants, expected to pay out as much as Standard Medicare prescription drug coverage pays and is therefore considered creditable coverage.

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

If a Medicare eligible individual goes 63 days or longer without prescription drug coverage that is creditable coverage, the monthly Medicare premium will go up at least 1% per month for every month they did not have that coverage. For example, if a Medicare eligible individual goes nineteen months without having creditable prescription drug coverage, the premium for Medicare drug coverage may consistently be at least 19% higher than the base Medicare premium, A Medicare eligible individual will have to pay this higher premium as long as they have Medicare prescription drug coverage. In addition, they may have to wait until the next November to enroll.

Medicare eligible individuals may enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. However, if a Medicare eligible

individual loses the current creditable prescription drug coverage through no fault of their own, the individual will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If a Medicare eligible individual enrolls in Medicare Part D, or in a Medicare Part C (Medicare Advantage Plan) that includes prescription drug coverage, that individual will lose the current prescription drug coverage under the Northwest Ironworkers Health and Security Plan and will not be able to get this coverage back. Further, the Part D premiums will not be reimbursed.

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 entitlement to Medicaid benefits. Benefits will be made in accordance with any assignment of rights by or on an individual's 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.

COORDINATION WITH TRICARE/CHAMPUS OR VETERANS AFFAIRS FACILITY SERVICES

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

If services are received 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 services are received 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 an Eligible Individual is 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, the Plan may advance payment of benefits pending resolution of the dispute, 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 Weekly Disability Income benefits for any Injury or Illness caused by the act or omission of another person, (known as the third party), where a potential opportunity for recovery exists from the third party, including, but not limited to, an Injury or Illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (i.e. coverage for underinsured or uninsured motorist), 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 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. In other words, by this agreement, the Plan will have an equitable lien in the Eligible Individual's recovery.

If the Plan provides benefits, the Plan is entitled to reimbursement of all benefits paid, 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.

Prior to advancing funds on the Eligible Individual's behalf, the Plan can require that an Eligible Individual and the Eligible Individual's attorney execute an agreement acknowledging this Plan's reimbursement right, including the obligation to hold an amount sufficient to satisfy the Plan's reimbursement amount in a trust account or escrow until the Plan's claims are resolved by mutual agreement or court order. Also, prior to advancing funds on the Eligible Individual's behalf, the Plan can require that the Eligible Individual provide 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 and any other information requested by the Plan to secure its reimbursement interest.

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 who receives or distributes the recovery funds 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 or the Eligible Individual's attorney 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, or the Trustees modify this provision related to advancing benefits. The Plan may also deny coverage for expenses incurred after recovery on the third party claim, if such expenses are related to the third party recovery and known or reasonably expected at the time of settlement.

If the Plan is not reimbursed upon recovery on a third party claim, 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, including those of family members, or by recovery from the source to which benefits were paid. 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.

In any legal action under this provision, venue may be laid in King County Superior Court or in the United States District Court for the Western District of Washington at Seattle, at the option of the Trustees.

After recovery from a third party or insurer, the Plan is relieved from any obligation to pay further benefits for the Injury or Illness that were reasonably expected or identifiable at the time of recovery up to the amount of the balance of the recovery.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Trustees have contracted with Fully Effective Employees, Inc. to provide an Employee Assistance Program (EAP) for Active Employees and their Dependents at no cost.

The EAP is a confidential service for you and your Dependents who have concerns or problems that are affecting work or home life. The program provides help with things like:

- Alcohol or drug-related problems.
- Personal/emotional problems.
- Stress-related issues.
- Marital/family issues.
- Financial problems.
- School-related problems your children are experiencing.
- An aging parent.

The program provides unlimited telephone access for you and your Dependents.

If you or your Dependents have a personal problem or crisis, an EAP counselor will provide assistance over the telephone. The counselor will assess the situation and help with short-term problem resolution. If you or your Dependents would like ongoing counseling or treatment, the EAP counselors can make referrals to resources in the community. Every effort will be made to make referrals to a resource that is covered under the Plan; however, referral for services from the EAP does not ensure the services are covered by the Plan, and you and your Dependents are responsible for paying for any services not covered under the Plan. The program provides unlimited telephone access for you and your Dependents.

EAP counselors will also follow up with you and your Dependents to determine if further assistance may be helpful. The EAP will provide support, if needed for up to two years,

You may also be referred to the EAP by the Trust if you test positive for drugs or alcohol as part of the Drug Free Workplace Program.

HOW TO ACCESS THE EAP

To use the service or to ask questions, call the EAP at (800) 648-5834. The service is available 24/7. When calling, tell the EAP Coordinator your name, the name of the Plan (Northwest Ironworkers Health and Security Plan) and the nature of the concern.

The EAP may also be visited at its website, ***www.fee-eap.com***. The login is r305 and the password is feeeap.

The website provides a host of helpful resources including detailed information about the EAP and how to use it, newsletters and articles on a variety of topics, self-assessments and information including issues such as aging, depression, anger management, and more.

DEFINITIONS

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

Active Employee – An Employee eligible for benefits on the basis of hours in the Hour Bank account, or COBRA self-payment following loss of their Bank eligibility, as described in the Eligibility section of this Booklet.

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

Coinsurance – An Eligible Individual's share of Covered Expenses, calculated as a percentage of the PPO Amount or UCR Amount, after any deductible.

Collective Bargaining Agreement – 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.

Complications of Pregnancy – 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 – A fixed dollar amount an Eligible Individual must pay for certain services (such as prescription drugs or office visits), usually when the service is received.

Cosmetic treatment – 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 – 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
- The lesser of the amount billed and the Usual, Customary and Reasonable Amount for Non-PPO Providers and the PPO Amount for PPO Providers; and
- Billed in accordance with uniform billing, industry standards and the Provider's PPO agreement; and
- Supported by medical records and other relevant documentation; and
- Covered under provisions of the Plan, or which are not otherwise excluded by the Plan.

Covered Provider – A healthcare provider who is acting within the scope of the provider's license or certificate under applicable state law. Certain licensed or certified professionals providing services covered by the Plan may be required to be under the supervision of an MD, DO, DD or DMD as determined by the Plan.

Covered Providers may include:

- Denturist
- Chiropodist
- Chiropractor
- Nurse Practitioner
- Physician's Assistant
- Licensed Practical Nurse
- Anesthetist
- Physical Therapist

- Certified Nurse Midwife
- Clinical Psychologist
- Mental Health Counselor or Marriage and Family Therapist
- Optometrist
- Acupuncturist
- Registered Nurse

Before receiving treatment from any practitioner other than an MD or DO, check with the Administration Office to find out if the expenses will be recognized as Covered Expenses.

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

Emergency or Emergency Medical Condition – A medical or dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in serious dysfunction of any organ or body part.

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

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

ERISA – 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 Health and Security Plan.

Experimental and/or Investigational. The Plan or its designee has the discretion and authority to determine if a drug, 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 drug or supply was provided, or the service, drug, or supply was considered for preauthorization under the Plan's Medical Management Programs), any of the following conditions were present with respect to one or more essential provisions of the drug, service or supply:

- The drug, 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;
- A drug, service, supply, care or treatment does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.
- The prescribed drug, 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 drug, 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 drug, service or supply or has it under consideration;
- The drug, service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Home Health Aide – 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 – 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 – 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 Agency – A hospital or agency possessing: a) a valid operating certificate that certifies the agency to provide hospice care services, or b) a non-profit or public health services agency possessing a valid certificate of approval in accordance within state or local law.

Hospital(s) – 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 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.

Hour Bank – The account established for an Employee to which hours are credited for contributions made by the employer to the Trust for the Employee's work. In certain instances, the account may also be credited with hours for which contributions are required to be made. See page 19.

Illness – 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 – 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.

Medically Necessary or Medical Necessity – 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 Covered 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-PPO Provider – A health care provider that is NOT under contract with the Preferred Provider Organization (PPO) 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 coinsurance) after the Plan has made payment.

Out-of-Area – Out-of-Area means there is no PPO Hospital, Treatment Facility or medical PPO Provider that can provide the services within a 20-mile radius of the Eligible Individual's residence, or within a 20 mile radius of where the services are performed.

Out-of-Pocket Maximum – This is the most an Eligible Individual pays during the calendar year before the Plan begins to pay 100% of certain

Covered Expenses for the remainder of the calendar year. There are separate Out-of-Pocket Maximums for PPO Providers and Non-PPO Providers, and for medical expenses and pharmacy expenses. This maximum never includes self-payments for coverage, balanced billed charges, dental expenses, or vision expenses. (See OUT-OF-POCKET MAXIMUM on page 53 for Medical and page 85 for Prescription Drugs.)

Physician(s) – A legally qualified physician or surgeon practicing within the scope of the Provider's license as a Medical Doctor (MD), Osteopath (DO), Naturopath (ND), Podiatrist (DPM) or Doctor of Dentistry (DDS, DMD).

Plan – The Northwest Ironworkers Health and Security Plan. This Booklet constitutes the Plan document for all benefits except those provided by the Health Maintenance Organization.

PPO Amount – The amount negotiated by the PPO with the PPO Provider for a Covered Expense. The PPO Amount is the maximum amount on which payment is based for medical services and supplies provided by a PPO Provider.

PPO Provider – A health care provider that is under contract with the Preferred Provider Organization (PPO) to provide services and supplies at agreed upon discounted rates as payment in full.

PPO Service Area – An area where a PPO Hospital, Treatment Facility or medical provider is within a 20 mile radius of where the service is performed.

Preferred Provider Organization or **PPO** – A network of health care providers that is under direct contract with the Plan to provide services and supplies at agreed-upon discounted rates as payment in full.

Prescription Drugs – 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.

Retiree or **Retired Employee** – A former Employee who is eligible for Retiree coverage under the Plan.

Skilled Nursing Facility – 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 health disease, drug addiction or alcoholism.

Totally Disabled – 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.

Treatment Facility – An institution that provides treatment for mental health or substance abuse that is licensed by and approved under the laws of the state in which the facility is located.

Trust Agreement or **Trust** – The Trust Agreement establishing the Northwest Ironworkers 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.

Union – 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 Health and Security Fund.

Usual, Customary and Reasonable Amount or **UCR Amount** – Usual, Customary and Reasonable (UCR) means the amount payable to a Non-PPO Provider as determined by the Board of Trustees for a particular service, and subject to the following:

1. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed.
2. In no event will the UCR charge exceed the amount billed or the amount for which the covered person is responsible;
3. UCR may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
4. The Plan's UCR methodology may vary from one particular claim to the next based on the facts and circumstance of the claim, the services provided and expected cost savings;
5. The Trust may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
6. Irrespective of the Trust's methodology or UCR determination, the Trustees reserve the right to negotiate an acceptable UCR amount directly with a provider.

For properly billed non-PPO professional service provider charges, the UCR charge shall be no higher than the 90th percentile identified by a commercially available database selected by the Trust. When there is, in the Trust's determination, minimal data available from the data base for a covered service, the Trust will determine the UCR charge by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Trust where one is not available from Medicare). In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Trust's determination applicable, the Trust will assign one.

For properly billed non-PPO facility charges, UCR means the amount determined by the Board of Trustees based on one or more of the following considerations; CMS reported cost-to-charge ratios, historically acceptable reimbursement amounts by similarly situated providers, commercially available benchmarks, Medicare reimbursements amounts, and other CMS-provided statistics.

Non-PPO Providers (including both professionals and facilities) which claim payment under the Plan shall be obligated to submit to a prompt

audit of their claims by the Trust, notwithstanding any internal rules they may have to the contrary. In the event a Non-PPO Provider refuses or delays a reasonable audit request by the Trust, the Trust shall have the right to withhold payment to the said Non-PPO Provider on the claim in question and on other pending or future claims by said Non-PPO Provider.

Utilization Management or UM – A managed care review procedure to determine the Medical Necessity, appropriateness, location, cost-effectiveness and appropriate billing 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, outpatient services, discharge planning and retrospective review, audits of provider billings, and provider fee negotiation.
- Case Management.

An independent Medical Management organization, staffed with licensed health care professionals, operates under an agreement with the Plan to act as UM Coordinator providing the Utilization Management services.

HOW TO FILE A CLAIM

Claim forms should be submitted within 90 days after services are rendered or a period of disability commences, or as soon as reasonably possible. All claims, supporting documentation, and additional information that is requested to process the claims must be submitted within one year of the date services are rendered. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered Covered Expenses and are excluded from coverage.

FOR MEDICAL BENEFITS

PPO Provider

If services are received from a PPO Provider, the provider will bill the Plan directly, and an Eligible Individual does not need to file a claim. Benefit payments are issued directly to PPO Providers. The Explanation of Benefits form (EOB) from the Administration Office will indicate the remaining balance that an Eligible Individual owes the PPO Provider.

However, an Eligible Individual must file a claim with Administration Office if there is other insurance that was not listed at the time of enrollment that is the primary payer (for example, through your spouse's employer) or if a third party may be liable for incurred expenses.

Non-PPO Provider

If services are received from a Non-PPO Provider, generally the Non-PPO Provider will submit a claim on your behalf. However, if the Non-PPO Provider fails to submit a claim, an Eligible Individual will need to file a claim.

In the case of Non-PPO Providers, payments will be made, at the Trust's option, to the Employee or Retiree, to their estate, to the provider or as required under federal law, including an individual designated under a qualified medical child support order. No assignment to a Non-PPO Provider whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust unless otherwise required by federal law.

If You Need to File a Claim

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

No claim will be accepted unless it is submitted with all supporting documentation, within one year from the date the service was performed. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered Covered Expenses and are excluded from coverage.

FOR DENTAL BENEFITS

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

No claim will be accepted unless it is submitted with all supporting documentation within one year from the date the dental treatment was performed. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered Covered Expenses and are excluded from coverage.

Orthodontic treatment must be preauthorized as appropriate and necessary prior to commencement of treatment. A pre-treatment estimate should also be requested by the treating dentist before any extensive dental work is done. The Administration Office will review the claim and provide an estimate of how much will be paid which helps avoid misunderstandings about the expenses that are covered.

FOR VISION BENEFITS

If services are received from a VSP provider, the VSP provider will file the claim.

If services are received from a non-VSP provider:

1. The Eligible Individual must pay the provider the full amount due.
2. The Eligible Individual must then file a claim for reimbursement. Write the Employee's name, date of birth, and Social Security number (last 4 digits), as well as the patient's name, date of birth and relationship to the Employee and Northwest Ironworkers Health and Security Fund on the bill, or submit an out-of-network claim form with the bill to:

   VSP
   Out of Network Provider Claims
   P.O. Box 385018
   Birmingham, AL 35238-5018
   (800) 877-7195
3. Reimbursement is made directly to the Eligible Individual and can only be assignable to the provider if the provider agrees.
4. No claim will be accepted unless it is submitted with all supporting documentation within one year from the date the vision services were completed. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date services were completed will not be considered and excluded from coverage.

FOR PRESCRIPTION DRUG BENEFITS

Refer to the **Prescription Drug Benefit** section, beginning on page 79, for instructions on how to use the retail and mail order Prescription Drug Programs.

FOR LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT AND WEEKLY DISABILITY INCOME BENEFITS

- Obtain a claim form from the 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 at the address listed on the ***Quick Reference Chart***.

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 a Physician or other Covered Provider recommended is not a claim under these procedures if the treatment or service has not yet been provided and the treatment or service does not require prior authorization. In this circumstance, a determination may be requested 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 presenting a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a claim under these procedures. However, if a request for prescription benefits is denied by the pharmacy or the Plan, in whole or in part, a claim and appeal may be filed 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 the Eligible Individual 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 the Eligible Individual's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Eligible Individual 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 the Eligible Individual until the date on which the Eligible Individual responds to the request for additional information.

If the information needed to process the claim is not submitted within one year from the date of service, the claim will not be considered and excluded from coverage.

Pre-Service Claims

A pre-service claim is a properly filed claim which must be preauthorized to receive full benefits from the Plan, such as inpatient hospital services (except emergency or maternity stays). 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 the Eligible Individual 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 the Eligible Individual's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Eligible Individual 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 the Eligible Individual until the date on which the Eligible Individual responds to the request for additional information.

If services 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 the life or health of the patient, or expose the patient 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 the 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. The Eligible Individual 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 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 Disability Income Claims

A claim for Weekly Disability Income 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 will provide 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 the Eligible Individual to make its decision, the Eligible Individual 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 the 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, Retiree, Dependent or other 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. A failure to submit a timely request for appeal will bar the right to further review of the matter, and the action of the Trustees (or the administrator acting for the Trustees) will be final and binding.

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.

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

REVIEW OF TRUSTEES' DETERMINATION

A claimant who remains dissatisfied with the Trustees decision on appeal may bring a civil action under ERISA § 502(a).

FILING CIVIL ACTION

Following exhaustion of the Trustees' Claim and Appeal Procedures, or following an adverse decision by the IRO, a claimant may bring a civil action under ERISA § 502(a). Any civil action must be brought within three years of the Trustees' issuance of a written decision on appeal. A failure to file a civil action within the three-year period will bar the right to further review of the appeal. The question on review of the Trustees' determination will be whether the Trustees' decision was an abuse of their discretion.

SOLE AND EXCLUSIVE PROCEDURES

The Plan's Claim and Appeal Procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected

by any action of the Trustees. The Claim and Appeal procedures must be exhausted prior to filing any legal action.

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 PPO Provider 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. Any payment in accordance with this provision shall discharge the obligation of the Trust hereunder.

AVAILABILITY OF TRUST 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 under the Plan 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 of Trustees 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, amend or eliminate Retiree coverages, 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 Eligible Individual or other individual has been paid or credited with more than he is entitled to under the Plan or under the law, the payment or credit will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Trust may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the Eligible Individual or other individual, or from the service provider, or it may offset future benefit payments due to the Eligible Individual or the Eligible Individual's family members by

the amount paid in error. The Trust may also take such further action as the Board shall determine.

MISREPRESENTATION

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the plan on account of such misrepresentation, as well as potential criminal liability.

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, Dependents, 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 CERTIFICATIONS

The Trust's privacy practices were effective April 14, 2003, and are administered in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR § 164. The Board of Trustees adopted the following provisions.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information ("PHI") has the same meaning in 45 CFR § 501.

REQUEST, USE AND DISCLOSURE OF PHI BY TRUSTEES

The Trustees are permitted to receive PHI from the Plan, and 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 involve 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 § 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 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

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.

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 website, ***www.ironworkerstrust.com.***

Right to Opt Out of Fundraising Communications. If the Trust participates in fund raising, you have the right to opt-out of all fundraising communications.

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.
PO 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.
PO 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.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

EFFECTIVE DATE

This Notice was effective April 14, 2003 and last amended effective September 11, 2013.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Name of Plan

This Plan is known as the Northwest Ironworkers 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.

7525 SE 24th Street, Suite 200

Mercer Island, WA 98040-2341

PO Box 34203
Seattle, WA 98124-1203

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 Disability Income, Dental, and Vision Benefits.

Type of Administration

This Plan is administered by the Board of Trustees, with the assistance of Welfare & 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 Disability Income and Vision benefits are provided directly from Trust assets. 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***. Amalgamated Life Insurance Company provides a policy of stop loss insurance for the Comprehensive Medical/Prescription Drug benefits.

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*
Jeff Ilenstine, Chairman Tri States Rebar Inc. 7208 E Indiana Ave Spokane, WA 99212-1287 (509) 922-5901	**Steve Pendergrass, Secretary** Ironworkers District Council of the Pacific NW 110 Main St, Suite 100 Edmonds, WA 98020-3180 (425) 771-4766
Ken Carr Carr Construction, Inc. 2718 SW Water Ave Portland, OR 97201-4810 (503) 235-3514	**Jason Fussell** Ironworkers Local No. 29 11620 NE Ainsworth Circle, Suite 200 Portland, OR 97220-9016 (503) 774-0777

EMPLOYER TRUSTEES	*UNION TRUSTEES*
Robert Decker Garco Construction 4114 E. Broadway Ave. Spokane, WA 99202-4531 (509) 710-8114	**Greg Gales** Ironworkers Union No. 14 PO Box 912 Waitsburg, WA 99361-0912 (509) 845-5226
Dick DeVries Western States Steel Erection Co., LLC 1119 Noblewood Dr Billings, MT 59101-6977 (406) 839-5941	**Robert (Bob) Korth** Ironworkers Local No. 86 4550 S 134th Place, Suite 102 Tukwila, WA 98168-3238 (206) 248-4246
Allan Harding Iron, Inc. 7108 S. Alton Way, Suite M Centennial, CO 80112 (303) 477-5029	**Anthony Ladd** Ironworkers Local No. 751 8141 Schoon St Anchorage, AK 99518-3047 (907) 563-4766
Dave Harrison Skanska USA Building 221 Yale Ave N, Suite 400 Seattle, WA 98109-5490 (206) 494-5404	**Christopher McClain** Ironworkers Local No. 86 4550 S 134th Place, Suite 102 Tukwila, WA 98168-3238 (206) 248-4246
Kevin Koester Apex Steel 935 Kirkland Ave Kirkland, WA 98033-6326 (425) 861-9520	**John Morse** Ironworkers Local No. 14 16610 E Euclid Ave Spokane, WA 99216-1808 (509) 927-8288
Kevin Patterson Schuff Steel 3003 N. Central Ave, Suite 700 Phoenix, AZ 85012 (971) 235-4309	**Rodney Sprinkle** Ironworkers Local No. 29 11620 NE Ainsworth Circle, Suite 200 Portland, OR 97220-9016 (503) 915-1447

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 ERISA RIGHTS

As a participant in the Northwest Ironworkers 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.

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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue,

N.W., Washington, D.C. 20210. The Seattle regional office of the Employee Benefits Security Administration is located at: 300 Fifth Avenue, Suite 1110, Seattle, WA 98104, telephone number (206) 757-6781

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

www.IronworkersTrust.com

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